East Lancashire Hospitals
NHS Trust

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

Safe

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East Lancashire Hospitals NHS Trust

TRUST BOARD MEETING (OPEN SESSION)

13 MARCH 2019, 13.00

SEMINAR ROOM 6, ROYAL BLACKBURN HOSPITAL

AGENDA

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

OPENING MATTERS				
TB/2019/028	**Chairman's Welcome**	Chairman	v	
TB/2019/029	**Open Forum** To consider questions from the public	Chairman	v	
TB/2019/030	**Apologies** To note apologies.	Chairman	v	
TB/2019/031	**Declaration of Interest Report** To note the directors register of interests and note any new declarations from Directors.	Chairman	d✓	Information/ Approval
TB/2019/032	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 9 January 2019.	Chairman	d✓	Approval
TB/2019/033	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2019/034	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2019/035	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2019/036	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information
TB/2019/037	**CQC Inspection Report**	Chief Executive	p✓	Information
QUALITY AND SAFETY				
TB/2019/038	**Patient Story** To receive and consider the learning from a patient story.	Director of Nursing	p	Information/ Assurance
TB/2019/039	**Corporate Risk Register** To receive an update on the Corporate Risk Register and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Medical Director	d✓	Information
TB/2019/040	**Board Assurance Framework** To receive an update on the Board Assurance Framework and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Medical Director	d✓	Approval

TB/2019/041	**Serious Incidents Requiring Investigation Report** To receive information in relation to incidents in month or that may come to public attention in month and be assured about the associated learning.	Medical Director	d✓	Information/ Assurance
STRATEGY				
TB/2019/042	**National NHS Staff Survey Results**	Director of HR and OD	d✓	Information
ACCOUNTABILITY AND PERFORMANCE				
TB/2019/043	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed, with items being raised by exception: • Introduction (Chief Executive) • Performance (Director of Operations) • Quality (Medical Director) • Workforce (Director of HR and OD) • Safer Staffing (Director of Nursing) • Finance (Director of Finance)	Executive Directors	d✓	Information/ Assurance
TB/2019/044	**Flu Vaccination Compliance Report 2018/19**	Director of HR and OD	d✓	Information/ Assurance
TB/2019/045	**7 Day Services Report** (February 2019 Submission)	Medical Director	d✓	Information/ Approval
GOVERNANCE				
TB/2019/046	**Finance and Performance Committee Update Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information/ Assurance
TB/2019/047	**Audit Committee Update Report** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information/ Assurance
TB/2019/048	**Trust Charitable Fund Update Report**	Committee Chair	d✓	Information/ Assurance
TB/2019/049	**Remuneration Committee Information Report**	Chairman	d✓	Information
TB/2019/050	**Trust Board Part Two Information Report** To note the matters considered by the Committee in discharging its duties	Chairman	d✓	Information
FOR INFORMATION				
TB/2019/051	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2019/052	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2019/053	**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	Chairman	v	

	attention? • Is the Board shaping a healthy culture for the Board and the organisation and holding to account? • Are the Trust's strategies informed by the soft intelligence from local people's needs, trends and comparative information? • Does the Board give enough priority to engagement with stakeholders and opinion formers within and beyond the organisation?			
TB/2019/054	**Date and Time of Next Meeting** Wednesday 8 May 2019, 1.00pm, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.	Chairman	v	

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 31

13 March 2019

Purpose Information / Approval

Title	Declaration of Interest Report
Author	Mrs A Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary

Summary: Section 5 of the Trust's Standing Orders describes the duties and obligations of Board Members in relation to declaring interests. The Register is available for public inspection. Following a recommendation from the audit carried out by the Mersey Internal Audit Agency (MIAA) Anti-Fraud Specialist, it is presented 3 times a year to the Trust Board. The presented Directors' Register of Interest will be included in the Trust's Annual Report.

Recommendation: The Board is asked to note the presented Register of Directors' Interests for inclusion in the Annual Report. Board Members are invited to notify the Company Secretary of any changes to their interests within 28 days of the change occurring.

Report linkages

Related to key risks identified on assurance framework	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	No
The Trust would be in breach of its own Standing Orders and its regulatory obligations should it omit to have proper arrangements in place for the Directors' declarations of interests.			
Equality	No	Confidentiality	No

(31) Declaration of Interest Report

Directors Register of Interests

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

Name and Title	Interest Declared	Date last updated
Professor Eileen Fairhurst Chairman	• Professor at Salford University (until 21.12.2017). • Trustee, Beth Johnson Foundation (until 31.03.2017). • Chairman of Bury Hospice (from 23.01.2017 until 19.06.2018) • Member of the Learning, Training & Education (LTE) Group and Higher Education Board (until 12.3.2017). • Chairman of the NHS England Performers Lists Decision making Panel (PDLP) (until November 2018)	17.01.2019
Kevin McGee Chief Executive	• Spouse is the Director of Finance and Commercial Development at Warrington and Halton Hospitals NHS Foundation Trust • Honorary Fellow at University of Central Lancashire	09.01.2019
Patricia Anderson Non-Executive Director	• Accountable Officer at Wigan Borough CCG (until 31.05.2018). • Public Sector Director on One Partnership (LIFTCO) (January 2015 until 31.05.2018) • Spouse is a recently retired Consultant Psychiatrist formerly employed at Mersey Care NHS Trust	09.01.2019
John Bannister Director of Operations	Positive Nil Declaration.	09.01.2019

Name and Title	Interest Declared	Date last updated
Stephen Barnes Non-Executive Director	• Chair of Nelson and Colne College. • Member of the National Board of the Association of Colleges (from 02.03.2017). • Vice Chair of the National Council of Governors of the Association of Colleges (from 02.03.2017).	09.01.2019
Martin Hodgson Director of Service Development	Positive Nil Declaration.	09.01.2019
Christine Hughes Director of Communications and Engagement	Positive Nil Declaration.	09.01.2019
Naseem Malik Non-Executive Director	• Independent Assessor- Student Loans Company- Department for Education - Public Appointment. • Fitness to Practice, Panel Chair: Health & Care Professions Tribunal Service (HCPTS) - Independent Contractor. • Investigations Committee Panel Chair at Nursing & Midwifery Council (NMC) - Independent Contractor. • NED and SID at Lancashire Care NHS Foundation Trust (until 29.07.2016). • Worked for Blackburn Borough Council (now Blackburn with Darwen Borough Council) in 1995/6. • NED at Blackburn with Darwen Primary Care Trust (from 2004 until 2010). • Relative (first cousin) is a GP in the NHS (GP Practice).	09.01.2019

Name and Title	Interest Declared	Date last updated
	• Relative (brother-in-law) is a Mental Health Nurse.	
Kevin Moynes Director of Human Resources & Organisational Development	• Spouse is a very senior manager at Health Education England (from 02.10.2017) • Governor of Nelson and Colne College (until 01.02.2018).	09.01.2019
Christine Pearson Director of Nursing	• Spouse is the Head of Medicines Optimisation, at Heywood, Middleton & Rochdale Clinical Commissioning Group	09.01.2019
Damian Riley Executive Medical Director	• National Clinical Assessment Service (NCAS) Clinical Assessor and Trainer - small amounts of work are undertaken in this role and funded by NCAS. • Member of British Medical Association Registered with General Medical Council. • Spouse is and employee - GP in Dyneley House Surgery, Skipton. • Sister is an employee of pharmaceutical company Novartis. • Spouse is a locum GP and may undertake work in local GP practices. There is potential for bias affecting relationships and interactions with CCGs and commissioners of primary care. • Spouse may undertake work in PWE practices, and ELHT has a financial commitment to PWE consortium.	09.01.2019
Richard Slater Non-Executive Director (Retired from the Board on 31 December 2018)	Positive Nil Declaration	31.12.2018

Name and Title	Interest Declared	Date last updated
Richard Smyth Non-Executive Director	• Consultant Solicitor with DLA Piper UK LLP Law Firm. DLA Piper undertakes work for the NHS. • Spouse is a Lay Member of Calderdale CCG. • Spouse is a Patient & Public Involvement and Engagement Lay Leader for the Yorkshire and Humber Patient Safety Translational Research Centre, based at Bradford Institute for Health Research, Bradford Royal Infirmary. • Sister is an advanced clinical nurse practitioner with Pennine Acute Hospitals Trust based at the Royal Oldham hospital. • Member of the Law Society.	09.01.2019
Professor Michael Thomas Associate Non-Executive Director	• Vice-Chancellor of UCLAN (to 30.11.2018).	09.01.2019
Michael Wedgeworth Associate Non-Executive Director	• Honorary Canon of Blackburn Cathedral in 2003 • Assistant Priest at Blackburn Cathedral since 1995. • Member of the Lancashire Health and Well-Being Board (from 2011 to 2017). • Elected Public Governor at Lancashire Care Foundation Trust and Chair of the Patient Experience Group (until April 2017). • Chair of Healthwatch Lancashire (until December 2017). • Healthwatch Representative on NHS governing bodies and Trusts (since 2015). • Member of the Lancashire and South Cumbria Sustainability and Transformation	09.01.2019

Name and Title	Interest Declared	Date last updated
	Programme Board and its workstream on Acute and Specialised Services (since 2015). • NED Representative for the Pennine Lancashire system on the Lancashire and South Cumbria Sustainability and Transformation Partnership Board (now the Integrated Care Organisation Board).	
David Wharfe Non-Executive Director	• Trustee of Pendleside Hospice (from June 2018)	09.01.2019
Jonathan Wood Director of Finance	• Spouse is the Director of Finance at the Oldham Care Group Hospital, part of Pennine Acute Hospitals NHS Trust. Pennine Acute Hospitals currently form part of the 'hospital chain' with Salford Royal Hospitals Foundation Trust. • Chair of Blackburn Cathedral Finance Committee	09.01.2019

Angela Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary, 21 February 2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 32

13 March 2019

Purpose Action

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

Summary: The minutes of the previous Trust Board meeting held on 9 January 2019 are presented for approval or amendment as appropriate.

Report linkages

Related strategic aim and corporate objective	As detailed in these minutes
Related to key risks identified on assurance framework	As detailed in these minutes

Impact

Legal	Yes	Financial	No
Maintenance of accurate corporate records			
Equality	No	Confidentiality	No

Previously considered by: NA

(32) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 1.00PM, 9 JANUARY 2019

MINUTES

PRESENT

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

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Associate Director of Corporate Governance/ Company Secretary	
Mrs C Hornby	ICG Quality & Safety Team Administrator	For Item TB/2019/010
Miss K Ingham	Corporate Governance Manager/Assistant Company Secretary	Minutes
Mrs M Montague	Business Manager, Integrated Care Group	For Item TB/2019/011
Mrs S Ridehalgh	Patient Experience Facilitator	For Item TB/2019/010
Mrs N Robinson	ICG Quality and Safety Lead	For Item TB/2019/010
Ms E Schofield	Deputy Director of HR and OD	For Item TB/2019/018
Mrs G Warburton	Neuro-Rehabilitation Lead	For Item TB/2019/011
Mrs A Roberts	Neuro-Rehabilitation Service Co-Ordinator	For Item TB/2019/011
Mrs S Grimshaw	Occupational Therapy Team Leader	For Item TB/2019/011

APOLOGIES

None to record

TB/2019/001 CHAIRMAN'S WELCOME

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

TB/2019/002 OPEN FORUM

There were no questions or queries raised by members of the public.

TB/2019/003 APOLOGIES

Apologies were received as recorded above.

TB/2019/004 DECLARATIONS OF INTEREST REPORT

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

Directors approved the Directors' Register of Interests, pending the removal of Professor Fairhurst's chairmanship of the NHS England Performers Lists Decision-Making Panel.

RESOLVED: Directors approved the Directors' Register of Interests pending the aforementioned change.

TB/2019/005 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 14 November 2018 were approved as a true and accurate record.

TB/2019/006 MATTERS ARISING

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

TB/2019/007 ACTION MATRIX

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

TB/2018/114: Action Matrix – Mrs Pearson confirmed that the Patient Participation Panel recruitment event will be re-run later in the month due to the low numbers of people who attended the initial session.

TB/2018/122 Lancashire and South Cumbria Integrated Care System Memorandum of Understanding – Mr McGee reported that the ICS was increasingly faced by ne policy changes. It had been agreed that a small number of areas would be used as practical examples of collaborative working, the first one being the stroke services.

RESOLVED: The position of the action matrix was noted.

TB/2019/008 CHAIRMAN'S REPORT

Professor Fairhurst reported that she had attended the Board meeting at the NHS Leadership Academy (North West) in November in addition to her usual attendance at the NHSI Chairs' meeting. Directors noted that Professor Fairhurst had attended a Joint Research Day which was held on the UCLan campus at Burnley. She commented that it was pleasing to see the involvement of Trust staff at the event and the clear impact that research has on patient care and experience.

Professor Fairhurst provided Directors with a summary of the various events that she had attended over the Christmas period, including the Volunteers' Christmas Party at Burnley General Teaching Hospital. She went on to report that she had attended the Celebration Event that the Trust had arranged with the Princes Trust; some of the individuals who attended the session are now either in full employment with the Trust or on the ELHT Staff Bank.

Directors noted that Mr Mark Youlton had retired from his post as accountable officer for East Lancashire Clinical Commissioning Group (CCG) and recognised the achievements that he had made in his time with the organisation. Professor Fairhurst confirmed that Mr Richard Slater had come to the end of his appointed term with the Trust as a Non-Executive Director on 31 December 2018 and took the opportunity to thank him for his contribution to the Trust during his tenure and wished him well for the future.

Professor Fairhurst commented that she was pleased to be working with NHS Improvement on the new programme for the development of aspiring Chairs. Her role will involve mentoring participants.

RESOLVED: Directors received and noted the update provided.

TB/2019/009 CHIEF EXECUTIVE'S REPORT

Mr McGee presented his report to Directors and highlighted a number of items, including the launch of the NHS Long Term Plan, the announcement of Sir David Behan as the new Chair of Health Education England, the merger of NHS Improvement and NHS England and the associated development of the various regional teams. Directors noted that the Integrated Care Partnership (ICP) has already extended the offer of a visit to the newly appointed Regional Director, Mr Bill McCarthy.

Mr McGee went on to provide a summary of the Trust specific work that had been undertaken since the last meeting, including the refurbishment of Ward 19 at Burnley General Teaching Hospital, the Trust's success at the recent HSJ awards and Professor Fairhurst's award of an Honorary Doctorate at UCLan for her contribution towards the development of the Medical School.

Four SPEC Panels have been held as part of the Nursing Assessment Performance Framework (NAPF) since the November Trust Board meeting. All four wards were successful at the panel stage and have been put forward to the Board for the award of a silver ward status. Directors agreed to award the following wards 'Silver Ward Status' following three successful 'green rated' NAPF visits and a successful SPEC panel: Marsden Ward at Pendle Community Hospital, the Coronary Care Unit at the Royal Blackburn Teaching Hospital, the Critical Care Unit at the Royal Blackburn Teaching Hospital and Ward C5 at the Royal Blackburn Teaching Hospital.

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

Directors approved the 'Silver Ward Status' for the Marsden Ward, the Coronary Care Unit, the Critical Care Unit and Ward C5 and congratulated them on their achievement.

TB/2019/010 PATIENT STORY

Mrs Pearson introduced Mrs Hornby, who is a member of staff within the Integrated Care Group. She was in attendance at the Board to share her experience of being a close family member of a patient being treated at the Trust.

Mrs Hornby reported that prior to his death; her brother-in-law Peter had received chemotherapy treatment at the Trust for oesophageal cancer. She provided a brief overview of Peter's journey from the initial appointment with his GP, through diagnostic testing and receiving the news that he had an inoperable cancer. She commented that whilst finding out about his diagnosis was difficult, it was made more unpleasant as a result of the consultant being very direct when he broke the news to them. He used the phrase "…. and we aren't

looking for a cure". The bluntness of the language used left the family feeling hopeless until they saw the Oncologist to discuss the treatment options.

Mrs Hornby went on to report that once Peter and his family had met with the Oncologist and the Cancer Nurses who would be involved in his treatment and care, they all felt far more positive and almost uplifted, despite the diagnosis remaining the same. Directors noted that the team involved in Peter's care carried out a great number of small acts of kindness and continued to do so during the three and a half years that he received treatment. Mrs Hornby commented that their treatment as a family was no different from that anyone would receive. It was to be applauded that everyone received such a high level of service and care.

Mrs Hornby reported that following Peter's death his family wanted to give something back to the department and, with the help of the Trust's Charity Fundraising Manager had organised an event which raised in excess of £2,000.

In response to Dr Riley's question, Mrs Hornby confirmed that neither she nor other members of the family had the opportunity to give any feedback to the Consultant who gave Peter his diagnosis. It was agreed that Dr Riley would ensure that this matter was addressed outside the meeting.

Mrs Pearson thanked Mrs Hornby for sharing her family's experience and asked whether the family had felt that they had sufficient information and support from the Trust. Mrs Hornby confirmed that the care staff were most welcoming and approachable and actively encouraged them to ask questions.

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

It was agreed that Dr Riley would ensure that the issue around the way in which difficult news was delivered to patients is addressed with the Oncology Team.

TB/2019/011 NEURO-REHABILITATION SERVICES

Mrs Warburton gave a presentation to the Directors regarding the development of the Trust's Neuro-Rehabilitation service. Her presentation highlighted the journey to become an integrated service. In addition, she provided an example of the standard care pathway and patient journey, the work being undertaken to progress the integration of the service and the challenges being faced. Mrs Warburton provided some examples of the continuous improvement work which is being undertaken in the service, including development of the competencies for Band 5 and 6 staff, developing improved research links with UCLan and improvement of the best practice network.

In response to Mr McGee's question, Mrs Montague confirmed that the team were proud of their achievements made within the service in the last 18 months and confirmed that work would continue to develop the service further.

Mrs Warburton confirmed that the service currently worked closely with the hyper acute rehabilitation service at Lancashire Teaching Hospitals NHS Foundation Trust and that the service occasionally accepts patients from out of the area, depending upon bed availability.

Mrs Grimshaw commented that one of the issues still to be addressed is the early input from social services which can have an impact upon the discharge of patients.

Professor Fairhurst thanked the staff for attending to give their presentation and recognised advances made in developing and improving the service.

RESOLVED: Directors received the presentation and noted its content.

TB/2019/012 ELECTRONIC PATIENT REFERRAL SYSTEM

Mr Bannister referred Directors to the previously circulated report and provided an overview of the work that had been undertaken to date to move away from a paper based referral system. He confirmed that the Trust had achieved this by the required date of October 2018. The work was carried out in two stages, the first stage being to move all referrals for suspected cancer across to the electronic system, with the second stage involving the roll-out of the system to all other referrals.

Directors noted the work which had been undertaken and recognised that reporting of compliance would be carried out through the Scheduled Care Board.

In response to Miss Malik's question, Mr Bannister confirmed that, should there be any referrals coming through via the old system, they would be accepted on the understanding that an electronic referral be submitted promptly.

RESOLVED: Directors received the report and noted its contents.

TB/2019/013 CORPORATE RISK REGISTER (CRR)

Dr Riley referred Directors to the previously circulated report and confirmed that two risks had been identified for inclusion on the register. They were noted to be: *Risk ID 4353: potential loss of images if equipment should fail or be stolen and Risk ID 7330 (aggregated risk) inability to identify, track & monitor the cohorts of women and newborns who require and have screening due to lack of an end-to-end IT System for Maternity.*

In response to Mr Smyth's comment relating to the actions to be carried out for *Risk ID 1810,* Dr Riley confirmed that the date at the end of the second bullet point was incorrect and

should have been replaced with the word 'ongoing'.

Directors discussed Risk *ID 5791: (Aggregated risk) failure to adequately recruit to substantive nursing posts may adversely impact on patient care and finance*. It was agreed that the likelihood score included on the target rating was higher than the likelihood score on the live register, which could not be correct and therefore needed to be reviewed.

In response to Professor Thomas's comments relating to *Risk ID 4353: Potential loss of images if equipment should fail or be stolen*, it was agreed that the information included in the 'hazard' and 'associated risks' columns should be revised to adequately differentiate the hazard and associated risks. Dr Riley confirmed that the hazard was the potential loss of data.

Directors received the report, noted its contents and approved the proposed document, pending the aforementioned corrections.

RESOLVED: **Directors were assured by the data presented and approved the CRR, pending the following amendments:**

- **Risk ID 1810 - the year denoted in the actions will be replaced with the word 'ongoing'**
- **Risk ID 5791 – the likelihood scores of the target score and current rating will be reviewed**
- **Risk ID 4353 – the information included in the 'hazard' and 'associated risks' columns will be revised to adequately differentiate the hazards and risks.**

TB/2019/014 BOARD ASSURANCE FRAMEWORK

Dr Riley presented the report and confirmed that the document now included whether the assurances were gained from internal or external sources, as per the request at the last Board meeting in November 2018.

He confirmed that there was a proposal to increase the risk score of *BAF risk 1: Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives* to 20 based on an increased likelihood of the risk materialising (likelihood 5 x consequence 4). Directors agreed to the proposed increase of the risk score. Dr Riley went on to suggest that the rating of *risk 2: recruitment and workforce planning fail to deliver the Trust objectives* and *risk 5: the Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements* should also be reviewed with a

view to increasing the score for BAF risk 2 and decreasing the score for BAF risk 5.

Mr Barnes agreed that the risk relating to workforce should be increased to reflect the two workforce risks included on the corporate risk register and suggested that a risk rating of 20 was adequate.

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

It was agreed that BAF risks 2 (workforce) and 5 (constitutional standards) would be considered further, with a view to revising the risk scores, for the next Trust Board meeting.

TB/2019/015 SERIOUS INCIDENTS REQUIRING INVESTIGATION REPORT

Dr Riley referred Directors to the previously circulated report and confirmed there had been 19 incidents meeting the criteria for reporting on the Strategic Executive Information System (STEIS) in the months of October and November 2018; all have had Duty of Candour (DOC) completed where necessary. He went on to report that there had been a number of incidents meeting internal Trust thresholds for internal investigations but had not required reporting on the STEIS system; DOC had been completed where necessary but there were three occasions where DOC had not been completed within the required timeframe.

Mr Wedgeworth commented that the overall report seemed to have several incidents being classified as 'catastrophic'. In response, Dr Riley provided an overview of the National Patient Safety Agency classifications and the way in which they should be applied. He confirmed that a number of the 'catastrophic' ratings related to non-clinical issues.

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

TB/2019/016 PLANNING DAY 2019/20 THEMES

Mr Hodgson reported that the Trust had held a planning day on 4 December 2018 with a range of partner organisations from across the Pennine Lancashire Integrated Care Partnership (ICP). He went on to confirm that the Trust is required to submit a one year business plan followed by a five year system-wide plan covering the Integrated Care System (ICS) and the ICP. Directors noted the themes that had been discussed at the planning day and where each theme aligned with Trust, IPC and/or ICS priorities.

In response to Mr Wedgeworth's question, Mr Hodgson confirmed that there was nothing within the Trust's existing Clinical Strategy which was at odds with the newly published NHS Long Term Plan. Mr McGee agreed and commented that the Trust's strategy supports the

content of the Ten Year Plan. Mr Wharfe asked whether there was a need for the Trust to refresh the existing Clinical Strategy to include references to working across the ICP and ICS. Dr Riley suggested that a refresh may be beneficial and added that at the time of writing the Strategy, the ICP and ICS were not in existence.

Directors went on to briefly discuss the emphasis that the Ten Year Plan had placed on the prevention agenda and the requirement for the NHS to take a greater role in it.

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

TB/2019/017 **EQUALITY, DIVERSITY AND INCLUSION**

Mr Moynes referred Directors to the previously circulated document and provided an overview of the content. He confirmed that the Trust remains committed to improving the experience of staff that have any of the seven protected characteristics. He reported that BME staff, experience poorer treatment than other members of staff against a range of measures. Mr Moynes highlighted the action plan that was appended to the report and provided an overview of the progress made since the last time the report was presented to the Board, including the roll out of interview coaching sessions for BME staff, the improved 'holding to account' process for staff and managers, and the planned Festival of Difference which is scheduled to take place in April 2019.

Mr Moynes went on to report that the Trust has been invited to participate in a leadership development programme with the NHS North West Leadership Academy to develop a Shadow Board which will help the Trust identify and develop its future leaders, to create a more diverse leadership pool and to provide additional input and insight into existing Trust Board issues. He explained that the Shadow Board would sit completely outside the Trust's governance structures and would have no decision making powers.

Mr McGee suggested that the Shadow Board was an exciting opportunity for the Trust and stated that he was in support of the Trust taking part. He queried the timescales involved and suggested that the initial timescale of May 2019 could be revised.

In response to Mr Smyth's question regarding the required time commitment from the Trust Board members, Mr Moynes confirmed that there was only a requirement for the Chairman/nominated Non-Executive Director who would chair the meeting and the Company Secretariat to circulate papers to the members of the Shadow Board.

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

It was agreed that Mr Moynes would seek clarification as to whether there was an opportunity to revise the go live date for

the North West Leadership Academy programme.

TB/2019/018 CULTURE AND LEADERSHIP UPDATE

Mr Moynes referred Directors to the previously circulated slide deck and provided an overview of the programme. He confirmed that the Trust was entering phase two of the work (design phase) to develop a positive culture and display excellent leadership. He confirmed that the work would be closely linked to the Trust's Health and Wellbeing Strategy and it adopted the LEAN principles embedded in the Vital Signs programme. The presentation included a recap of the focus for the first year of the programme and the vision for the Trust's workforce. In addition, the presentation went on to explain the development of the Trust's approaches to approval and implementation, an overview of the eight priority areas, including standards of behaviour, talent management and quality appraisal and a schedule for delivery of the eight priorities.

Mr Bannister suggested that there were times when it was possible to lose sight of the work that was taking place and its importance in the wider context. He went on to suggest that there were areas where the culture and leadership were exemplary, but that it was not replicated across the entire Trust. Mr McGee responded that the highest performing organisations within the NHS have standardised ways of working, and there was a need to embed such methods across the Trust.

RESOLVED: Directors noted the update provided.

TB/2019/019 INTEGRATED PERFORMANCE REPORT

Mr McGee introduced the report to the Directors and confirmed that the report related to the period to the end of December 2018. He went on to suggest that there was a need to review the way in which the report was presented and discussed at the Board and proposed that only high level reporting took place with an emphasis on questions and answers.

He went on to confirm that the Trust had been challenged in terms of demand throughout December and into January. He thanked staff on behalf of the Board for their commitment to the Trust and for delivering safe, personal and effective care despite the pressures.

a) Performance

Mr Bannister reported that the majority of the performance metrics had been discussed at the closed session of the Board earlier in the day and there was nothing further to report to the Board. In response to Dr Riley's question, Mr Bannister confirmed that the Trust had

met the 62 day cancer target for the month of November; however this position could change following the conclusion of data validation.

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

b) Quality

Dr Riley reported that there had been one Never Event identified; however, it was a historical case and had been reclassified as a Never Event since the last meeting. He provided an overview of the incident and confirmed that it had been discussed in greater detail at the closed Board session earlier in the day.

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

c) Workforce

Mr Moynes reported that staff sickness was 5.1% for the month of December, which was in line with the same period in 2017. He reminded Directors that the nominations for the Trust's STAR Awards remained open, but would close in the coming weeks.

Mr Wharfe stated that there had been a comprehensive discussion at the last Finance and Performance Committee regarding the need for more emphasis on workforce reporting, development of suitable metrics, particularly in relation to bank and agency usage/spend and sickness rates. He went on to suggest that this was particularly important when considered in relation to the discussions held earlier in the meeting relating to the Board Assurance Framework and the potential move away from a detailed discussion of these metrics at the Board.

Mr McGee agreed that there needed to be an increase in the reporting of workforce metrics and suggested that there be a quarterly focus on workforce at future Finance and Performance Committee meetings.

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

d) Safer Staffing

Mrs Pearson reported that NHS England have published further guidance following on from the Hard Truths document with which the Board members were familiar. She went on to suggest that the Quality Committee receive the required reporting that is set out in the

report. Directors agreed that that was a sensible approach.

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

e) Finance

Mr Wood confirmed that the majority of the financial performance reporting had taken place within the closed session of the Board and there was no further update to provide.

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

Mrs Hughes suggested that the Board may wish to consider the implementation of social media being used at future Trust Board meetings, perhaps in the form of a live tweet stream. She suggested that a member of the Trust's Communications Team could attend the meetings and post tweets relating to the Board papers and resultant questions asked/answered. Directors discussed this proposal and it was agreed that further discussion on the matter would take place outside the meeting.

Professor Fairhurst acknowledged the significant reduction in the number of complaints that had been received and remained open and thanked Mrs Pearson and the Patient Experience and Customer Care Teams.

Directors discussed the possible ways in which the Integrated Performance Report could be meaningfully reported to the Board without revisiting all the information and discussions that had taken place at the various Board sub-committees prior to the meeting. Mr Wood suggested that there was a need to escalate risks from the various sub-committees, but agreed that there was a need to review the balance of the discussions held at the sub-committees and the Board.

RESOLVED: **Executive Directors will consider how best to present the Integrated Performance Report at future meetings of the Board to ensure that the necessary information can be shared and adequate discussion and debate can take place.**

Directors agreed to consider the suggestion to include some form of social media coverage of the Board meetings in the future.

TB/2019/020 FINANCE AND PERFORMANCE COMMITTEE UPDATE REPORT

Mr Wharfe presented the report and provided an overview of the discussion held at the meeting. Directors briefly discussed the presentation of the Integrated Performance Report to the Committee and confirmed that the detailed discussion about the document should happen at the Committee with exception reporting to the Board.

RESOLVED: Directors received the report and noted its content.

TB/2019/021 QUALITY COMMITTEE UPDATE REPORT

Mrs Anderson presented the report and highlighted a number of items that had been discussed by the Committee, including the Customer Experience Annual Report, the significant reduction in falls and the Mental Health 12 Hours Breach Summary Report. In relation to the 12 hours report Mrs Anderson confirmed that the Committee had undertaken significant discussions on the matter and had felt strongly that a system wide resolution was required.

Dr Riley highlighted the Committee's receipt of an assurance report relating to Uro-Gynae Vaginal Mesh Implants following a letter received by Medical Directors from NHS Improvement and NHS England. The assurance report outlined the ways in which the Trust will monitor the use of vaginal mesh implants and review the internal guidance developed. He confirmed that NHSI/E requested that the item be discussed at Trust Board, but due to the timeframes involved it was not possible. Hence, it had been presented to the Committee instead.

RESOLVED: Directors received the report and noted its content.

TB/2019/022 TRUST CHARITABLE FUNDS COMMITTEE UPDATE REPORT

a) Trust Charitable Funds Update Report

Mr Barnes presented the report and provided a summary of the discussions that had taken place at the last meeting of the Committee. He highlighted the continuation of fundraising as part of the Million Pound Appeal.

Directors noted that progress was being made in terms of engaging with businesses to increase corporate donations.

b) Charity Annual Accounts

This item was considered with the Board acting as the Corporate Trustee for the ELHT&Me charity.

Mr Barnes presented the annual accounts for the Charity and provided an overview of the content. Directors noted that the accounts pertained to the 2017/18 financial year. Mr Wood reported that Grant Thornton, external auditors had completed their audit of the accounts and had not sought additional clarification on any of the content.

The Corporate Trustee approved the accounts for submission in line with the required timeframe.

RESOLVED: **The accounts were approved by the Corporate Trustee for submission, in line with the required timeframe.**

TB/2019/023 TRUST BOARD PART TWO INFORMATION REPORT

The report was presented to the Board for information.

TB/2019/024 ANY OTHER BUSINESS

There were no matters of business raised under this item.

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

TB/2019/025 OPEN FORUM

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

TB/2019/026 BOARD PERFORMANCE AND REFLECTION

Professor Fairhurst invited comments and observations about the meeting from the Directors. Mr Hodgson suggested that the building blocks were in place to develop a healthy culture for the Board and wider organisation. He went on to comment that the Shadow Board referenced under item TB/2019/017 would be beneficial for future leaders. Mrs Anderson commented that the patient story and Neurorehabilitation presentation were evidence of the way in which services have developed for the benefit of the patients. Mr Bannister echoed the comments made by Mrs Anderson in relation to the Neurorehabilitation service and added that the cultural change that has taken place within the team should not to be underestimated.

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

TB/2019/027 DATE AND TIME OF NEXT MEETING

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

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 34

13 March 2019

Purpose Information

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

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2018/114: Action Matrix	*Board Performance and Reflection:* Mrs Pearson to provide an update on the open session and launch of the Patient Panel	Director of Nursing	March 2019	Verbal Report
TB/2019/010: Patient Story	It was agreed that Dr Riley would ensure that the issue around the way in which difficult news was delivered to patients is addressed with the Oncology Team.	Medical Director	March 2019	Verbal Report
TB/2019/013: Corporate Risk Register (CRR)	The following amendments will be made to the Corporate Risk Register: • Risk ID 1810 - the year denoted in the actions will be replaced with the word 'ongoing' • Risk ID 5791 – the likelihood scores of the target score and current rating will be reviewed • Risk ID 4353 – the information included in the 'hazard' and 'associated risks' columns will be revised to adequately differentiate the hazards and risks.	Medical Director	March 2019	Agenda Item March 2019
TB/2019/014: Board Assurance Framework	It was agreed that BAF risks 2 (workforce) and 5 (constitutional standards) would be considered further, with a view to revising the risk scores, for the next Trust Board meeting.	Executive Directors	March 2019	Agenda Item March 2019

Item Number	Action	Assigned To	Deadline	Status
TB/2019/017: Equality, Diversity and Inclusion	It was agreed that Mr Moynes would seek clarification as to whether there was an opportunity to revise the 'go live' date for the North West Leadership Academy programme.	Director of HR and OD	March 2019	Verbal Report
TB/2019/019: Integrated Performance Report	Executive Directors will consider how best to present the Integrated Performance Report at future meetings of the Board to ensure that the necessary information can be shared and adequate discussion and debate can take place. Directors agreed to consider the suggestion to include some form of social media coverage of the Board meetings in the future.	Executive Directors Executive Directors	March 2019 March 2019	Verbal Report Verbal Report

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 36

13 March 2019

Purpose Information

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

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

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

Report linkages

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

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

CEO Report

March 2019

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

One - National Headlines

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

NHS App begins public rollout

After successful testing with more than 3,000 patients across 30 GP practise in England, the NHS App has started its public rollout.

Once a GP practice is connected, patients will be able to use the NHS App to:

- book and manage appointments at their GP practice
- order their repeat prescriptions
- securely view their GP medical record
- check their symptoms using NHS 111 online and the health A-Z on the NHS website
- register as an organ donor
- choose whether the NHS uses their data for research and planning

The app will figuratively place the NHS into patient's pockets, empowering them to have more control over their own healthcare, and give greater access to services. Most practices will go live between April and June 2019, with the NHS App expected to be fully rolled out to practices and patients by 1 July 2019.

Celebrating a decade of improved patient outcomes

Principle health leaders are celebrating ten years of the surgical safety checklist, which has saved countless lives and improved outcomes for patients in England and around the world. Launched by the World Health Organisation in June 2008, with substantial input from UK clinicians, the checklist was mandated for use in the NHS in January 2009. It is now in regular use across the UK, as well as worldwide. The success of the checklist has led to further

improvements and similar checklists being used in other clinical areas, including maternity, emergency care, and intensive care units.

The simple 19 item tool addresses serious and avoidable surgical complications. During the pilot stage the rate of major inpatient complications dropped from 11% to 7%, and the inpatient death rate following major operations fell from 1.5% to 0.8%.

Ten years on the checklist continues to form the basis of improvement in safety in hospitals, with surveys consistently showing patient's strong support.

Uncertainty around 'no deal' for leaving the EU

NHS Trusts are continuing to prepare for the possibility of a 'no deal' exit from the EU. Areas of concern are: supply of medicines and devices, supplies of goods and services, workforce and research and development. The impact of a 'no deal' exit on the health and adult social care sector is not limited to these areas, and the Department of Health and Social Care (DHSC) is also developing contingency plans to mitigate risks in other areas.

In preparation for a 'no deal' exit, the DHSC, with the support of NHS England and Improvement, and Public Health England, has set up a national Operational Response Centre. It will be the centre's responsibility to issue EU Exit-related information across the system. Trusts have been urged to prepare their own contingency plans in line with DHSC guidance.

Government committed to waive EU settled status fee

The government has agreed to waive the planned settle status fee for EU nationals living in the UK. Previously, the government had said EU nationals would need to pay the full fee of £65, and £32.50 for children, to gain settled status.

The fee was intended to part fund the cost of the Home Office settled status scheme. However, the Prime Minister announced that the fee will now be scrapped entirely when the programme to register is launched in full at the end of March – and anyone who has applied during the pilot scheme will have their fee repaid.

NHS commits to long term support for race equality

A new report, NHS Workforce Race Equality Standard, was launched in January highlighting the experience of black and minority ethnic (BME) people working in the NHS. It described the year on year improvements in the recruitment of BME people and a positive increase in BME personnel now holding the most senior NHS roles. However, progress is still required in a number of key areas.

To build on the advancements made and to tackle the problem areas, funding has been agreed for the next seven years by NHS England's Chief Executive and Director for the Workforce Race Equality Standard. One million pound will be released each year until at least 2025 to support this important programme of work. A team of 42 experts, recruited from within the existing workforce, will work with senior staff to further close the gaps between BME and white staff.

Linked with the NHS Long Term Plan, this programme of work will not only improve the experience of staff, leading to better patient outcomes, but will also help to shape the future of the national health service.

New digital sepsis checks help older patients

Digital checks that can prevent dementia and falls in older people, and save lives through diagnosis of sepsis, are among a range of tools being made available in hospitals across the country. One in eight hospital patients are affected by delirium, which can make people unsteady on their feet, increases the risk of developing dementia and can result in longer hospital stays or admission to a care home. However, these problems can be avoided through timely and effective care. The toolkits enable doctors and nurses to run through a symptoms checklist on a mobile computer or handheld device.

The scheme is just one of a series that is being rolled out across the country through the adoption of toolkits, known as blueprints, which allow NHS hospitals to implement improvements quicker and more easily to transform care and improve services for patients and staff.

Improving cancer screening

A major overhaul of cancer screening has been launched to improve care and save lives. Professor Sir Mike Richards will be recommending how national screening programmes will be upgraded to ensure patients benefit from new technologies and treatments. There are currently three national cancer screening programmes in England; Cervical screening, Breast screening and Bowel screening. As part of his work, Sir Mike wants to hear views and ideas from staff, patients and other groups to inform recommendations for the future of cancer screening.

In addition, lung cancer scanning trucks, which will operate from supermarket car parks, are being rolled out across the country in a drive to save lives by catching the condition early. The roll out has the potential to reach around 600,000 people over four years, detecting approximately 3,400 cancers, and saving hundreds of lives.

The targeted screening will help improve survival rates by going first to some of the areas with the highest death rates from lung cancer. It will not just identify more cancers quickly but pick up a range of other health conditions including chronic obstructive pulmonary disease.

NHS recruitment campaign inspires young male nursing applicants

A record breaking number of male school leavers have applied to be nurses following NHS England's successful "We Are The NHS" recruitment campaign. The number of 18-year-old men applying to study nursing has increased by more than 50% in a decade, according to new figures from UCAS, the body that arranges university courses. A total of 30,650 people applied for nursing degrees this year, up 4.3% on 2018. Applications had previously dropped by almost a third, 31%, between 2016 and 2018. Some 2,650 men applied for nursing and midwife courses, up 210 on the previous year.

More to be done to improve NHS staff's mental health

Health Education England have published a report on improving mental health support for NHS Staff. Recommendations from the NHS Staff and Learner's Mental Wellbeing Commission report include fast-tracked referrals, tailored support sessions after traumatic incidents, rest spaces for on-call staff, a 24/7 advice phone line and the introduction of a "workplace well-being guardian" in every NHS organisation. The report received backing by Matt Hancock, the Health and Social Care Secretary.

Two - Pennine Lancashire Headlines

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

Together a Healthier Future update

A communications strategy for the Pennine Plan has been developed and widely shared with stakeholders via the members of the Pennine Lancashire partnership – Together a Healthier Future (TAHF). This was recently approved by the Partnership Leaders Forum and will now be implemented with some urgency. A dedicated Communications Manager has been appointed and she will be taking up her post next month.

Our 'New Model of Care' puts people, their families and communities at the heart of everything, aiming to put them in control of their own health and wellbeing. By securing a sustainable health and social care service our community can remain as healthy as possible for as long as possible.

ELHT is a key player in TAHF and we are calling on our workforce to help communicate the purpose, goals and desired outcomes of this ambitious programme. Demand is growing, capability is improving and available funding is increasing only slightly. We need the new approaches set out in the Pennine Plan to prevent as much illness as possible so we can provide cutting edge care and services when and where people need them.

Community groups receive mental health support

£40,000 of funding is being made available to support projects designed to prevent suicide and reduce self-harm. Community groups within Lancashire and South Cumbria will have the opportunity to apply for pots of funding between £500 and £5,000. Particular focus will be encouraged on reducing suicide in middle aged men and reducing self-harm in local communities. Any community group, charity or organisation will be able to apply for the funding at www.healthierlsc.co.uk/suicidepreventionfund.

New primary care networks set to improve patient care

General practices across Lancashire and South Cumbria are transforming the way they work to improve services for patients. By joining together and working with community service providers and other health and care organisations, they will form – a partnership known as **primary care networks**.

The development of primary care networks was included in the NHS Long Term Plan, and is key to the transformation of primary care and community services. Lancashire and South Cumbria will see an investment of £1.75 million to support the development of primary care networks. Every practice across the whole of Lancashire and South Cumbria is included or linked to one of the 41 primary care networks that have been established. With an ageing population and growing number of people living with long term conditions like diabetes and heart disease, strengthening primary care services through the development of networks is hugely important to helping people to stay healthier and more independent for longer.

Investing in local communities

Nearly half a million pounds is going to be spent in local communities across Lancashire and South Cumbria, tackling the factors which have the greatest impact on people's health.
The £471,000 investment from NHS England will be used to design better care around our communities' needs, with Healthier Lancashire and South Cumbria also being selected as one of four places in the country to receive nationally and internationally recognised expertise to drive this forward. This will see work in areas including Barrow, Blackpool, Burnley, Chorley and Skelmersdale to look at how data and intelligence can be better used by GPs and community services to help people live longer, healthier lives.

One example is using data to identify people who have multiple long term conditions and understanding the ways in which they can be supported to prevent complications and live independently. This approach will be developed across Lancashire and South Cumbria to make a real difference to people's lives.

Volunteer Learning Passport launched

A learning passport specifically for volunteers in health and social care has been launched in pilot form across Pennine Lancashire. Developed and funded in partnership with Health

Education England e-Learning for Healthcare, the passport will allow volunteers to work across multiple organisations without having to repeat the same basic training.

The NHS, Local Authorities, and the Voluntary, Community and Faith Sectors are all taking part in the pilot that covers six training sessions including health and safety, data securing and safeguarding for children and adults. The Volunteer Learning Passport is one of eight work streams in the Pennine Lancashire Volunteer Strategy and Action Plan for 2018/19.

Plans to reduce childhood obesity

As part of the TAHF programme, Blackburn with Darwen Council led on a bid that will see an initial £10,000 coming in from the Government's Childhood Obesity Trailblazer Programme. The Pennine Lancashire bid was just one of 13 successful applications, when 102 local authorities applied to take part in the initial discovery phase of the programme. The money will be used to improve access and awareness around healthier choices for children and families.

New contract brings big reform to GP services

The recent publication of a new GP contract, has been seen as one of the first major pillars in the implementation of the NHS Long Term Plan. Patients across Pennine Lancashire will be able to access expert advice from pharmacists, physiotherapists, paramedics, physician associates and social prescribing support workers being introduced into general practices.

It is anticipated that the introduction of pharmacists alone will help to reduce the chances of patients needing hospital care. Currently, up to 10% of hospital admissions in the elderly population are medicines-related, and research shows that as many as 50% of patients do not take their medicines as intended.

By growing and developing the general practice workforce the current and future needs of the community will more be accurately met.

Three - ELHT Headlines

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

Use of the Trust Seal

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

- On 8 January 2019 the seal was applied to the Deed of Surrender of part relating to a lease of land and premises at Queens Park Hospital (Royal Blackburn Teaching Hospital), between ELHT and Consort HealthCare (Blackburn) Ltd. The Chief Executive, the Director of Finance and the Director of Nursing were the signatories.
- On 8 January the seal was applied to the Licence to Underlet relating to a lease of land and premises (Ground Floor Level Cafeteria) at Queens Park Hospital (Royal Blackburn Teaching Hospital) between ELHT, Consort HealthCare Ltd, WHSmith Hospitals Ltd. and WHSmith Hospitals Holding Ltd. The Chief Executive and Director of Finance were the signatories.
- On 8 January the seal was applied to the Licence to Underlet relating to a lease of land and premises (Retail Unit) at Queens Park Hospital (Royal Blackburn Teaching Hospital) between ELHT, Consort HealthCare Ltd, WHSmith Hospitals Ltd and WHSmith Hospitals Holding Ltd. The Chief Executive and Director of Finance were the signatories.
- On 8 January the seal was applied to the Licence to Underlet relating to a lease of land and premises (seating area adjacent to the Cafeteria) at Queens Park Hospital (Royal Blackburn Teaching Hospital) between ELHT, Consort HealthCare Ltd, WHSmith Hospitals Ltd. and WHSmith Hospitals Holding Ltd. The Chief Executive and Director of Finance were the signatories.
- On 8 January the seal was applied to the Licence to carry out works relating to the Ground Floor Level Cafeteria at Queens Park Hospital (Royal Blackburn Teaching Hospital), between ELHT, Consort HealthCare Ltd, WHSmith Hospitals Ltd and WHSmith Hospitals Holdings Ltd. The Chief Executive and Director of Finance were the signatories.
- On 8 January the seal was applied to the Licence to carry out works relating to the Retail Unit at Queens Park Hospital (Royal Blackburn Teaching Hospital), between

ELHT, Consort HealthCare Ltd, WHSmith Hospitals Ltd and WHSmith Hospitals Holdings Ltd. The Chief Executive and Director of Finance were the signatories.

- On 29 January the seal was applied to the Deed of Grant of Easement relating to Burnley Ambulance Station, Briercliffe Road, between ELHT, East Lancashire Capital Projects and ESP Electricity Ltd. The Chief Executive and Director of Service Development were the signatories.
- On 31 January the seal was applied to the Deed of Variation relating to the licence for Amazon Lockers, between ELHT, Consort HealthCare Ltd. The Director of Operations and the Director of Service Development were the signatories.
- On 21 February the seal was applied to the Contract of Sale relating to the former Stepping Stones Clinic and the transfer of whole of registered title of the property, between ELHT and Little Gem Transport Museum. The Medical Director and Director of Nursing were the signatories.
- On 21 February the seal was applied to the Contractor's Duty of Care Warranty relating to the design and construction of a new satellite ambulance station at Casterton Avenue, between ELHT, East Lancashire Capital Projects Ltd and Eric Wright Construction Ltd. The Medical Director and Director of Nursing were the signatories.
- On 21 February the seal was applied to the Consultant's Duty of Care Warranty relating to the construction of a new satellite ambulance station at Casterton Avenue, between ELHT and Booth King Partnership Ltd. The Medical Director and Director of Nursing were the signatories.
- On 21 February the seal was applied to the Consultant's Duty of Care Warranty relating to the construction of a new satellite ambulance station at Casterton Avenue, between ELHT and DLA Freeman White Healthcare Architecture Ltd. The Medical Director and Director of Nursing were the signatories.

Prince's Trust programme promises bright futures

Thirteen young adults from across East Lancashire have graduated with honours from the latest 'Get Into Hospital' work opportunity programme, run by the Trust in partnership with The Prince's Trust. The four-week programme saw students gain valuable work experience in various hospital departments, including management accounts, catering, patient services and laundry services to equip them for working life. The student's hard work has already paid dividends with one person accepting a full-time job at the Trust and 11 graduates gaining shift work via the hospital's staff bank.

Largest Student Nurse Intake to Date

The latest and largest intake of student nurses have proudly started their ward duties at the Trust. Our patients across the five hospitals sites are benefitting from 148 student nurses taking up their nursing placements. The students began their nurse training with the University of Central Lancashire (UCLan) in September 2018. The number of students joining the Trust has nearly doubled from last year's intake. Despite a national shortage ELHT continues to attract more nurses, as well as successfully retaining those nurses it already employs.

Honorary titles for ELHT medical professionals

Twenty-three ELHT doctors, consultants and senior directors were recently awarded with honorary titles by the University of Central Lancashire (UCLan). The titles were bestowed in recognition of their help with the development, research and support of the University's School of Medicine. Six were made Honorary Professors, three selected as Honorary Clinical Senior Lecturers, while 14 are now Honorary Senior Lecturers. It is the first time the University's Medical School has given honorary positions to ELHT staff. A celebratory event took place on 5 February at the University's Preston Campus to welcome the first group into the UCLan community.

'Best ever' ratings for maternity services

ELHT received praised for achieving one of the best results in the country. The recent CQC Maternity survey gathered feedback about the experiences of women who gave birth in our birthing centres, hospitals and in the community. We were named as one of only nine NHS Trusts identified as being "better than expected", and also achieved our best ever results.

To be so well thought of by mothers and their families is a wonderful achievement for the Trust and a true reflection of the excellent service provided by the maternity staff across East Lancashire.

Best ever NHS Staff Survey results, again!

For the fourth year running our response rate has risen, showing increased engagement by our staff and a willingness to honestly share their views. This year the NHS Staff Survey results were split into 10 newly introduced 'themes'. This provides an overview of staff experience. The excellent news is that the Trust is rated above the national average against nine out of 10 key themes.

These are:

- Health and wellbeing
- Immediate managers
- Morale
- Quality of appraisals
- Quality of care
- Safe environment - bullying and harassment
- Safe environment – violence
- Safety culture
- Staff engagement

We are equal to the national average for equality, diversity and inclusion – something we are working very hard to improve. Each individual question result can be viewed on the main NHS Staff Survey website, which also enables national and peer comparison.

Charity love

Love was in the air during February when ELTH&Me held two Valentine's day raffles. Two romantic hampers for two – full of luxury items and tasty treats - where on offer to make the lucky winners days! Over £500 was raised at events held on the Blackburn and Burnley sites.

Marathon man

Adam Wallwork, Diagnostic Radiographer at ELHT is training to run the London marathon to raise funds for Trust's Newborn Intensive Care Unit (NICU). If that wasn't challenging enough, Adam will be running in a 13lb lead suit, specially designed for the occasion by Rothband, free of charge. Adam has already secured 88% of his £1,500 target with 54 days to go until the starting gun fires on Sunday 28 April.

A special type of quite room

A very special project has been made possible by the generous donations by our local community. ELHT&Me invested the funds to provide a 'quiet room' on ward C18. The room provides a haven of tranquillity for patients and their loved ones at a time when they need it the most. The very unassuming room provides our patients with a vital restful space away from the hustle and bustle of the busy ward environment, somewhere calming and soothing, as well as uplifting, a retreat in the heart of the hospital!

The big NHS walk

This year sees the launch of the very first ELHT&Me Big NHS Walk. On Sunday 23 June, registered participants will have a choice of two, flat 12-mile routes – one starting at Burnley General Teaching Hospital and the other setting off from the Royal Blackburn Teaching Hospital. The two routes are specially designed to allow walkers to enjoy some of the most beautiful parts of East Lancashire, to meet up with colleagues and make new friends along the way. It is a great opportunity for us to come together with our colleagues, friends, family and patients to celebrate the work we do for and in, our community. Registration is now open for the Blackburn and Burnley routes.

East Lancashire Hospitals
NHS Trust

Four – Communications and Engagement

A summary of the external communications and engagement activity.

January 2019

Communications and Engagement

Monthly Media Update

During January ELHT has...

- Welcomed our biggest ever intake of student nurses
- Begun work on the children's play area and garden of memories
- Ongoing winter pressure messages issued
- Issued cold and inclement weather guidance
- Prepared for CQC results arrival
- Push on staff flu vaccinations

BBC cameras film Physiotherapist Mobeen Janjua as he talks with a patient

Press and Media Relations

36 ↓ Mentions in all media

17 ↑ Media enquiries handled

12 → Media releases issued this month

89% ↓ of stories were positive or neutral

Top Stories

- Opened the Older Peoples Rapid Assessment (OPRA) Unit
- Work has begun on the Children's play area
- Received the best ever maternity patient survey results to date.
- Welcomed our biggest ever intake of student nurses beginning their placements on our wards.

The monthly media net score (positive minus negative)

+ 44

Website

Our website got **102,962** page views by **35,996** people

The most viewed webpage was – Visiting times

Social media and digital

Followers on social media

9,385

5,681

1,219

39,478
Avg Weekly Facebook Reach

139,000
Twitter Impressions

82%
Facebook page responsiveness

520
Twitter mentions

The most talked about issues on our social networks

- CQC rating of 'Good' with areas of Outstanding
- First hospitals to stock vegan friendly nut milk by BBC Apprentice runner up Camilla Ainsworth
- NHS Staff Survey results best ever

Posts of the month

Facebook review rating

4.5

Other activity

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

Safe | Personal | Effective

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

Communications and Engagement

Monthly Media Update

During February ELHT has…

- Received our Best ever NHS Staff Survey results
- Announced we will be the new providers of the Lancashire Diabetic Eye Screening Service
- Begun to stock BBC Apprentice finalist's vegan friendly 'nut milk'

We have improved our 'GOOD' rating to include areas of OUTSTANDING.

Press and Media Relations

52 ↑ Mentions in all media

11 → Media enquiries handled

15 ↑ Media releases issued this month

92% → of stories were positive or neutral

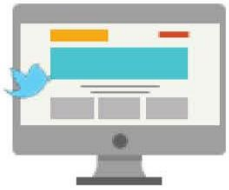
Top Stories

- ELHT rated 'outstanding' for young people's mental health
- Health professionals given honorary titles
- Top 9 in the country for Maternity services
- WH Smith launches new look store at hospital

The monthly media net score (positive minus negative)

+ 48

Website



Our website got **120,692** page views by **43,414** people

The most viewed webpage was – Vote for your employee of the year

Social media and digital

Followers on social media

9,515

5,698

1,266

40,039
Avg Weekly Facebook Reach

176,000
Twitter Impressions

80%
Facebook page responsiveness

549
Twitter mentions

The most talked about issues on our social networks

- CQC rating of 'Good' with areas of Outstanding
- First hospitals to stock vegan friendly nut milk by BBC Apprentice runner up Camilla Ainsworth
- NHS Staff Survey results best ever

Posts of the month

Facebook review rating

4.5

Other activity

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

Safe | Personal | Effective

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

Five - Chief Executive's Meetings

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

February 2019 Meetings

Date	Meeting
1 February	Pennine Lancs Chief officers discussions
4 February	Executive Team
4 February	Chairman/CEO meeting
4 February	UCLan/ELHT Celebration Event
6 February	Integrated Care System Board
6 February	Team Brief Burnley
6 February	ELHT/UCLan Strategic Board
7 February	A&E Delivery Board
8 February	Membership of ACCEA training session
11 February	Diagnostics Programme Vision Workshop
11 February	Pennine ICS / ICP Quarterly Meeting
11 February	Directors sessions
12 February	Chairman/CEO meeting
13 February	AOs CEOs and STP Execs
13 February	Board Development Session
13 February	Richard Slater presentation
20 February	Partnership Leaders Forum
21 February	Meeting with Bill McCarthy Regional Director for the North
21 February	NHS NW Leadership Academy
25 February	Pennine Lancs Chief Officers discussions

25 February	Finance & Performance Committee
25 February	Nuffield Trust Study teleconference
25 February	Community Volunteer Awards photo
26 February	Risk Summit – Mental Health
26 February	Chairman/CEO meeting
26 February	Employee of the Month
27 February	Operational Delivery Board
27 February	Team Brief filming
28 February	Visit to the Integrated Neighbourhood Team

March 2019 Meetings

Date	Meeting
4 March	Financial Planning meeting
4 March	HSJ teleconference
4 March	Introductory meeting with Dr Fazal Dad, Principle of Blackburn College
4 March	Executive Meeting
4 March	Stroke System Event
4 March	Integrated Care System Board
4 March	Team Brief BGTH & PCH
4 March	A&E Delivery Board workshop
5 March	L&SC Provider Board
11 March	Pennine Lancs Chief Officers discussion
11 March	Meeting with Mick Cartledge CEO Burnley Borough Council
12 March	Executive Meeting
12 March	Chairman/CEO meeting

12 March	Consultant Leadership Course
13 March	Trust Board
14 March	Partnership Leaders Group
14 March	ELHT/UCLan/BWD BC meeting
15 March	Report our Session
18 March	Vital Signs Transformation Guiding Board
26 March	Executive Meeting
27 March	Operational Delivery Board
27 March	Filming Team Brief
28 March	Diagnostic Project Group

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

13 March 2019

Item 37

Purpose Information

Title	CQC Inspection Report
Author	Name, Job Title
Executive sponsor	Name, Job Title

Summary: The presentation provides Board members with an overview of the recent Care Quality Commission (CQC) Inspection Report Findings

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

East Lancashire Hospitals NHS
NHS Trust

CQC Inspection Report

Safe | Personal | Effective

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019
Community	Requires improvement Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Mental health	Good Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019
Overall trust	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Burnley General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good → ← Feb 2019	Good → ← Feb 2019	Good → ← Feb 2019	Good → ← Feb 2019	Good → ← Feb 2019	Good → ← Feb 2019
Medical care (including older people's care)	Good ↑ Feb 2019	Good → ← Feb 2019	Good → ← Feb 2019	Good → ← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Surgery	Good → ← Feb 2019	Good → ← Feb 2019	Good → ← Feb 2019	Good → ← Feb 2019	Good ↓ Feb 2019	Good → ← Feb 2019
Services for children and young people	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
End of life care	Good May 2016	Good May 2016	Good May 2016	Good May 2016	Good May 2016	Good May 2016
Maternity and gynaecology	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Outpatients and diagnostic imaging	Good Jul 2014	N/A	Good Jul 2014	Requires improvement Jul 2014	Good Jul 2014	Good Jan 2014
Overall*	Good → ← Feb 2019	Good → ← Feb 2019	Good → ← Feb 2019	Good → ← Feb 2019	Good → ← Feb 2019	Good → ← Feb 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Royal Blackburn Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↓ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Requires improvement ↓ Feb 2019
Medical care (including older people's care)	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019
Surgery	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good ↓ Feb 2019	Good →← Feb 2019
Critical care	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Services for children and young people	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
End of life care	Good May 2016	Good May 2016	Good May 2016	Good May 2016	Good May 2016	Good May 2016
Outpatients and diagnostic imaging	Good Jul 2014	N/A	Good Jul 2014	Requires improvement Jul 2014	Good Jul 2014	Good Jul 2014
Overall*	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Blackburn Birth Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires improvement Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Overall*	Requires improvement Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Community health inpatient services	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Community end of life care	Good Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019	Good Feb 2019	Good Feb 2019	Outstanding Feb 2019
Overall*	Requires improvement Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist community mental health services for children and young people	Good Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019
Overall	Good Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

TRUST BOARD REPORT

13 March 2019

Item 39

Purpose Information

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

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

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

Report linkages

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

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	No

Introduction

1. There are currently 11 live risks on the CRR which are as follows:

Risk	Title	Current Score
7010	Aggregated Risk - Failure to meet internal & external financial targets in year will adversely impact the continuity of service Risk Rating	20
8061	Management of Holding List	16
7067	Aggregated Risk - Failure to obtain timely MH treatment impacts adversely on patient care, safety and quality	15
1810	Failure to adequately manage the Emergency Capacity *and* Flow system.	15
5790	Aggregated risk – Failure to adequately recruit to substantive medical posts may adversely impact on patient care and finance.	15
5791	Aggregated Risk - Failure to adequately recruit to substantive nursing & midwifery posts may adversely impact on patient care and finance.	15
7583	Loss of facility for Level 3 Containment in pathology	15
7008	Failure to comply with the 62 day cancer waiting time.	15
7552	Risk that PACS downtime occurs and brings delay to patient pathways or delays in operating theatre activity.	15
4353	Potential loss of images (OCT and FFA) if equipment should fail or be stolen	15
7330	Aggregated risk – Inability to identify, track & monitor the cohorts of women and new borns who require and have screening due to lack of an end-to-end IT System for Maternity.	15

New Risk added onto the CRR (as a linked risk) as agreed at January RAM meeting:

Risk	Title	Current Score
7816	Medical (psychiatric) waiting list (This is a linked risk to 5790 – which is an aggregated risk around the failure to recruit to substantive medical posts.	15

New Risks added onto the CRR as agreed at February RAM meeting:

Risk	Title	Current Score
8016	Management of Holding List	16

Risks de-escalated from the CRR post-January RAM meeting:

Risk	Title	Current Score
7513	Aggregated Risk - Radiology capacity issues would impact on inpatient flow, Referral to Treatment (RTT) and Patient Experience'	9

Risks approved at the January RAM meeting but not added onto the CRR:

Risk	Title	Current Score
8017	Refurbishment of the Cardiac Catheter lab will reduce capacity by up to 50% for a 3 month period	20
8009	The potential of losing EU Workers in the case of `No Deal` Brexit.	12

2. No risks were de-escalated from the CRR at February RAM meeting.
3. Whilst 8017 was due to be discussed at the DMB last Wednesday 06th February, 2019; 8009 has seen a reduction in score, has been added onto the Trust-wide Risk Register (TWRR) and is now being monitored via the newly formed Brexit Task and Finish Group chaired by the Director of Finance.

New Risks reviewed for inclusion onto the Corporate Risk Register:

4. The following risks were presented for review and discussion at the January RAM and approved for inclusion onto the CRR:
   a) **Risk ID 8017: Refurbishment of the Cardiac Catheter lab will reduce capacity by up to 50% for a 3 month period:** This risk was presented alongside the options appraisals. It involves the refurbishment of the Cardiac Catheter Lab which will have a major impact on capacity by up to 50% for a 3-4 month period. In order to maintain operational activities, achieving targets and maintaining patient flow, it was recognised as a priority that a second hard standing is required on the RBH site to ease pressure during the period of the refurbishment. After some discussions members approved this risk for the CRR

and requested that its financial component be escalated to the Capital Planning Board.

b) **Risk ID 8009: The potential of losing EU Workers in the case of `No Deal` Brexit.** This risk relates to the ongoing uncertainty around Brexit and the potential of losing EU nationals who work with the Trust should the UK crashed out of the EU with no deal. An initial assessment has been undertaken which indicates that there are currently 117 EU nationals (with a significant number being doctors and nurses) who work for the Trust. A number of actions identified by the Trust are being implemented in mitigating the potential impact of this risk should it be realised. This risk was approved for the CRR with a request for targeted communication to be circulated.

c) **Risk ID 7816: Medical (psychiatric) waiting list.** This risk relates to the increased waiting list for medical appointments following the resignation of Consultants, Specialty Doctors and change in working patterns in the last 12 months within the workforce. It was highlighted that there are ongoing concerns with a national shortage of Consultants as evidenced by the inability to recruit to Consultant Child & Adolescent Psychiatrist Posts after the first advertisement. Further solutions to fill the gap within the medical workforce will be considered, including recruitment from alternative specialities and/or locum appointments and international recruitment. This risk was approved for the CRR as a linked risk to the overall risk (5790 – around failure to recruit to substantive medical posts).

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

a) **Risk ID 8061: Management of Holding List.** This risk relates to patients who should have had their re-appointments for review by the end of January but who haven`t been re-booked due to capacity constraints. Members then discussed the potential impact of this risk and asked for assurance for timeframes for clearing the backlog and what`s being done to regularly review the lists to prioritise patients who may come to harm as a result of any further delay. It was agreed that patients who might have been harmed as a result of the delay will be reported onto Datix as incidents as such incidents will be managed through our incident management process. Members were assured that this is being regularly monitored as Execs are constantly updated and that funding has been secured for a staff who will focus on reviewing these lists and prioritising patients. This risk was approved for the CRR.

Risks presented for approval for closure at both January and February RAM meetings:

6. No risks were presented and approved for closure during the above meetings.

Corporate Risk Register (Appendix 1):

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

Conclusion

8. Members of the Trust Board are hereby requested to:
   a) Review and scrutinise the Corporate Risk Register (appendix 1).
   b) Gain assurance that the Trust is robustly managing its extreme risks in line with best practice and its Risk Management Strategy.
   c) Approve this report.

David Tita, Risk Manager, February 2018

	Appendix 1: The Corporate Risk Register – Current Risks				
Title	**Aggregated Risk – Failure to meet internal and external financial targets in year will adversely impact the Continuity of Service Risk Rating**				
Risk ID	7010	Date opened	25/08/2016		
Risk Handler	Allen Graves	Exec Director/Risk Lead	Jonathan Wood		
Identified in BAF Risk ID	**BAF/04:** The Trust fails to achieve a sustainable financial position and appropriate financial risk rating with the Single Oversight Framework.				
Linked to Risks:	1487 - Failure to deliver the SRCP- (15) 1489 - Failure to meet the activity and income targets - (12) 6692 - Risk to safe, personal and effective service delivery due to lack of quality information from Community IT systems (EMIS) - (10)				
Initial Rating	**Likelihood: 3** **Consequence: 5** **Total: 15**	Current Rating:	**Likelihood: 5** **Consequence: 4** **Total: 20**	Target Rating:	**Likelihood: 4** **Consequence: 3** **Total: 12**
What is the Hazard	• Failure to meet the targets will result in the Trust having an unsustainable financial position going forward and the likely imposition of special measures		What are the risks associated with the hazard		• If Divisions deliver their SRCP and meet their Divisional financial plans the Trust will achieve its agreed control total. • Breach of control totals will likely result in special measures for the Trust, adverse impact on reputation and loss of autonomy for the Trust. • Sustainability and Transformational funding would not be available to the Trust. • Cash position would be severely compromised
What controls are in place	• Standing Orders • Standing Financial Instructions • Procurement standard operating practice and		What are the gaps in controls		• Individual acting outside control environment in place

	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		
What assurances are in place	• Variety of financial monitoring reports produced to support planning and performance • Monthly budget variance undertaken and reported widely • External audit reports on financial systems and their operation • Monthly budget variance undertaken by Directorate and reported at Divisional Meeting • Monthly budget variance report produced and considered by corporate and Trust Board meetings • Internal audit reports on financial system and their operation	What are the gaps in assurance	• None identified.

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected Completion date	Progress on implementation of action	RAG Rating
1	Per individual linked risks	Allen Graves	27/09/2018	27/09/2018	completed	
2	Risk mitigation action plans are appended to each of the linked risks and are reviewed by the Divisions on an on-going basis with assurances being provided to Divisional meetings.	Allen Graves	Ongoing	Ongoing	On track	

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

			delayed decision making or clinical intervention.
What controls are in place	The following controls have been put into place: (1) Meeting held between the Divisional Triad and the Ophthalmology Triad to discuss the current risk and agree next steps (Friday 19th Jan). (2) Escalated concerns to the Executive Team through Exec Part 2 Meeting (Tuesday 23rd Jan). (3) Request sent to all Directorates requesting all patients on holding lists who expected their appointment before the end of January who do not have a booked appointment to be initially assessed for any potential harm that could have been caused due to the delay to being seen. Suitable RAG ratings need to be applied to all these patients (Wednesday 6th February). Information to be collected in a standardised format. (4) RAG status for each patient to be added to the comments field on the patient record in OWL to capture current RAG status. This will allow future automated reports to be produced (starting weekend 2nd and 3rd Feb). (5) Meeting held with the Directorate Managers from all Divisions to understand the position of all Directorate holding lists (Wednesday 30th January and weekly thereafter). (6) All patients where harm is indicated or flagged Red to be actioned immediately. Directorates to agree plans to manage these patients depending on numbers. (7) A process has been agreed to ensure all	What are the gaps in controls	• Patients currently booked into appointments that are not RAG rated will drop into the Holding List if appointments are cancelled and will not have a RAG rating identified. • Patients that are added to the holding list from other sources such as theatres Wards and Med Sec's will currently not have a RAG identified.

	follow up patients in the future are assigned a RAG rating at time of putting them on the holding list. Rolling out new process from 6th February across the Trust. (8) An automated reporting system is in development to ensure oversight of the risk stratified lists by speciality. (9) Underlying demand and capacity gaps must be quantified and plans put in place to support these specialities in improving the current position and reduce the reliance on holding lists in the future. (10) Report being provided weekly to the Executive Team.		
What assurances are in place	• None identified	What are the gaps in assurance	• None identified

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected Completion date	Progress on implementation of action	RAG Rating
1	Weekly review of the Holding List by identified fail safe officer	Natalie Brockie	07/03/2019	07/03/2019	On track	
2	Standardised DCO1 referral form for Trust Wide use	Susan Elliston	07/03/2019	07/03/2019	On track	
3	Detailed capacity and demand comparison	Leigh Hudson	07/05/2019	07/05/2019	On track	

Title	**Aggregated Risk - Failure to obtain timely Mental Health treatment impacts adversely on patient care, safety and quality.**				
Risk ID	7067	Date opened	06/10/2016		
Risk Handler	Jonathan Smith	Exec Director/Risk Lead	John Bannister		
Identified in BAF Risk ID	**BAF/03:** Lack of effective engagement within partnership organisations (ICS and ICP) results in failure to work together causing detrimental effect on the health and wellbeing of our communities. **BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).				
Linked to Risks:	2161 - Failure to provide sufficient skilled staffing for the needs of Tier 4 patients on the Paediatrics Ward will adversely continue - (12) 7582 -Inability to meet the needs of high risk mental health patients on in patient wards within ICG - (8) (5083 – Linked to 7582 - Failure to have a robust system to assess and manage patients with mental health needs - 15).				
Initial Rating	**Likelihood: 5** **Consequence: 3** **Total: 15**	Current Rating:	**Likelihood: 5** **Consequence: 3** **Total: 15**	Target Rating:	**Likelihood: 2** **Consequence: 3** **Total: 6**
What is the Hazard	• ELHT is not a specialist provider or equipped to provide inpatient mental health services. However, patients with mental health need do present to the Trust and they may require both physical and mental health assessments, treatment and referral to specialist services. • Due to lack of specialist knowledge, this may cause deterioration of the patient. • Staff generally do not have training in physical interventions and restraint.		What are the risks associated with the hazard		• Breach of statutory targets • Impact on other patient care due to resource use and patients and/or carers perceptions • Risk of harm to other patients • Impact on staffing (medical and nursing) to monitor/ manage patients with MH needs • Patient deterioration, or failure to Safeguard • Risk of patient harm to themselves
What controls are	• Frequent meetings to minimise risk between senior LCFT managers, specialist and urgent care		What are the gaps in controls		• Unplanned demand • ELCAS only commissioned to

in place	commissioners and Senior ELHT managers to discuss issues and develop pathways to mitigate risk including; Mental Health Shared Care policy, OOH Escalation pathway for Mental health patients, Instigation of 24hrs a day Band 3 MH Observation staff. Ring fenced assessment beds within LCFT bed base (x1Male, x1Female). In Family Care ongoing liaison with ELCAS and Commissioners • Monthly performance monitoring • Monitoring through Pennine Lancashire Improvement pathway • Monitoring by Lancashire and Cumbria Mental Health Group • Twice weekly review of performance at Executive Team teleconference • Discussion and review at four times daily clinical flow meeting • Introduction of mental health triage service within ED		provide weekday service • Limited appropriately trained agency staff available
What assurances are in place	• Appropriate management structures in place to monitor and manage performance • Appropriate monitoring and escalation processes in place to highlight and mitigate risks • Ongoing monitoring of patient feedback through a variety of sources • Escalation of adverse incidents through internal and external governance processes • Review of performance by Executive Team members on a weekly basis • Monthly Performance Report to Trust Board • Appropriate escalation and management policies and procedures are in place and regularly reviewed • Joint working with external partners on pathways and design improvements • 12 hour breach monitoring	What are the gaps in assurance	• The daily system teleconference between health and social partners was stood down from daily to twice weekly w/c 2-7-18.

	• Cluster reviews of 12 hour breaches undertaken. Presented at A and E Delivery board and SIRI (if required) • Every 12 hour breach is incident reported and has a timeline undertaken to identify themes for shared learning • Themes from timelines/cluster reviews are discussed weekly with commissioners, NHS England and LCFT • SOP in place for management of high risk patients (recently reviewed and up-dated)		

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	Progress on implementation of action	RAG Rating
1	Emergency Care Improvement Programme mental health "Deep dive" - audit	Jillian Wild	29/06/2018	29/06/2018	Completed	
2	Daily teleconference with LCFT commenced 9-7-18 due to LCFT being at OPEL level 4	Jillian Wild	27/09/2018	27/09/2018	Completed	
3	New procedures to be introduced for creating a safe environment to cohort high risk mental health patients	Jillian Wild	27/09/2018	27/09/2018	Completed	
4	Per linked risks. Risk mitigation action plans are appended to each of the linked risks and are reviewed by the Divisions on an on-going basis with assurances being provided to Divisional meetings	Jillian Wild	Ongoing	Ongoing	On track	

Title	**Aggregated Risk: Failure to adequately manage the Emergency Capacity *and* Flow system.**				
Risk ID	1810	Date opened	05/07/2013		
Risk Handler	Tony McDonald	Exec Director/Risk Lead	John Bannister		
Identified in BAF Risk ID	**BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety)				
Linked to Risks:	908 - The inability to provide performance and patient care due to low medical staffing levels within the ED department – (12) 7587 - There is a risk that patient's in ED at RBH are not always receiving optimal care due to a lack of embedded clinical systems- (12) 7108 - Extreme escalation areas open in response to capacity issues in ICG - (8)				
Initial Rating	**Likelihood: 5 Consequence: 3 Total: 15**	Current Rating:	**Likelihood: 5 Consequence: 3 Total: 15**	Target Rating:	**Likelihood: 3 Consequence: 3 Total: 9**
What is the Hazard	• Lack of bed capacity across the Trust can lead to extreme pressure resulting in a delayed delivery of the optimal standard of care across departments. • At times of extreme pressure this increase in the numbers of patients within the emergency pathway makes medical/nursing care difficult and impacts on clinical flow.		What are the risks associated with the hazard		• Patients being managed on trolleys in the corridor areas of the emergency /urgent care departments impacting on privacy and dignity. • Delay in administration of non-critical medication. • Delays in time critical patient targets (four hour standard, stroke target, sepsis six, and access to early senior review for trauma patients). • Delay in patient assessment • Potential complaints and litigation. • Potential for increase in staff sickness and turnover. • Increase in use of bank and agency staff to backfill. • Lack of capacity to meet unexpected

			demands. • Delays in safe and timely transfer of patients
What controls are in place	• Daily staff capacity assessment • Daily Consultant ward rounds • Opening of Ambulatory Emergency Care Unit for Acute Medicine including frailty patients and rapid chest pain assessment. • Review of the use of the old Ambulatory Emergency Care for Surgery in progress. • Pennine Lancashire and ELHT Winter Plans approved by Pennine Lancashire A&E Delivery Board and ELHT Operational Delivery Board to support safety and timely care and movement of patients. • Introduction of ED & UCC Trigger Tools and Escalation arrangements including actions cards for relevant roles and services linked to Trust Resilience and Escalation Policy and Procedures. • Establishment of specialised flow team • Bed management teams • Delayed discharge teams • Ongoing recruitment • Ongoing discussion with commissioners for health economy solutions • ED/UCC/AMU will take stable assessed patients out of the trolley space/bed to facilitate putting the unassessed patients in to bed/trolley • Introduction of Full Capacity Protocol • Refined 2 hourly patient flow meetings	What are the gaps in controls	• Trust has no control over the number of attendees accessing ED/UCC services
What assurances are in place	• Regular reports to a variety of specialist and Trust wide committees • Consultant recruitment action plan • Escalation policy and process	What are the gaps in assurance	• None identified

	• Monthly reporting as part of Integrated Performance Report • Weekly reporting at Exec Team • System Oversight by Pennine Lancashire A+E Delivery Board		

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected Completion date	Progress on implementation of action	RAG Rating
1	Numerous actions are incorporated within the Emergency Care Pathway Redesign Programme which forms part of the Trust's Transformation Programme	Jonathan Smith	Ongoing	Ongoing	On track	
2	Review the impact of the newly introduced Full Capacity Protocol and refined patient flow meetings	Jonathan Smith	01/09/2016	01/09/2016	Completed	
3	Development of Ambulatory and Emergency Care Unit and new pathways	Jonathan Smith	01/09/2019	01/09/2019	On track	
4	Mitigating actions are deployed on a daily basis at an operational level to reduce the risk to patient care	Jonathan Smith	Ongoing	Ongoing	On track	

Title	**Aggregated risk – Failure to adequately recruit to substantive medical posts may adversely impact on patient care and Finance.**				
Risk ID	5790	Date opened	11/09/15		
Risk Handler	Simon Hill	Exec Director/Risk Lead	Damian Riley		
Identified in BAF Risk ID	**BAF/02:** Recruitment and workforce planning fail to deliver the Trust objectives. **BAF/04:** The Trust fails to achieve a sustainable financial position and appropriate financial risk rating with the Single Oversight Framework. **BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations.				
Linked to Risks:	4488 - Inadequate Senior Doctor Cover for MFOP - (12), 7268 - Clinical, financial and organisational risks of (SOS) and T&O short and long term rota gaps – (9), 5557 - (Adequate Medical Staffing - 12) 3835 - Failure to appoint to vacant oncologist posts is impacting on service delivery and provision of safe, personal, effective care - (9), 7401- There is a risk that patients may not receive timely clinical care due to a lack of junior doctor cover on medical wards in ICG - (10)				
Initial Rating	**Likelihood: 5 Consequence: 3 Total: 15**	Current Rating:	**Likelihood: 5 Consequence: 3 Total: 15**	Target Rating:	**Likelihood: 3 Consequence: 3 Total: 9**
What is the Hazard	• Gaps in medical rotas require the use of locums to meet service needs at a premium cost to the Trust		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	What are the gaps in controls	• Reduction in agency staffing costs form previous year has already been demonstrated, however, the availability of medical staff to fill permanent posts continues in some areas, linked to regional or national shortages in some specialties.
What assurances are in place	• Directorate action plans to recruit to vacancies. • Reviews of action plans and staffing requirements at Divisional meetings. • Reviews of action plans and staffing requirements at trust Board meetings and Board subcommittees. • Reviews of plans and staffing requirements at performance meetings • Analysis of detailed monthly report through AMG (Agency Monitoring Group). Areas for targeted action understood.	What are the gaps in assurance	• None identified.

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	Progress on implementation of action	RAG Rating
1	Per individual linked risks	Simon Hill	10/07/2017	10/07/2017	Completed	
2	Ongoing recruitment and innovative packages offered	Simon Hill	Ongoing	Ongoing	On track	
3	Workforce transformation and new models of skill mix	Simon Hill	Ongoing	Ongoing	On track	
4	On-going pressure to reduce locum rates	Simon Hill	Ongoing	Ongoing	On track	
5	All requests to exceed capped rates to be approved by medical directorate on a case by case basis	Simon Hill	Ongoing	Ongoing	On track	

Title	**Aggregated risk –Failure to adequately recruit to substantive nursing posts may adversely impact on patient care and Finance.**				
Risk ID	5791	Date opened	11/09/15		
Risk Handler	Julie Molyneaux	Exec Director/Risk Lead	Christine Pearson		
Identified in BAF Risk ID	**BAF/02:** Recruitment and workforce planning fail to deliver the Trust objectives. **BAF/04:** The Trust fails to achieve a sustainable financial position and appropriate financial risk rating with the Single Oversight Framework. **BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations.				
Linked to Risks:	3804 - Failure to recruit and retain nursing staff across inpatient wards and departments may result in inadequate nurse staffing - (12) 7496 - There is a risk of failing to deliver financial balance against the ICG nursing budget - (12)				
Initial Rating	**Likelihood: 3 Consequence: 5 Total: 15**	Current Rating:	**Likelihood: 3 Consequence: 5 Total: 15**	Target Rating:	**Likelihood: 4 Consequence: 2 Total: 8**
What is the Hazard	• Use of agency staff is costly in terms of finance and levels of care provided to patients		What are the risks associated with the hazard	• Breach of agency cap • Agency costs jeopardising budget management	
What controls are in place	• Daily staff teleconference • Reallocation of staff to address deficits in skills/numbers • Ongoing reviews of ward staffing levels and numbers at a corporate level • Daily review of acuity and dependency to staffing levels • Recording and reporting of planned to actual staffing levels and Care Hours per Patient Day (CHPPD) • E-rostering KPI's		What are the gaps in controls	• Unplanned short notice leave and sickness. • Non elective activity impacting on associated staffing • Break downs in discharge planning • Individuals acting outside	

	• Ongoing recruitment campaigns • Overseas recruitment as appropriate • Establishment of internal staff bank arrangements • Senior nursing staff authorisation of agency usage • Monthly financial reporting		control environment
What assurances are in place	• Daily staffing teleconference with Divisional Director of Nursing • 6 monthly formal audit of staffing needs to acuity of patients • Formal review of nursing and midwifery establishments annually more often if required • Exercise of professional judgment on a daily basis to allocate staff appropriately, alongside Safe Care acuity data • Monthly integrated performance report contains staffing data containing planned to actual nurse staffing levels and CHPPD • Active progression of recruitment programmes in identified areas.	What are the gaps in assurance	• None identified.

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	Progress on implementation of action	RAG Rating
1	All current planned actions completed as shown in “what controls are in place”	Julie Molyneaux	03/09/2018	03/09/2018	Completed	
2	Non-Medical Bank and Agency Group	Julie Molyneaux	Ongoing	Ongoing	On track	
3	Risk mitigation action plans are appended to each of the linked risks and are reviewed by the Divisions on an ongoing basis with assurances being provided to Divisional meetings	Julie Molyneaux	Ongoing	Ongoing	On track	

Title	**Loss of facility for Level 3 Containment in pathology**				
Risk ID	7583	Date opened	26/11/2017		
Risk handler	Pamela Henderson	Exec Director/Risk Lead	Jonathan Wood		
Identified in BAF Risk ID	**BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).				
Linked to Risks:	N/A				
Initial Rating	**Likelihood: 3 Consequence: 5 Total: 15**	Current Rating:	**Likelihood: 3 Consequence: 5 Total: 15**	Target Rating:	**Likelihood: 1 Consequence: 5 Total: 5**
What is the Hazard	• Changes to air pressure to resolve the air pressure fault (risk 7342) have caused rips and bubbling of the vinyl wall covering from the wall. If the wall covering integrity is damaged beyond immediate repair the CL3 facility will be put out of use. The vinyl has split on many occasions and continues to be an ongoing hazard.		What are the risks associated with the hazard		• If the vinyl wall covering is damaged, the containment properties of the facility are compromised and therefore it cannot be used. • Crowthorn Ltd has reassessed the remedial action undertaken by Engie Raised concern about the ongoing viability of the repairs as vinyl has ripped repeatedly and been repaired on multiple occasions and is likely to continue being breached until fully refurbished.
What controls are in place	• The contractor, Atlas, has been appointed by Consort and plans will be finalised between all Consort, Atlas and the Trust next week commencing 15th Oct 2018. The plan then		What are the gaps in controls		• Unexpected breach could occur between the daily (and weekly) checks

	needs approval by HSE. The works programme will take up to 50 weeks. Monitoring remains in place. The back stop date for the completion of the works will be November 2019. Once completed the facility will be brought up to the correct prevailing standards. • The vinyl wall covering is checked every morning before processing is started and findings recorded on a worksheet. If tears are found, Engie is informed immediately and work does not start until they have filled the breach with silicon sealant. This will only be effective as long as the breaches are small. • Current safe procedures for working in CL3 to be adhered to as per policy • Visual inspection of vinyl wall covering recorded daily and repairs conducted before any processing can begin. • Consort to repair/refurbished wall covering to repair damage.		
What assurances are in place	• Completed worksheets available demonstrating checks are conducted daily. • Risk assessment and actions reviewed at departmental quality meetings and CLM governance meetings. • Refurbishment plan available from Consort (works commencing 04/01/2019).	What are the gaps in assurance	• Unexpected breach could occur between the daily (and weekly) checks.

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	Progress on implementation of action	RAG Rating
1	Discussion with PFI partners and specialists progressing to remedy issues	Pamela Henderson	30/11/2018	30/11/2018	Completed	
2	Consort have taken on the proposed refurbishment and plans are going out to tender in the near future. Consort to repair/refurbish wall covering to repair	Pamela Henderson	30/04/2019	30/04/2019	On track	

		damage.					
	3	Building work scheduled to commence on 4th Jan 2019 by Atlas.	Pamela Henderson	04/01/2019	04/01/2019	Completed. Refurbishment worked started and is ongoing. Regular meetings held every 2 weeks with Consort, Engie, Atlas and Trust.	

Title	**Failure to comply with the 62 day cancer waiting time.**				
Risk ID	7008	Date opened	01/08/2018		
Risk Handler	William Wood	Exec Director/Risk Lead	John Bannister		
Identified in BAF Risk ID	**BAF/05: T**he Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).				
Linked to Risks:	N/A				
Initial Rating	**Likelihood: 3 Consequence: 3 Total: 9**	Current Rating:	**Likelihood: 5 Consequence: 3 Total: 15**	Target Rating:	**Likelihood: 3 Consequence: 2 Total: 6**
What is the Hazard	• Cancer treatment delayed. • Potential to cause clinical harm to a patient if the treatment is delayed. • Damage to Organisational reputation.		What are the risks associated with the hazard	• Trust fails to achieve compliance with the 85% national standard for the cancer 62 day waiting time target. • The Trust is performance managed for failure to comply with cancer waiting time targets - the cancer waiting times are key performance indicators for all NHS providers. • Potential to cause clinical harm to a patient if the treatment is delayed. • There is also a risk to the patient experience and risk of adverse publicity/reputation to the Trust.	
What controls are in place	Immediate ongoing actions to improve performance a) CNS engagement with virtual PTL b) Cancer escalation process modified and re-issued c) Cancer Hot List issued twice weekly d) Additional theatre capacity		What are the gaps in controls	• Multiple Actions require recruitment of 'difficult to recruit' personnel. • Patient choice and compliance is a factor which cannot easily by influence.	

	e) Daily prioritisation of elective and cancer activity by clinical and pathway urgency. f) Additional Alliance funding provided to Radiology for in-house Cancer Reporting in March g) Re-validate previous months (review all treatments capture, all breaches and re-allocations) h) Continued micro-management of all patients at risk on hot list i) Senior Directorate Managers to attend all PTLs in coming weeks to gain assurance of efficient and appropriate process. j) Weekly performance forecast issued to Cancer Management Team and DGMs. k) Ongoing Breach analysis		
What assurances are in place	• None identified	What are the gaps in assurance	• None identified

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	Progress on implementation of action	RAG Rating
1	Patient education	William Wood	Ongoing	Ongoing	On track	
2	Collaborative working with Primary Care	William Wood	Ongoing	Ongoing	On track	
3	Recruitment to vacancies within Clinical service	William Wood	Ongoing	Ongoing	On track	
4	Capacity review	William Wood	Ongoing	Ongoing	On track	
5	Pathway review – New alliance pathway for Prostate, Upper GI, Colorectal and Lung	William Wood	30/04/2019	Ongoing	On track	
6	Investment of Alliance Funding in pathways to improve processes	William Wood	Ongoing	Ongoing	On track	

	7	Establishment of Template Biopsy Service at ELHT for Urology	William Wood	31/03/2019	31/03/2019	On track	

Title	Risk that PACS downtime occurs and brings delay to patient pathways or delays in operating theatre activity.				
Risk ID	7552		Date opened	25/10/2017	
Risk Handler	Victoria Hampson		Exec Director/Risk Lead	John Bannister	
Identified in BAF Risk ID	**BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk of safety & poor patient experience).				
Linked to Risks:	N/A				
Initial Rating	**Likelihood: 5 Consequence: 3 Total: 15**	Current Rating:	**Likelihood: 5 Consequence: 3 Total: 15**	Target Rating:	**Likelihood: 3 Consequence: 3 Total: 9**
What is the Hazard	• Lack of data available while treating patient could cause harm. • The system is regularly failing / turning over so that images are not available as required. • The system is regularly failing / turning over so that images are not available as required. The impact of this for the Orthopaedic team is that clinics are delayed/ overrunning and patients are waiting longer than required. • On occasion patients have left having not been able to get the necessary information to talk through their appropriate care. • The impact for theatres is also real and in the past cases have had to be cancelled due to delays and unavailability of appropriate images.		What are the risks associated with the hazard	The risks are: • Trust targets • Delays in patient pathway. • Downtime in clinics and theatres due to regular system failure. • Poor patient experience having to wait around while backup systems are used. • Some occasions backup systems have failed • Increased complaints. • Concerns re patient in theatre and system going down meaning may have to stop / delay operating. This may cause patient harm. • This is happening weekly and in some instances daily Clinics are delayed and the impact on patients is they have to wait around. The impact on the consultants is then the clinic	

			over runs into the afternoon session.
What controls are in place	• Currently we have backup systems involving getting physical or disk copies of images but this still puts big delays in the system. • Although there is a plan to bring the new PACS online early next year the current situation is that the risk is still very much live and frequently effecting patient care. • Finance Director involved in discussions with Managed Equipment Service who holds the contract for the provision of PACS equipment. • Trust is hoping to get a PACS system that is fit for purpose. • We are reliant on the PACS and IT teams.	What are the gaps in controls	• The above controls can`t stop the system from going down. • The impact of this for the Orthopaedic team is that clinics are delayed or overrunning and patients are waiting longer than required. • On occasion patients have left having not been able to get the necessary information to talk through their appropriate care. • The impact for theatres is also real as cases have had to be cancelled in the past due to delays and unavailability of appropriate images.
What assurances are in place	• Current controls can only reduce the potential impact patients.	What are the gaps in assurance	• Controls are being manually implemented and can`t stop the system from going down.

Actions to be carried out in mitigating this risk

	No	Action	Action Lead	Due date	Expected completion date	Progress on implementation of action	RAG Rating
	1	New PACS online system to go operational early next year	Victoria Hampson	29/03/2019	31.08.2019 (Original completion date is 29.03.2019 but it has been moved to 31.08.2019 as project has commenced)	PACS replacement process ongoing. Hardware installation and data migration to commence approximately March 2019. Go Live planned for August 2019	

Title	**Potential loss of images (OCT and FFA) if equipment should fail or be stolen**				
Risk ID	4353		Date opened	10/09/2014	
Risk Handler	Joanne Preston		Exec Director/Risk Lead	John Bannister	
Identified in BAF Risk ID	**BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk of safety & poor patient experience).				
Linked to Risks:	N/A				
Initial Rating	**Likelihood: 5 Consequence: 3 Total: 15**	Current Rating:	**Likelihood: 5 Consequence: 3 Total: 15**	Target Rating:	**Likelihood: 2 Consequence: 3 Total: 6**
What is the Hazard	• The imaging equipment at Royal Blackburn Hospital and Burnley General Hospital are used on a daily basis for all out-patient clinics, as well as the FFA equipment at Royal Blackburn Hospital. Thousands of images per year. All patient information and images are stored on the machines hard drive as there is no server in ophthalmology to back these images up. The machine at BGH is currently taking seven minutes to store one image which is a concern to EBME. • There is the potential loss of images / information if the machine breaks down as there is no backup for this equipment. There has been loss of images during the cyber-attack and images have previously been lost when using previous		What are the risks associated with the hazard		• The imaging equipment at Royal Blackburn Hospital and Burnley General Hospital are used on a daily basis for all out-patient clinics, as well as the FFA equipment at Royal Blackburn Hospital. Thousands of images per year. All patient information and images are stored on the machines hard drive as there is no server in ophthalmology to back these images up. The machine at BGH is currently taking seven minutes to store one image which is a concern to EBME. • There is the potential loss of images / information if the machine breaks down as there is no backup for this equipment. There has been loss of images during the cyber-attack and images have previously been lost when using previous topcom machine. There has been ad hoc saving to disc (at BGH site) but this is not straightforward to do.

	topcom machine. There has been ad hoc saving to disc (at BGH site) but this is not straightforward to do.		
What controls are in place	• Machine has full service contract. • In house support from EBME • Locks in place on FFA and OCT rooms to prevent theft of equipment. • Disc back up is only control that has been in place ad hoc and there is no protocol or established time period for this procedure or designated (experienced) responsible person to do.	What are the gaps in controls	• No server in place for Ophthalmology images • No back up in place for Ophthalmology images
What assurances are in place	• None identified	What are the gaps in assurance	• None identified

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	Progress on implementation of action	RAG Rating
1	Urgent meeting between Ophthalmology & IT	Joanne Preston	04/12/2018	04/12/2018	Completed	
2	Visit / scoping exercise by IT to Ophthalmology department	Joanne Preston	05/12/2018	05/12/2018	Completed	
3	Short term 'fix' (control) to image storage	Joanne Preston	28/02/2019	28/02/2019 (Original completion date is 28.02.2019, confirmation awaited as paper is being prepared.	On track	
4	Long term image storage solution	Joanne Preston	05/12/2020	05/12/2020	On track	

Title	**Aggregated risk – Inability to identify, track & monitor the cohorts of women and newborns who require and have screening due to lack of an end-to-end IT System for Maternity.**				
Risk ID	7330		Date opened	29/01/2018	
Risk Handler	Angela O`Toole		Exec Director/Risk Lead	Christine Pearson	
Identified in BAF Risk ID	**BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety & poor patient experience).				
Linked to Risks:	7123 - Inadequate Safeguarding Information Recorded in Maternity Notes (12).				
Initial Rating	**Likelihood: 3 Consequence: 5 Total: 15**	Current Rating:	**Likelihood: 3 Consequence: 5 Total: 15**	Target Rating:	**Likelihood: 2 Consequence: 5 Total: 10**
What is the Hazard	• Inability to identify the cohort of women, fetus' and babies who require screening in the antenatal and postnatal period. • Potential for abnormal screening tests not to be followed up/acted upon as midwives working in community do not have access to the ICE system. • Impacts on resources and staff time managing these gaps, collect data and track this cohorts of women. • Potential for litigation. • Potential for adverse media coverage and negative reputation to the Trust. • An emerging hazard relating to the Newborn Physical Infant Examination		What are the risks associated with the hazard	• Inability to achieve the national mandated screening target for the Antenatal and Newborn Screening Programme and provide assurance to Public Heath England and Quality Assurance. • Abnormal screening results not identified and acted upon within the required timescales. • Significant avoidable harm to a mother and baby. • The current system is not robust, designed or organized to reduce the likelihood of errors occurring and the impact of errors when they occur. • The current paper based system does not support staff to deliver reliable safe systems of	

	whereby assurance is not being provided to PHE and QA that neonates are being referred and followed up within a timely manner.		care. • Poor patient experience. • Potential fines for not meeting national targets / KPI's. • Potential to be identified as outliers nationally in national reports for example the National Maternal Perinatal Audit / National Neonatal Audit. • Potential for staff to be stressed and fatigued when involved in clinical incidents due lacking of equipment for them to provide safe, personal, effective care. • Potential for the Trust to be identified as having a poor safety culture due to lack of resources. • Midwives and Maternity Support Workers manually input data in a variety of ways.
What controls are in place	• Dedicated clinic for quadruple screening. • Limited locally designed databases to track and monitor the cohort	What are the gaps in controls	• The local databases that have been developed have no staffing resources dedicated to checking this daily and is reliant on staff ad hoc checking the databases. • The quad clinic is still reliant on staff booking women into this clinic and there is error still for women to be missed as this is not done electronically. • The CERNER EPR IT system procured by the trust is forecasted to implement in 2020. As yet there is no programme of works for when the maternity system will be implemented. • There is no interoperability between Athena, BadgerNet and NIPESMART thereby limited assurance is provided to PHE and QA that neonates are being screened appropriately and ongoing referrals being undertaken within the required timescales.

What assurances are in place	• Risk assessment to be reviewed every 3 months at Divisional Management Board and progress against the actions overall risk discussed and escalated through the Risk Assurance Meeting. • Risk assessment to be monitored via the Risk Assurance Meeting once accepted on to the Trust Risk Register	What are the gaps in assurance	• The current paper-based system for identifying and tracking cohorts of women for screening isn`t effective, reliable and robust.

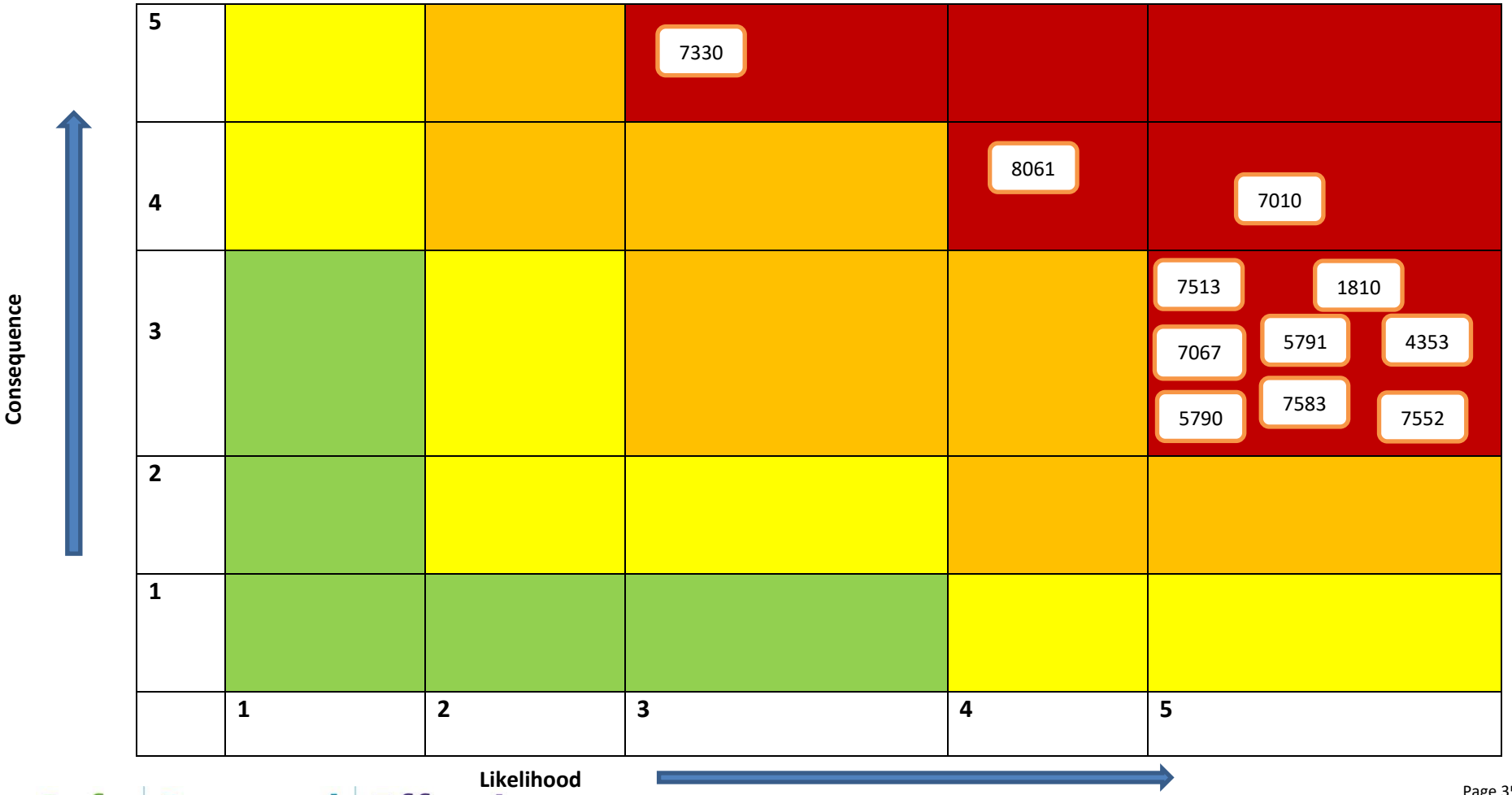
Actions to be carried out in mitigating this risk

No	Action	Action Lead	Completion /due date	Expected completion date	Progress on implementation of action	RAG Rating
1	To review and identify gaps in data submission	Angela O`Toole	12/08/2018	12/08/2018	Completed	
2	To continue to monitor processes in division in relation to record keeping	Angela O`Toole	12/08/2018	12/08/2018	Completed	
3	To work alongside IM&T in the procurement of an end to end maternity system	Angela O`Toole	29/03/2019	29/03/2019	On track	
4	To work alongside IM&T to develop and implement an end to end Maternity System	Angela O`Toole	29/03/2019	29/03/2019	On track	

Appendix 2: One page representation of the Corporate Risk Register as at 28th February 2109 mapping all risks onto the 5X5 Matrix based on current score (11 Risks in total)

RAG Key:

	Outstanding/ Overdue		In progress & on track		Completed



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East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 40

13 March 2019

Purpose Approval

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

Summary: The Executive Directors have revised the BAF and examined the controls and assurances, together with any gaps, to establish whether they have changed since the January Board meeting. In line with the discussions at the last Board meeting the risk ratings for BAF risk 2 and BAF risk 5 have been revised. A new risk score of 20 (4x5) is recommended for BAF risk 2 increasing it from the previous score of 12, with both the likelihood and the consequence scores increasing by one score. The risk score for BAF risk 5 has been decreased from 16 to 12 (3x4) with the likelihood score decreasing from 4 to 3. The risk scores for the rest of the BAF risks have not changed. The revised BAF has been considered by the various forums set out at the bottom of the page and it was agreed to recommend to the Board to agree the changes to the risk scores to BAF risks 2 and 5 together with the changes to the controls/assurances and updates presented in this report.

Recommendation: The Board is asked to discuss the risks on the BAF, including the controls, potential sources of assurance, gaps and actions to address and mitigate these and agree the revised BAF together with the changed risk scores for BAF risks 2 and 5.

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

Quality Committee (27 February 2019)

Operational Delivery Board (27 February 2019)

Finance and Performance Committee (25 February 2019)

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

Risk 1: Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives.

5. The risk score remains 20 (likelihood 5 x consequence 4).
6. There is a proposal to revise the consequences of the risk materialising. It is proposed that the following text is removed: *"Mismatch between demand and capacity will result in inability to balance elective versus emergency care"* and the following two consequences are included: *"Reduced ability to achieve access and operational standards"* and *"Reduced ability to improve quality standards".*
7. The following key controls have been updated to include:
   a) The Trust is working across the Pennine Lancashire footprint a single transformation plan: 'The Pennine Lancs Way'. This will offer benefits in terms of sharing resources and joint savings and quality plans.
   b) The programme is monitored through the Improvement Practice Office who report to the Operational Delivery Board and the Finance and Performance Committee.

c) All schemes are aligned to our clinical, financial, operational and workforce strategy.

d) The Trust has been selected to be in the 1st cohort of the new NHSI Lean programme "vital signs" and is working with the NHSI Lean team to develop a single improvement methodology across Pennine Lancashire.

e) There are a number of delivery steering groups covering the transformation themes, which monitor delivery, consider risks/mitigation and set direction. This programme is now evolving as a result of the Trust and the system developing its Pennine Lancashire Way improvement methodology, resulting from being a part of the NHSI Vital Signs programme. The initial phase of this programme is covering the frailty pathway (whole system working), Theatres improvement and a HR/workforce development piece. The impact in each of these areas is reported through the Operational Delivery Board and the Finance and Performance Committee. We are also developing an executive overview group as recommended which has started during November 2018. This meeting will take place every two weeks with oversight being visible through an Executive Leadership Wall.

8. The potential sources of assurance section now includes:

a) Executive sponsorship of each transformation/improvement scheme - weekly reviews (internal source of assurance).

b) Post advertised/interviews for transformation/improvement (internal source of assurance).

c) Agreed the alignment of the neighbourhood improvement programme with the wider system improvement programme (internal/external source of assurance).

9. The gaps in control section has been updated to confirm that there is no single clinical strategy group for Pennine Lancashire which brings together primary and secondary care clinicians.

10. The actions planned and updates have been revised to include:

a) Established a Pennine Lancashire planning group which includes representation from ELHT, CCG's and the PMO and has developed the first draft of the activity plan for 2019/20. The process has been positive at system level and should help to drive the contract settlement with the CCG's. The Trust has also completed detailed demand and capacity analysis at specialty level, involving CCG partners.

b) For 19/20 the systematic approach has been aligned with national and ICS strategy.

c) A planning event was held on 4 December with ICP partners, the planning process was agreed including Vital Signs priorities which are aligned to the long term plan, the Pennine Lancs plan and ELHT clinical strategy (golden thread).

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

11. There is a proposal to **increase the risk score from 12** to **20** based on both the increased likelihood of the risk materialising and the consequence of the risk materialising (likelihood **4** x consequence **5**). This proposal is based on the current trend of increased costs of bank and agency staff. The Committee should note that controls are being reviewed and tightened and discussions are taking place with wider ICS to support with wider solutions

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

a) Review of absence management process to support staff attendance and to mitigate need for use of bank and agency (internal source of assurance)

b) Quarterly report on workforce metrics to Finance & Performance Committee (internal source of assurance).

c) Benchmarking of agency spend is available through the Model Hospital data (external source of assurance).

13. Actions and updates have been updated as to include the following:

a) HCA recruitment continues, contributing to the reduction in HCA bank shift requests adding further stability and flexibility to our support workforce.

b) Festival of diversity planned for the last week of April 2019.

c) Funding has been secured from the NHS NorthWest Leadership Academy (NWLA) to deliver a shadow Board programme aimed at improving opportunities to manage talent for greater diversity at sub-Board and Board level, this work will commence in June 2019.

d) The Trust launched the volunteer learning passport in January 2019 enabling mobility of volunteers between organisations. There will be an evaluation period at the end of February 2019.

e) The Apprenticeship Strategy is now in place and includes proposals/agreement to passport levy between partner organisations.

f) Alignment of workforce Transformation Board to oversee delivery of priorities.

g) Exploration of opportunities to manage medical agency staffing differently has commenced in January 2019. Proposed restructure of Trust Medical Staffing team to amalgamate the existing locum booking team with the Temporary Staffing team, to ensure greater consistency of service provided to the whole workforce

h) Ten Workforce Repository and Planning Tool (WRAPT) planning projects are underway across the organisation.

14. The following action has now been completed and moved to the potential sources of assurance column:

a) A Senior Medical Staffing Performance Review Group established - responsibility for reviewing all consultant job plans, consultant vacancies etc. adding further rigor on our appropriate use of resource (internal source of assurance).

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

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

16. The actions planned and updates section had been reviewed and now includes the following updates:

a) Meetings are ongoing regarding the acute Programme and more focused work is taking place in Stroke, Vascular, Urological Cancer and Diagnostics. A range of services are being developed for Head & Neck.

b) East Lancashire CCG extended the Community Services contract by 12 months allowing for the principles of the new clinical model at ICP level to be developed. Ongoing progress is being made with more focus on the future model of care (not the current model of care). An update will be provided at the Trust Board in March 2019.

c) The following text has been removed: *"A Planning Group has been formed and a demand and capacity exercise will be completed by 14 January 2019"* and has been replaced with *"The Director of Service Development has led discussions with other providers of CAMHS services about potential future configurations and alliance, the model was universally supported."*

d) A neighbourhood system event was held at end of January 2019.

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

17. The **risk score remains at 20** (likelihood 5 x consequence 4).
18. The potential sources of assurance section has been updated and now includes:
    a) Model Hospital benchmarking (including cost per Weighted Activity Unit) (external source of assurance).
    b) ICS Led Theatre Productivity analysis (external source of assurance).
19. The actions planned/update section now includes:
    a) Cash borrowings have increased above plan as a consequence of not delivering A&E PSF and non-cash backed SRCP.
    b) Detailed plan for 2019-20 to be developed in light of additional financial focus.
    c) Merge medical + non-medical temporary staffing groups for improved oversight chaired by DOF.

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

20. There is a proposal to reduce the **risk score from 16** to **12** based on a reduced likelihood of the overall risk materialising (likelihood **3** x consequence **4**).
    a) Key controls have been updated to include the undertaking of weekly operational performance meetings.
    a) Potential sources of assurance have been updated to include the recently confirmed CQC rating of the Trust 'Good' (maintained) (January 2019) with a number of improvements across various areas, including some services being classed as ‘outstanding’ (internal/external source of assurance).
21. The actions have been updated to include the following:
    a) The Patient Participation Panel held an open day on 17 January 2019. The launch of the panel will take place on 27 February 2019 and will initially be made up of 15-20 people.
    b) The Trust is developing a full business case regarding the emergency care pathway and is anticipated to be ready for presentation and sign off in early 2019. Delays in completion due to refinement of clinical pathways and impact on building design.
    c) The Frailty Assessment Unit opened on 7 January 2019.

d) The Surgical & Ambulatory Emergency Care unit moved into the old ambulatory care on 7 January 2019 and additional beds were opened on ward B14.

e) The escalation ward in the Victoria wing at Burnley General Teaching Hospital opened on 15 November 2018 providing an additional 24 beds.

f) CQC report published on 12 February 2019, improvements in some areas and outstanding services.

g) Following discussion at Trust Board in January 2019, a review of the BAF 5 risk rating has been undertaken. The risk score likelihood has been reduced from 4 to 3 reducing the overall score to 12 from 16. Reasons for recommending the reduction is based upon delivery of cancer & RTT targets and improved resilience linked to the emergency pathway.

Angela Bosnjak-Szekeres, Associate Director of Corporate Governance, 1 March 2019.

Our Strategic Objectives

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

Reference Number: BAF/01

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

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

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

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

Key Controls *What controls/ systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2018/19**			
						Q1	**Q2**	**Q3**	**Q4**
The transformation programme has been set for 2018-19 for the Trust, covering following themes: 1. Emergency care pathway 2. Model ward 3. Productivity & Efficiency 4. Community 5. Support services The Trust is working across the Pennine Lancashire footprint a single transformation plan. 'the Pennine Lancs Way'. This will offer benefits in terms of sharing resources and joint savings and quality plans. The programme is monitored through the Improvement Practice Office who report to the Operational Delivery Board and the Finance and Performance Committee. All schemes are aligned to our clinical, financial, operational and workforce strategy. The Trust has been selected to be in the 1st cohort of the new NHSI Lean programme "vital signs" and are working with the NHSI Lean team to develop a single improvement methodology across Pennine Lancashire. There are a number of delivery steering groups covering the transformation themes, which monitor delivery, consider risks/mitigation and set direction. This programme is now evolving as a result of the Trust and the system developing its Pennine Lancashire Way improvement methodology, resulting from being a part of the NHSI Vital Signs programme. The initial phase of this programme is covering the frailty pathway (whole system working), Theatres improvement and a HR/workforce development piece. The impact in each of these areas is reported through the Operational Delivery Board and the Finance and Performance Committee. We are also developing an executive overview group as recommended which has started during November 2018. This meeting will take place every two weeks with oversight being visible through an Executive Leadership Wall.	**Internal Assurances** Monthly performance and Sustaining Safe, Personal and Effective Care report which reports to the Operational Delivery Board, Finance and Performance Committee and the Trust Board with associated information papers and minutes. Performance monitoring in all areas covering quality, delivery, finance and people (staff/patients): a. Monthly performance report b. Incident reporting (eg SIRI Report) c. Complaints data d. ICO breaches e. WRES reporting f. Number of disciplinaries/grievances g. Patient stories h. Staff survey i. Friends and families tests j. Finance Assurance Board Clinical Effectiveness Committee acting as a governance mechanism for the agreement of internal pathways. ELHT continues to have provider to provider discussion (e.g. GP federations) with the aim of refining clinical pathways. Emergency care pathway good example of collaborative working used as a blueprint for other system working moving away from organisational boundaries. The introduction of the Financial Assurance Board (FAB) will strengthen governance and oversight. Revised Performance Assurance Framework presented to the Finance and Performance Committee on 29 October 2018 and to the Operational Delivery Board on 31 October. The final version was presented to the Finance and Performance Committee on 26 November 2018. Executives sponsorship of each transformation/improvement scheme - weekly reviews. Post advertised/interviews for transformation/improvement. **External Assurances** System-wide reporting is currently being developed through the Pennine Lancs Business Intelligence group and the Pennine Lancs Way programme. ICP system level aiming to prioritise health improvements that can deliver beneficial outcomes more quickly. Care Professional Board workshop with a wider audience held in August 2018 resulted in the creation of Pennine Lancashire Professional Leadership Committee, bringing together relevant professionals to support the Pennine Lancashire transformation. Several senior ELHT clinicians attending and actively participating in the Professional Leadership Committee and associated workshops. **Internal / External Assurances** Agreed transition to one transformation plan and one improvement methodology - allowing all schemes to gain traction and improve delivery. Medial Director of the Trust appointed as the Professional Lead for the Pennine Lancashire ICP influencing the collaborative work on transformation. Good track record of successfully bidding for tenders in the last 12 months. Finance and Performance Committee agreed process for the review of tenders and service implementation 12 months after the tender bid. Model Hospital and GIRFT (Speciality benchmarked performance and efficiency data) reviewed at Clinical Effectiveness Committee. Agreed the alignment of the neighbourhood improvement programme with the wider system improvement programme.	15	10	16	5x4	16	20	20	20

Gaps in Control *Where we are failing to put controls/ systems in place. Where we are failing in making them effective.*	Gaps in Assurance *Where we are failing to gain evidence that our controls/ systems, on which we place reliance, are effective.*	Actions Planned / Update *Dates, notes on slippage or controls/assurance failing.*
Capacity and resilience building in relation to the service redesign is in early phase. Risk that through the transition from the original transformation plan to the Pennine Lancashire Way programme that delivery of the aims of the original programme may not be achieved or are delayed. Gaps in control in respect of the following and their impact on the transformation programme: • Workforce improvement capacity • Workforce capability • Competing priorities • Dependency on stakeholders to deliver key pieces of transformation • System wide working and no one 'true north' as a system • Financial constraints • Short term regulatory targets detracting from the delivery of short to medium term objectives of the transformation programme. Opportunities to link transformation objectives to appraisals. No single clinical strategy group for Pennine Lancashire bringing together primary and secondary care clinicians.	Assurance in place about the process, but assurance about the delivery and benefits is still work in progress at this stage. Dependency on stakeholders to deliver key pieces of transformation. Linking between clinical effectiveness and the transformation programme needs to be developed. The need to explore the interdependencies between BAF risks 1 and 3 and the system transformation in areas such as community services and the emergency care pathway. Exploring the opportunities in a changing leadership at collaborative level and linking into the new system executive roles. Winning tenders creates a risk of reaching a point where services cannot be maintained due to the lack of relevant/appropriate infrastructure. This has the potential to affect all risks identified in the BAF. Practical application and delivery of the transformation plan together with resourcing needs to be addressed in the near future . Model Hospital and associated processes still developing. Early planning of improvement events and flexible approach to enable the release of clinicians for improvement activities. Not delivering the percentage increase regarding the productivity and Efficiency transformation that we aspire to. Internal changes are needed, external efficiencies require Pennine Lancashire whole system working. Risks associated with the high concentration of efficiency schemes being scheduled to release savings in the second half of the year, the potential impact which winter pressures may have on this work and the number of non-recurrent schemes in the plan.	Using the Financial Assurance Board meetings and our membership of Pennine Lancashire to influence delivery of transformation. The transformation programme is working with the Pennine Lancashire Partnership Delivery Group to agree the strategic goals for the system to ensure that transformation plans are aligned to these in future and to ensure that ELHT business plans are also aligned. The business planning round for 2019-20 will be improved in respect of alignment and prioritisation. The first event was held on 4 December 2018. The outcomes of the planning day will inform the Value Stream Analysis (VSA) programme for 2019/20. A system wide value stream analysis for the frailty pathway took place in August 2018. This identified an agreed 'future state' for frailty. The programme will now ensure the delivery of this programme over the coming 12 months. This will pick up some of the improvement work of the original transformation plan. In addition the Pennine Lancs Way is also planning events in respect of a HR/workforce development and assisting in the theatres improvement journey. Regular reporting on progress through the Finance and Performance Committee Executive Overview Group for monitoring the progress and deliverables of the Pennine Lancashire Way improvement methodology set up in November 2018. Divisions attending Finance and Performance Committee from September 2018 onwards to provide assurance on the delivery of SRCP. Increased systematic view of benchmarking information to support change. Transformation and Improvement Practitioner is being appointed for Pennine Lancashire/ELHT. Training Programme commenced. Established Pennine Lancashire planning group (ELHT, CCGs, PMO) developed the first draft of the activity plan for 2019/20 - positive process at system level - this should drive the contract settlement with the CCG's. Also completed detailed demand and capacity analysis at specialty level. involving CCG partners. For 19/20 the systematic approach has been aligned with national and ICS strategy. on 4th December a planning event was held with ICP partners, the planning process was agreed including Vital Signs priorities which are aligned to the long term plan, the Pennine Lancs plan and ELHT clinical strategy (golden thread).

Reference Number: BAF/02

Responsible Director(s): Director of HR and OD

Aligned to Strategic Objectives: 2, 3 and 4.

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

Consequences of the Risk Materialising:

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

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2018/19**			
						Q1	**Q2**	**Q3**	**Q4**
Workforce Transformation strategy in place and associated Divisional and Trust-wide plans monitored through the Workforce Transformation Board. Divisional Workforce Plans aligned to Business & Financial Plans Divisional Performance Meetings Reports to Finance & Performance Committee Recruitment strategy and plans linked to Workforce Plans. Trust Workforce Controls group in place to review all vacancies and support the Workforce Transformation strategy. One Workforce Planning Methodology across Pennine Lancashire Workforce planning at STP level, e.g. Apprenticeships, recruitment and retention initiatives, collaborative medical banks and talent management. Pennine Lancashire Workforce Transformation Group Divisional finance and performance meetings	**Internal Assurances** On-going monitoring of vacancies and bank/agency usage at Trust Operational Delivery Board via Trust performance report. Performance measures, time limited focus groups with action plans, board and committee reports, regulatory and inspection agencies, stakeholders, internal audit. WRES action plan with timelines in place. Regular reporting to the Board on progress. Work with the Fanshawe Report. Ongoing monitoring of workforce diversity through the re-establishment of the Diversity and Inclusion Steering Group and Trust Operational Delivery Board. Workforce Control Group regularly reports to the Executive on workforce control measures and indicators. Dashboard developed. Annual report to the Quality Committee. Medical and Non-Medical Agency Group in place. Dashboard giving overview of bank/agency usage presented to the Executive team meeting monthly. Additional scrutiny from a nursing perspective. The Performance Assurance Framework Lean Programme (Vital Signs) overall linking into workforce transformation. Workforce Dashboard reporting key performance indicators within division on a monthly basis Agency staffing group monitoring the use of agency spend. Implementation of Allocate rostering/ publication dates for rosters. Uptake of flu vaccine across the workforce. Completion rates of the annual staff survey and low rates of turnover. Integrated performance report. Review of absence management process to support staff attendance and to mitigate need for use of bank and agency. Quarterly report on workforce metrics to Finance & Performance Committee. A Senior Medical Staffing Performance Review Group established - responsibility for reviewing all consultant job plans, consultant vacancies etc. adding further rigor on our appropriate use of resource. **External Assurances** Friends and family test (further detail in BAF risk 5) Benchmarking of agency spend is available through the Model Hospital data.	16	10	12	4x5	12	12	12	20

Gaps in Control *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	Gaps in Assurance *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	Actions Planned / Update *Dates, notes on slippage or controls/assurance failing.*
National recruitment shortages, capacity for delivery of transformation programmes, financial restrictions. Reduction of CPD monies from HEE (could be off-set by the apprenticeship levy). Varying incentive schemes/packages across provider sector. Implications of Brexit on the workforce - uncertainty/ workforce are yet to be determined. Integrated workforce assurance group Broader equality and diversity group	Inability to control external factors (Brexit, visas etc).	Currently there are a further 126 external nurses in the recruitment pipeline due to start with the Trust been now and March 2019. 23 nurses have been sourced via the global learners programme. HCA recruitment continues, contributing to the reduction in HCA bank shift requests adding further stability and flexibility to our support workforce. E&D Action Plan Festival of Diversity planned for the last week in April. Culture and Leadership Programme is now entering phase 2 (Design) and an update was presented to the Trust Board on 9 January 2019. Significant progress made with WRES action plan. The NHS National Workforce Race Equality Standard (WRES) 2017 data analysis report December 2017 demonstrated continued improvement and ELHT are highlighted as better than average in Indicator 6: a decrease in the overall percentage of staff experiencing harassment, bullying or abuse from other colleagues. Review of internal data in January demonstrates further improvements in WRES indicators 1, 2 and 3. The national WRES lead attended the Trust in October 2018 and following this, a refreshed WRES action plan will be produced. A broader Workforce Transformation Group will be established from February 2019 to consider the wider diversity agenda. Funding has been secured from the NHS NorthWest Leadership Academy (NWLA) to deliver a shadow Board programme aimed at improving opportunities to manage talent for greater diversity at sub-Board and Board level. Commencing in June 2019. Vital signs improvement programme is underway to improve employee experience from recruitment to leaving the organisation. The Workforce Transformation Strategy addresses the future workforce supply pipeline, opportunities to up skill current staff, introducing new competencies, e.g. Physicians Associates and Associate Nurses and establishing new ways of working. The 2018-19 Business Planning approach has included a Workforce Planning and Transformation return from each Division which will inform the Trusts and Pennine Lancashire Transformation and Workforce priorities. We are now working with ICP partners to undertake systematic and integrated workforce transformation linked to the NHSI LEAN improvement programme. We are working across the ICS to develop a mobility agreement to assist with the movement of staff across the region. A Recruitment and Retention Strategy is being developed to underpin a system wide approach to recruitment. 10 Workforce Repository and Planning Tool (WRAPT) planning projects are underway across the organisation. HEE funding secured to develop clinical leadership for workforce transformation through the WRAPT process. Establishment of a Care Academy for Pennine Lancashire to secure a talent pipeline locally Development of a Recruitment and Retention strategy to reflect emerging labour market and to sell ELHT and Pennine Lancashire as employer of choice. Launch of volunteer learning passport in January 2019 enabling mobility of volunteers between organisations. There wil lbe an evaluation period at the end of February 2019. Apprenticeship strategy in place and proposals/agreement to passport levy between partner organisations. Alignment of workforce Transformation Board to oversee delivery of priorities. Exploration of opportunities to manage medical agency staffing differently has commenced in January 2019. Proposed restructure of Trust Medical Staffing team to amalgamate the existing locum booking team with the Temporary Staffing team, to ensure greater consistency of service provided to the whole workforce

Reference Number: BAF/03

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

Aligned to Strategic Objectives: 3 and 4

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

Consequences of the Risk Materialising:

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

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2018/19**			
						Q1	**Q2**	**Q3**	**Q4**
Pennine Lancashire System Leaders' Forum meets to discuss strategy. Engagement by senior leaders in wider transformation programmes. Regular Board updates and decisions on key actions. At Pennine Lancashire level health improvement priorities agreed (HIMPs). HIMPs reporting to the Professional Leadership Committee (PLC) Number of senior clinicians involved with ICS work groups. Professional Leadership Committee (PLC) has ELHT representation. ICS Finance Group and ICP Finance and Investment Group with ELHT senior representation . The ELHT Chief Executive is the senior responsible officer (SRO) for the Pennine Lancashire Transformation Programme, sits on the System Leaders Forum and on the Integrated Care System for Lancashire and South Cumbria (ICS) Programme Board. The Trust's Medical Director is the professional lead for the Pennine Lancashire ICP. Vital Signs Programme ensures the ICP as a system is having a significant participation as part of the transformation programme. ICS level Planning Group has been formed and met for the first time on 3 December 2018. The Director of Service Development attends to represent the ICP. The role of the group is around the 5 year plan which is due to be developed by summer 2019.	**Internal Assurances** Verbal and written updates, where appropriate Board approvals will be established and permissions will be provided by the Board to let Executives progress the generation of ideas and options with external stakeholders. Potential gains in strengthened reputation with regulators and across the ICS footprint with regular reporting to the Board via the Finance and Performance Committee on progress, milestones and risks linked to the gateway process. Mitigation in place for creating single teams across the system, e.g, 'one workforce' with timelines for implementation. Progress covered under BAF risk 2. **Internal / External Assurances** The Pennine Lancashire and ICS Cases for Change have been published. Pennine Lancashire resource in post working on developing models of care against specific improvement priorities (paediatrics, respiratory and frailty). Health and Wellbeing Improvement Partnerships (HIMPs) at Pennine Lancashire level reviewed around the health improvement priorities and the majority are relatively well established with minor changes needed to link into the new structures. ICS governance oversight forms part of the Audit Committee standing agenda for 2018/19. Fostering good relationships with GP practices and Federations e.g. service pilots and as a result of tenders and general dialogue. Pennine Lancashire ICP Memorandum of Understanding agreed by stakeholders. ELHT Chief Executive chairing the ICS Providers' Forum. ELHT hosting the Providers Programme Director for the ICS Provider Board who reports to the Chief Executive of ELHT. Director of Service Development leading on the construction of the work programme with the Directors of Strategy from all the providers. Component business cases at Pennine Lancashire level forming a draft overarching ICP plan. Plan on a page for the ICP, connecting to the Plan on a page for ELHT completed and shared with the Commissioners. CEO of ELHT and Accountable Officer of East Lancashire CCG jointly chairing the Pennine Lancashire ICP Programme. Posts for Portfolio Holders at ICP level are in development. Cultural development programme for system level leadership established with involvement of all senior leaders across the ICP. ICS architecture on clinical services is developing (eg pathology, stroke and frailty). Positive feedback from service reviews (stroke and endoscopy). Structures in place for the Out of Hospital stream with the Trust significantly contributing to the workstream. Clinical leadership through the Professional Leadership Committee (PLC) at Pennine Lancashire ICP level giving consistent message about the importance of working as a system. Strengthening the relationship with primary care networks' leadership. Associate Medical Director for Service Improvement appointed, increasing our capacity for clinical leadership in relation to service improvements. Pennine Lancashire Delivery Group has ELHT representation and is chaired by the Trust's Chief Executive. A&E Delivery Board meets monthly, chaired by the ELHT Chief Executive. Progress on collaborative efforts in relation to the emergency pathway is covered under BAF risk 5. Vital Signs is a system wide transformation programme across the Pennine Lancashire ICP. Patient experience strategy envisages good patient and public involvement to support the collaborative transformation. Progress with work covered under BAF risk 1. Producing ELHT demand and capacity plan to be signed off by the Executive Team. The wider system demand and capacity plan will be signed off by the Partnership Delivery Group. Pennine Lancashire Partnership Delivery Group is the engine/delivery room for the ICP. The group has been given delegated authority from the Pennine Lancashire Leaders Forum. The planning process is driven through this group. The Pennine Lancashire system planning reports into the Partnership Delivery Group.	16	12	12	3x4	12	12	12	12

Gaps in Control *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	Gaps in Assurance *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	Actions Planned / Update *Dates, notes on slippage or controls/assurance failing.*
System leaders agreed a process to develop the governance system across Pennine Lancashire; however this is still in development ICS System Management model is in early stages of development. Decision making process for Pennine Lancashire system will need agreement. Priorities of the individual organisations and those of the system not being aligned/agreed. There is a need for consistent leadership across the system. Building trust and confidence and agreeing collaborative approaches to service provision	Timeline for consultation with public - uncertainty about the detail of the consultation for the component business case at ICP level. Lack of unified approach in relation to procurement by Commissioners. Priorities of CCGs starting to be aligned with priorities for pathway redesign (e.g. stroke) but this work is still in the early phases. Future role of NHSE/NHSI merged teams to be determined. Creation of single teams for care functions to deliver the transformation agenda at system level. Ensuring consistent capacity to work externally as well as internally by building system collaboration into the leadership roles and having good joined leadership programmes. Adequate assurance mechanism that the service integration plans are on track together with the rigour of governance arrangements/lack of delegation from the sovereign bodies to the system. it is unclear what the impact of the changes in senior leadership in partner organisations will be.	Regular updates provided to Board and the Audit Committee. Standing agenda item at Execs and Trust Board. Across the ICS footprint the Medical Directors of the four Trusts agreed to focus on urology, vascular services, stroke, emergency department, interventional radiology and gastrointestinal bleed, and neonatology. At ICS level all providers met to formulate work programme - 3 categories of services agreed a) services that are fragile now b) services where there is no immediate risk but possible in the not too distant future c) services that need to be managed across the whole footprint. Agreement on the way of taking this forward to be agreed. Prioritisation of diagnostics, pathology and cancer work streams agreed. Next steps in a process to be agreed. Update in Quarter 4. Meetings are ongoing regarding the acute Programme and more focused work is taking place in Stroke, Vascular, Urological Cancer and Diagnostics. A range of services are being developed for Head & Neck. Pennine Lancashire ICP component business case prepared and consultation in progress. Focus on developing at LDP level wider deliverables. East Lancashire CCG extended the Community Services contract by 12 months allowing for the principles of the new clinical model at ICP level to be developed. Ongoing progress is being made with more focus on the future model of care (not the current model of care). An update will be provided at the Trust Board in March 2019. Good co-production on developing clinical model across the ICS for CAMHS services was presented to the Commissioners on 6 August, outcome awaited. The model (stage 1) had been signed and providers are working on the detail (stage 2). A timetable has been produced, presented to local commissioners and approved by them (1 year plan). Milestones have been developed and a financial exercise has been undertaken to determine the resources required to implement the new model. The Director of Service Development has led discussions with other providers of CAMHS services about potential future configurations and alliance, the model was universally supported. Neighbourhood system event held at end of January 2019.

Reference Number: BAF/04

Responsible Director(s): Director of Finance

Aligned to Strategic Objectives: 3 and 4.

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

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

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2018/19**			
						Q1	**Q2**	**Q3**	**Q4**
Budgetary controls (income & expenditure) in place including virement authorisation, workforce control, monthly performance meetings and variance analysis. Measures to mitigate financial risk overseen by Finance and Performance Committee.	**Internal Assurances** Monthly reporting to Finance and Performance reports and the Board to reflect financial position. Separate reporting available to support assurances on the transformation programme. Regular Performance Review meetings between Executives and Divisions. Using the Performance Accountability Framework (PAF) to provide assurance that action is taken to help ensure the delivery of objectives. Financial objective included in individual appraisals. Setting of financial objectives in senior management appraisals. Budget setting Financial Forecasts Briefings on risk Pipeline of schemes to reduce cost. Use of data sources (e.g. Model hospital data.) to drive improvement and mitigate deterioration. Evidencing the routine use of benchmarking data to drive positive change. Revised Performance Accountability Framework presented to the Finance and Performance Committee on 29 October 2018 and to the Operational Delivery Board on the 31 October 2018, with final approval by the Finance and Performance Committee at the end of November. The introduction of the Financial Assurance Board (FAB) will strengthen governance and oversight. **External Assurances** External audit view on value for money. Model Hospital benchmarking (including cost per Weighted Activity Unit). ICS Led Theatre Productivity analysis.	16	12	20	5x4	20	20	20	

Gaps in Control *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	Gaps in Assurance *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	Actions Planned / Update *Dates, notes on slippage or controls/assurance failing.*
Additional workforce controls to remain in place. Policies and procedures may require amendments where they are no longer fit for purpose. Controls around transformation schemes and SRCP to be monitored by the PMO and the Finance Department with Division to be held to account via the PMO. Gaps in control regarding funding for A&E and STF funding - recovery plan underway. Lack of standardisation in applying rostering controls. Weaknesses in discretionary non-pay spend Deterioration in the underlying financial position requiring additional transformation schemes in 2018/19. SRCP being delivered non-recurrently. Officers operating outside the scheme of delegation. Inadequate funding assumptions applied by external bodies (pay awards) Hidden costs of additional regulatory requirements - highlighted with NHSI Cost shunting of public sector partners increasingly managed through ICS and ICP Failure to meet Provider Sustainability Fund requirements Agency and locum sign off with escalation of cost	Utilise the internal audit programme to test for assurance on core controls, SRCP and transformation plans. Lack of consistency in divisional governance processes. Understanding the changes in income services (NHS and private). Weaknesses in appraisals and accountability framework.	Regular updates to Board and Finance and Performance Committee Actions and risk relating to the achievement of 'incentivised funding' (e.g. Provider Sustainability Funding) will be routinely reviewed. Risks in relation to the impact of the changes to CQUIN and Provider Sustainability Funding arrangements to the end of 2018/19 are being managed and reporting to the Quality Committee and Finance and Performance Committee. Agency and locum sign off with escalation of cost, total hours booked and average per hour will be reported to the Finance and Performance Committee from September 2018 as part of the Financial Performance Report. Cash borrowings have increased above plan as a consequence of not delivering A&E PSF and non cash backed SRCP. Detailed plan for 2019-20 to be developed in light of additional financial focus. Merge medical + non-medical temporary staffing groups for improved oversight chaired by DOF.

Reference Number: BAF/05

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

Aligned to Strategic Objectives: 1, 3 and 4.

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

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

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score 2018/19**			
						Q1	**Q2**	**Q3**	**Q4**
Monthly divisional performance meetings feeding into the ODB and Finance and Performance Committee and weekly operational performance meeting covering RTT, cancer, 4 hour performance and holding list management monitoring delivery against the divisional business plans and the operational delivery standard. Engagement meetings with CQC and CQC Steering Group in place monitoring performance against the CQC standards. Quality and safety compliance assessed by each division and assurance through the Divisional Quality and Safety Boards (DQSB) reporting into the Quality Committee Sub-Committees. Divisional assurance boards feeding into the operational sub-committees and the Quality Committee. Nursing Assessment Performance Framework reporting through to the Quality Committee and involvement of NEDs on the SPEC Panels and Board approval for the award of SPEC awards. A&E Delivery Board with Emergency Care Pathway assurance feeding into it. System-wide Scheduled Care Board with elective pathway assurance feeding into it. Daily nurse staffing review using safe care/allocate Nursing and Midwifery. Weekly Medical Staffing Review - Nursing and Midwifery staffing review feeding into the annual professional judgement review for all wards. Operational flow meetings at 08.30, 12.30, 15.30, 18.00 and 19.30 Weekly operational performance meetings.	**Internal Assurances** IPR reporting to the ODB and at Board/Committee level. Regular deep dive into the IPR through Finance and Performance Committee. Delivery of RTT and most cancer standards, action plan for 62 day cancer standard in place, emergency care pathway action plan in place, both monitored through the Finance and Performance Committee, and at operational level through the Operational Delivery Board and Executive. ED performance and four hour improvement action plan aligned with the NHSI Rapid Improvement Collaborative and agreed by NHS England. Performance monitoring provided through the Emergency Care Pathway Programme Board (progress reporting) as part of the transformation programme governance. Regular reporting from the divisions into the operational sub-committees and the Quality Committee. Alignment with national priorities through the quality and safety governance mechanisms. Silver accreditation under the Nursing Assessment and Performance Framework following three successive green assessments continues. There are currently eight Silver Accreditation of a ward approved by the Trust Board with further three awaiting approval. Increased number of assessments under the framework planned all inpatient wards completed in ICG and SAS. Work started on Family Care and Community Services and a plan is in place for 2018/19. Significant reduction in the number of complaints upheld by the Ombudsman. Comprehensive system for addressing complaints. Reduction on overall number of complaints, 50+ and 40+ days continues with regular reporting at operational and Board level. CQC Steering Group meets regularly and is chaired by the Director of Nursing and includes representation by all the Clinical Divisions. Mini mock-CQC visits regularly carried out and focussing on all areas with regular reporting back to the Quality Committee. Reduction in use of nursing bank and agency staff continues, revisiting the specialing policy with further reduction in spend. Staffing escalation process for nursing including forecast gaps in staffing and senior decision making. Standard Operating Procedure (SOP) developed and monitoring through Nursing and Midwifery Leaders' Forum. Patient Safety Walkrounds. Delayed Transfers of Care have been reduced to below 3% and target achieved in the last quarter. The Performance Assurance Framework - Revised document presented to the Finance and Performance Committee and Operational Delivery Board at the end of October, with final approval at the end of November. System-wide approach to elective care pathway through the System Scheduled Care Board, supported operationally by the Access and Choice Committee. Recovery plans in relation to the risks around some of the national trajectories addressed through the Emergency Care Pathway Transformation programme, Scheduled Care Programme, Cancer Improvement Action Plan. Regular monitoring by Executive Team and ODB. Weekly monitoring of complaints and reporting to the Patient Experience Committee and End of Life Care Group Staffing (nursing/midwifery) report to Quality Committee. NAPF - operational monitoring through the Nursing and Midwifery Leaders' Forum monthly, receiving assurance from the Assistant Director of Nursing and NAPF team and monitoring by matrons at ward level where they carry out mini-NAPFs on a weekly basis to keep up the improvement work. **External Assurances** Trust rated 'Good' by CQC in 2018 with various improvements in various areas and some outstanding services. Nurse staffing review as part of the IPR. Staff Care Allocate and daily monitoring of allocation for staff and three times daily matrons meetings to monitor. Audit carried out by MIAA for nurse staffing received significant assurance. Internal Audit (MIAA) have carried out an emergency care risk assessment audit which gained an assurance rating of 'Significant Assurance' in November 2018. **Internal / External Assurances** System wide approach to Emergency Care Pathway, as part of monthly A&E Delivery Board supported operationally by the A&E Delivery Group. PLACE assessments - percentage improved in all areas and monitoring continues. Annual PLACE report presented to the Quality Committee for assurance. Nursing and Midwifery Leaders' Forum also monitor. Patient Experience Committee receive minutes of the PLACE Steering Group. NAPF Team also monitors environmental issues linking to PLACE Assessments. Positive responses to Friends and Family Test and patient surveys with improvement areas identified. Monitoring at ward level, local divisions prepare monthly patient experience action plans that feed into the Patient Experience Committee that reports to the Quality Committee. Monitoring monthly by the Nursing and Midwifery Leaders' Forum. Positive response and results from the 2018 National Staff Survey.	15	9	12	3x4	12	16	16	12

Gaps in Control *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
Restrictions in the supply of medical, nursing, midwifery and other staff groups to meet demand. Reference in BAF risk 2. Risk of mental health providers not being able to ensure sufficient assessment and treatment capacity. Restrictions in the primary care system to ensure sufficient capacity. Insufficient capacity to deliver comprehensive seven day services across all areas. Insufficient bed capacity to ensure there are no delays from decision to point of admission. The heating system failure at Accrington Victoria Community Hospital necessitated a temporary cessation of patients to Ward 2 results in a loss of 19 beds.	Staffing gaps on rotas. Gaps in assurance from the medical staffing perspective. E-Rostering inability to fill all vacant shifts/short term sickness or non-attendance. Challenges to the delivery of the four hour standard and the delivery of the 62 day cancer standard Extended waiting times for mental health patients. Continued non-elective activity is placing pressure on the elective care and the RTT standard. Wards and departments overdue for refurbishment due to the lack of decant facilities. Temporary funding secured for an additional member of staff enabling the Nursing Assessment Performance Framework (NAPF) team to carry out further assessments.	Review of the complaints element of the Patient Experience Strategy has been launched and a user friendly version developed and presented to the Patient Experience Committee in October 2018 and launched in November. The Patient Participation Panel held an open day on 17 January 2018. The launch of the panel will take place on 27th February 2019 and will initially be made up of 15-20 people. The Trust is developing a full business case regarding the emergency care pathway and is anticipated to be ready for presentation and sign off in early 2019. Delays in completion due to refinement of clinical pathways and impact on building design.. Plans for staffing and estates challenges have progressed as follows: 1. Emergency care pathway action plan in place and is monitored monthly through the ECP Programme Board. Redesign emergency care workforce plan carried out as planned and agreed with NHSI, awaiting response. 2. Ambulatory Care Emergency Unit opened as planned on 14 September 2018. Fortnightly service reviews carried out to ensure service delivery as expected. 3. Business case approved by the Trust Board and submitted to NHSI in July 2018 for the extended acute medical facility. Still no formal response from NHSI received. 4. Frailty Assessment Unit opened on 7th January 2019. Surgical & Ambulatory Emergency Care unit moved to the old ambulatory care on 7th of Jan 2019 and additional beds opened on B14. Board receives regular SRCP and transformation updates. Nursing Assessment and Performance Framework (NAPF) assessments are continuing. Ten Silver Accreditation of wards approved by the Trust Board. with a further one to be presented to the Trust Board for approval. Further inspections planned for a number of wards awaiting third assessment following two green assessments. Work is planned within the NAPF team to develop the process to incorporate non-nursing areas, such as pharmacy. Objective is for a 50% reduction in all red wards by the end of March 2019. Core 24 (Lancashire Care Foundation Trust mental health programme) implementation commenced in April 2018 and will run until March 2019. Development of mental health decision unit planned by July 2018 had been delayed by external partners. Unit has opened in August 2018. The Trust continues to work with external partners. The system wide action plan for mental health services has been agreed by the ICS in November. Develop escalation facilities in Victoria wing at BGTH by October 2018, convert ward C3 to allow use as a decant ward in the next financial year (after Easter 2019). Escalation ward in Victoria wing in Burnley opened on 15th November 2018 providing 24 additional beds. CQC report published on 12 February 2019, improvements in some areas and outstanding services. Following discussion at Trust Board in January 2019, a review of the BAF 5 risk rating has been undertaken. The risk score likelihood has been reduced from 4 to 3 reducing the overall score to 12 from 16. Reasons for recommending the reduction is based upon delivery of cancer & RTT targets and improved resilience linked to the emergency pathway.

TRUST BOARD REPORT

Item 41

13 March 2019

Purpose Information Assurance

Title	Serious Incidents Requiring Investigation Report for December 2018 and January 2019
Author	Mrs R Jones, Patient Safety Manager
Executive sponsor	Mrs A Brown, Associate Director in Quality and Safety

Summary: This report provides a summary of the Serious incidents and Duty of Candour requirements that have occurred within the Trust in December 2018 and January 2019

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

Report linkages

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

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

Contents:

Executive Summary

1. Trust has reported 17 strategic executive information system incidents in December 2018 and January 2019
   - All duty of candours has been served in appropriate cases.
   - Root Cause Analysis (RCA) Investigations are in progress with nominated leads

2. Trust has requested 6 internal root cause analysis investigations within the Divisions:
   - All duty of candours have been served in appropriate cases, Root cause analysis investigations are in progress

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

Strategic executive information system* (STEIS) – *SIRIs reported in December 2018 and January 2019

3. There have been 17 serious incidents requiring investigation which have been reported through Strategic Executive Information System (STEIS). Each incident has had a rapid review undertaken and a copy has been sent to the commissioner and regulatory bodies. The Associate Director of Quality and Safety has commissioned a root cause analysis investigation for each incident and on completion these will be presented to the serious investigation requiring investigation (SIRI) panel. The table on the following pages provides details of these incidents:

Number	eIR	Division	Incident reported	Reported to STEIS within 2 working days	Category/Allegation	Relevant to Duty of candour	Rapid Review	Any immediate changes initiated	Level of harm	Next steps
1	1147961	SAS	04/07/18	N	200 units instead of 20 units of insulin administered	N	Y	Patient aware and immediate actions taken, no physical harm ensured. Incident taken to medicines management / medication error harm reduction group	Low / Minor	RCA to SIRI
2	1157016	ICG	17/12/18	Y	Unwitnessed fall to the floor causing harm	Y	Y	Incident taken to the Falls Steering Group	Severe / Major	RCA to SIRI
3	1156851	FC	13/12/18	N	Still birth	Y	Y	Work ongoing with “saving babies lives” and “each baby counts”	No harm – impact not prevented	HSIB to investigate
4	1156607	ICG	08/12/18	N	Patient readmitted, concerns of review in a&e	Y	Y	Initial judgement – no immediate changes indicated	Death / Catastrophic	RCA to SIRI
5	1158736	ICG	19/01/19	Y	Unwitnessed fall causing harm	Y	Y	Ongoing harms reduction project - Falls Steering Group	Severe / Major	RCA to SIRI
6	1157697	ICG	01/01/19	Y	Witnessed fall causing harm	Y	Y	Ongoing harms reduction project - Falls Steering Group	Severe / Major	RCA to SIRI

7	1159251	ICG	27/01/19	Y	Pressure sore Grade 3	Y	Y	Initial judgement – no immediate changes initiated	Moderate	RCA to SIRI
8	1158737	ICG	19/01/19	Y	Pressure sore – Grade 3	Y	Y	Verified and this is an abscess – requested de-esc from STEIS	No harm - Impact not prevented	Awaiting CCG response
9	1159017	ICG	24/01/19	N	Failure to diagnose leading to deterioration of patient	Y	Y	Ongoing harms reduction project with Deteriorating patients Steering Group	Death / Catastrophic	RCA to SIRI
10	1157050	FC	17/12/18	N	Concerns raised over mother potentially administering calpol to new born baby	N	Y	Initial judgement – no immediate changes initiated	No harm - Impact not prevented	RCA to SIRI
11	1157966	ICG	06/01/19	N	Grade 4 pressure ulcer	Y	Y	Initial judgement – no immediate changes initiated	Moderate	RCA to SIRI
12	1157451	FC	26/12/18	N	Baby fall causing harm	Y	Y	Ongoing harms reduction project - Falls Steering Group	Moderate	RCA to SIRI
13	1159351	SAS	29/01/19	Y	Structured judgement review undertaken to look at care and delivery services given to patient – potential diagnosis failure	N – to be delivered on completion of RCA	Y	Initial judgement on structured judgement review 2 to commence investigation	Level of harm to be determined on completion of RCA	RCA to SIRI

14	1157699	SAS	01/01/19	N	Grade 3 pressure ulcer	Y	Y	Initial judgement – no immediate changes initiated	No harm - Impact not prevented	RCA to SIRI
15	1157247	SAS	21/12/18	N	Return to theatre – injury to bladder	Y	Y	Initial judgement – no immediate changes initiated	Moderate	RCA to SIRI
16	1159274	ICG	28/01/19	N	Elderly patient admitted with self-harm, lack of senior medical review / delay in treatment	Y	Y	Initial judgement – no immediate changes initiated	Death / Catastrophic	RCA to SIRI
17	1158335	SAS	13/01/19	N	Delay in treatment for surgical condition patient then went on to deteriorate	Y	Y	Initial judgement – no immediate changes initiated	Death / Catastrophic	RCA to SIRI

Nb: The incidents where there has been a delay in reporting to STEIS is either due to:

a) Awaiting rapid review to determine the level of harm

b) Incident not thought to be STEIS but then on presentation to DSIRG panel agreed for this to be escalated to STEIS.

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

Non-strategic executive information system – serious incidents requiring investigations reported in December 2018 and January 2019

4. There were 6 non-strategic executive information system incidents deemed to be serious incidents requiring investigation. A rapid review has been undertaken where further information was required and duty of candour completed on all moderate and above incidents in line with trust policy. A full root cause analysis investigations have been requested and once complete will be presented to each divisional serious investigation review group (DSIRG) panel.

	eIR1	Division	Incident reported	Category/Allegation	Relevant to Duty of	Rapid Review done?	Any immediate changes initiated	Level of Harm	Next steps
1	eIR1156446	ICG	05/12/18	Concerns over transfer of patient who was potentially not medically fit	N	Y	SAFER project ongoing on wards	Low / Minor	RCA to DSIRG
2	eIR1158371	ICG	14/01/19	Misdiagnosis which caused a delay in treatment	Y	Y	Initial judgement – no immediate changes initiated	Moderate	RCA to DSIRG
3	eIR1157425	ICG	25/12/18	Misdiagnosis causing delay in treatment –	N	Y	Initial judgement – no immediate changes initiated	No harm - Impact prevented	RCA to DSIRG
4	eIR1158820	SAS	21/01/19	Delay in treatment for imminent spinal cord compression identified on CT scan, patient had no signs or symptoms at the time, attended 2 weeks later	Y	Y	Initial judgement – no immediate changes initiated	Moderate	RCA to DSIRG
5	eIR1157073	SAS	18/12/18	Potential unsafe transfer of patient	N	Y	SAFER project ongoing on wards	No harm - Impact not prevented	RCA to DSIRG
6	eIR1157495	ICG	27/12/18	Nutritional incident	N	Y	Initial judgement – no immediate changes initiated	No harm - Impact not prevented	RCA to DSIRG

Duty of Candour

5. Duty of candour is a legal and regulatory requirement following the visit from CQC and reviewed at its Well Led Framework. The Trust has put measures in place for the delivery of duty of candour and education has been delivered. A daily duty of candour report is sent out to divisional Quality and Safety Teams for assurance and to monitor compliance.

6. Of the above reported incident Duty of candour has not yet started on eir1159351due to the level of harm not confirmed at this stage.

Duty of candour internal audit:

7. Duty of candour regulation 20 sets out that each Trust has to adhere to the following:
   a) A verbal apology is to be given within 10 working days
   b) Duty of candour is to be documented within the case notes
   c) Letter offered to the patients/relatives/carers as a follow up of the apology and investigation as part of best practice (no time specified within the legal requirements).

8. An audit was carried out on parts A and B of regulation 20 for assurance of compliance.

9. 25 case notes of incidents reported within 2018 were audited:
   a) 3 incidents had level of harm reduced to no/low minor harm therefore duty of candour did not apply
   b) 1 was subject to a structured judgement review where it was agreed if the findings were of moderate level of harm or above on completion of the investigation then duty of candour will be served.

10. Of the remaining 21 case notes the following was audited:

Duty of candour regulations:	Yes	No	Compliance %
Verbal apology given within 10 working days	21	0	100%
Duty of candour documented within case notes	7	13	37%*

*1 set of case notes were not the originals therefore documentation of duty of candour was not able to be confirmed.

Recommendations

a) For all confirmed moderate harm or above incidents that an email is sent to the clinical lead to ensure that duty of candour is formally documented within the case notes.
b) Re-audit of duty of candour in August 2019
c) Communication to be sent out to all clinical staff reminding them that duty of candour needs to be documented within patients' case notes.

Part 3: Incident reporting, investigation and learning improvements

11. Over last 12 months the Quality and Safety Team have made a number of improvements and developments to policies, training, documentation, Datix and the introduction of learning from deaths new process. A number of the improvements have come from recommendations on the back of audits and internal/external reviews.

Policies:

a) C003 V5 Incident reporting – Amendments: Reflection of changes in internal roles, timescales for the management of incident, Just Culture Template, Removal of Investigation information (see update policy C012 Policy for Investigation (including RCA) of incidents, complaints and claims
b) CO12 V9 Investigation policy for incidents, claims and complaints – amendments: complete rewrite of policy which incorporates a number of recommendations made within the external Verita Report.
c) C143 v2 Learning from Deaths – New policy - To outline the Trust's strategy and procedure for learning from deaths and to provide guidance for all staff involved in mortality reviews to ensure that deaths are reviewed appropriately and enable learning from the service provided to deceased patients prior to their death are reported into the organisation to promote continuous improvement in care.
d) C002 v11 Risk management strategy – Amendments made which includes definitions of risk management, better articulation, how 5x5 matrix can facilitate risk scoring, use of PDCA cycle for risk management, governance process and KPIs. The purpose of this document is to set out the approach adopted by the Trust to ensure the robust identification, assessment, monitoring, management and governance of all risks across the organisation.
e) C145 Risk Management procedure – This is a new policy. The purpose of this document is to set out the approach adopted by the Trust to ensure the robust

identification, assessment, monitoring, management and governance of all risks across the organisation

Training:

12. A full programme of training packages have been developed and are now available for all trust staff to book on the Learning Hub;
    a) RCA training - provides staff with the skills and tools required to complete a structured investigation of serious incidents or complaints
    b) Introduction to Human Factors - is designed to help staff gain an understanding of human factors approaches, and look how to apply these to help improve safety within their work or environment.
    c) Incident Reporting and Handling Training - provides training and oversight to all members of staff to make them confident in reporting, reviewing and managing an incident on the incident module on Datix
    d) Duty of Candour –to provide staff with the importance of being open and honest when an incident has occurred and an outline of the regulations the Trust is to adhere to
    e) Risk Management - to provide staff training to make them more confident on how to report a risk, add SMART actions to a risk as well as explain the importance of effective risk management to the Trust, implement the Trust`s risk management process, governance arrangements and the difference between a risk and an issue

Documentation:

13. A number of templates, letters and leaflets have either been updated in line with national guidance and/or recommendations from external stakeholders to help support staff and patients/carers/families. These are all available on the Trust OLI site and/or DATIX:
    a) Duty of Candour letter(s) and information leaflet
    b) A range of RCA template reports including aids to completion
    c) Terms of reference including aid to completion

DATIX and Monitoring:

14. As part of the development to help improve incident reporting and learning lessons to improve patient safety a number of quality improvements have been made to the DATIX system:

a) Risk Register form redesign to be presented at next divisional directorate meeting
b) Continued development of the SJR process and Datix form design
c) In 2018 a new IR1 form was developed and launched to improve the quality / accuracy of reporting and user experience
d) Dashboards Tracker have been developed for numerous areas, notably Divisional Trackers to facilitate monitoring of but RCA, ToR, Concise Reports, Rapid Reviews, Actions, Risks, Overdue Incidents, SJR, LD & Paediatric Mortality Reviews
e) Corporate tracker – Daily triage of incidents, rapid review report, and tracker of incidents awaiting further information, status of incidents (i.e. final approvals)
f) Redesign on Actions module to enable Actions from SIRI / D-SIRG to be assigned to staff and monitored on Action Trackers
g) Auto feedback for Incidents is sent to the Reporter of the Incident at the point of Finally Approval, details include Lessons Learned and Action taken during investigation.
h) Time bands were implemented so that times of incidents were automatically assigned the time band for which the incident occurred in, which facilitates trend analysis of incidents by time within the Datix application / without the use of Excel
i) Learning Disability & Paediatrics Mortality Reviews have been developed in Datix alongside Structured Judgement Reviews

15. There are a number of further developments and improvements planned over the next twelve months:

a) Review and update of the incident daily triage process
b) Review and update of Soft Intel and create joint guidance with the CCG with clear timescales for responses
c) Mapping of Incidents, Complaints and deaths to identify early notification of possible cases leading to Inquests, Claims and Care proceedings
d) A PowerBi Dashboard is being developed to provide a Trust overview of quality and safety data in real time which will allow early escalation to gain assurance of appropriate actions.
e) Datix:
   i. A good Practice Reporting form has been developed in the Complaints module and is ready to be tested pending approval.
   ii. User Dashboards will be rolled out with Datix Profiles to assist with sight of the users records and overview of trends in the area in which they work.

iii. A rebuild of location hierarchy is required to ensure all services are named correctly and sit under the correct Directorates / Divisions

Summary

16. With all of the above improvements made we have seen better quality of reporting and investigation of incidents across the Trust in all levels of harm. The number of outstanding rapid reviews has decreased significantly over the past 12 months and more are being completed within the 48 hour timeframe. Requests for extensions for investigations have decreased and we are working towards decreasing these further over the next 12 months. Risk management, whilst improvement has been made it is felt that it needs to be embedded in business as usual.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 42

13 March 2019

Purpose Information

Title	2018 National Staff Survey Report and Findings
Author	Mrs L Barnes, Head of Staff Health Wellbeing, Organisational Development and Staff Engagement
Executive sponsor	Mr K Moynes, Director of HR and OD

Summary: Board members are asked to note the 2018 National Staff Survey report and the key findings identified. Members are also asked to support the outlined recommendations and next steps.

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Executive summary

1. This report summarises the findings from the 2018 NHS Staff Survey for East Lancashire Hospitals NHS Trust (ELHT). Members are asked to note the current findings and support the recommendations detailed within the report.

Introduction

2. The Trust undertook a full census in 2018 and a total of 8071 staff were eligible to complete the survey. 3655 staff returned a completed questionnaire, giving a response rate of 45% which is above average for Acute Trusts in England, and compares with a response rate of 43% (3375) in the 2017 survey, which is an increase on the previous year's response rate.
3. Figure 1 below details the return rate by division/directorate and compares with 2017 response rates.

Figure 1: Return rate by division/directorate

Locality	Response rate 2017	Response rate 2018
Trust Head Quarters	63.8%	75% ↑
Diagnostics & Clinical Support	61.8%	61% ↓
Estates and Facilities	44.4%	23% ↓
Family Care	31.1%	46% ↑
Finance and Informatics	76.9%	66% ↓
Quality and Safety	78.4%	72% ↓
Integrated Care Group	33.8%	32% ↓
Human Resources & Organisational Development	72.6%	89% ↑
Research and Development	70.6%	81% ↑
Surgical and Anaesthetics Services	33.9%	48% ↑
Overall	**43%**	**45%** ↑

4. The new National Staff Survey Benchmark report for East Lancashire Hospitals NHS Trust contains results for themes and questions from the 2018 NHS Staff Survey, and historical results back to 2014 where possible. These results are presented in the context of the best, average and worst results for similar organisations where appropriate. Data in this report is weighted to allow for fair comparisons between organisations (see appendix 1 for the full report). The report is presented in the form of ten themes to provide a high level overview of the results for an organisation. The themes are as follows:
   a) Equality diversity and inclusion.
   b) Health and wellbeing.
   c) Immediate managers.
   d) Morale.
   e) Quality of appraisals.
   f) Quality of care.
   g) Safe environment- Bullying and harassment.
   h) Safe environment- Violence.
   i) Safety culture.
   j) Staff engagement.
5. The ten themes are scored consistently on a 0-10pt scale.
   As in previous years the question level data is presented in percentage scores.
   The overall indicator for staff engagement scale summary scores are 1 minimum and 5 maximum.

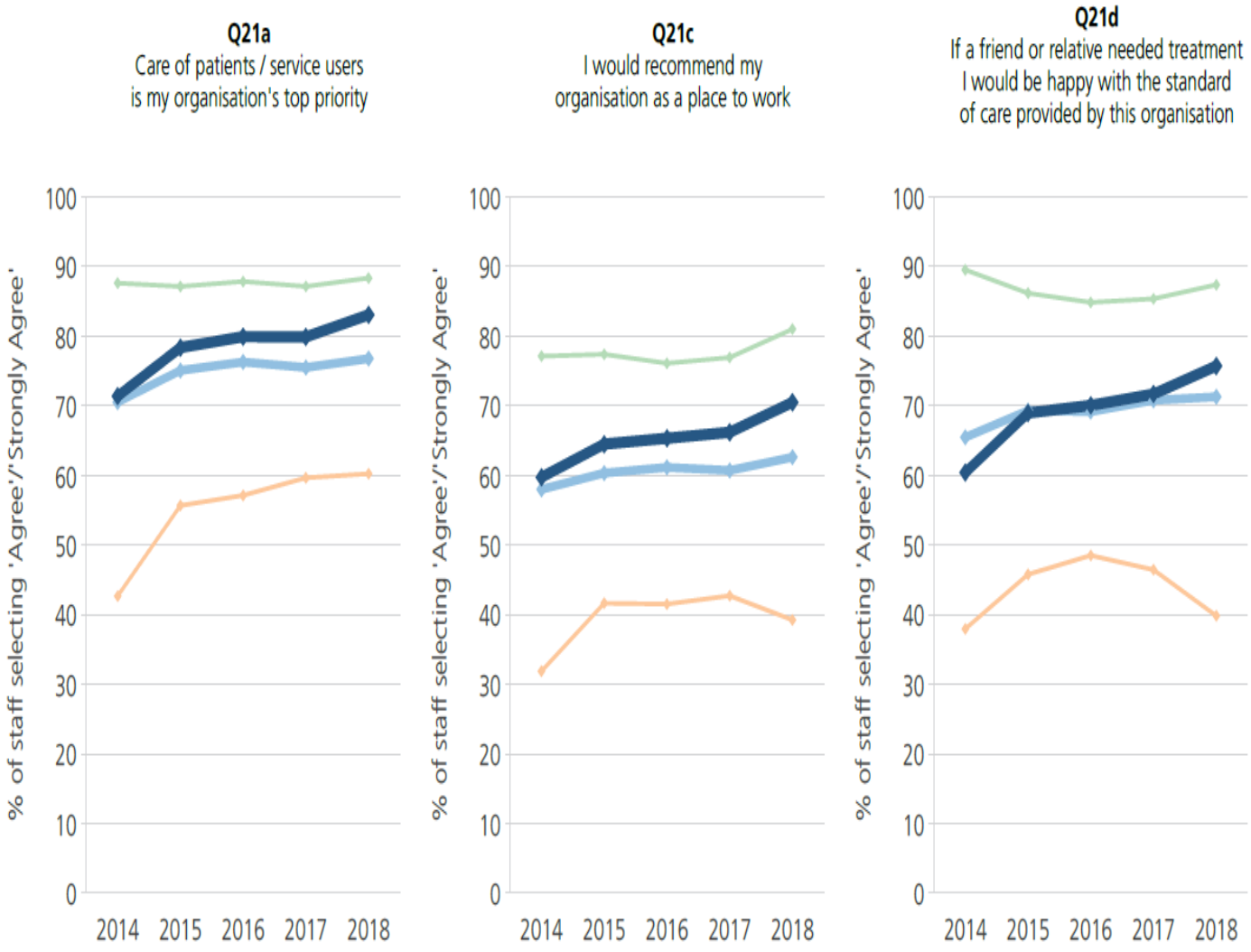
Overall indicator for staff engagement at East Lancashire Hospitals NHS Trust

6. The staff engagement indicator score is 3.93. A score of 1 indicates that staff are poorly engaged (with their work, their team and their Trust) and 5 indicates that staff are highly engaged. The Trusts score of 3.93 is above average when compared with other Acute Trusts (Acute Trust average 3.80). The ELHT score has significantly increased from the 2017 Staff Survey score of 3.86. ELHT are ranked as joint 7th out of 132 Trusts nationally when compared with all Acute and Combined Acute and Community Trusts based on this score.
7. The overall indicator of staff engagement is calculated using 9 questions. Three questions focus on advocacy, motivation and involvement.

8. Staff advocacy: Staff belief that care of patients/service users is the organisations top priority (Q21a) Staff recommendation of the Trust as a place to work (Q21c) and if a friend/relative needed treatment I would be happy with the standard of care provided by this organisation (Q21d) scores have all significantly improved when compared with 2017 and the scores are significantly better than average when compared with other Acute Trusts.

9. Staff motivation: I look forward to going to work (Q2a) and I am enthusiastic about my job (Q2b) have both significantly improved when compared with 2017 and the scores are significantly better than average when compared with other Acute Trusts.
Time passes quickly when I am working (Q2c) has reduced slightly but the score is still significantly better than the Acute Trust average.

Figure 2: Staff advocacy questions

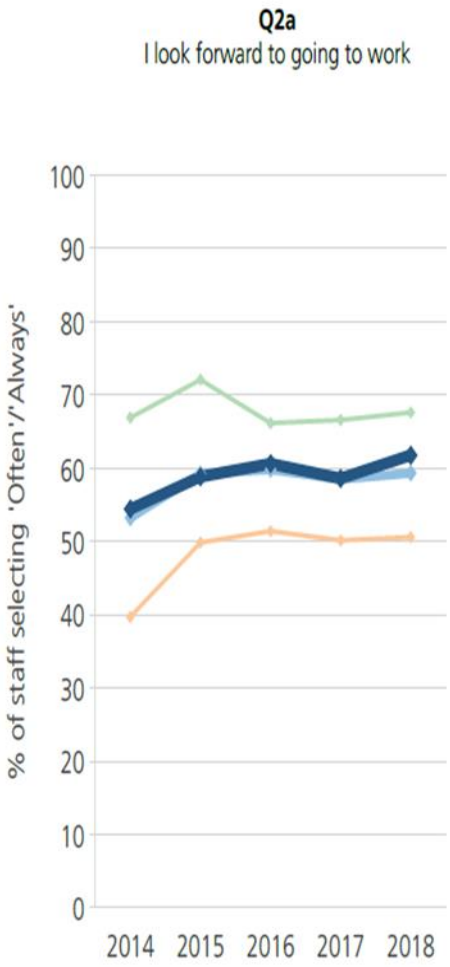


	2014	2015	2016	2017	2018
Best	87.6%	87.1%	87.8%	87.1%	88.3%
Your org	71.3%	78.3%	79.9%	79.9%	83.0%
Average	70.5%	75.0%	76.2%	75.5%	76.7%
Worst	42.6%	55.6%	57.1%	59.6%	60.2%

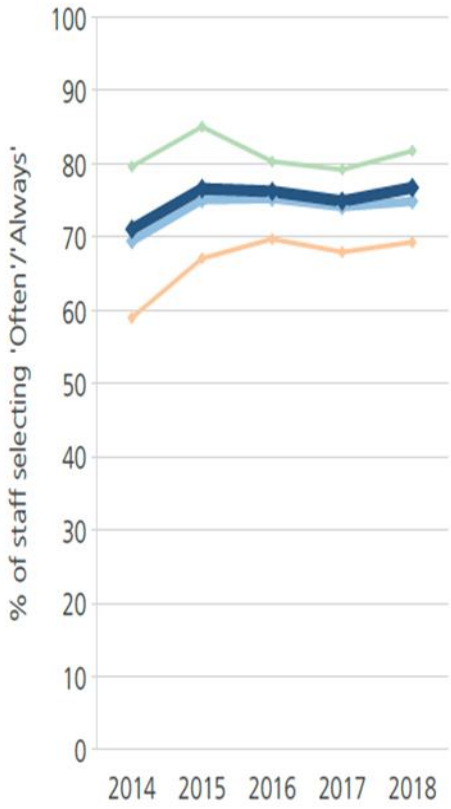
	2014	2015	2016	2017	2018
Best	77.1%	77.4%	76.1%	76.9%	81.0%
Your org	59.7%	64.5%	65.3%	66.2%	70.5%
Average	58.0%	60.3%	61.1%	60.7%	62.6%
Worst	31.9%	41.6%	41.5%	42.7%	39.2%

	2014	2015	2016	2017	2018
Best	89.5%	86.1%	84.8%	85.3%	87.3%
Your org	60.4%	68.9%	70.0%	71.6%	75.7%
Average	65.4%	69.3%	69.1%	70.8%	71.3%
Worst	37.9%	45.8%	48.5%	46.4%	39.8%

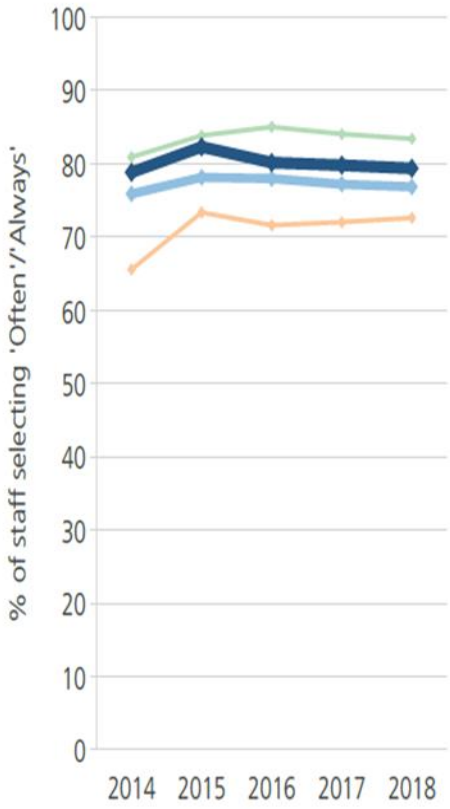
Figure 3: Staff motivation



	2014	2015	2016	2017	2018
Best	66.9%	72.0%	66.1%	66.6%	67.6%
Your org	54.4%	58.8%	60.6%	58.6%	61.8%
Average	53.2%	59.2%	59.8%	58.5%	59.3%
Worst	39.7%	49.8%	51.4%	50.1%	50.6%



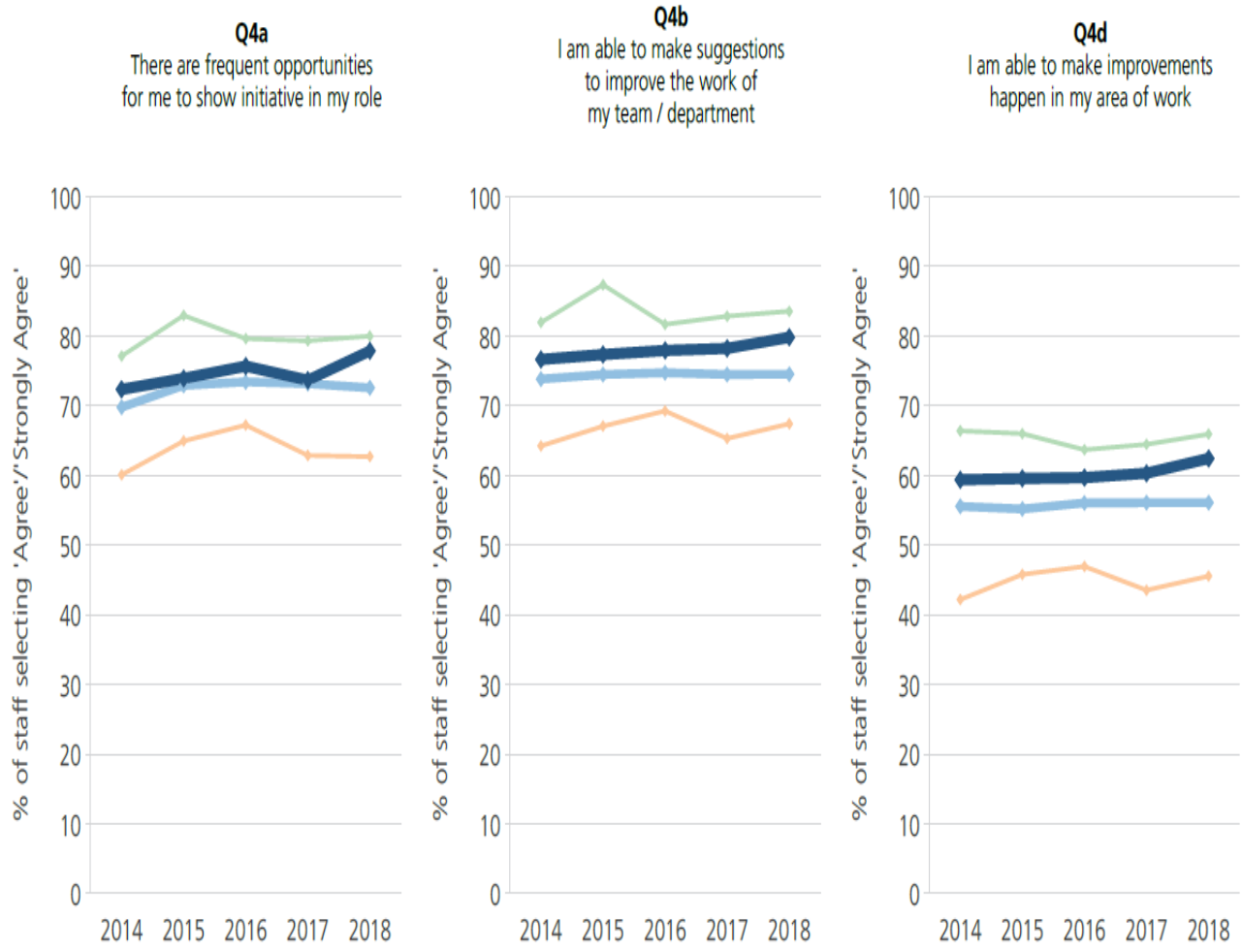
	2014	2015	2016	2017	2018
Best	79.6%	85.0%	80.3%	79.2%	81.7%
Your org	71.0%	76.6%	76.2%	74.8%	76.7%
Average	69.4%	75.0%	75.2%	74.1%	74.8%
Worst	58.9%	67.0%	69.7%	67.9%	69.3%



	2014	2015	2016	2017	2018
Best	80.9%	83.8%	85.0%	84.0%	83.4%
Your org	78.8%	82.3%	80.1%	79.8%	79.3%
Average	75.9%	78.1%	77.9%	77.2%	76.8%
Worst	65.5%	73.3%	71.6%	72.0%	72.6%

10. Staff involvement: There are frequent opportunities for me to show initiative in my role (Q4a), I am able to make suggestions to improve the work of my team/department (Q4b) and I am able to make improvements happen in my area of work (Q4d) have all significantly improved when compared with the 2017 scores and are all better than the Acute Trust average.

Figure 4: Staff involvement



	2014	2015	2016	2017	2018
Best	77.1%	82.9%	79.6%	79.3%	80.0%
Your org	72.3%	73.9%	75.7%	73.6%	77.8%
Average	69.8%	72.9%	73.4%	73.1%	72.5%
Worst	60.1%	64.9%	67.2%	62.8%	62.7%

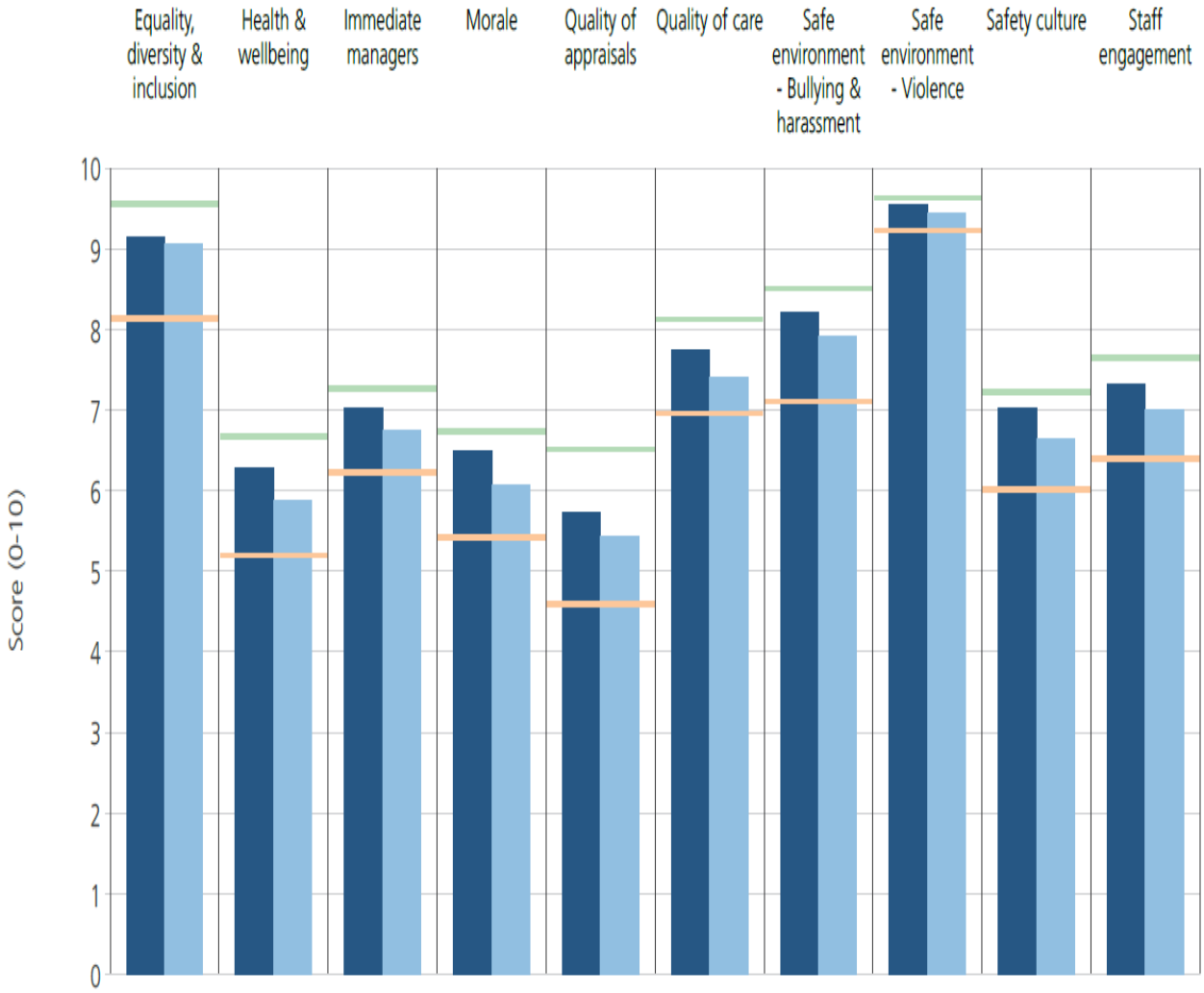
	2014	2015	2016	2017	2018
Best	81.9%	87.3%	81.6%	82.8%	83.5%
Your org	76.6%	77.3%	77.9%	78.2%	79.8%
Average	73.8%	74.4%	74.7%	74.5%	74.5%
Worst	64.2%	67.0%	69.2%	65.3%	67.4%

	2014	2015	2016	2017	2018
Best	66.4%	66.0%	63.7%	64.4%	65.9%
Your org	59.4%	59.5%	59.7%	60.3%	62.4%
Average	55.5%	55.2%	56.0%	56.1%	56.1%
Worst	42.2%	45.8%	46.9%	43.5%	45.5%

Summary of Themes

11. The ELHT staff satisfaction responses were better than average in 9 of the 10 themes and equal to the average in one theme (Equality diversity and inclusion).

Figure 5: theme overview



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
Your org	9.1	6.3	7.0	6.5	5.7	7.7	8.2	9.5	7.0	7.3
Average	9.1	5.9	6.7	6.1	5.4	7.4	7.9	9.4	6.6	7.0
Worst	8.1	5.2	6.2	5.4	4.6	7.0	7.1	9.2	6.0	6.4
No. responses	3,502	3,539	3,565	3,460	3,133	3,194	3,455	3,431	3,501	3,634

12. The table below presents the results of significance testing conducted on this year's theme scores and those from last year. It details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2018 score is significantly higher than last year's. Whereas: ↓ indicates that the 2018

score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Figure 6: Statistically significant themes

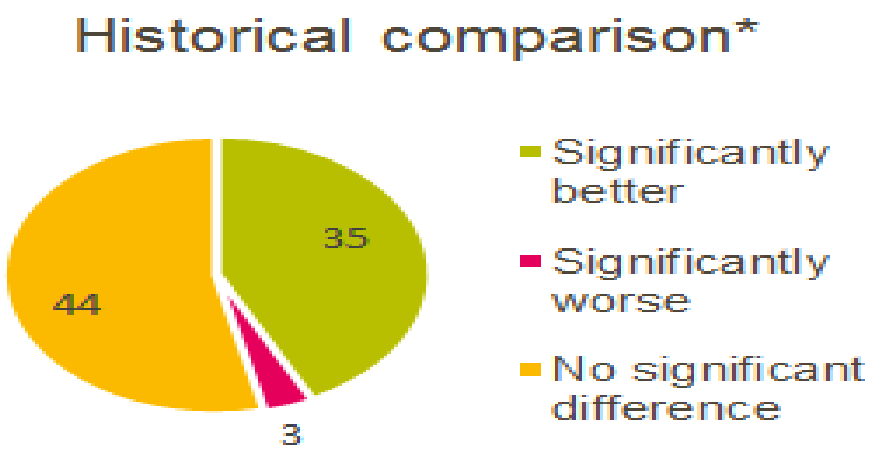
Theme	2017 score	2017 respondents	2018 score	2018 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.1**	3290	**9.1**	3502	Not significant
Health & wellbeing	**6.2**	3319	**6.3**	3539	Not significant
Immediate managers	**6.8**	3315	**7.0**	3565	↑
Morale		0	**6.5**	3460	N/A
Quality of appraisals	**5.5**	2930	**5.7**	3133	↑
Quality of care	**7.7**	2894	**7.7**	3194	Not significant
Safe environment - Bullying & harassment	**8.2**	3245	**8.2**	3455	Not significant
Safe environment - Violence	**9.5**	3205	**9.5**	3431	Not significant
Safety culture	**6.8**	3296	**7.0**	3501	↑
Staff engagement	**7.1**	3356	**7.3**	3634	↑

13. The table above demonstrates four themes with statistically significance higher scores when tested using a two-tailed t-test with a 95% level of confidence. The four themes demonstrating the significantly higher scores compared to last year are: immediate managers, quality of appraisals, safety culture and staff engagement.

Question level comparison

14. 82 questions can be compared historically between 2017 and 2018. The chart below demonstrates that 35 questions scored significantly better, 44 questions no significant difference and 3 questions significantly worse when compared with 2017.

Figure 7: Question level historical comparison



Workforce Race Equality Standard (WRES) Indicators

15. Four of the WRES indicators are drawn from the national NHS staff survey. Within the last 2 years BME staff have been engaged in meaningful and sustained ways, to start exploring why there are such differences between the treatment and experiences of white and BME staff – and importantly, how the existing gaps can be closed.

16. In the spirit of continuous learning and transparency, the Trust have held a WRES group, held Big conversations, 1:1 interviews, training, communications which in turn has given confidence to BME colleagues to have their say by voicing their concerns in the staff survey.

a) **WRES Indicator Five** - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. This has improved by 1% from the previous year for both BME and White staff.

b) **WRES Metric Six -** Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. This has deteriorated by 2% from the previous year for both BME and White staff.

c) **WRES Metric Seven-** Percentage believing that the Trust provides equal opportunities for career progression or promotion. BME staff remain less likely than white staff to believe that ELHT provides equal opportunities for career

progression. The gap between white and BME staff on this indicator increased from 19% in 2017 to 21% in 2018.

d) **WRES Metric Eight-** Q17B. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues?

BME staff remain significantly more likely to experience discrimination at work from colleagues and their managers, the percentage of BME staff reporting that in the last 12 months they have personally experienced discrimination at work from staff remained static.

External benchmarking

17. Based on benchmarking data from the NHS Staff Survey Co-ordination Centre St Helens and Knowsley Teaching Hospitals NHS Trust achieved the highest overall engagement score of all Acute and Combined Acute and Community Trusts with a score of 4.06. ELHT is joint 7th nationally for the overall engagement score (see appendix 2).
18. Regionally based on the overall engagement score when compared with North West Trusts ELHT is 3rd out of 23. (see appendix 3)

Recommendations

19. All senior leaders to champion the benefits of timely feedback, regular 1:1s, appraisals/personal development reviews; and ensure all staff have a quality appraisal/personal development review within the organisation on an annual basis.
20. All staff must be encouraged to embrace the approach to early resolution to minimise conflict in the workplace and eradicate unwanted disrespectful behaviour at ELHT.
21. Consider a greater investment in health and wellbeing interventions in 2019/20 as part of the Health and Wellbeing Strategy. Review and recognise our hotspots and target areas of greatest need with evidence based early intervention.
21. Design and deliver training and development which enables managers to deliver supportive and compassionate management practices to minimise work related stress and conflict and build resilience in the workforce. Along with encouraging staff and managers to access the opportunities available to improve their leadership skills and management practices.

23. Continued support by the Trust Board / Senior Management to work with the Staff Guardian to embed the culture of speaking out safely. Further promotion of the "if you see something, say something" campaign to raise awareness and assurance to all staff that the Trust encourages and supports staff who raise concerns if they feel safety is at risk.
24. Continued focus and effort to increase visibility and communication from senior managers on all sites at East Lancashire Hospitals NHS Trust for example: back to the floor visits; meet the board events and patient safety walkabouts on sites beyond the Royal Blackburn site.
25. Progress ELHTs Trust wide action plan on the Workforce Race and Disability Equality standards to ensure all staff have equal opportunities which supports progress and outcomes towards a more representative and diverse workforce.
26. Divisions to understand their divisional data, particularly divisional strengths and areas for improvement. This will be supported by feedback workshops facilitated by the Staff Engagement Team and the Picker Institute scheduled to take place on the 20th and 21st March 2019. It is recommended that as many line managers as possible along with the senior management team of all divisions/directorates attend these sessions.
27. Divisions to utilise this year's Big Conversations specifically focusing on staff experience and engagement as a mechanism to discuss the current climate and culture at ELHT. Using a participative approach together with the workforce, divisions will formulate divisional action plans to target areas of improvement and celebrate successes.
28. The development of a corporate action plan with supporting Divisional action plans facilitating a joined up approach to addressing the survey findings. Presentation of these plans is due at the Employee Engagement Sponsor Group in quarter one of 2019/20 with ongoing oversight and monitoring during 2019/20.
29. It is recommended that if there are any directorate teams that were identified as hot spots for poor staff experience in the 2017 National Staff Survey and remain hotspots in the 2018 National Staff Survey, further diagnostics, support and interventions are agreed and implemented.
30. It is recommended that the vast majority of 2019 staff surveys are sent via electronic survey rather than paper survey. This has proven to be more successful in Trusts

that have consistently maintained high response rates across their organisations and has proven successful in increasing our response rate in 2018.

Conclusion

31. The staff survey results for 2018 are really positive and pleasingly staff engagement and experience continues to improve despite significant challenges and pressures seen across the organisation.
32. Nationally and regionally East Lancashire Hospitals NHS Trust benchmarks very well with other Acute Trusts and is in the top 10 nationally for the overall staff engagement score, nevertheless we will strive to make further improvements over the coming year.
33. The improvements demonstrated in the 2018 National Staff Survey along with improvements seen in the quarterly Staff Friends and Family Test are indicators that the long term approach that the organisation committed to is having the desired effect throughout the Trust. However there is still room for improvement and enhancing communication and engagement continues to remain a key improvement priority in 2019. The culture and leadership programme that the board has committed to will further enhance and enable our commitment to move from good to outstanding with staff engagement at the heart of ELHTs progress.

Next steps

34. Dates have now been circulated to provide sessions to support Divisions in developing a 'bespoke' action plan led by the Staff Engagement Team and The Picker Institute via the Staff Survey Workshops being held on the 20th and 21st March 2019.
35. Staff engagement and experience will be the focus for the 2019 round of 'Big Conversations' commencing in April through to May of this year.

    Once the Divisional Staff engagement action plans have been formulated they will be a standing agenda item on the Divisional performance meetings and also monitored via the Employee Engagement Sponsor Group.
36. The priorities currently being progressed in the design and delivery phases of the Culture and Leadership programme will be implemented over 2019 to support staff experience and engagement across the organisation.

Lee Barnes, Head of Staff Health and Wellbeing, Organisational Development and Staff Engagement, 28.02.2019

Appendices

Appendix 1: ELHT Full Staff Survey Results

Appendix 2: Overall staff engagement score 2017 v 2018 Top 10- National (Acute and Combined Acute & Community Trusts)

NHS Staff Survey overall engagement score benchmarking data- North West				
Overall Engagement score			Acute/ Combined Acute & Community Trust	Rank
2017	2018	Trend		
3.95	4.06	↑	St Helens And Knowsley Hospitals NHS Trust	1
3.96	4.00	↑	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	2
3.96	4.00	↑	Surrey and Sussex Healthcare NHS Trust	2
3.93	3.98	↑	Northumbria Healthcare NHS Foundation Trust	3
3.99	3.98	↓	Guy's and St Thomas' NHS Foundation Trust	3
3.95	3.97	↑	West Suffolk NHS Foundation Trust	4
3.90	3.95	↑	Frimley Health NHS Foundation Trust	5
3.95	3.95	-	University Hospital Southampton NHS Foundation Trust	5
3.93	3.94	↑	South Warwickshire NHS Foundation Trust	6
3.91	3.94	↑	The Newcastle upon Tyne Hospitals NHS Foundation Trust	6
3.86	3.94	↑	Bolton NHS Foundation Trust	6
3.90	3.93	↑	Royal Devon and Exeter NHS Foundation Trust	7
3.93	3.93	-	Chelsea and Westminster Hospital NHS Foundation Trust	7
3.86	3.93	↑	East Lancashire Hospitals NHS Trust	7
3.90	3.92	↑	Northern Devon Healthcare NHS Trust	8
3.90	3.92	↑	Kingston Hospital NHS Foundation Trust	8
3.85	3.91	↑	Leeds Teaching Hospitals NHS Trust	9
3.87	3.91	↑	Sherwood Forest Hospitals NHS Foundation Trust	9
3.89	3.91	↑	Royal Surrey County Hospital NHS Foundation Trust	9
3.81	3.91	↑	Yeovil District Hospital NHS Foundation Trust	9
3.86	3.90	↑	Royal Berkshire NHS Foundation Trust	10
3.91	3.90	↓	Gateshead Health NHS Foundation Trust	10

Appendix 3: Overall staff engagement score 2017 v 2018 Regional (Acute and Combined Acute & Community Trusts)

NHS Staff Survey overall engagement score benchmarking data- North West				
Overall Engagement score			Local Acute Trust	Rank
2017	2018	Trend		
3.95	4.06	↑	St Helens And Knowsley Hospitals NHS Trust	1
3.86	3.94	↑	Bolton NHS Foundation Trust	2
3.86	3.93	↑	East Lancashire Hospitals NHS Trust	3
3.85	3.89	↑	Mid Cheshire Hospitals NHS Foundation Trust	4
3.83	3.87	↑	East Cheshire NHS Trust	5
3.85	3.87	↑	Airedale NHS Foundation Trust	6
3.79	3.85	↑	University Hospitals of Morecambe Bay Foundation Trust	7
-	3.84	-	Manchester University NHS Foundation Trust	8
3.78	3.83	↑	Salford Royal	9
3.89	3.83	↓	Tameside & Glossop Integrated Care NHS Foundation Trust	10
3.95	3.82	↓	Wrightington, Wigan and Leigh NHS Foundation Trust	11
3.83	3.81	↓	Blackpool Teaching Hospitals	12
3.75	3.79	↑	Royal Liverpool & Broadgreen University Hospitals Trust	13
3.74	3.79	↑	Warrington and Halton Hospitals NHS Foundation Trust	14
3.75	3.78	↑	Calderdale and Huddersfield NHS Foundation Trust	15
3.72	3.77	↑	Aintree University Hospital NHS Foundation Trust	16
3.75	3.77	↑	Countess of Chester Hospital NHS Foundation Trust	16
3.78	3.76	↓	Lancashire Teaching Hospitals NHS Foundation Trust	17
3.73	3.74	↑	Stockport NHS Foundation Trust	18
3.71	3.73	↑	Pennine Acute Hospitals NHS Trust	19
3.75	3.68	↓	Wirral University Teaching Hospital NHS Foundation Trust	20
3.63	3.62	↓	Southport and Ormskirk Hospital NHS Trust	21

3.62	3.61	↓	North Cumbria University Hospitals NHS Trust	22

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT
13 March 2019

Item 43

Purpose Monitoring

Title	Integrated Performance Report (to January 2019)
Author	Mr M Johnson, Associate Director of Performance and Informatics
Executive sponsor	Mr J Bannister, Executive Director of Operations

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

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

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objective The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

(43) Integrated Performance Report

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: Not applicable

Board of Directors, Update

Corporate Report

Executive Overview Summary

A total of thirteen incidents were reported to StEIS during January 2019. There were no never events.

There were two clostridium difficile infections detected during January, which is below trajectory for the month. The cumulative position is 23 against trust target of 27 for the year. No hospital acquired MRSA infections were detected during January 2019.

Nursing and midwifery staffing in January 2019 continued to be a challenge, with 8 areas falling below an 80% average fill rate for registered nurses on day shifts.

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

The Trust experienced significant pressures during January, resulting in a reduction in the 'Emergency Care 4 hour standard' to 77.8%, below the 95% threshold. (Pennine A&E Delivery Board).

The number of ambulance handovers over 30 minutes increased during January, with the average handover time increasing to 19:02 minutes from 16:45 minutes in December. The HAS compliance remained above the threshold.

There were 16 mental health breaches of the 12 hour trolley wait standard in January, all of these were as a result of waits for mental health beds within Lancashire Care Foundation Trust.

Flow through the hospital has been challenging through the month and the proportion of delayed discharges has increased in January to 3.8% which is above the 3.5% threshold. This equates to 31 beds lost per day.

The 6wk diagnostic target was met in January at 0.4%

The number of operations cancelled on the day increased in January, however there were no breaches of the 28 day standard.

For the first time in 14 months, the Referral to Treatment (RTT) target was not achieved at 91.5% below the 92% standard. This was predominantly as a consequence of high numbers of cancellations of procedures on the RBH site.

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

As predicted, the cancer 62 day target was not achieved in December at 78.5% and the 2 week breast symptomatic was also not achieved at 91.1%, below the 93% standard. Performance was good against all other cancer standards.

Sickness rates are above threshold (5.1%) on par with last year.

The vacancy rate reduced to 7.3% in January, which is below last year (8.2%), however remains above threshold.

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

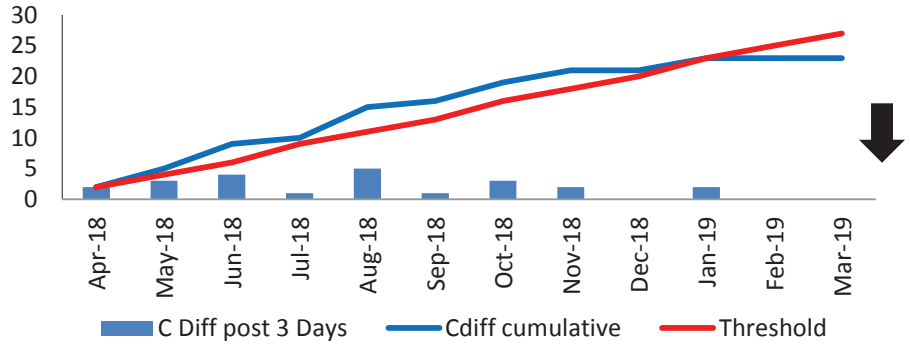
The revised 2018-19 underlying control total for the Trust of a £15.8 million deficit has been met for the ten months of 2018-19, with a £13.0 million deficit reported excluding £4.3 million of Provider Sustainability Funding.

Introduction

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

SAFE

C Difficile

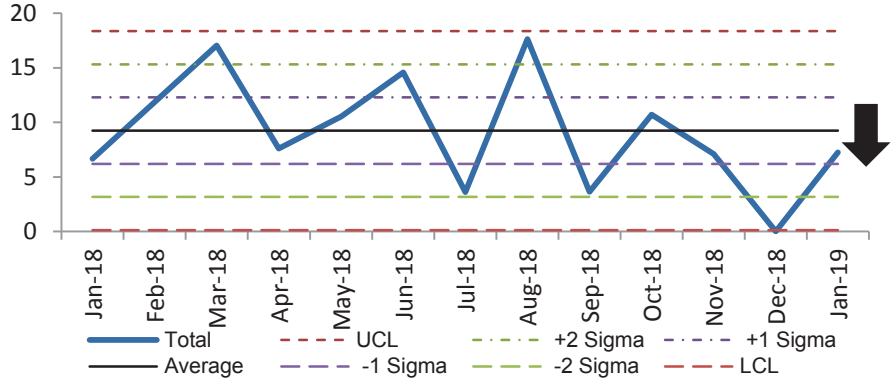


There were no post 2 day MRSA infections reported in January. Year to date there has been 1 case attributed to ELHT.

There were two Clostridium difficile toxin positive isolates identified in the laboratory in January which were post 3 days of admission.

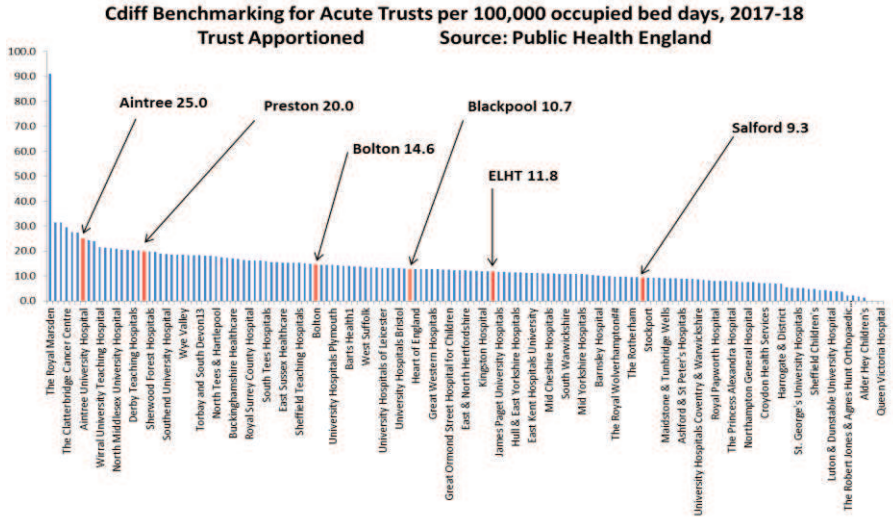
The year to date cumulative figure is 23 against the trust target of 27. The detailed infection control report will be reviewed through the Quality Committee.

C Difficile per 100,000 occupied bed days



The rate of infection per 100,000 bed days increased in January to 7.2, however still below average.

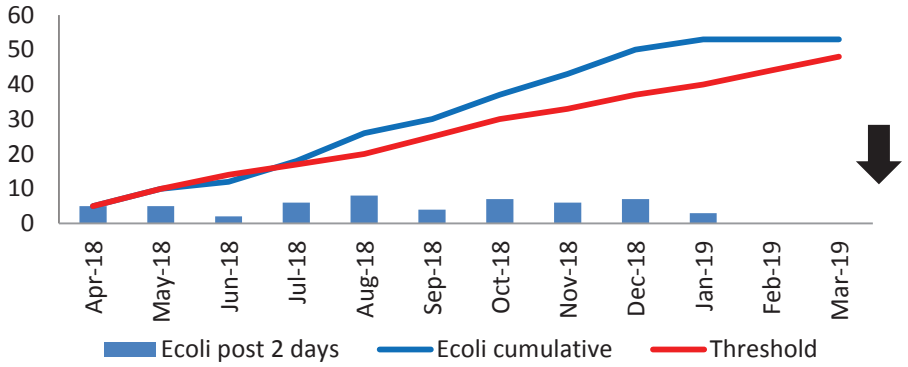
C Difficile benchmarking



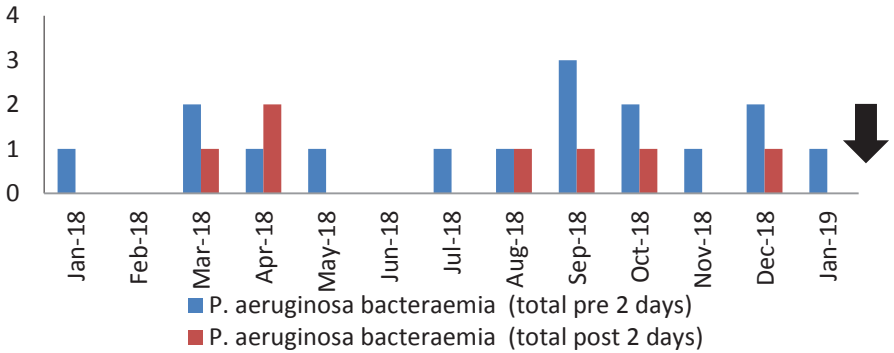
ELHT ranked 71st out of 151 trusts in 2017-18 with 11.8 clostridium infections per 100,000 bed days. The best performing trust had 0 and the worst performer had 91 infections per 100,000 bed days.

SAFE

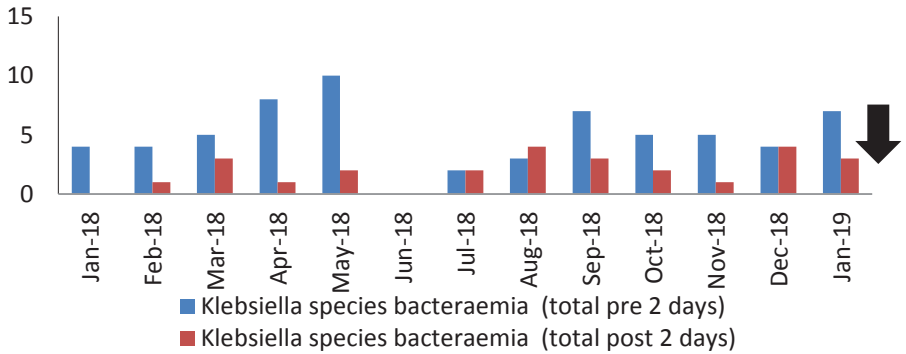
E. Coli



P.aeruginosa



Klebsiella



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

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

This year we should have no more than 48 E. coli bacteraemia. Year to date we have had 50 cases.

There were three E.coli bacteraemia detected in January, which is above the monthly threshold.

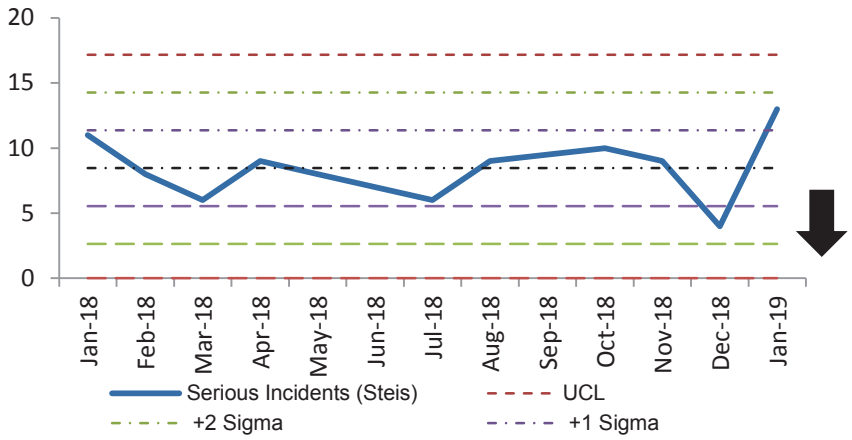
From April 2017, NHS Trusts must report cases of bloodstream infections due to *Klebsiella species* and *Pseudomonas aeruginosa* to Public Health England.

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

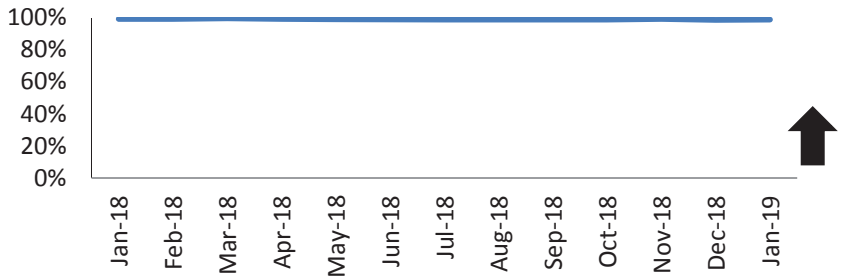
The work on catheter care, prevention of line infections, sepsis and improving hydration will help prevent healthcare associated bloodstream infections

SAFE

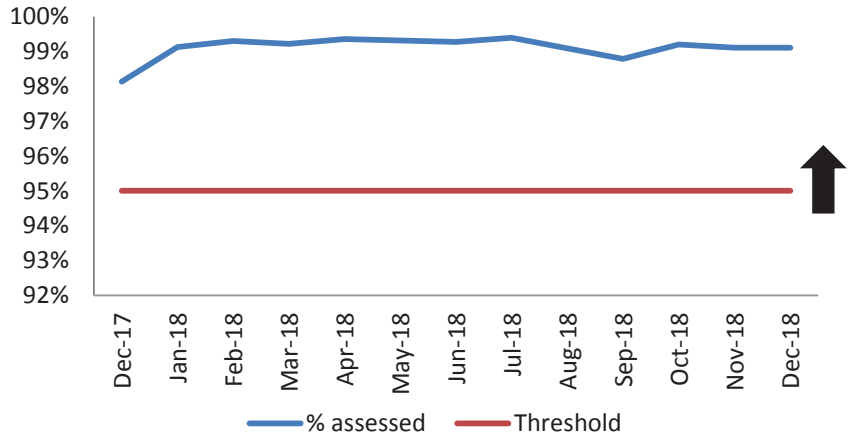
Serious Incidents



% Harm Free Care from safety thermometer



VTE assessment



There were no never events reported in January.

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

StEIS Category	No. Incidents
Pressure ulcer	4
Sub optimal care of deteriorating patient	3
Maternity/ Obstetric (Baby only)	2
Slips, trips & falls	2
Surgical/ Invasive procedure	1
Treatment delay	1

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

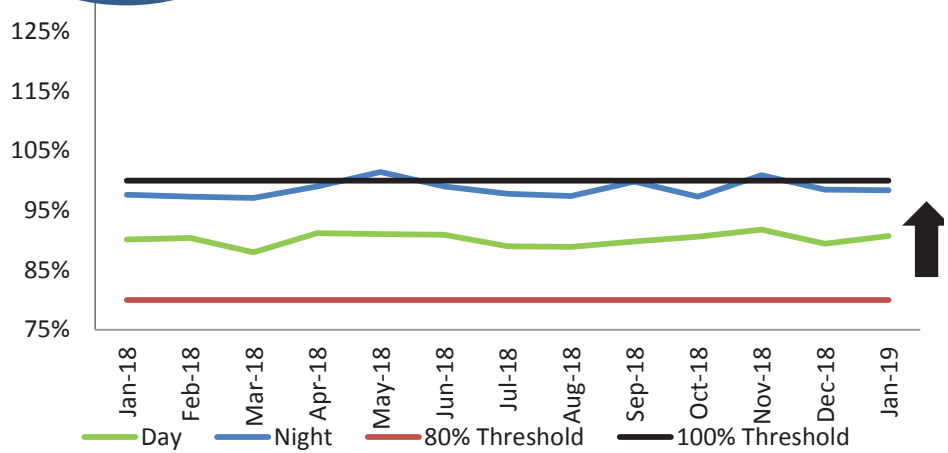
The Trust remains consistent with the percentage of patients with harm free care at 99.0% for January using the National safety thermometer tool.

For January we are reporting the current pressure ulcer position,

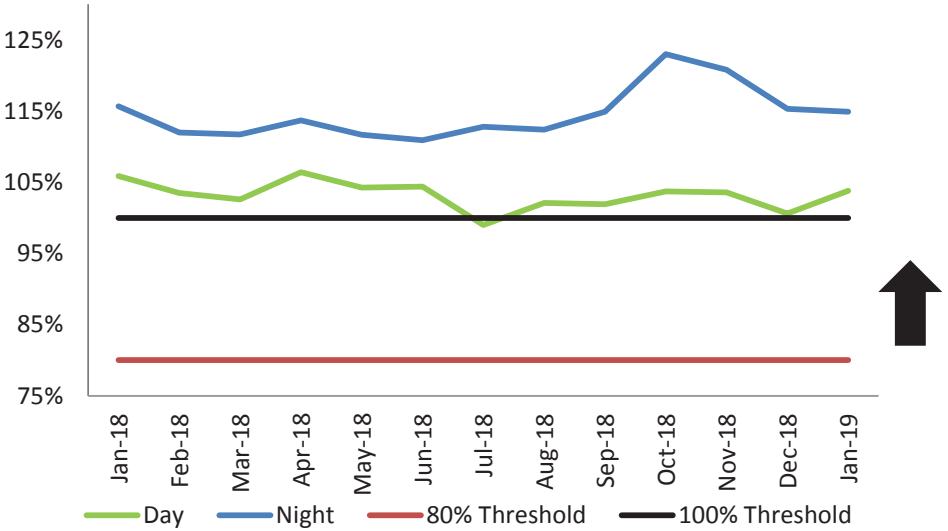
Pressure Ulcers	Hospital Aquired	Community Aquired
Grade 2	1	4
Grade 3	0	1
Grade 4	0	1
Acquired potential deep tissue injury	3	
Unstageable acquired - to be determined later	0	

SAFE

Registered Nurses/ Midwives



Care Staff



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

Of the 8 areas below the 80% for registered nurses on day shifts, all were due to lack of co-ordinator presence which is in addition to safe staffing levels.

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

Average Fill Rate

	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
Month	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	registered nurses/ midwives	care staff	registered nurses/ midwives	care staff
Jan-19	90.7%	103.8%	98.4%	114.9%	27,614	8.53	8	0	0	0

Red Flag Incidents

There were 0 red flag incidents reported in January 2019. However on reviewing staffing DATIX by the division of ICG, 2 DATIX relating to C4 ward would constitute a “red flag” Both incidents relate to night duty shifts when 2 registered nurses were on duty and their normal staffing numbers would be 3. One incident describes, “delayed” patient treatment and the second “delayed analgesia” No harm was identified.

The divisions have been reminded to actively encourage staff to enter any staffing concerns they have into DATIX, particular under the relevant “red flag category”

Actions taken to mitigate risk:

- Safe staffing conference at 10 am followed up with meetings through out the day where required to ensure safe staffing, with contingencies agreed for weekends and out of hours, utilising acuity and dependency (Safe Care)
- Extra health care assistant shifts are utilised to support registered nurse gaps if required
- On going active recruitment.
- The Trust has engaged with Health Education England (HEE) to work collaboratively with the Global Learners Programme. From the first cohort of nurses, 10 have arrived at the Trust, 6 now have their NMC registration. Another 3 registered nurses are expected in March, 2 in April and 1 in September, with 3 of this original cohort still needing to undertake the English language test and CBT prior to applying to the NMC. Another 19 nurses (cohort 2) are in the process of undertaking the appropriate tests and visa requirements. All have passed the English language test, 7 have passed CBT with the remaining 12 due to sit their CBT in February. Further collaboration with HEE and St Vincent’s and the Grenadines has yielded another 6 registered nurses, all of whom are exempt from the English language test and who are in the process of undertaking the required tests and visa requirements
- A further cohort of trainee nurse associates are in the process of being recruited

Family Care January 2019

Maternity

No Exceptions to report. Where the midwife staffing levels are not at the maximum levels, staff are rotated dependent on acuity and services diverted to other areas of maternity to maintain safety at all times. This is completed formally as part of safety huddles within a 24 hour period with interim or point prevalent huddles if required. Acuity and activity are assessed four times daily with a multi professional team being part of the safety huddles on Central Birth Suite, the huddles assess the whole picture across maternity services at ELHT and staff with relevant skills and competencies are moved accordingly to ensure safe staffing throughout the services.

Month	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Staffed to full Establishment		01:28.6	01:29	01:28.2	01:28.7	01:29.2	01:29	01:27	01:26	01:28	01:27	01:27
Excluding mat leave and vacancies		1:29.84	01:30	01:29.3	01:29.9	01:30.8	01:30	01:28.4	01:27.5	01:29	01:28	01:28
With gaps filled through ELHT Midwife staff bank		01:28.5	01:28.4	01:28.5	01:28.8	01:29.4	01:29	01:27	01:26	01:28	01:27	01:27
		Bank usage 9.59 WTE	Bank usage 10.4 WTE	Bank usage 6.35 WTE	Bank Usage 7.9 WTE	Bank Usage 9.5 WTE	Bank Usage 9.28 WTE	Bank Usage 9.5 WTE	Bank Usage 6.5WTE	Bank Usage 5.74WTE	Bank Usage 5.8WTE	Bank Usage 7.0WTE

The staffing figures do not reflect how many women were in labour or acuity of areas.
The midwife to birth ratio should be 1:28 for the period 01/10/18 - 31/03/19

Family Care Staffing Red Flag Events

On reviewing Datix 6 incidents were reported overall as Red Flag events in Family Care Division in November.
Of these 6 incidents reported 1 has been excluded as they related to ELCAS medical staffing.

Of the remaining 5 incidents reported 4 of them occurred within Maternity Services and 1 related to Ward 27 Paediatrics, all related to staffing issues.
The incidents were reported under the following category and sub-categories:

Maternity Services - 4
1 staffing issue – missed breaks. *No harm, impact not prevented*.
1 staffing issue – staff shortage midwives. *No harm, impact prevented.*
1 staffing issue – staff moved to another site / ward. *No harm, impact not prevented.*
1 staffing issue – staff moved to another site / ward. *No harm, impact prevented.*

Paediatric Unit – 1
1 staffing issue – staff shortage nursing. *No harm, impact not prevented*.

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

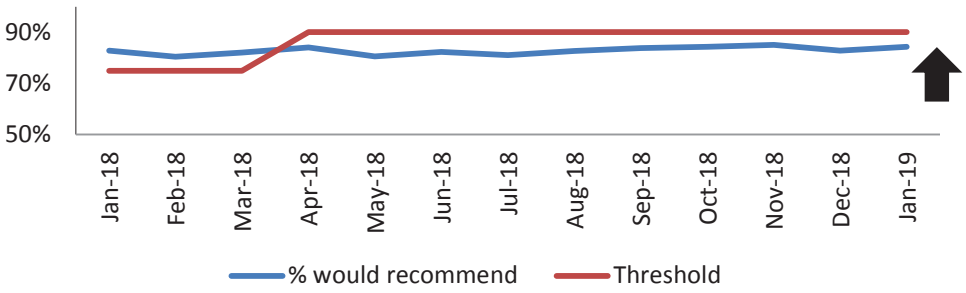
NICU
No exceptions to report. Nurse staffing levels for the acuity are monitored throughout the day and if acuity changes shift are put out to bank and agency to fill the gaps to ensure safe staffing and where necessary the unit closed to external admissions to maintain safety.

Paediatrics
No exceptions to report. Acuity are closely monitored and recorded 3 times throughout the day on safe staffing.

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

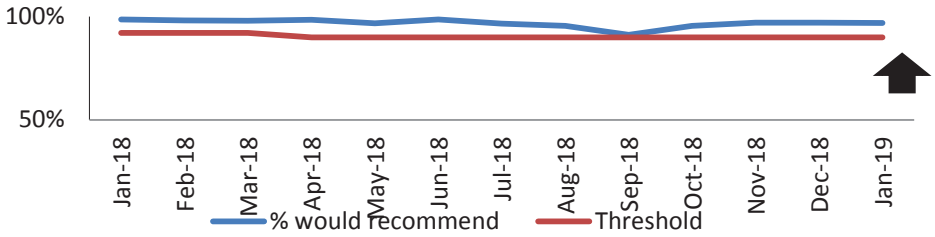
CARING

Friends & Family A&E



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

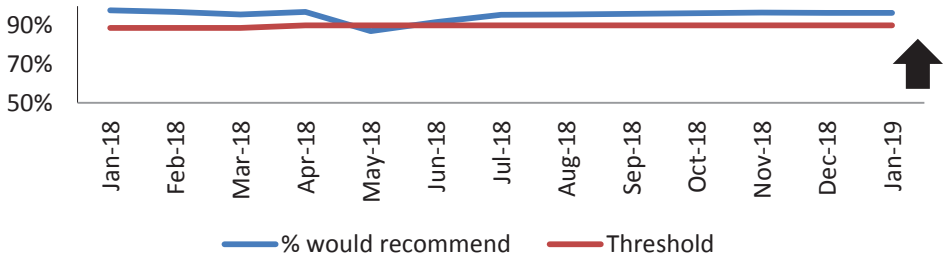
Friends & Family Inpatient



The proportion that would recommend A&E to friends and family has improved in January to 84.4% with a response rate of 19.7%

The proportion that would recommend inpatient services has reduced slightly on last month to 96.9% in January. The response rate was 46.3%

Friends & Family Community

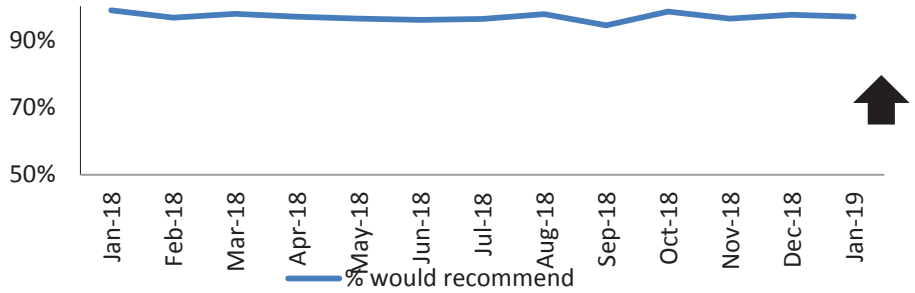


Community services would be recommended by 96.5% in January.

Maternity services would be recommended by 96.8% in January.

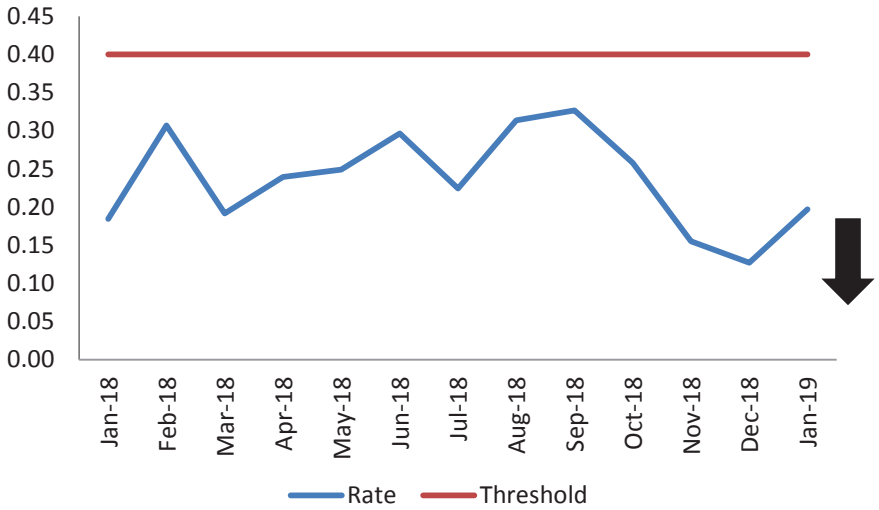
Volunteer support is now available for inputting responses and matrons are alerted to areas with low response rates.

Friends & Family Maternity



CARING

Complaints per 1000 contacts



The Trust opened 25 new formal complaints in January.
The number of complaints closed was 21.

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

For January the number of complaints received was 0.2 Per 1,000 patient contacts.

Patient Experience

January 2019 Totals	Dignity	Information	Involvement	Quality	Overall
	Average Score %	Average Score %	Average Score %	Average Score %	Average Score %
Trust	96	91	93	92	92
Integrated Care Group – Acute	96	91	94	92	93
Integrated Care Group – Community	94	92	92	94	93
Surgery	95	89	91	93	91
Family care	98	93	96	95	96
Diagnostic and Clinical	94	93	92	74	88

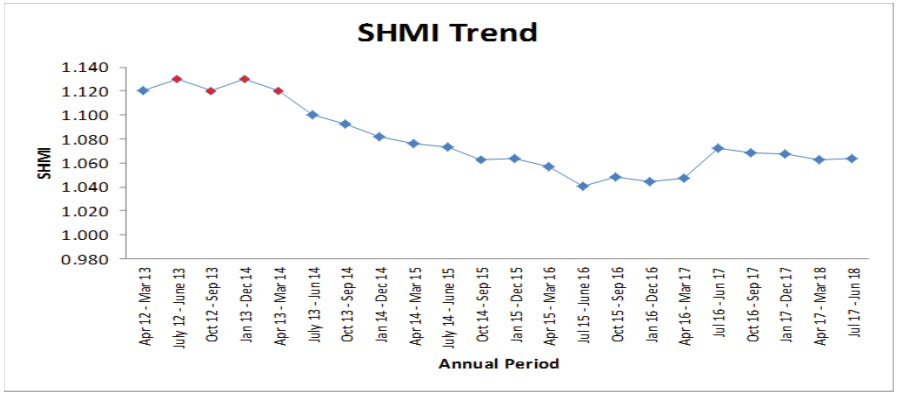
The table demonstrates divisional performance from the range of patient experience surveys in January 2019. The threshold is a positive score of 90% or above for each of the 4 competencies.

The overall Trust performance from the range of patient experience surveys is above the threshold of 90% for all of the 4 competencies in January 2019.

Two divisional areas fell below threshold in January - the Information competency in Surgical Division and the Quality competency in Diagnostic & Clinical Support.

EFFECTIVE

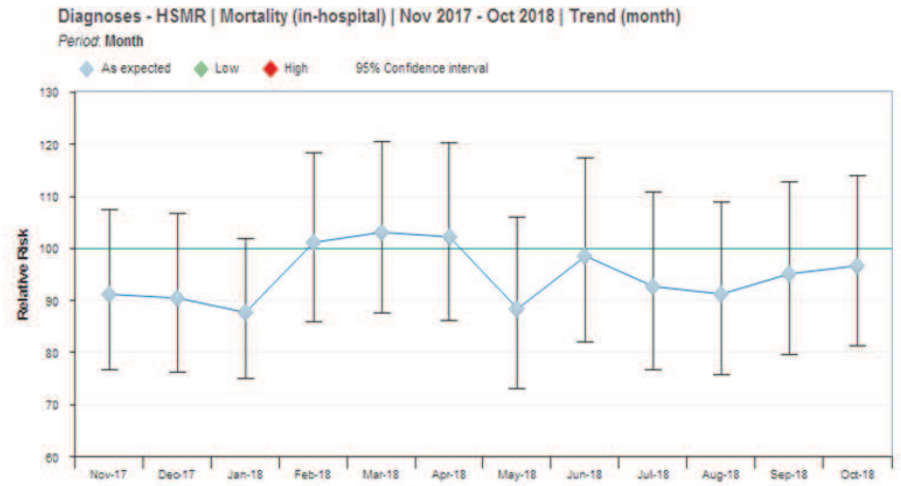
SHMI Published Trend



Dr Foster HSMR rolling 12

	HSMR Rebased on latest month Nov 17 – Oct 18 (Risk model July 18)
TOTAL	94.6 (CI 90.1 – 99.3)
Weekday	94.7 (CI 89.5 – 100.1)
Weekend	94.4 (CI 85.6 – 103.9)
Deaths in Low Risk Diagnosis Groups	67.2 (CI 36.7 – 112.8)

Dr. Foster HSMR monthly Trend



The latest Trust SHMI value as reported by the Health and Social Care Information Centre and Care Quality Commission for the period July 17 to June 18 has increased slightly to 1.069 and is still within expected levels, as published in January 19.

The latest indicative 12 month rolling HSMR (November 17 – October 18) remains 'significantly better than expected' at 94.6 against the monthly rebased risk model.

The weekday HSMR is also 'significantly better than expected'

Septicaemia continues to alert on the HSMR and the SHMI.

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

One further learning disability death was reviewed through the Learning Disability Mortality Review Panel in December. All cases have been reported to the LeDeR National Programme. The LDMR Panel continue to meet on a monthly basis as required to review cases.

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

Structured Judgement Review Summary

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

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

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

	Month of Death																	
Stage 1	pre Oct 17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	TOTAL
Deaths requiring SJR (Stage 1)	47	52	41	29	40	31	30	30	24	26	29	23	37	30	17	19	28	533
Allocated for review	46	52	40	29	39	30	29	29	23	26	27	20	28	22	10	11	13	474
SJR Complete	46	50	35	28	34	27	24	22	15	11	17	9	13	9	5	0	1	346
1 - Very Poor Care	2	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	3
2 - Poor Care	8	4	4	4	4	2	1	2	1	2	1	0	1	1	0	0	0	35
3 - Adequate Care	14	16	8	10	10	8	9	4	3	0	6	2	2	3	3	0	0	98
4 - Good Care	19	26	21	9	19	13	11	14	7	6	8	4	8	5	1	0	1	172
5 - Excellent Care	3	4	2	4	1	4	3	2	4	3	2	3	2	0	1	0	0	38
Stage 2																		
Deaths requiring SJR (Stage 2)	10	4	4	5	4	2	1	2	1	2	1	0	1	1	0	0	0	38
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Allocated for review	6	4	3	4	4	2	1	2	1	2	1	0	1	1	0	0	0	32
SJR-2 Complete	6	4	3	4	4	2	1	1	1	2	1	0	1	1	0	0	0	31
1 - Very Poor Care	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2
2 - Poor Care	3	1	2	1	1	1	0	1	0	0	0	0	1	0	0	0	0	11
3 - Adequate Care	2	3	1	3	2	1	0	0	1	2	1	0	0	1	0	0	0	17
4 - Good Care	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
5 - Excellent Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	pre Oct 17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Total
stage 1 requiring allocation	1	0	1	0	1	1	1	1	1	0	2	3	9	8	7	8	15	59
stage 1 requiring completion	0	2	5	1	5	3	5	7	8	15	10	11	15	13	5	11	12	128
Backlog	1	2	6	1	6	4	6	8	9	15	12	14	24	21	12	19	27	187
stage 2 requiring allocation	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
stage 2 requiring completion	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Backlog	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2

Commissioning for Quality and Innovation

EFFECTIVE

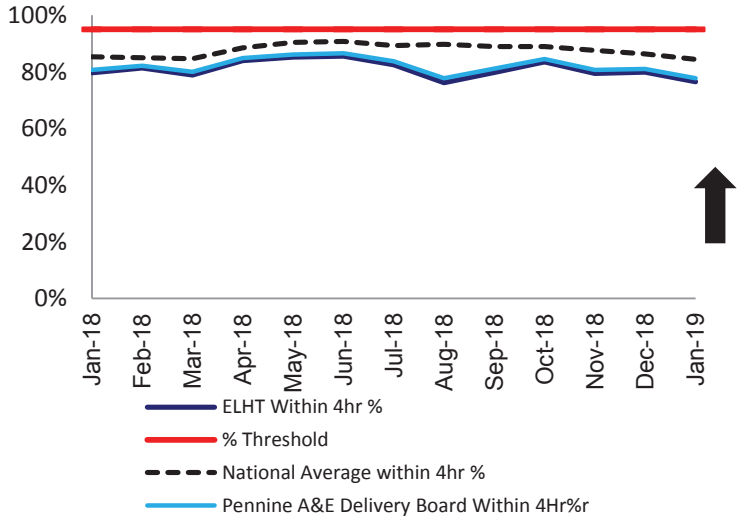
in 2018/19 the Trust is participating in the following 5 national CQUIN schemes as agreed with the CSU in 2017/18:

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

CQUIN Scheme		Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Q1	Q2	Q3	Q4
national	**NHS STAFF HEALTH & WELLBEING** - Flu Vaccine Uptake	**75%**									**85.6%**	**93%**					85.6%	
national	**SEPSIS PART A- IDENTIFICATION**- TOTAL %	**90.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**				**100%**	**100%**	**100%**	
national	**SEPSIS PART B - ANTIBIOTIC ADMINISTRATION - TOTAL %**	**90.0%**	**90.4%**	**93.4%**	**90.6%**	**92.2%**	**100.0%**	**96.9%**	94.4%	97.1%	96.2%				**91.5%**	**96.4%**	95.9%	
national	**SEPSIS PART C - ANTIBIOTIC REVIEW -** % Prescriptions Reviewed within 72 Hrs	**Q1 25% Q2 50% Q3 75% Q4 90%**	**100%**				**90%**			**96%**					**100%**	**90%**	**96%**	
national	**REDUCTION IN ANTIBIOTIC CONSUMPTION- PART D**- Total antiobiotic consumption per 1000 admissions	**4845.1**	**5107.3**				**5,110.3**								5,107	5,110		
national	-Antibiotic % Reduction on 2016 baseline	**-2.0%**	**5.4%**				**5.5%**								5.4%	5.5%		
national	- Total consumption of carbapenem per 1000 admissions	**31.9**	**42.1**				**38.0**								42.1	38		
national	-Carbapenam % Reduction on 2016 baseline	**-3.0%**	**32.2%**				**19.2%**								32.20%	19.20%		
national	- Increase proportion of antiobiotic usage within the Access group of the AWaRe category	***>=55%***	**58.4**				**59.1**								58.4	59		

RESPONSIVE

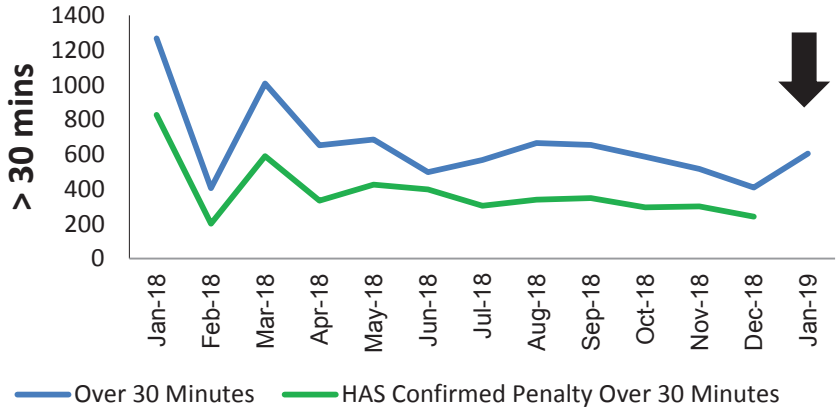
A&E 4 hour standard % performance



Overall performance against the ELHT Accident and Emergency four hour standard deteriorated in January to 76.5%, which remains below the 95% threshold. The performance against the Pennine A&E Delivery Board four hour standard has also deteriorated to 77.8% in January.

The number of attendances during January was 16,495 and of these 12,832 were treated and left the department within 4 hours. (Pennine A&E Delivery Board)

Ambulance Handovers



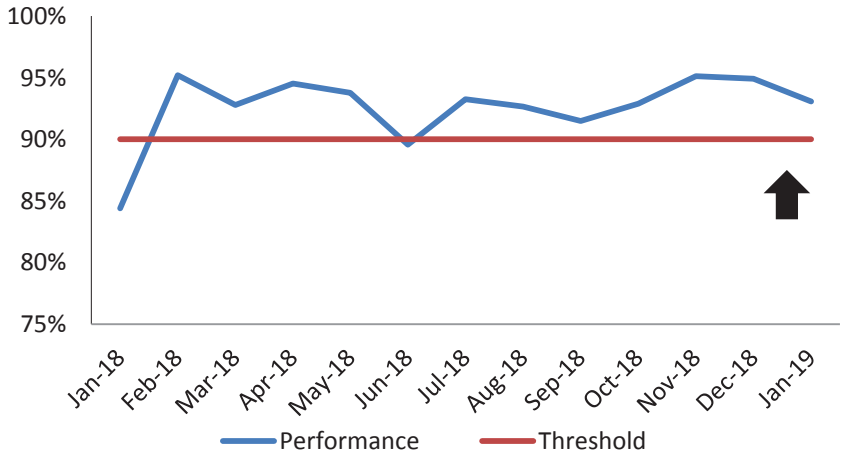
The national performance deteriorated to 84.4% in January (All types) with 3 out of 134 reporting trusts with type 1 departments achieving the 95% standard.

There were 16 reported breaches of the 12 hour trolley wait standard from decision to admit during January. All were mental health breaches. Rapid review timelines are completed in accordance with the NHS England Framework and a root cause analysis will be undertaken.

The number of handovers over 30 minutes increased to 604 in January compared with 410 for December. The average handover time has increased in January to 19:02 minutes from 16:45 minutes in December.

The validated NWAS penalty figures are reported as at December as;- 106 missing timestamps, 216 handover breaches (30-60 mins) and 25 handover breaches (>60 mins).

HAS Compliance

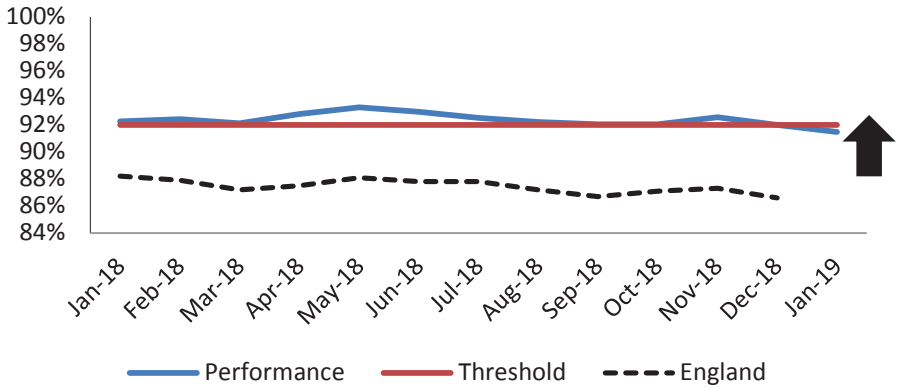


The ambulance handover compliance indicator measures the compliance with PIN entry on completion of patient handover. This was achieved at 93.1% in January, which is above the 90% threshold.

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

RESPONSIVE

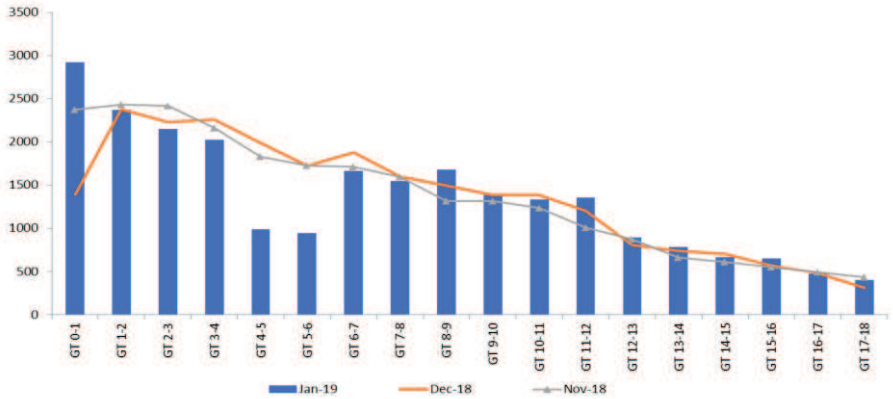
RTT Ongoing



The 18 week referral to treatment (RTT) % ongoing position was not achieved in January with 91.5% patients, waiting less than 18 weeks to start treatment at month end.

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

RTT Ongoing 0-18 Weeks



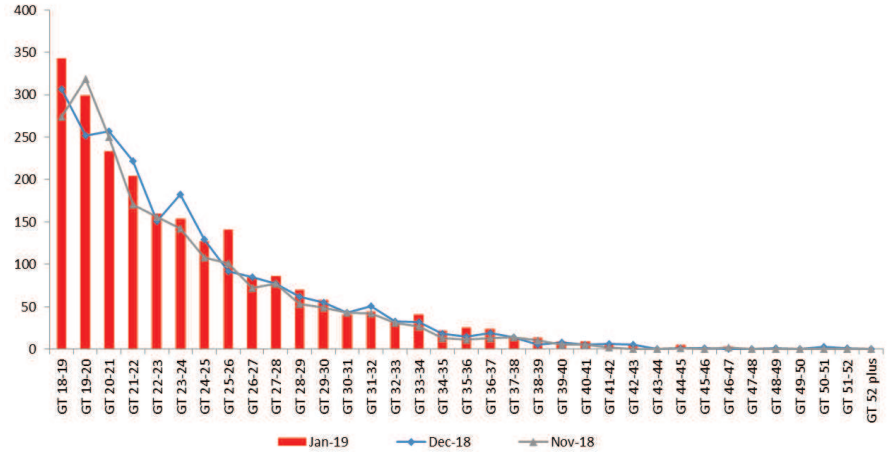
The total number of on-going pathways has reduced in December to 26,502 from 26,677 in December.

There has been an increase in patients waiting over 18 weeks at the end of January to 2254 from 2131 in December.

The median wait has increased to 7.3 weeks in January from 6.9 weeks in December.

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

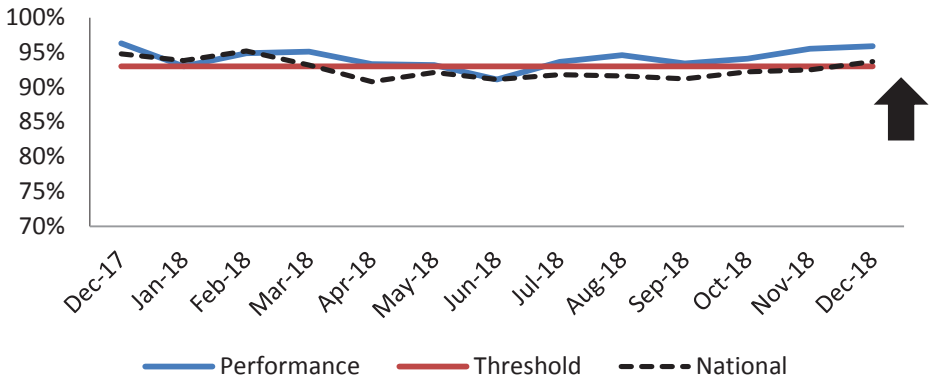
RTT Over 18 weeks



The latest published figures from NHS England show continued failure of the ongoing standard nationally (reported 1 month behind), with 86.6% of patients waiting less than 18 weeks to start treatment in December, compared with 87.3% in November.

RESPONSIVE

Cancer 2 Week

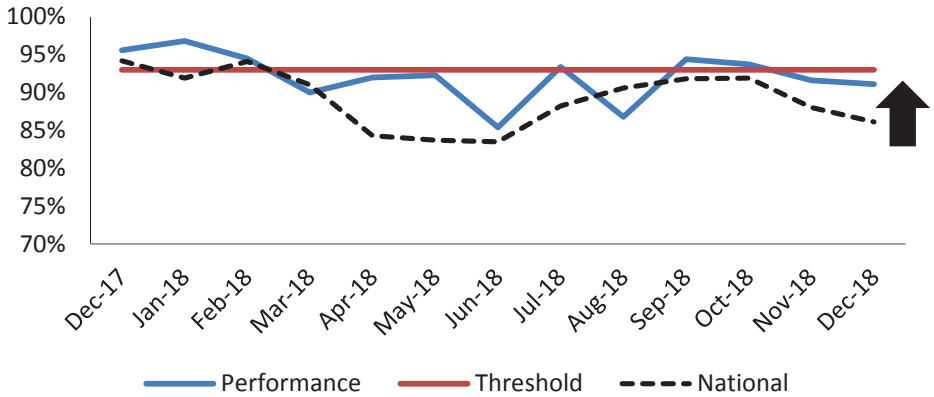


The cancer 2 week wait for GP referrals standard was achieved in December at 95.9%, above the 93% standard.

Quarter 3 performance was also above threshold at 95.1%

National performance also met the standard in December.

Cancer 2 Week - breast

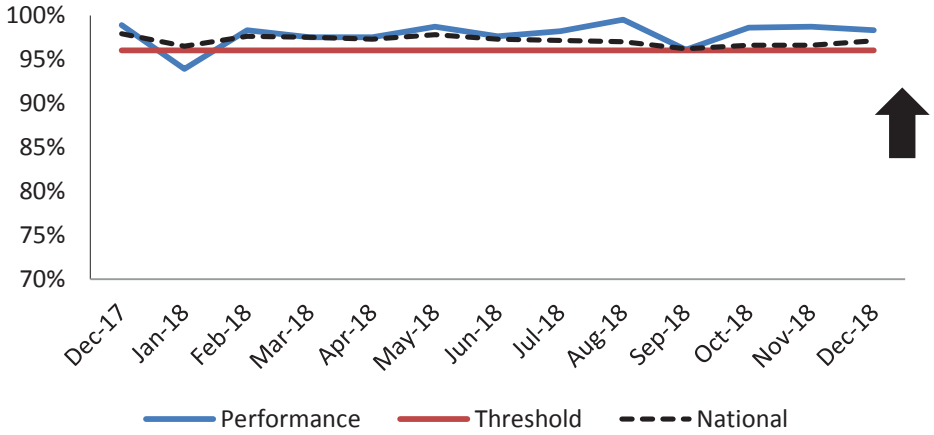


The 2 week breast symptomatic standard was not achieved in December at 91.1%, below the 93% standard.

The quarter 3 performance was below threshold at 92.1%

National performance remains below the standard in December.

Cancer 31 day

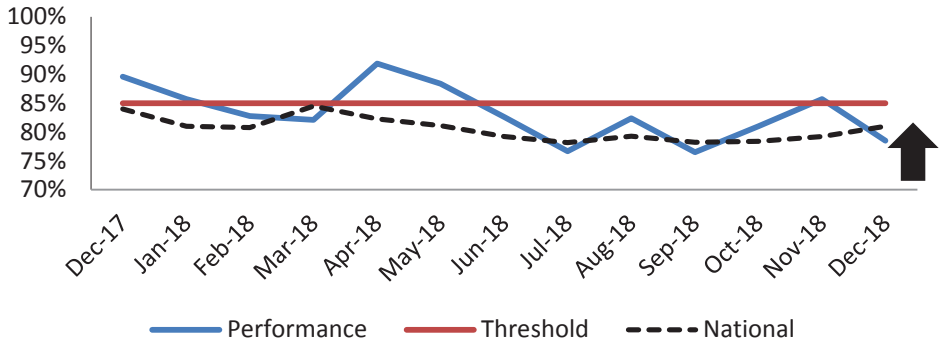


The 31 day target was achieved in December at 98.3%, above the 96% standard.

The standard was also met for quarter 3 at 98.6%

RESPONSIVE

62 Day Cancer

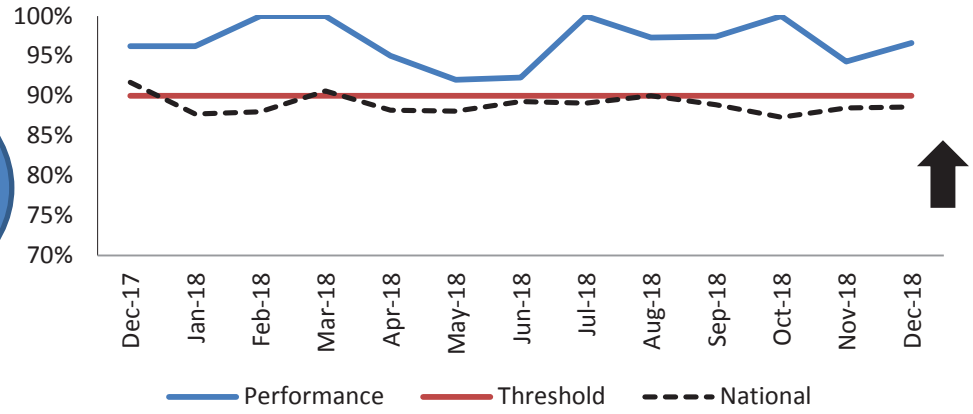


62 day performance was not achieved in December at 78.5%, below the 85% threshold.

Quarter 3 performance was below threshold at 82.0%

National performance has been consistently below the standard.

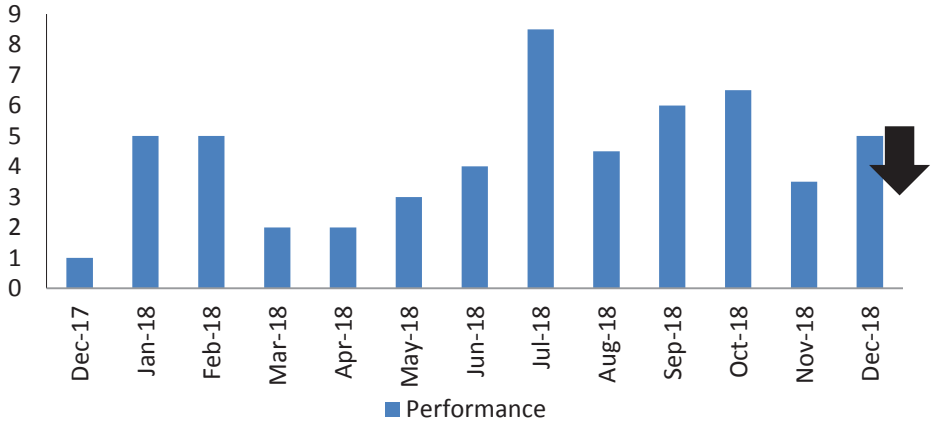
62 Day Screening



The 62 day screening standard continued to be achieved in December at 96.6%

Quarter 3 was also acheived at 97.3%

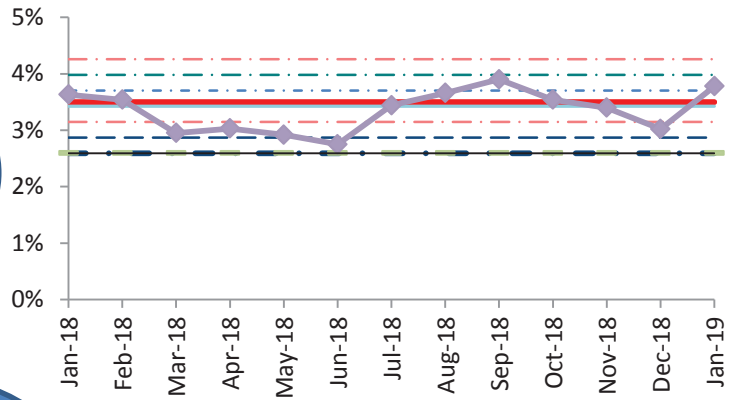
Cancer Patients Treated > Day 104



There were 5 breaches allocated to the Trust, treated after day 104 in November and will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the Consultants involved in the pathway as required.

RESPONSIVE

Delayed Discharges per 1000 bed days

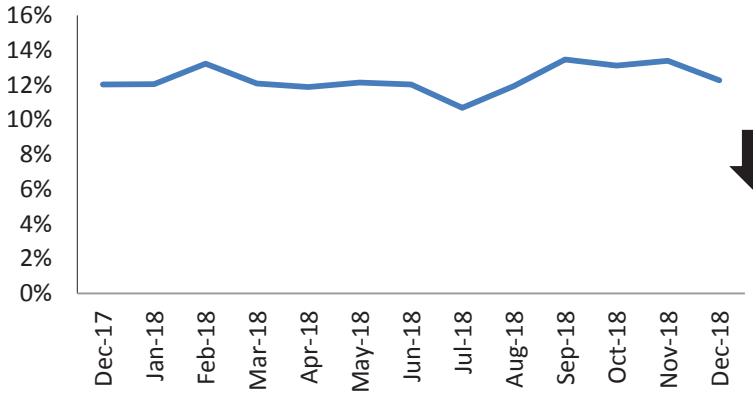


The proportion of delays reported against the delayed transfers of care standard has increased during January to 3.8% which is above the threshold of 3.5%.

This equates to an average of 31 beds lost per day in January. The top three reasons for the bed days lost due to delayed discharge are; 'Awaiting completion of assessment' (40%), 'Patient or family choice' (21%), 'Awaiting community equipment' (13%), The achievement of this target is multi-factorial, linked to complex discharge processes involving ELHT and partners.

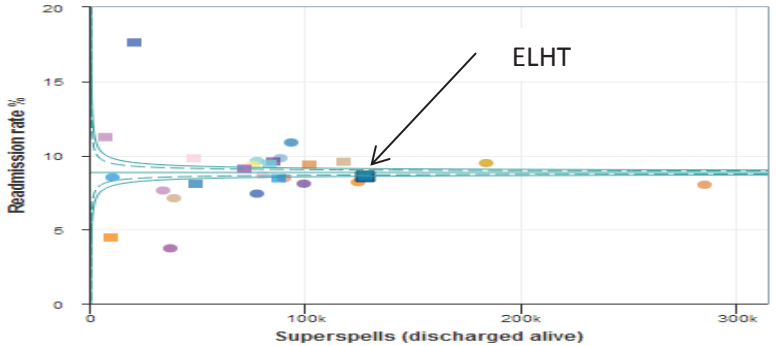
There is a full action plan which is monitored through the Finance & Performance Committee.

Emergency Readmissions

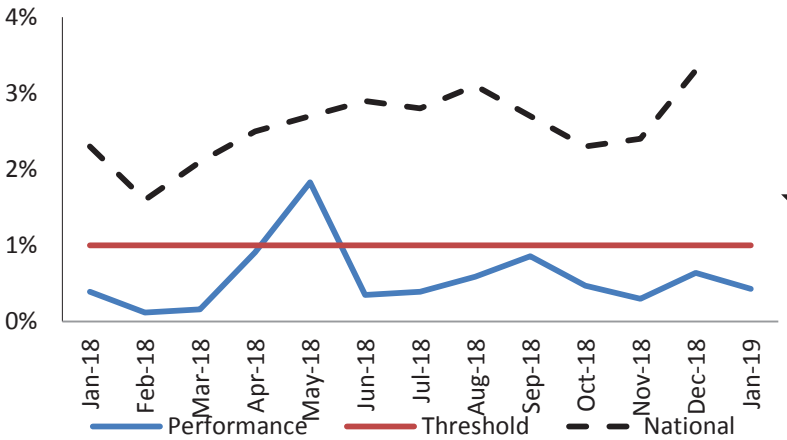


The emergency readmission rate has decreased to 10.6% in December 2018 (reported 1 month behind) compared to 12.0% in December 2017. Dr Foster benchmarking shows the ELHT readmission rate is below the North West average.

Readmissions within 30 days vs North West - Dr Foster
July 2017 - June 2018



Diagnostic Waits



In January 0.4% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is within the 1% threshold. Nationally, the performance is still failing the 1% target at 3.3% in December (reported 1 month behind), compared with 2.4% in November.

RESPONSIVE

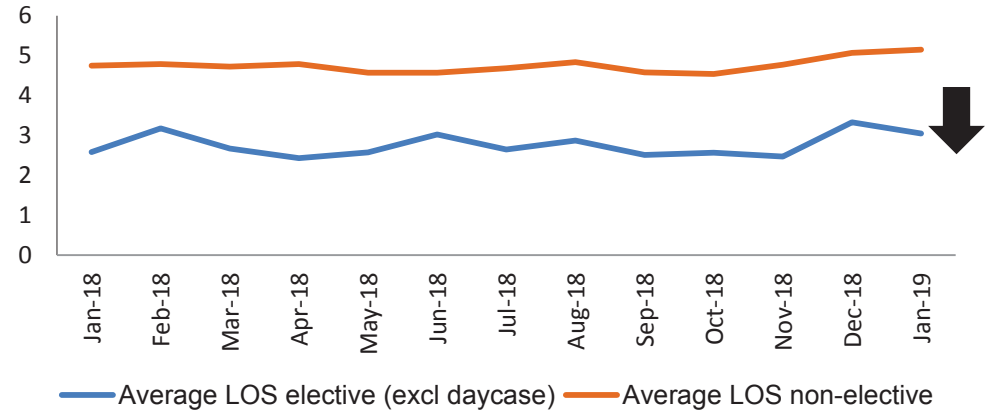
Average Length of Stay Benchmarking

Dr Foster Benchmarking November 17 - October 18

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	61,566	9,692	51,874	3.3	2.6	-0.7
Emergency	55,450	55,450	0	4.5	4.7	0.2
Maternity/ Birth	13,331	13,331	0	2.1	2.4	0.3
Transfer	216	216	0	10.2	26.9	16.7

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

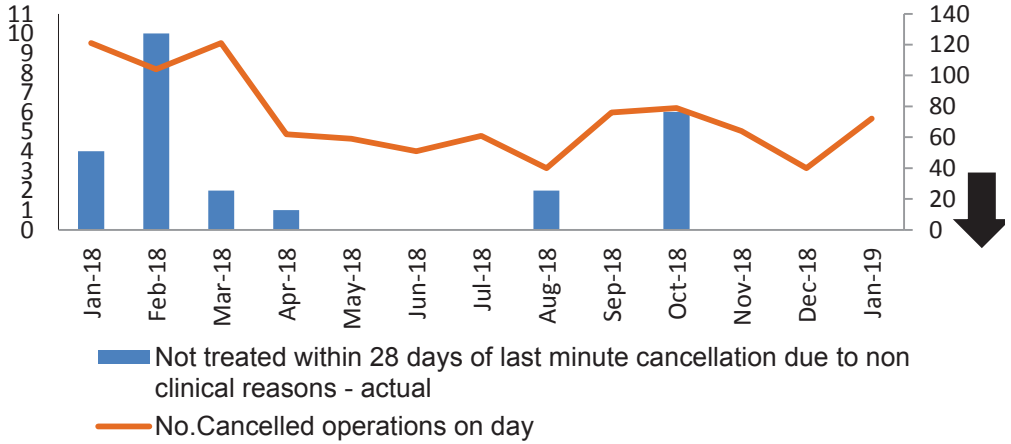
Average Length of Stay



The Trust non elective average length of stay increased to 5.2 days in January, compared to 5.1 in December and 4.8 in January 18.

The elective length of stay (excluding day case) has decreased to 3.1 days in January from 3.3 days in December, however remains higher than January 18 (2.6)

Operations cancelled on day - 28 day standard

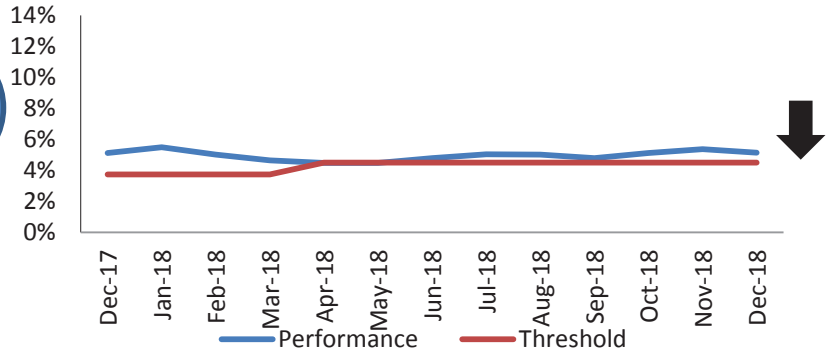


There were 72 operations cancelled on the day of operation - non clinical reasons, in January. There were no 'on the day' cancelled operations not rebooked within 28 days in January.

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

WELL LED

Sickness

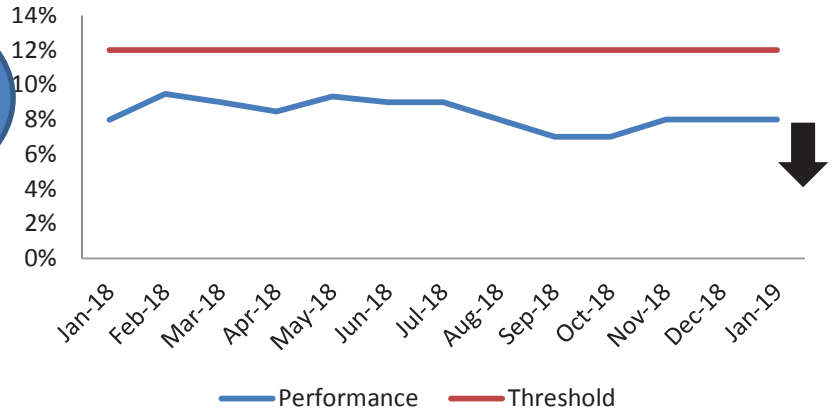


The sickness absence rate has improved from 5.4% in November to 5.1% in December 2018. The current rate is on par with previous year, however still above threshold.

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

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

Turnover Rate

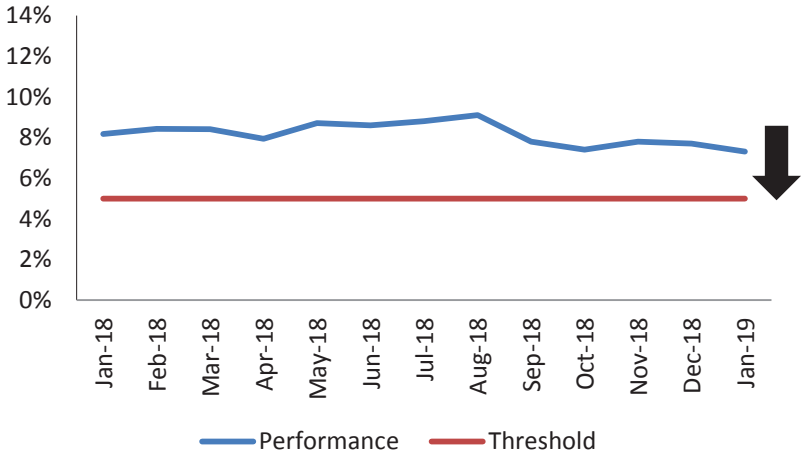


The trust turnover rate has remained at 8% in January and the vacancy rate has decreased to 7.3% in January from 7.7% in December.

Overall the Trust is now employing 7465 FTE staff in total. This is a net increase of 33 FTE from the previous month. The number of nurses in post at January 2019 stood at 2311 FTE which is 12 higher than last month and a net increase of 262 FTE since 1st April 2013.

As at 29th January 2019 there are 69 external/R&R nurses in the recruitment pipeline, scheduled to start between now and September 2019 and 46 changing posts internally. These figures include 1 overseas nurse through the HEE Global Learners Programme (GLP) who is predicted to start with the trust in February. This, together with the 9 already in post, will bring the total to 10 arrived in trust

Vacancy Rate



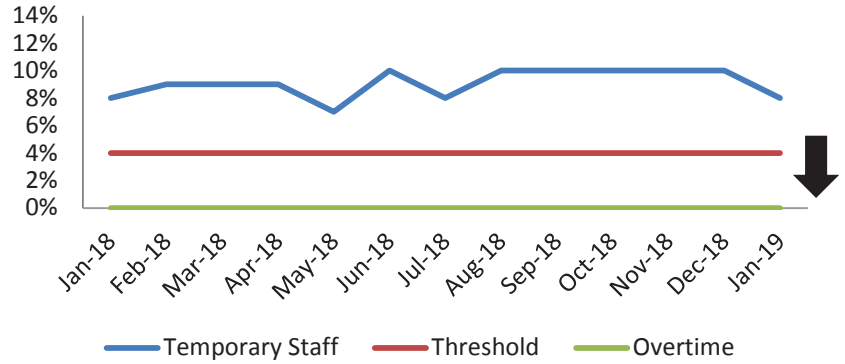
The vacancy rate for nurses now stands at 10.2% (263 FTE)

As of February 2019 there are 112 FTE Medical Posts vacant of which 46 posts have been offered and awaiting pre-employment checks or confirmation of start dates to be agreed

The vacancy rates for doctors now stands at 7.53% (47 FTE).

WELL LED

Temporary costs and overtime as % total pay

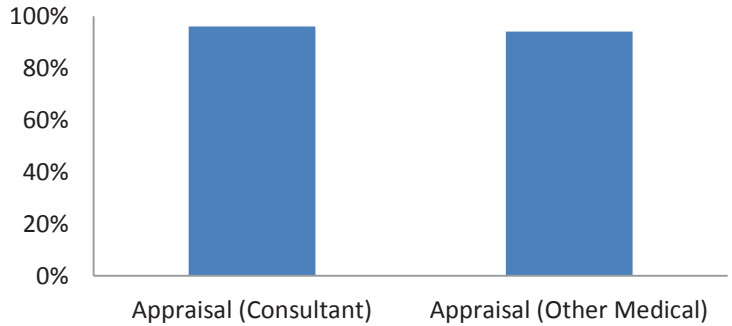


In 2017/18 East Lancashire Hospitals NHS Trust spent £27.4m on temporary staffing for the year. (£12,832,971 agency; £14,626,488 bank).

This represented 8% of the overall pay bill. (9% 2016/17;8% 2015/16; 9% 2014/15; 8% 2013/4; 5.5% 2012/13).

In April to January 2019 £26.9 million was spent on temporary staff. £11.4 million expenditure on agency staff and £15.5 million expenditure on bank staff. Wte staff worked (8,131 wte) was 193 wte less than is funded substantively (8,324 wte). Pay costs are £1.1m more than budgeted establishment in January.

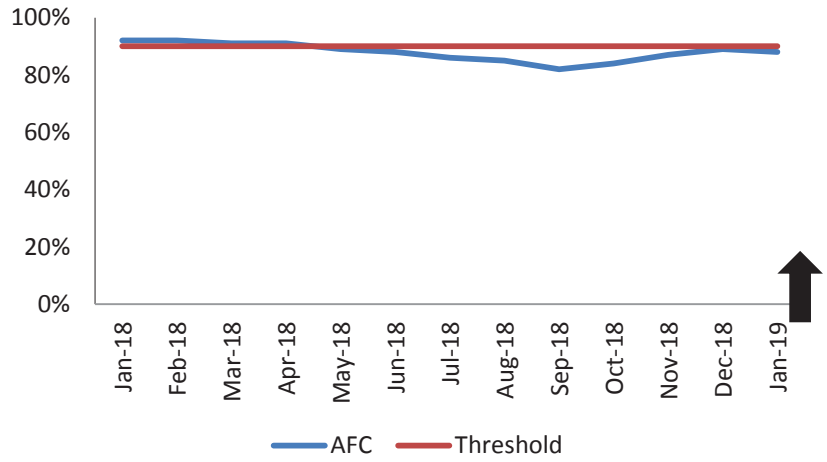
Appraisals, Consultant & Other Medical



At the end of January 19 there were 589 vacancies

The appraisal rates for consultants and career grade doctors are reported cumulative year to date, April – January 2019 and reflect the number of reviews completed that were due in this period.
The consultant and medical staff appraisal rates are above threshold at 96% and 94% respectively.

Appraisals AFC



The AFC appraisal rate continues to be reported as a rolling 12 month figure and remains below threshold at 88% in January.

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

WELL LED

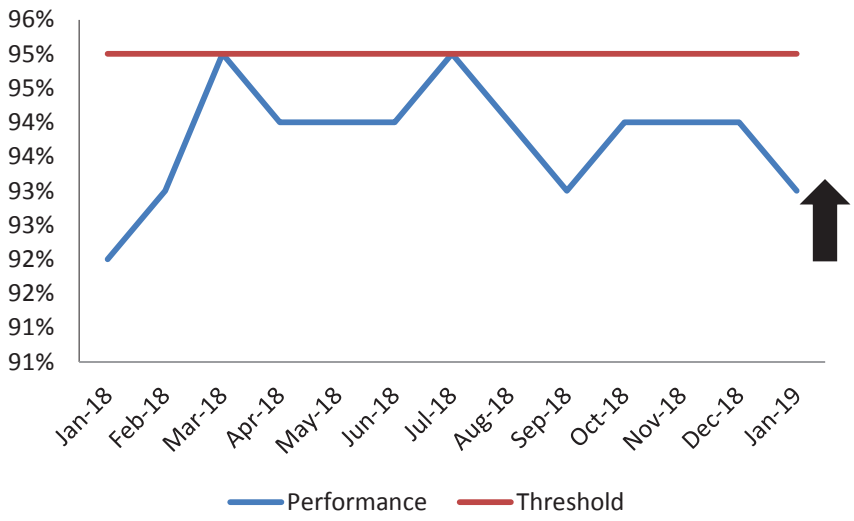
Job Plans

There are 288 Consultants and 27 SAS doctors registered with a job plan on Allocate.
The round has just been opened again for job planning in January to be completed by 31 March.

13 Consultants job plans are currently at 1st stage sign off
7 Consultants job plans are currently at 2nd stage sign off
221 Consultants job plans are currently with the consultant to review
45 Consultants job plans are currently in discussion with the 1st stage manager

25 SAS job plans are currently with the SAS doctor to review
1 SAS job plan in discussion with the 1st stage manager

Information Governance Toolkit



Information governance toolkit compliance has reduced to 93% in January below the 95% threshold.

Core Skills Training % Compliance

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

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

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

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

WELL LED

Finance & Use of Resource metrics

Area	Metric	Actual YTD Performance	Actual YTD Score	Forecast outturn Performance	Forecast outturn Score
Financial sustainability	Capital service capacity	0.7	4	0.7	4
	Liquidity (days)	(9.4)	3	(11.6)	3
Financial efficiency	I&E margin	(2.1%)	4	(2.0%)	4
Financial control	Distance from financial plan	(0.4%)	2	(0.4%)	2
	Agency spend	37.1%	3	47.5%	3
Total			3		3

Cumulatively to the end of month 10 (31st January 2019), the Trust has an underlying deficit in its income and expenditure (I&E) position of £13.0 million before Provider Sustainability Funding (PSF). The financial position has deteriorated by £1.4 million in month prior to PSF. It can be confirmed that the cumulative financial position reported to the end of month 10 is in line with the plan prior to PSF. 70% of the available PSF has been achieved to date relating to achievement of the financial target £4.3 million of an available £ 6.2 million.

The Trust is forecasting that it will meet its control total for the financial year subject to the current forecasts and mitigations that have been put in place. The forecast outturn is a £15.8 million deficit before PSF and a £10.2million deficit after receiving £5.6 million of the available £8.0 million available PSF funding in relation to achieving the financial performance.

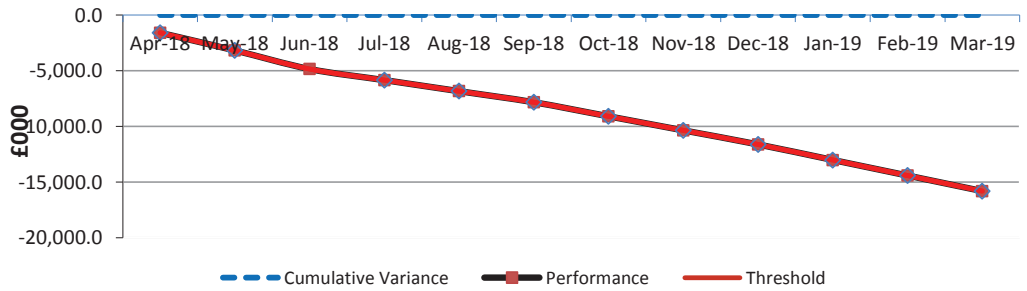
The Safely Releasing Cost Programme (SRCP) target is £18.0 million for 2018-19. £12.5 million has been actioned to date, of which £5.8 million is recurrent.

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

The 'Finance and use of resources metrics score' has remained at 3 for the financial year to date.

The cash balance at the 31st January 2019 was £1.6 million, a reduction of £0.9 million in month. Earlier this month, the Trust received the remaining £1.8 million of the planned £5.5 million of revenue support loans for the year. An application has now been submitted to NHS Improvement (NHSI) to draw down a further £3.8 million of revenue support loans in March to maintain cash balances for the Trust above the minimum balance set by NHSI of £2.5 million.

Adjusted financial performance



* - excludes PSF allocation

Efficiency Savings

Division	Target	Green	Amber	Red	Total	(Over) / Under Identified	Total Green Schemes
		£000's	£000's	£000's	£000's	£000's	%
Integrated Care Group	3,154	2,750	476	0	3,226	(72)	87%
SAS	3,720	2,186	1,210	11	3,406	314	59%
Family Care	2,423	1,263	61	15	1,338	1,085	52%
DCS	1,103	1,391	302	0	1,693	(590)	126%
Estates & Facilities	1,440	920	26	0	946	495	64%
Corporate Services	536	389	169	0	558	(22)	73%
Cross divisional	0	0	0	2,779	2,779	(2,779)	
Targetted Transformation	5,624	3,574	120	360	4,055	1,569	64%
Total	**18,000**	**12,473**	**2,364**	**3,165**	**18,000**	**0**	

Non Rec	Rec	Identified
£000's	£000's	£000's
700	2,050	2,750
1,822	364	2,186
828	435	1,263
41	1,350	1,391
60	860	920
16	373	389
0	0	0
3,156	417	3,574
6,624	5,849	12,473

APPENDIX 1

Safe

		Threshold 18/19	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Monthly Sparkline
M64	CDIFF	27	2	3	5	2	3	4	1	5	1	3	2	0	2	
M64.1	Cdiff Cumulative from April	27	29	32	37	2	5	9	10	15	16	19	21	21	23	
M65	MRSA	0	0	0	0	0	0	1	0	0	0	0	0	0	0	
M124	E-Coli (post 2 days)	48	3	4	3	5	5	2	6	8	4	7	6	7	3	
M154	P. aeruginosa bacteraemia (total pre 2 days)		1	0	2	1	1	1	1	1	3	2	1	2	1	
M155	P. aeruginosa bacteraemia (total post 2 days)	4	0	0	1	2	0	0	0	1	1	1	0	1	0	
M156	Klebsiella species bacteraemia (total pre 2 days)		4	4	5	8	10	4	2	3	7	5	5	4	7	
M157	Klebsiella species bacteraemia (total post 2 days)	16	0	1	3	1	2	1	2	4	3	2	1	4	3	
M66	Never Event Incidence	0	1	0	1	1	0	0	0	0	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	0	0	0	
C28	Percentage of Harm Free Care	92%	99.3%	99.3%	99.6%	99.3%	99.2%	99.6%	98.9%	98.9%	99.6%	98.8%	99.3%	98.7%	99.0%	
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%	99.1%	99.3%	99.2%	99.4%	99.5%	99.3%	99.4%	99.5%	98.8%	99.2%	99.1%	99.1%		
M69	Serious Incidents (Steis)		11	8	6	9	8	10	6	9	6	10	9	4	13	
M70	CAS Alerts - non compliance	0	2	0	0	2	0	0	0	0	0	0	0	0	0	
M146	Safer Staffing -Day-Average fill rate - registered nurses/midwives (%)	80%	90%	90%	88%	91%	91%	91%	89%	89%	90%	91%	92%	89%	91%	
M147	Safer Staffing -Day-Average fill rate - care staff (%)	80%	106%	104%	103%	106%	104%	104%	99%	102%	102%	104%	104%	101%	104%	
M148	Safer Staffing -Night-Average fill rate - registered nurses/midwives (%)	80%	98%	97%	97%	99%	101%	99%	98%	97%	100%	97%	101%	99%	98%	

M149	Safer Staffing -Night-Average fill rate - care staff (%)	80%	116%	112%	112%	114%	112%	111%	113%	112%	115%	123%	121%	115%	115%	
M150	Safer Staffing - Day -Average fill rate - registered nurses/midwives- number of wards <80%	0	10	7	12	5	5	8	9	14	11	14	9	9	8	
M151	Safer Staffing - Night -Average fill rate - registered nurses/midwives- number of wards <80%	0	0	0	1	0	0	0	1	3	3	2	2	1	0	
M152	Safer Staffing - Day -Average fill rate - care staff- number of wards <80%	0	1	1	1	0	1	1	1	1	0	0	0	0	0	
M153	Safer Staffing - Night -Average fill rate - care staff- number of wards <80%	0	1	1	1	1	1	1	0	0	0	0	0	0	0	

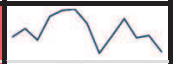
Caring

		Threshold 18/19	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Monthly Sparkline
C38	Inpatient Friends and Family - % who would recommend	90%	98.6%	98.1%	97.9%	98.5%	96.8%	98.7%	96.6%	95.6%	91.2%	95.5%	97.1%	97.1%	96.9%	
C31	NHS England Inpatients response rate from Friends and Family Test		48.6%	45.7%	47.8%	49.3%	36.2%	41.5%	48.6%	50.5%	47.9%	54.2%	47.3%	43.3%	46.3%	
C40	Maternity Friends and Family - % who would recommend	90%	98.8%	96.6%	97.7%	96.8%	96.3%	95.9%	96.2%	97.6%	94.3%	98.4%	96.3%	97.4%	96.8%	
C42	A&E Friends and Family - % who would recommend	90%	82.8%	80.4%	82.1%	84.1%	80.5%	82.3%	81.1%	82.7%	83.9%	84.3%	85.1%	82.8%	84.4%	
C32	NHS England A&E response rate from Friends and Family Test		20.1%	20.9%	22.4%	23.1%	17.1%	20.8%	19.7%	20.0%	22.9%	20.6%	20.2%	19.9%	19.7%	
C44	Community Friends and Family - % who would recommend	90%	97.7%	96.9%	95.6%	97.0%	87.1%	91.7%	95.5%	95.6%	96.0%	96.3%	96.7%	96.5%	96.5%	
C15	Complaints – rate per 1000 contacts	0.4	0.2	0.3	0.2	0.2	0.2	0.3	0.2	0.3	0.3	0.3	0.2	0.1	0.2	
M52	Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Effective

		Threshold 18/19	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Monthly Sparkline
M73	Deaths in Low Risk Categories - relative risk	Outlier	47.3	52.4	43.5	51.6	52.0	57.6	61.9	52.6	62.9	67.2				
M74	Hospital Standardised Mortality Ratio - Weekday (DFI Indicative)	Outlier	90.4	88.5	89.8	92.2	91.7	91.1	90.6	91.1	93.0	94.7				
M75	Hospital Standardised Mortality Ratio - Weekend (DFI Indicative)	Outlier	93.2	91.1	91.1	90.3	90.5	91.2	95.8	96.6	95.5	94.4				
M54	Hospital Standardised Mortality Ratio (DFI Indicative)	Outlier	91.1	89.1	90.2	91.7	91.4	91.1	91.9	92.5	93.7	94.6				
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Outlier			1.06			1.06			1.07					
M159	Stillbirths	<5	3	2	4	3	1	4	2	2	3	3	3	1	0	
M160	Stillbirths - Improvements in care that impacted on the outcome		0	0	1											
M89	CQUIN schemes at risk	0														

Responsive

		Threshold 18/19	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Monthly Sparkline
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	95%	79.6%	81.4%	78.9%	84.0%	85.3%	85.6%	82.5%	76.1%	79.8%	83.5%	79.5%	80.0%	76.5%	
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	95%	80.7%	82.2%	80.1%	84.9%	86.1%	86.6%	83.8%	77.8%	81.2%	84.6%	80.7%	81.0%	77.8%	
M62	12 hour trolley waits in A&E	0	5	13	23	9	3	34	37	36	20	30	22	18	16	
M81	HAS Compliance	90%	84.40%	95.21%	92.79%	94.53%	93.79%	89.57%	93.26%	92.66%	91.49%	92.88%	95.13%	94.91%	93.07%	
M82	Handovers > 30 mins ALL	0	1267	405	1008	652	685	497	568	665	654	586	517	410	604	
M82.c	Handovers > 30 mins ALL (NWAS Confirmed Penalty)	0	827	201	589	334	426	399	305	340	349	296	300	241		
C1	RTT admitted: percentage within 18 weeks	N/A	72.2%	72.2%	73.1%	69.7%	71.9%	71.6%	73.0%	72.9%	71.9%	72.9%	67.6%	76.2%	64.6%	
C3	RTT non- admitted pathways: percentage within 18 weeks	N/A	90.7%	92.4%	92.1%	90.6%	93.5%	93.2%	92.4%	90.9%	89.5%	89.3%	89.6%	90.8%	89.9%	
C4	RTT waiting times Incomplete pathways %	92%	92.3%	92.4%	92.1%	92.8%	93.3%	93.0%	92.5%	92.2%	92.1%	92.1%	92.6%	92.0%	91.5%	

C4.1	RTT waiting times Incomplete pathways Total	<25,920	22,968	23,006	24,124	23,754	24,320	24,418	25,086	26,690	26,986	26,858	26,728	26,677	26,502	
C4.2	RTT waiting times Incomplete pathways -over 40 wks		34	40	34	25	25	25	9	19	15	12	10	23	29	
C37.1	RTT 52 Weeks (Ongoing)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1%	0.4%	0.1%	0.2%	0.9%	1.8%	0.4%	0.4%	0.6%	0.9%	0.5%	0.3%	0.6%	0.4%	
C18	Cancer - Treatment within 62 days of referral from GP	85%	85.7%	82.8%	82.1%	91.9%	88.4%	82.6%	76.7%	82.4%	76.5%	81.0%	85.7%	78.5%		
C19	Cancer - Treatment within 62 days of referral from screening	90%	96.2%	100.0%	100.0%	95.0%	92.0%	92.3%	100.0%	97.3%	97.4%	100.0%	94.3%	96.6%		
C20	Cancer - Treatment within 31 days of decision to treat	96%	93.9%	98.3%	97.5%	97.5%	98.7%	97.6%	98.2%	99.5%	96.1%	98.6%	98.7%	98.3%		
C21	Cancer - Subsequent treatment within 31 days (Drug)	98%	98.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94%	94.8%	91.2%	96.0%	89.2%	97.5%	92.7%	91.4%	96.0%	92.2%	87.0%	95.7%	94.7%		
C24	Cancer - seen within 14 days of urgent GP referral	93%	93.0%	94.9%	95.1%	93.3%	93.2%	91.1%	93.7%	94.6%	93.4%	94.1%	95.5%	95.9%		
C25	Cancer - breast symptoms seen within 14 days of GP referral	93%	96.8%	94.5%	90.0%	92.0%	92.3%	85.4%	93.4%	86.8%	94.4%	93.7%	91.6%	91.1%		
C36	Cancer 62 Day Consultant Upgrade	85%	89.4%	95.8%	92.3%	90.0%	90.4%	96.3%	90.0%	90.0%	89.3%	97.4%	91.7%	89.0%		
C25.1	Cancer - Patients treated > day 104		5	5	2	2	3	4	9	5	6	7	4	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	4	10	2	1	0	0	0	2	0	6	0	0	0	
M138	No.Cancelled operations on day		121	104	121	62	59	51	61	40	76	79	64	40	72	
M55	Proportion of delayed discharges attributable to the NHS	3.5%	3.6%	3.5%	3.0%	3.0%	2.9%	2.8%	3.4%	3.7%	3.9%	3.5%	3.4%	3.0%	3.8%	
C16	Emergency re-admissions within 30 days		12.1%	13.2%	12.1%	11.9%	12.1%	12.0%	10.7%	11.9%	13.5%	13.1%	13.4%	12.3%		
M90	Average LOS elective (excl daycase)		2.6	3.2	2.7	2.4	2.6	3.0	2.6	2.9	2.5	2.6	2.5	3.3	3.1	
M91	Average LOS non-elective		4.8	4.8	4.7	4.8	4.6	4.6	4.7	4.8	4.6	4.5	4.8	5.1	5.2	

Well led

		Threshold 18/19	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Monthly Sparkline
M77	Trust turnover rate	12%	8.0%	9.5%	9.0%	8.5%	9.3%	9.0%	9.0%	8.0%	7.0%	7.0%	8.0%	8.0%	8.0%	
M78	Trust level total sickness rate	4.5%	5.5%	5.0%	4.6%	4.5%	4.5%	4.8%	5.1%	5.0%	4.8%	5.1%	5.4%	5.1%		
M79	Total Trust vacancy rate	5%	8.2%	8.4%	8.4%	7.9%	8.7%	8.6%	8.8%	9.1%	7.8%	7.4%	7.8%	7.7%	7.3%	
M80.3	Appraisal (AFC)	90%	92.0%	92.0%	91.0%	91.0%	89.0%	88.0%	86.0%	85.0%	82.0%	84.0%	87.0%	89.0%	88.0%	
M80.3	Appraisal (Consultant)	90%	93.0%	95.0%	97.0%	97.0%	97.0%	97.0%	97.0%	90.0%	95.0%	96.0%	95.0%	94.0%	96.0%	
M80.4	Appraisal (Other Medical)	90%	96.0%	95.0%	98.0%	98.0%	98.0%	98.0%	98.0%	85.0%	94.0%	92.0%	96.0%	94.0%	94.0%	
M80.2	Safeguarding Children	90%	95.0%	96.0%	96.0%	96.0%	96.0%	96.0%	97.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	
M80.2	Information Governance Toolkit Compliance	95%	92.0%	93.0%	95.0%	94.0%	94.0%	94.0%	95.0%	94.0%	93.0%	94.0%	94.0%	94.0%	93.0%	
F8	Temporary costs as % of total paybill	4%	8%	9%	9%	9%	7%	10%	8%	10%	10%	10%	10%	10%	8%	
F9	Overtime as % of total paybill	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
F1	Adjusted financial performance (deficit) including PSF (£M)	(7.7)	(3.0)	(3.4)	(2.7)	(1.6)	(3.2)	(3.6)	(4.6)	(5.2)	(5.9)	(6.6)	(7.2)	(7.9)	(8.7)	
F1.1	Adjusted financial performance (deficit) excluding PSF (£M)	(15.8)						(4.8)	(5.8)	(6.8)	(7.8)	(9.1)	(10.3)	(11.6)	(13.0)	
F2	SRCP Achieved % (green schemes only)	100.0%	79%	80%	107%	8%	17%	18%	29%	32%	50%	52%	55%	64%	69%	
F3	Liquidity days	>(14.0)	(9.6)	(10.0)	(10.5)	(5.4)	(9.4)	(5.7)	(8.4)	(10.0)	(9.3)	(10.2)	(11.4)	(12.2)	(9.4)	
F4	Capital spend v plan	85%	88%	73%	95%	38%	81%	67%	61%	80%	82%	81%	77%	83%	85%	
F16	Finance & Use of Resources (UoR) metric - overall	3	3	3	3	3	3	2	3	3	3	3	3	3	3	
F17	Finance and UoR metric - liquidity	4	3	3	3	4	4	2	3	3	3	3	3	3	3	
F18	Finance and UoR metric - capital service capacity	4	3	3	3	2	3	4	4	4	4	4	4	4	4	
F19	Finance and UoR metric - I&E margin	4	3	3	3	4	4	4	4	4	4	4	4	4	4	
F20	Finance and UoR metric - distance from financial plan	4	2	2	2	4	1	1	2	2	2	2	2	2	2	

F21 Finance and UoR metric - agency spend	1	2	2	2	2	1	1	2	2	2	3	3	3	3	
F12 BPPC Non NHS No of Invoices	95%	95.3%	95.4%	95.0%	95.2%	96.3%	96.5%	96.2%	95.9%	95.7%	95.8%	96.0%	96.0%	96.1%	
F13 BPPC Non NHS Value of Invoices	95%	94.9%	95.1%	95.1%	96.9%	95.6%	96.1%	96.5%	96.7%	97.0%	97.2%	96.8%	96.7%	96.6%	
F14 BPPC NHS No of Invoices	95%	94.0%	92.4%	95.6%	96.6%	97.3%	97.8%	98.1%	97.7%	96.7%	96.9%	96.8%	96.6%	96.0%	
F15 BPPC NHS Value of Invoices	95%	97.7%	97.5%	98.2%	99.3%	99.5%	99.4%	99.3%	98.9%	98.6%	98.9%	98.2%	98.4%	98.1%	

Safe Staffing (Rota Fill Rates and CHPPD) Collection

Organisation : RXR East Lancashire Hospitals Trust
Month : Jan-19

Trust Website where staffing information is available

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

Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
					midwives/nurses		Care Staff		midwives/nurses		Care Staff									
Site code	Hospital Site name	Ward Name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Nurses & Midwives	Care staff	Overall
RXR60	ACCRINGTON VICTORIA HOSPITAL - RXR60	Ward 2	314 - REHABILITATION		-	-	-	-	-	-	-	-	0.0%	0.0%	0.0%	0.0%	0	#DIV/0!	#DIV/0!	#DIV/0!
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Acute Stroke Unit (ASU)	300 - GENERAL MEDICINE		1,860	1,548	1,488	1,338	1,116	1,116	1,116	1,116	83.2%	89.9%	100.0%	100.0%	670	3.98	3.66	7.64
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B18	320 - CARDIOLOGY		1,812	1,542	1,116	1,452	1,116	1,116	1,116	1,092	85.1%	130.1%	100.0%	97.8%	785	3.39	3.24	6.63
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B20	100 - GENERAL SURGERY		1,488	1,254	744	1,008	744	744	744	732	84.3%	135.5%	100.0%	98.4%	534	3.74	3.26	7.00
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B22	110 - TRAUMA & ORTHOPAEDICS		1,488	1,284	2,232	2,148	744	732	1,860	1,824	86.3%	96.2%	98.4%	98.1%	634	3.18	6.26	9.44
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B24	110 - TRAUMA & ORTHOPAEDICS		1,488	1,314	1,116	1,164	744	744	744	816	88.3%	104.3%	100.0%	109.7%	633	3.25	3.13	6.38
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B4	430 - GERIATRIC MEDICINE		1,488	1,206	2,232	2,136	744	744	1,488	1,608	81.0%	95.7%	100.0%	108.1%	729	2.67	5.14	7.81
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Blackburn Birth Centre	501 - OBSTETRICS		930	968	495	459	667	656	333	333	104.0%	92.7%	98.4%	100.0%	36	45.09	22.01	67.10
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C1	300 - GENERAL MEDICINE		1,788	1,572	1,188	1,158	744	744	516	1,056	87.9%	97.5%	100.0%	204.7%	477	4.86	4.64	9.50
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C10	300 - GENERAL MEDICINE		1,488	1,320	1,488	1,614	744	732	1,116	1,272	88.7%	108.5%	98.4%	114.0%	667	3.08	4.33	7.40
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C11	300 - GENERAL MEDICINE		1,488	1,194	1,488	1,488	744	744	1,116	1,272	80.2%	100.0%	100.0%	114.0%	675	2.87	4.09	6.96
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C14A	100 - GENERAL SURGERY		1,302	1,242	744	720	744	744	372	660	95.4%	96.8%	100.0%	177.4%	511	3.89	2.70	6.59
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C14B	100 - GENERAL SURGERY		1,302	1,224	744	810	744	744	372	612	94.0%	108.9%	100.0%	164.5%	497	3.96	2.86	6.82
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C18A	100 - GENERAL SURGERY		1,302	1,254	744	822	744	744	372	708	96.3%	110.5%	100.0%	190.3%	533	3.75	2.87	6.62
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C18B	100 - GENERAL SURGERY		1,302	1,236	744	744	744	744	372	564	94.9%	100.0%	100.0%	151.6%	535	3.70	2.44	6.15
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C2	301 - GASTROENTEROLOGY	MEDICINE	1,488	1,194	1,116	1,212	1,116	1,092	1,116	1,080	80.2%	108.6%	97.8%	96.8%	753	3.04	3.04	6.08
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C22	101 - UROLOGY	120 - ENT	2,232	2,190	1,488	1,896	1,116	1,164	1,488	1,632	98.1%	127.4%	104.3%	109.7%	1011	3.32	3.49	6.81
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C3	300 - GENERAL MEDICINE		1,674	1,476	1,488	1,482	1,116	1,164	1,116	1,476	88.2%	99.6%	104.3%	132.3%	829	3.18	3.57	6.75
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C4	301 - GASTROENTEROLOGY	MEDICINE	1,488	1,176	1,116	1,134	1,116	1,068	1,116	1,128	79.0%	101.6%	95.7%	101.1%	735	3.05	3.08	6.13
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C5	430 - GERIATRIC MEDICINE		1,116	870	1,488	1,422	744	744	1,116	1,236	78.0%	95.6%	100.0%	110.8%	432	3.74	6.15	9.89
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C6	340 - RESPIRATORY MEDICINE	MEDICINE	1,488	1,176	1,116	1,068	1,116	1,092	744	732	79.0%	95.7%	97.8%	98.4%	756	3.00	2.38	5.38
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C7	340 - RESPIRATORY MEDICINE	MEDICINE	1,488	1,176	1,116	1,206	744	756	744	996	79.0%	108.1%	101.6%	133.9%	672	2.88	3.28	6.15
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C8	340 - RESPIRATORY MEDICINE	MEDICINE	1,860	1,548	1,488	1,470	1,116	1,104	744	792	83.2%	98.8%	98.9%	106.5%	575	4.61	3.93	8.55
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C9	300 - GENERAL MEDICINE		1,488	1,230	1,488	1,554	744	744	1,116	1,260	82.7%	104.4%	100.0%	112.9%	672	2.94	4.19	7.13
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Children's Unit	420 - PAEDIATRICS		4,836	4,416	1,116	1,122	3,581	3,465	326	389	91.3%	100.5%	96.8%	119.4%	934	8.44	1.62	10.06
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Coronary Care Unit (CCU)	320 - CARDIOLOGY		1,488	1,248	744	756	1,116	1,116	-	-	83.9%	101.6%	100.0%	0.0%	273	8.66	2.77	11.43
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Critical Care Unit	192 - CRITICAL CARE MEDICINE		6,732	6,756	1,080	936	6,474	6,402	372	324	100.4%	86.7%	98.9%	87.1%	593	22.19	2.12	24.31
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D1	300 - GENERAL MEDICINE		1,488	1,188	1,116	1,116	744	756	744	744	79.8%	100.0%	101.6%	100.0%	619	3.14	3.00	6.15
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D3	300 - GENERAL MEDICINE		1,488	1,296	1,116	1,098	744	792	744	804	87.1%	98.4%	106.5%	108.1%	611	3.42	3.11	6.53
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUA)	300 - GENERAL MEDICINE		3,720	3,564	2,232	2,436	3,348	3,276	1,488	1,800	95.8%	109.1%	97.8%	121.0%	1266	5.40	3.35	8.75
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUB)	300 - GENERAL MEDICINE		3,348	3,186	2,604	2,538	2,976	2,904	1,488	1,428	95.2%	97.5%	97.6%	96.0%	1234	4.94	3.21	8.15
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Neonatal Intensive Care Unit	420 - PAEDIATRICS		4,836	4,590	372	379	4,464	3,804	-	216	94.9%	101.9%	85.2%	21600.0%	582	14.42	1.02	15.45
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Surgical Triage Unit	100 - GENERAL SURGERY		1,788	1,746	1,344	1,338	1,302	1,398	972	1,020	97.7%	99.6%	107.4%	104.9%	637	4.94	3.70	8.64
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Antenatal Ward	501 - OBSTETRICS		1,488	1,729	744	720	1,116	1,116	744	732	116.2%	96.8%	100.0%	98.4%	123	23.13	11.80	34.93
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Burnley Birth Centre	501 - OBSTETRICS		1,395	1,349	372	424	1,116	1,122	372	349	96.7%	113.8%	100.5%	93.8%	60	41.18	12.88	54.05
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Central Birth Suite	501 - OBSTETRICS		4,092	4,044	744	768	4,092	3,996	744	744	98.8%	103.2%	97.7%	100.0%	228	35.26	6.63	41.89
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Gynaecology and Breast Care Ward	502 - GYNAECOLOGY		1,020	938	528	528	788	788	326	326	92.0%	100.0%	100.0%	100.0%	292	5.91	2.92	8.83
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Postnatal Ward	501 - OBSTETRICS		2,418	2,610	1,260	1,392	2,232	2,232	1,488	1,488	107.9%	110.5%	100.0%	100.0%	887	5.46	3.25	8.71
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Rakehead	314 - REHABILITATION		1,116	870	1,860	2,016	744	744	744	1,332	78.0%	108.4%	100.0%	179.0%	447	3.61	7.49	11.10
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 15	110 - TRAUMA & ORTHOPAEDICS		1,350	1,326	1,086	1,032	744	744	888	900	98.2%	95.0%	100.0%	101.4%	521	3.97	3.71	7.68
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 16	300 - GENERAL MEDICINE		1,860	1,506	1,488	1,830	744	744	1,488	1,824	81.0%	123.0%	100.0%	122.6%	856	2.63	4.27	6.90
RXR70	CLITHEROE COMMUNITY HOSPITAL - RXR70	Ribblesdale	314 - REHABILITATION		1,860	1,560	1,488	1,626	1,116	1,116	1,488	1,692	83.9%	109.3%	100.0%	113.7%	956	2.80	3.47	6.27
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Hartley	314 - REHABILITATION		1,488	1,182	1,116	1,158	744	744	744	876	79.4%	103.8%	100.0%	117.7%	728	2.65	2.79	5.44
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Marsden	314 - REHABILITATION		1,488	1,218	1,860	1,848	744	744	744	1,104	81.9%	99.4%	100.0%	148.4%	715	2.74	4.13	6.87
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Reedyford	314 - REHABILITATION		1,488	1,170	1,116	1,332	744	744	744	1,080	78.6%	119.4%	100.0%	145.2%	701	2.73	3.44	6.17
		Total			85,635	77,685	53,853	55,898	59,683	58,722	37,584	43,168	90.72%	103.80%	98.39%	114.86%	27614	4.94	3.59	8.53

Ward Staff Summary - Jan 2019

Executed on: 21/02/2019 at: 10:47:21 AM

Division: All 3 Available Divisions Selected
Directorate: All 17 Available Directorates Selected
Site: All 4 Available Hospital Sites Selected
This report is based on the 44 wards which submitted data for the monthly Safer Staffing return

R: ≥ ±10% | A: ≥ ±5% | G: < ±5% | R: > 0 | G: = 0 | R:≥ 5% | G:< 5% | R:≥ 4.75% | G:< 4.50%

Site	Cost Centre Code	Ward	Day Shift						Night Shift						Pressure Ulcers Acquired			Falls with Harm (Mod & Above)	Infections Acquired		Vacancies WTE (RegN/M + HCA)*		Sickness/Absence RegN/M + HCA)*	
			Registered Nurses / Midwives			Care Staff			Registered Nurses / Midwives			Care Staff												
			Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	G2	G3	G4		C Diff	MRSA	WTE Vacant	% Vacant	WTE Days	% Abs Rate
EC: Surgical & Anaes Services																								
EC02: General Surg Services																								
RBH	5142	Ward C14A	1,302	1,242	79.03%	744	720	119.89%	744	744	100.00%	372	660	145.16%	0	0	0	0	1	0	6.20	25.89%	15.28	2.84%
	5143	Ward C18A	1,302	1,254	79.03%	744	822	119.89%	744	744	100.00%	372	708	145.16%	0	0	0	0	0	0	1.07	4.44%	7.00	1.00%
	5144	Surgical Triage Unit	1,788	1,746	79.03%	1,344	1,338	119.89%	1,302	1,398	100.00%	972	1,020	145.16%	0	0	0	0	0	0	5.66	15.26%	75.00	7.56%
	5145	Ward C14B	1,302	1,224	79.03%	744	810	119.89%	744	744	100.00%	372	612	145.16%	0	0	0	0	0	0	6.48	27.06%	31.56	5.78%
	5146	Ward C18B	1,302	1,236	79.03%	744	744	119.89%	744	744	100.00%	372	564	145.16%	0	0	0	0	0	0	5.08	20.91%	18.16	3.05%
EC03: Urology																								
RBH	5128	Ward C22	2,232	2,190	79.03%	1,488	1,896	119.89%	1,116	1,164	100.00%	1,488	1,632	145.16%	0	0	0	0	0	0	3.76	12.50%	53.00	6.72%
EC04: Orthopaedic Services																								
BGH	4393	Ward 15	1,350	1,326	79.03%	1,086	1,032	119.89%	744	744	100.00%	888	900	145.16%	0	0	0	0	0	0	4.40	12.59%	104.47	11.07%
RBH	5366	Ward B24	1,488	1,314	79.03%	1,116	1,164	119.89%	744	744	100.00%	744	816	145.16%	0	0	0	0	0	0	4.88	15.76%	4.80	0.59%
	5367	Ward B22	1,488	1,284	79.03%	2,232	2,148	119.89%	744	732	100.00%	1,860	1,824	145.16%	0	0	0	0	0	0	2.47	5.29%	73.99	5.40%
EC05: Head & Neck																								
RBH	5119	Ward B20 Max Fac	1,488	1,254	79.03%	744	1,008	119.89%	744	744	100.00%	744	732	145.16%	0	0	0	0	0	0	4.01	14.57%	104.16	13.71%
EC09: Anaesth & Critical Care																								
RBH	5362	Elht Critical Care	6,732	6,756	79.03%	1,080	936	119.89%	6,474	6,402	100.00%	372	324	145.16%	0	0	0	0	0	0	22.16	16.48%	151.57	4.37%
ED: Family Care																								
ED07: General Paediatrics																								
RBH	5210	Inpatient	4,836	4,416	79.03%	1,116	1,122	119.89%	3,580.50	3,465	100.00%	325.50	388.50	145.16%	0	0	0	0	0	0	52.71	64.38%	94.08	5.07%
ED08: Gynae Nursing																								
BGH	4169	Gynae And Breast Care Ward	1,020	938	79.03%	528	528	119.89%	787.50	787.50	100.00%	325.50	325.50	145.16%	0	0	0	0	0	0	2.00	6.96%	54.80	6.65%
ED09: Obstetrics																								
BGH	4165	Birth Suite	4,092	4,044	79.03%	744	768	119.89%	4,092	3,996	100.00%	744	744	145.16%	0	0	0	0	0	0	-8.04	-11.98%	36.44	1.60%
	4192	Burnley Birth Centre	1,395	1,348.50	79.03%	372	423.50	119.89%	1,116	1,122	100.00%	372	349	145.16%	0	0	0	0	0	0	-1.70	-3.81%	28.52	2.22%
	4200	Antenatal Ward 12	1,488	1,729	79.03%	744	720	119.89%	1,116	1,116	100.00%	744	732	145.16%	0	0	0	0	0	0	-2.04	-6.60%	74.51	6.92%
	4203	Postnatal Ward 10	2,418	2,610	79.03%	1,260	1,392	119.89%	2,232	2,232	100.00%	1,488	1,488	145.16%	0	0	0	0	0	0	-2.97	-5.35%	63.25	3.48%
RBH	5256	Blackburn Birth Centre	930	967.50	79.03%	495	459	119.89%	666.50	655.75	100.00%	333.25	333.25	145.16%	0	0	0	0	0	0	4.26	8.98%	71.88	5.28%
ED11: Neonates																								
RBH	4215	Nicu	4,836	4,590	79.03%	372	379	119.89%	4,464	3,804	100.00%	0	216	-	0	0	0	0	0	0	-1.86	-2.33%	117.36	4.64%
EH: Integrated Care Group																								
EH05: Business Support Unit																								
RBH	6078	Ward C3	1,674	1,476	79.03%	1,488	1,482	119.89%	1,116	1,164	100.00%	1,116	1,476	145.16%	0	0	0	0	0	0	20.14	46.95%	51.88	7.35%

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

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

Ward Staff Summary - Jan 2019

Executed on: 21/02/2019 at: 10:47:21 AM

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Site	Cost Centre Code	Ward	Day Shift						Night Shift						Pressure Ulcers Acquired			Falls with Harm (Mod & Above)	Infections Acquired		Vacancies WTE (RegN/M + HCA)*		Sickness/Absence RegN/M + HCA)*	
			Registered Nurses / Midwives			Care Staff			Registered Nurses / Midwives			Care Staff												
			Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	G2	G3	G4		C Diff	MRSA	WTE Vacant	% Vacant	WTE Days	% Abs Rate
EH15: Acute Medicine																								
RBH	5058	AMU A	3,720	3,564	79.03%	2,232	2,436	119.89%	3,348	3,276	100.00%	1,488	1,800	145.16%	0	0	0	0	0	0	10.33	12.58%	120.52	5.43%
	6092	AMU B	3,348	3,186	79.03%	2,604	2,538	119.89%	2,976	2,904	100.00%	1,488	1,428	145.16%	0	0	0	0	0	0	12.83	15.68%	174.64	8.19%
EH20: Respiratory																								
RBH	5063	Ward C6	1,488	1,176	79.03%	1,116	1,068	119.89%	1,116	1,092	100.00%	744	732	145.16%	0	0	0	0	0	0	4.54	13.76%	96.60	10.95%
	5064	Ward C8	1,860	1,548	79.03%	1,488	1,470	119.89%	1,116	1,104	100.00%	744	792	145.16%	0	0	0	0	0	0	6.56	17.12%	4.20	0.43%
	6027	Ward C7	1,488	1,176	79.03%	1,116	1,206	119.89%	744	756	100.00%	744	996	145.16%	0	0	0	0	0	0	6.94	22.93%	117.16	15.67%
EH25: Cardiology																								
RBH	5095	Coronary Care	1,488	1,248	79.03%	744	756	119.89%	1,116	1,116	100.00%	0	0	-	0	0	0	0	0	0	2.66	10.82%	11.88	1.75%
	5097	Ward B18	1,812	1,542	79.03%	1,116	1,452	119.89%	1,116	1,116	100.00%	1,116	1,092	145.16%	0	0	0	0	0	0	-0.56	-1.65%	76.41	7.13%
EH30: Gastroenterlogy																								
RBH	5050	Ward C2	1,488	1,194	79.03%	1,116	1,212	119.89%	1,116	1,092	100.00%	1,116	1,080	145.16%	1	0	0	0	0	0	9.57	26.78%	95.12	12.03%
	5062	Ward C4	1,488	1,176	79.03%	1,116	1,134	119.89%	1,116	1,068	100.00%	1,116	1,128	145.16%	0	0	0	1	0	0	14.02	38.41%	74.60	10.70%
	6103	Ward C11	1,488	1,194	79.03%	1,488	1,488	119.89%	744	744	100.00%	1,116	1,272	145.16%	0	0	0	1	0	0	7.81	21.86%	50.27	5.81%
	6106	C1 (Gastro)	1,788	1,572	79.03%	1,188	1,158	119.89%	744	744	100.00%	516	1,056	145.16%	0	0	0	0	0	0	13.03	39.48%	106.28	15.75%
EH35: Mfop & Complex Needs																								
BGH	4613	Rakehead Nursing Staff	1,116	870	79.03%	1,860	2,016	119.89%	744	744	100.00%	744	1,332	145.16%	0	0	0	0	1	0	3.42	10.37%	32.56	3.57%
	6094	Ward 16 Sept 13	1,860	1,506	79.03%	1,488	1,830	119.89%	744	744	100.00%	1,488	1,824	145.16%	0	0	0	0	0	0	3.15	7.65%	161.92	13.67%
PCH	4581	Marsden Ward	1,488	1,218	79.03%	1,860	1,848	119.89%	744	744	100.00%	744	1,104	145.16%	0	0	0	0	0	0	2.81	7.86%	14.96	1.51%
	4582	Reedyford Ward	1,488	1,170	79.03%	1,116	1,332	119.89%	744	744	100.00%	744	1,080	145.16%	0	0	0	0	0	0	4.55	15.57%	78.68	10.39%
	4583	Hartley Ward	1,488	1,182	79.03%	1,116	1,158	119.89%	744	744	100.00%	744	876	145.16%	0	0	0	0	0	0	6.57	21.23%	25.52	3.44%
RBH	5023	Ward D1	1,488	1,188	79.03%	1,116	1,116	119.89%	744	756	100.00%	744	744	145.16%	0	0	0	0	0	0	6.26	20.42%	57.00	7.29%
	5036	Acute Stroke Unit (B2)	1,860	1,548	79.03%	1,488	1,338	119.89%	1,116	1,116	100.00%	1,116	1,116	145.16%	0	0	0	0	0	0	10.33	22.12%	80.40	7.13%
	5037	Ward B4	1,488	1,206	79.03%	2,232	2,136	119.89%	744	744	100.00%	1,488	1,608	145.16%	0	0	0	0	0	0	6.21	14.14%	96.92	8.29%
	5048	Ward C10	1,488	1,320	79.03%	1,488	1,614	119.89%	744	732	100.00%	1,116	1,272	145.16%	0	0	0	0	0	0	6.34	17.16%	28.92	3.21%
	6096	Ward C5	1,116	870	79.03%	1,488	1,422	119.89%	744	744	100.00%	1,116	1,236	145.16%	0	0	0	0	0	0	7.38	22.37%	37.96	5.04%
	6105	Ward C9	1,488	1,230	79.03%	1,488	1,554	119.89%	744	744	100.00%	1,116	1,260	145.16%	0	0	0	0	0	0	5.25	14.69%	77.80	8.23%
EH44: Speciality Medicine																								
RBH	5040	Ward D3	1,488	1,296	79.03%	1,116	1,098	119.89%	744	792	100.00%	744	804	145.16%	0	0	0	1	0	0	1.57	5.29%	30.76	3.66%
EH70: Comm In Patient Care																								
CLI	R141	Ribblesdale Ward	1,860	1,560	79.03%	1,488	1,626	119.89%	1,116	1,116	100.00%	1,488	1,692	145.16%	0	0	0	0	0	0	2.64	6.01%	69.01	5.39%
Total for 44 wards shown					**90.72%**			**103.80%**			**98.39%**			**114.86%**	**1**	**0**	**0**	**3**	**2**	**0**	**282.88**	**15.27%**	**2,951.80**	**5.98%**

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

13 March 2019

Item 44

Purpose Information
Assurance

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

Summary: The Board members are asked to note the current success of this year's Seasonal Influenza (Flu) campaign at ELHT and the achievement of exceeding last year's achievement of 92.3% with a final uptake of 93.6%.
Whilst also outlining the success of this year's campaign this report outlines those reasons that, on the balance of evidence and personal circumstances, staff have decided against having the vaccine as per the Flu Letter requirements.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives. Recruitment and workforce planning fail to deliver the Trust objectives The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	No

Executive summary

1. On the 7th September 2018 the 'Annual Flu Letter' titled *Health care worker Flu Vaccination* was sent to all Chief Executives of NHS Trusts.
2. As part of this letter it is expected that each Trust will use its public board papers to locally report their performance on overall vaccination uptake rates and also the numbers of staff declining their vaccinations and their reasons for doing so.
3. This report outlines the final uptake of flu vaccinations and also those reasons that, on the balance of evidence and personal circumstances, staff have decided against having the vaccine.
4. Appendix 2 of the 'Annual Flu Letter' outlined a suggested opt out criteria that should be collected and reported to allow for national comparisons. These finding have been presented in this paper. The Annual Flu Letter and Appendices can be viewed by clicking here.

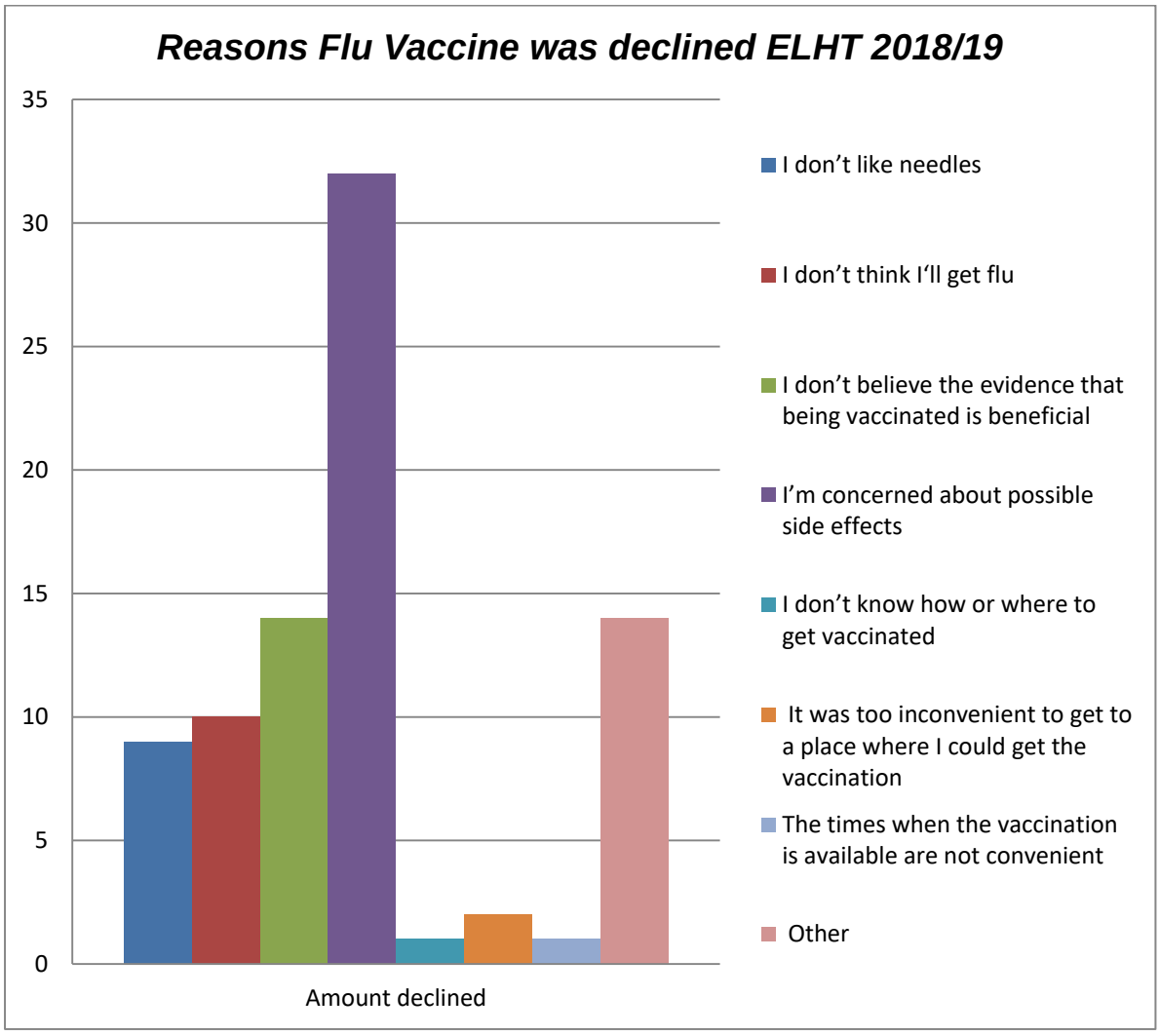
Introduction

5. The final uptake of flu vaccinations by frontline Health Care Workers (HCW) at ELHT is **93.6%** and has exceeded last year's campaign of 92.3%.
6. The 2018/19 campaign has already demonstrated huge success by building on previous year's initiatives; however the purpose of this paper is to highlight those reasons that people may have declined their vaccine and those divisions where declining vaccines was most prevalent.

Opt Out data Collection:

7. Every member of the organisation was contacted via email and asked to respond, if they were choosing to decline this year's vaccine, with their reasons for declining as outlined in Appendix 2 of the flu letter.
8. 83 people responded to enquiries related to opting out of the offer of having their flu vaccination and these are presented below.

Opt Out Data Collection results:



Division	Number of Opt out Responders
Corporate	13
DCS	26
Family Care	2
ICG	26
SAS	8
Unknown	8

9. There were 14 reasons that were classified as 'Other' in the 'Opt Out' feedback that was received. These reasons varied considerably with one such response stating *'Personal choice'*

Recommendations

10. The Annual Flu plan for the 2019/20 campaign will be presented to Trust board in October 2019. It is recommended that the board note the actions in place for the 2019/20 Flu campaign and continue to support the implementation of the plan across the organisation.
11. It is recommended that the 2019/20 campaign continues to support staff by educating them regarding the strong evidence base that exists regarding the benefits of having the flu vaccination and in so doing help to ease people's concerns where the evidence demonstrates people's concerns are unproven i.e. regarding the potential side effects of the vaccine.

Conclusion

12. This 2018/19 Flu uptake has surpassed last year's totals and has been successful in achieving an uptake of **93.6%.**
13. The number of people accepting this year's flu vaccination is significantly higher compared to those that have opted out of getting this year's vaccination therefore the number of responses gained from people opting out of their vaccine was expected to be low.
14. ELHT will continue to build on 2018/19s campaign leading into the 2019/20 campaign and will add emphasis to educating staff by 'Myth Busting' whilst continuing to promote the evidence base supporting the flu vaccinations benefits.

Future steps

15. Planning and implementation for 2019/20 campaign.

Phil Denney, Head of Occupational Health & Wellbeing

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

13 March 2019

Item 45

Purpose Information / Approval

Title	7 Day Services Report
Author	Dr J Dean, Deputy Medical Director
Executive sponsor	Dr D Riley, Executive Medical Director

Summary: This report summarises the progress and performance of East Lancashire Hospitals NHS Trust against the NHS England 7 day standards. Significant progress continues both with the priority standards and in other areas. Monitoring has changed from a national 6 monthly on line sample audit to local monitoring with a Board report template from NHS England. Six monthly reporting to Board and NHS England/Improvement is required. A return to NHS England was required at the end of February and forms the basis of this report.

Within ELHT Divisions are collecting data against standards 2 (Consultant review within 14 hours of non-elective admission) and standard 8 (Daily of twice daily consultant review of non-elective inpatients). A Standard of 90% for standards 2 and 8 has now also been set by NHS England. Specific reporting for specialised services is also required.

We are developing ongoing continuous monitoring of time to consultant review as a professional standard within each speciality. For February 2019 within Medicine 76% of acutely admitted patients are seen by a consultant within 14 hours of admission, with 81% on weekdays and 65.5% at weekends. The target of 90% is met for all patients admitted between 8pm and midday, 7 days a week. Whilst this is a reduction from 88% achieved in April 2018, we have increased consultant delivered ambulatory emergency medical care with 20 additional patients per day being discharged within 14 hours, 7 days a week. In Surgery on average 73% of patients had consultant review during weekdays and 66.5% at weekends, an improvement from 47% overall in April 2018. In Paediatrics 65% of children had consultant review with 14 hours (66% in April 2018), this was 60% at weekends and 66.5% on weekdays. Stroke services have continued to improve as demonstrated by SSNAP data. Additional consultant appointments have been made in Surgery and would be required in Paediatrics to meet the standard. Extended consultant shift hours would be required in Medicine. Electronic real time recording and reporting via an EPR would enable prioritisation, and help achieve the standard.

We have available investigations and interventions for all modalities 7 days a week for emergencies. Significant increases in weekend multiprofessional working have been delivered within Medicine during the winter period, increasing weekend discharges.

Comparative data has not been published by NHS England since 2017.

Recommendation: The Board is asked to note the contents of the report, and will receive 6 monthly updates in this format.

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 their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities.

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

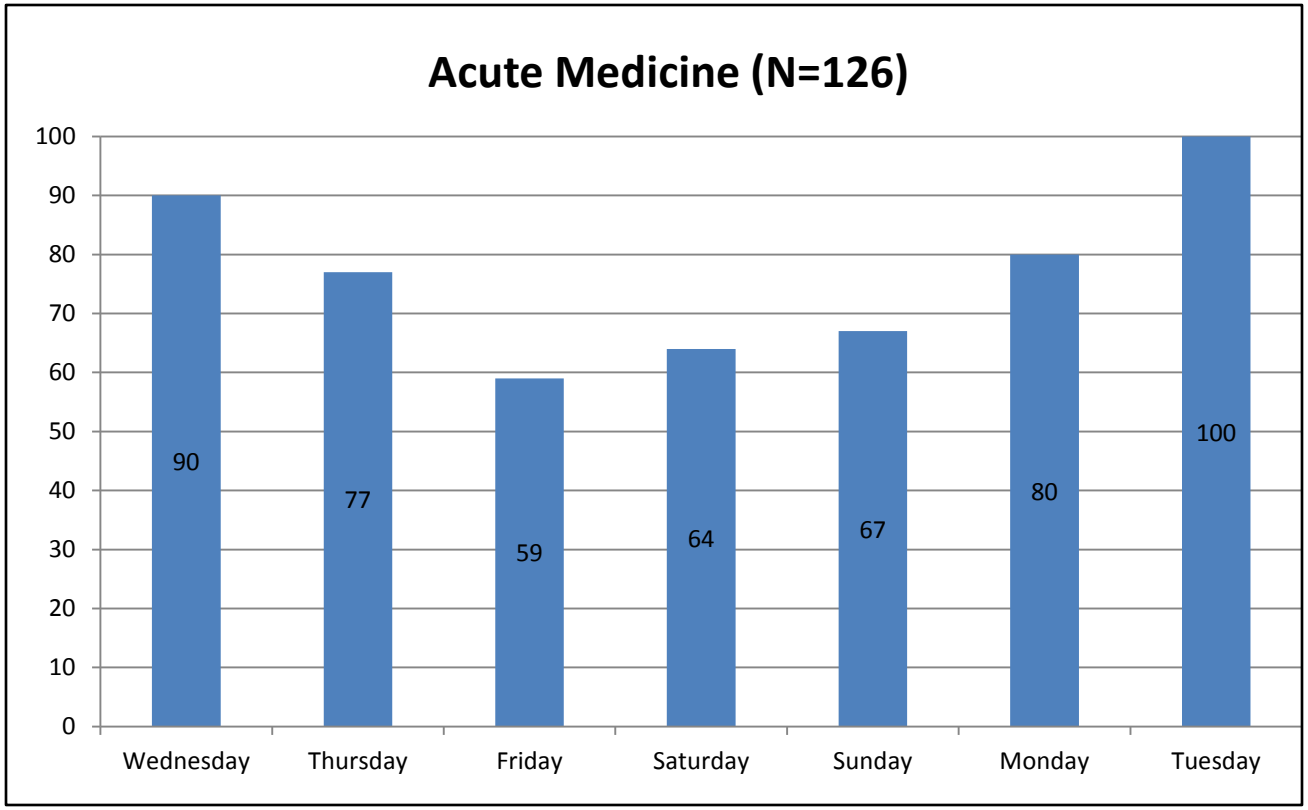
Previously considered by: Simultaneously reported to Divisional Boards. Previous report to Operational Delivery Board.

7 Day Services Data Feb 2019 submission

East Lancashire Hospitals NHS Trust.

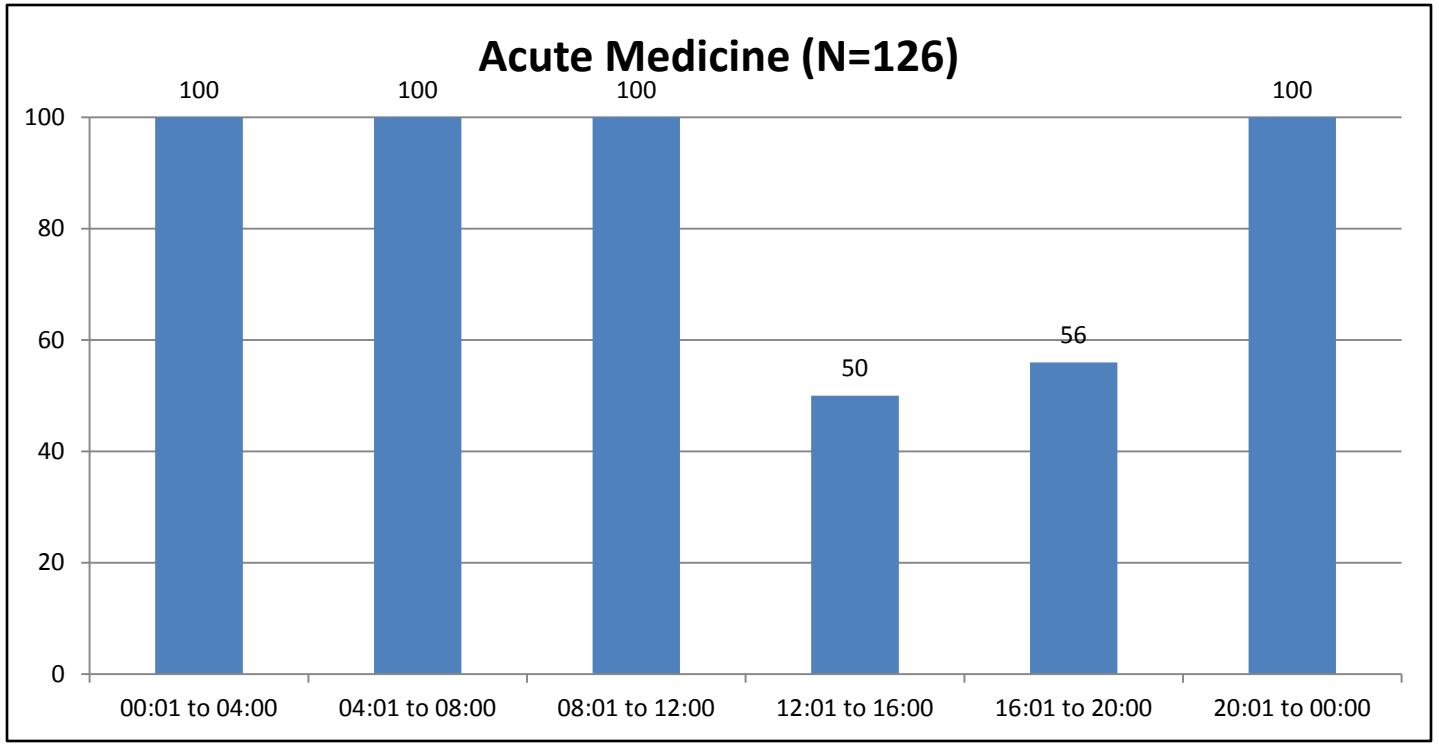
Safe | Personal | Effective

% seen within 14 hours of admission by day of week



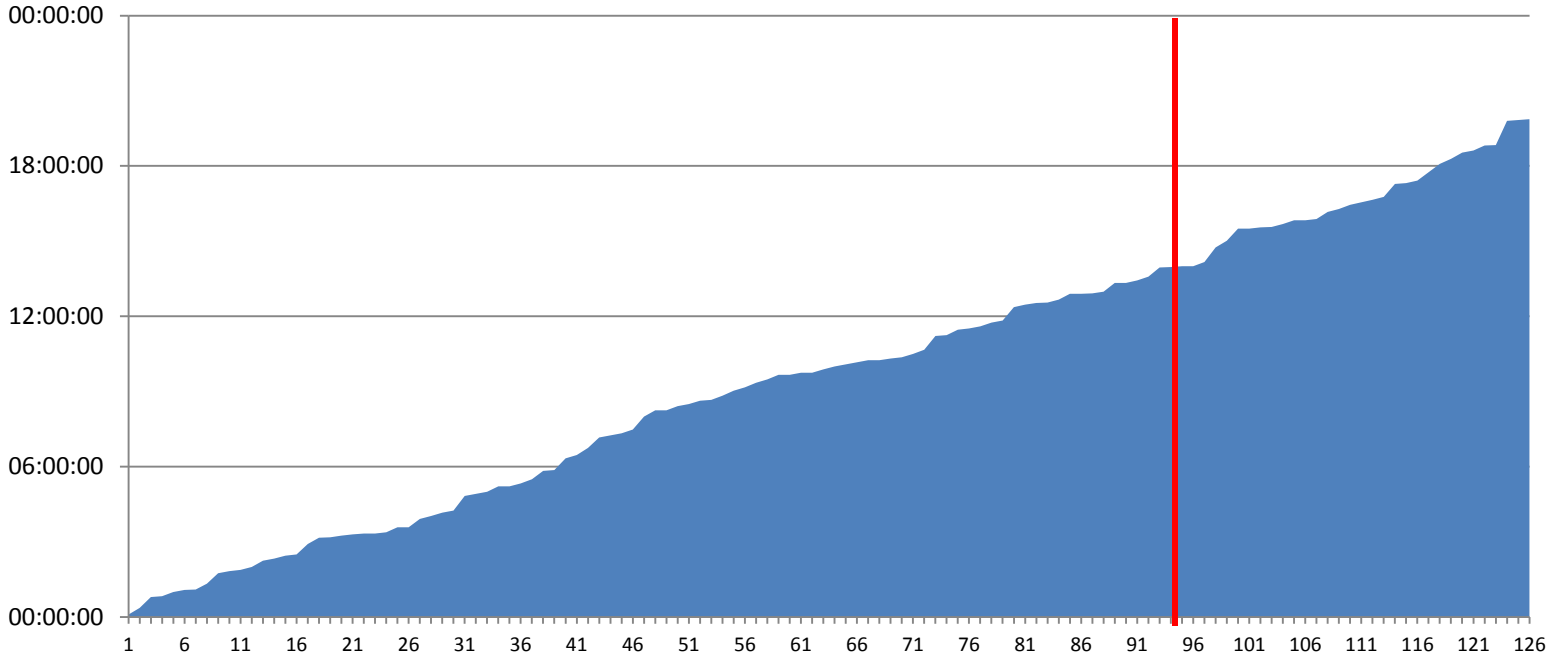
Safe | Personal | Effective

% seen within 14 hours by hour of admission



Safe | Personal | Effective

Overall Time to review from admission by patient (n=126)



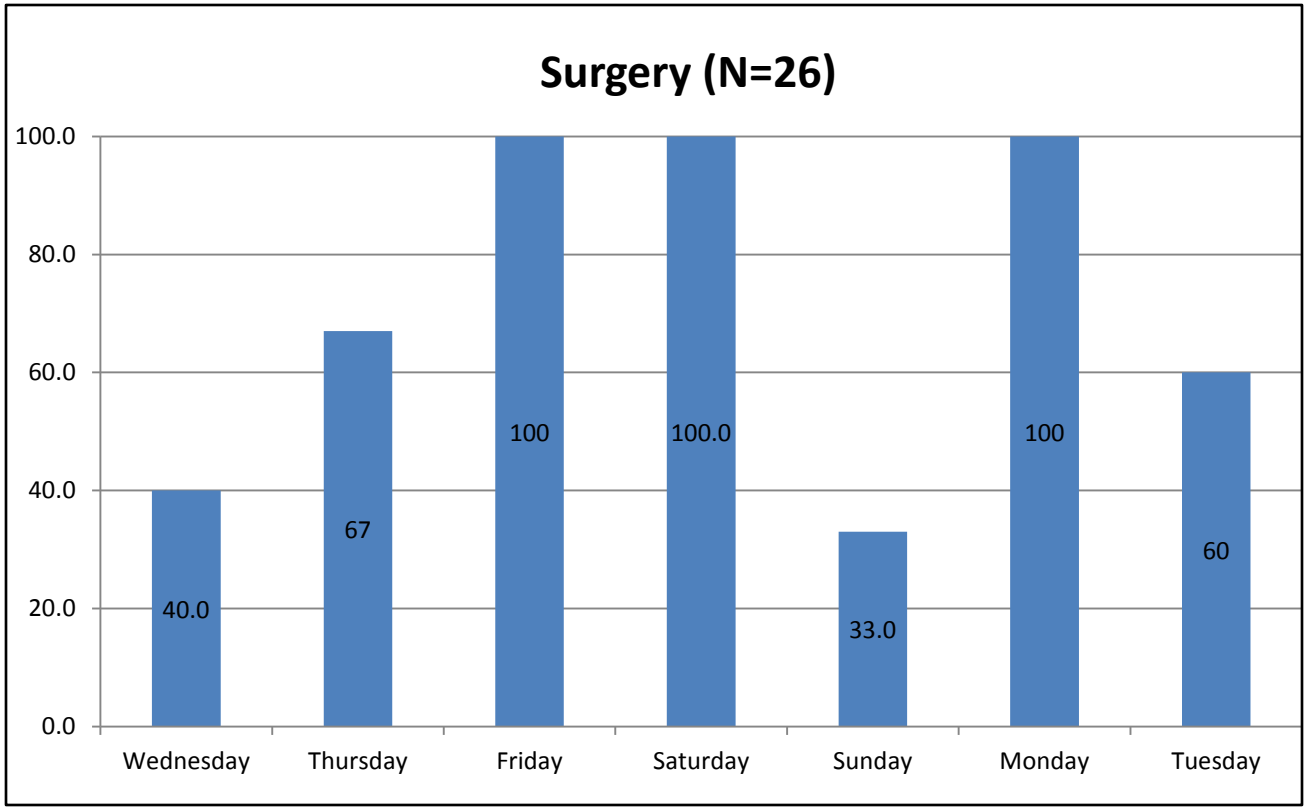
Note: Red line shows 14 hour review Compliance

Range: 00:06 to 19:52 hrs

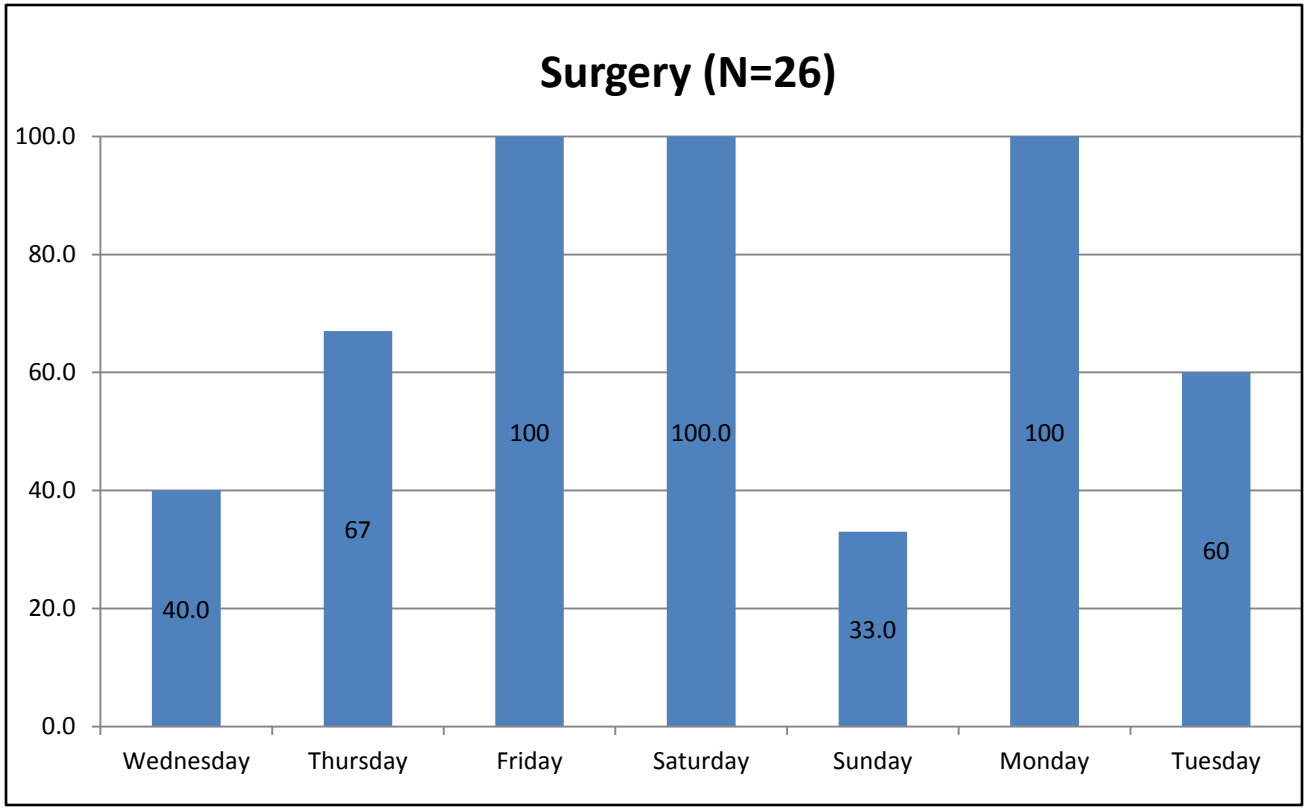
Average time to review: 09:45 hrs **Median:** 09:53 hrs

Safe | Personal | Effective

% seen within 14 hours of admission by day of week

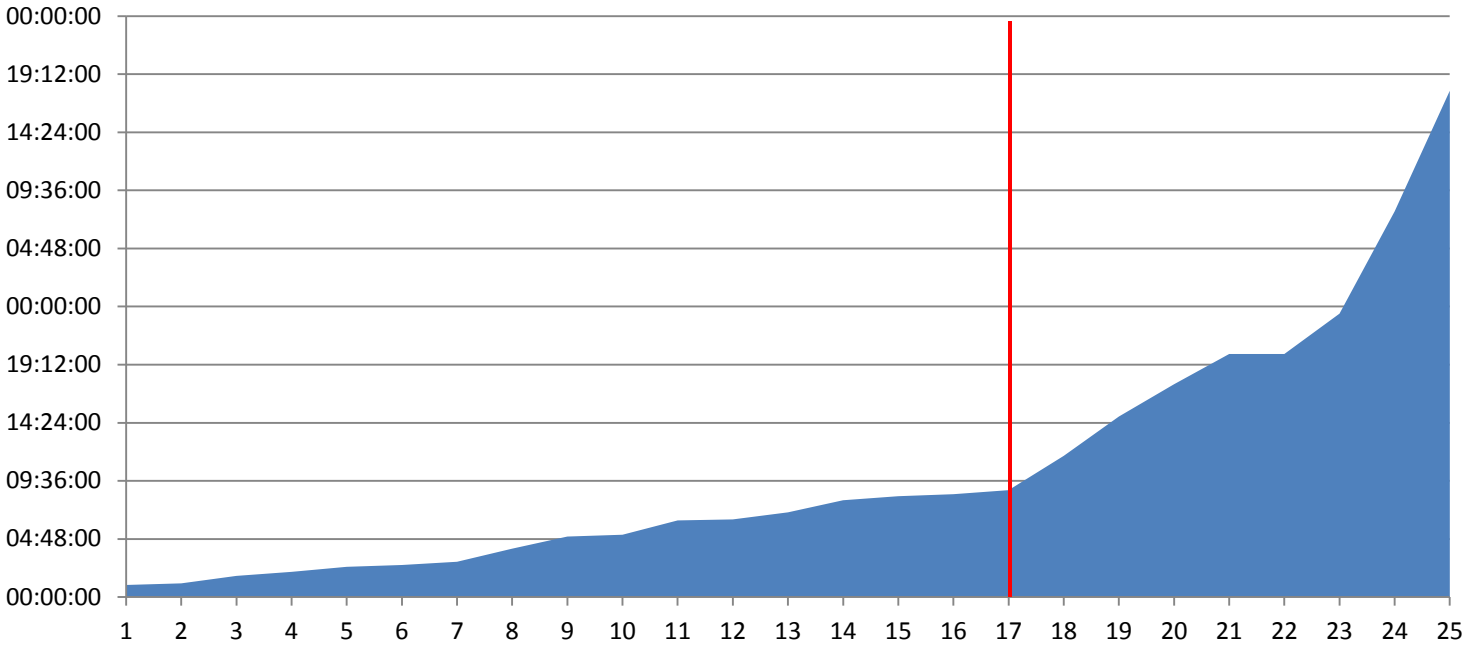


% seen within 14 hours of admission by day of week



Safe | Personal | Effective

Overall Time to review from admission by patient (n=24, where in 2 time not recorded)

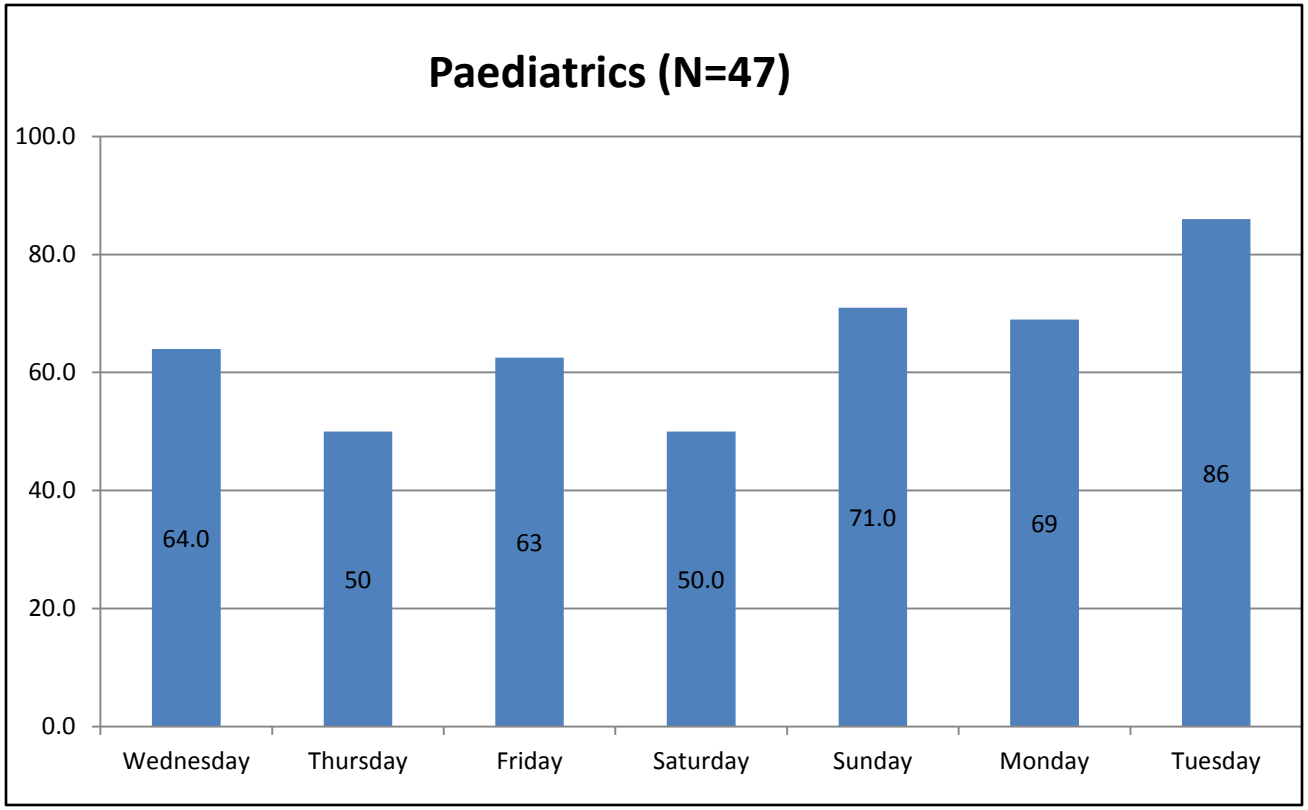


Note: In the 2 cases where no time was documented, both were identified as failing 14 hour target

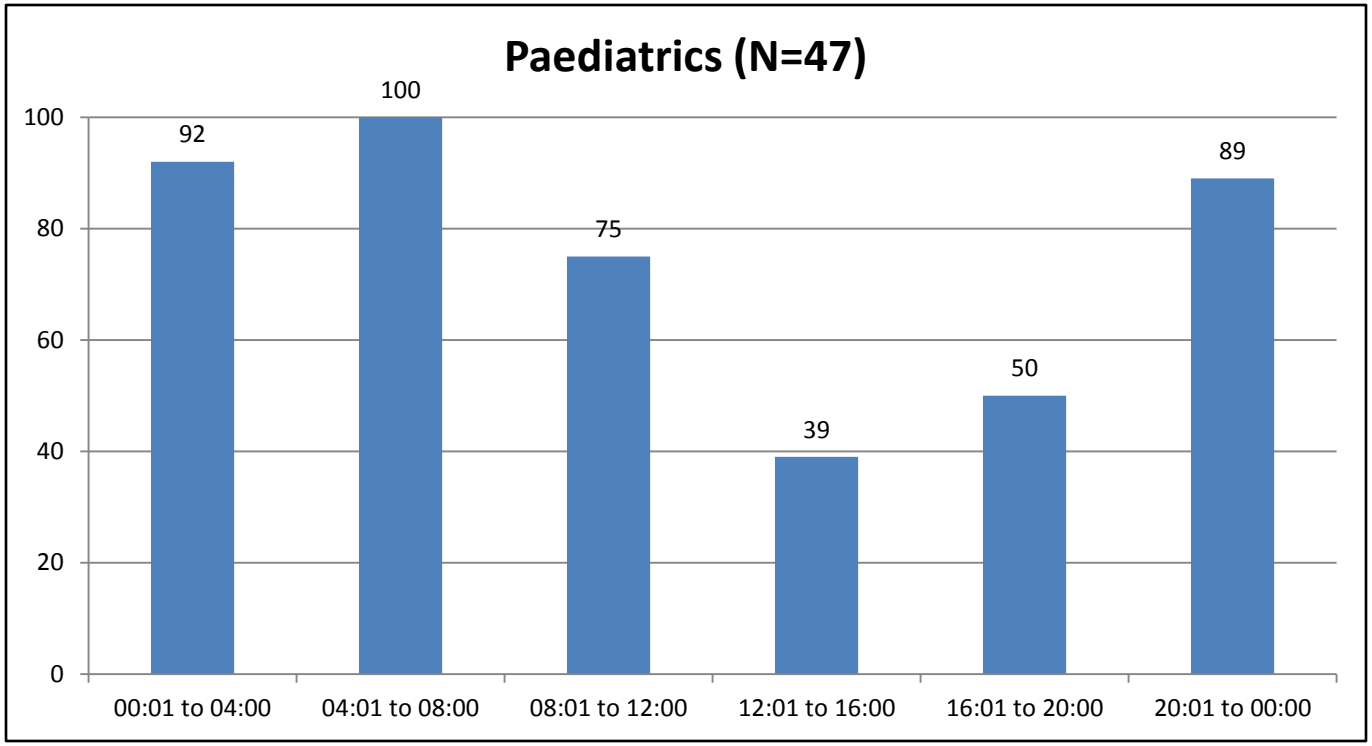
Range was 01:00 to 41:50 hrs

Average time to review 10:41hrs Median: 07:00 hrs

% seen within 14 hours of admission by day of week

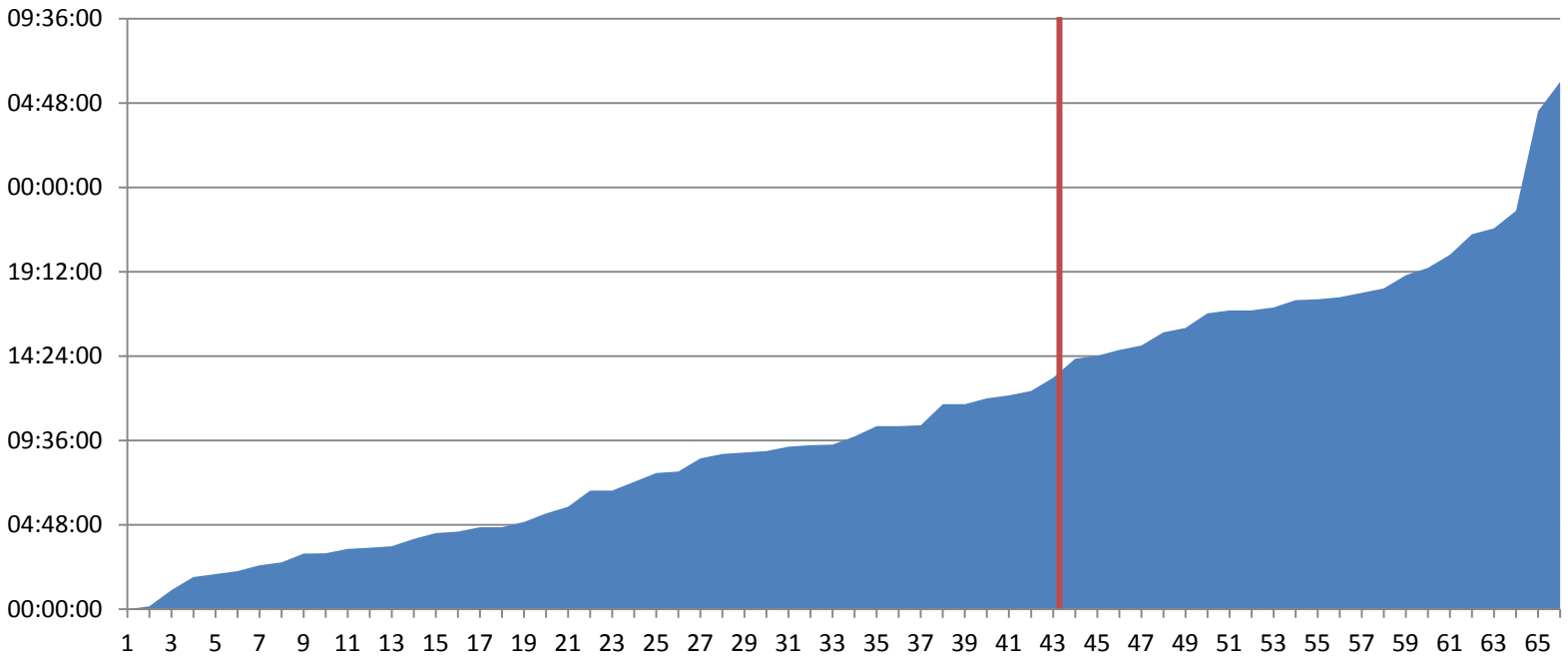


% seen within 14 hours by hour of admission



Safe | Personal | Effective

Overall Time to review from admission by patient (n=66, where no time documented in 5 cases)



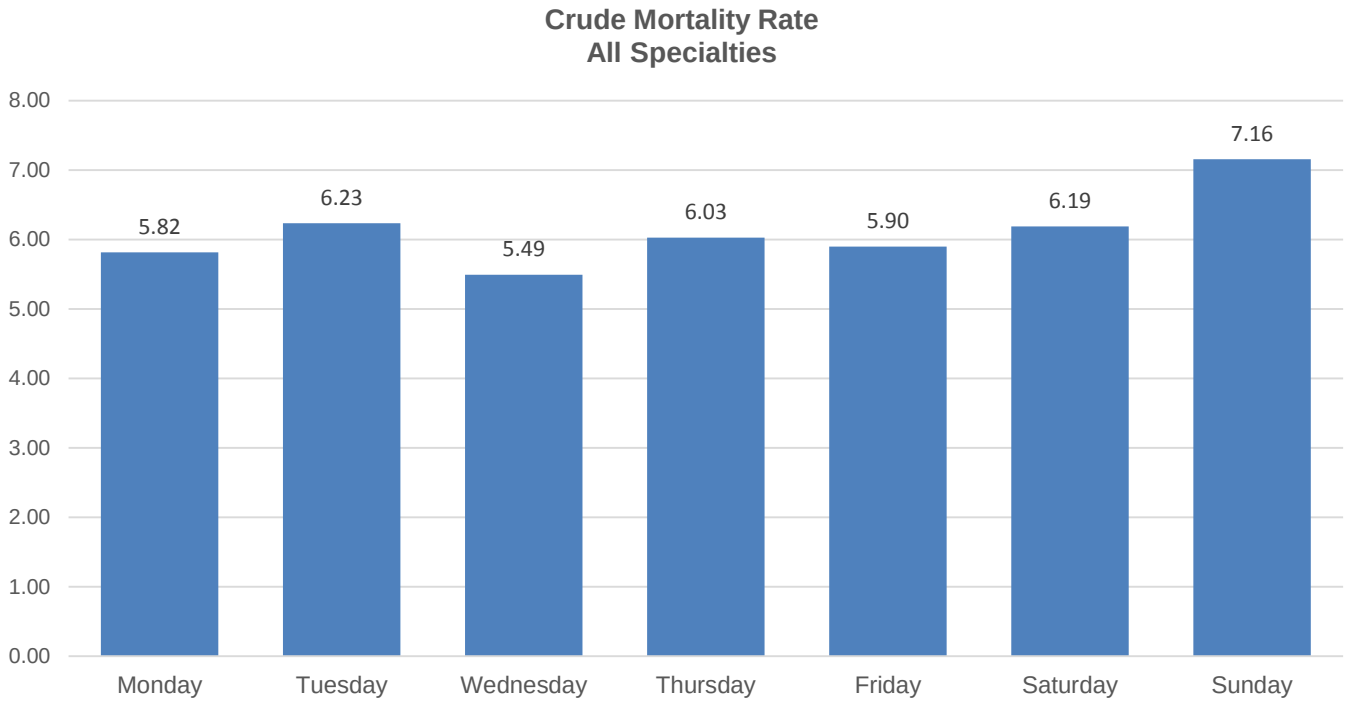
Note: Red line shows 14 hour review for 66/71 cases, in the 5 cases where no time documented it was recorded that 4/5 consultant reviews were within 14 hours

Range was -04:36 to 30:00 hrs (where 1 patient reviewed by consultant prior to admission

Average time to review 10:46 Median: 09:22

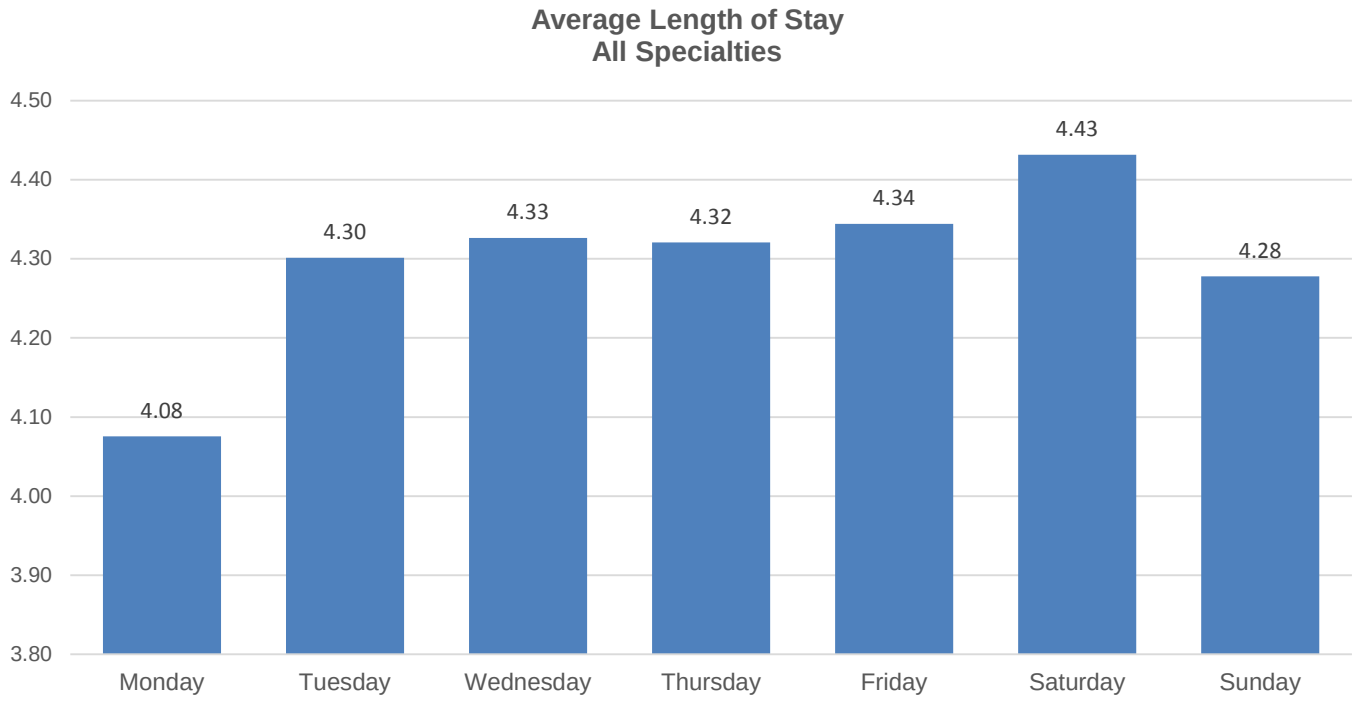
Safe | Personal | Effective

Mortality by day of the week 2018



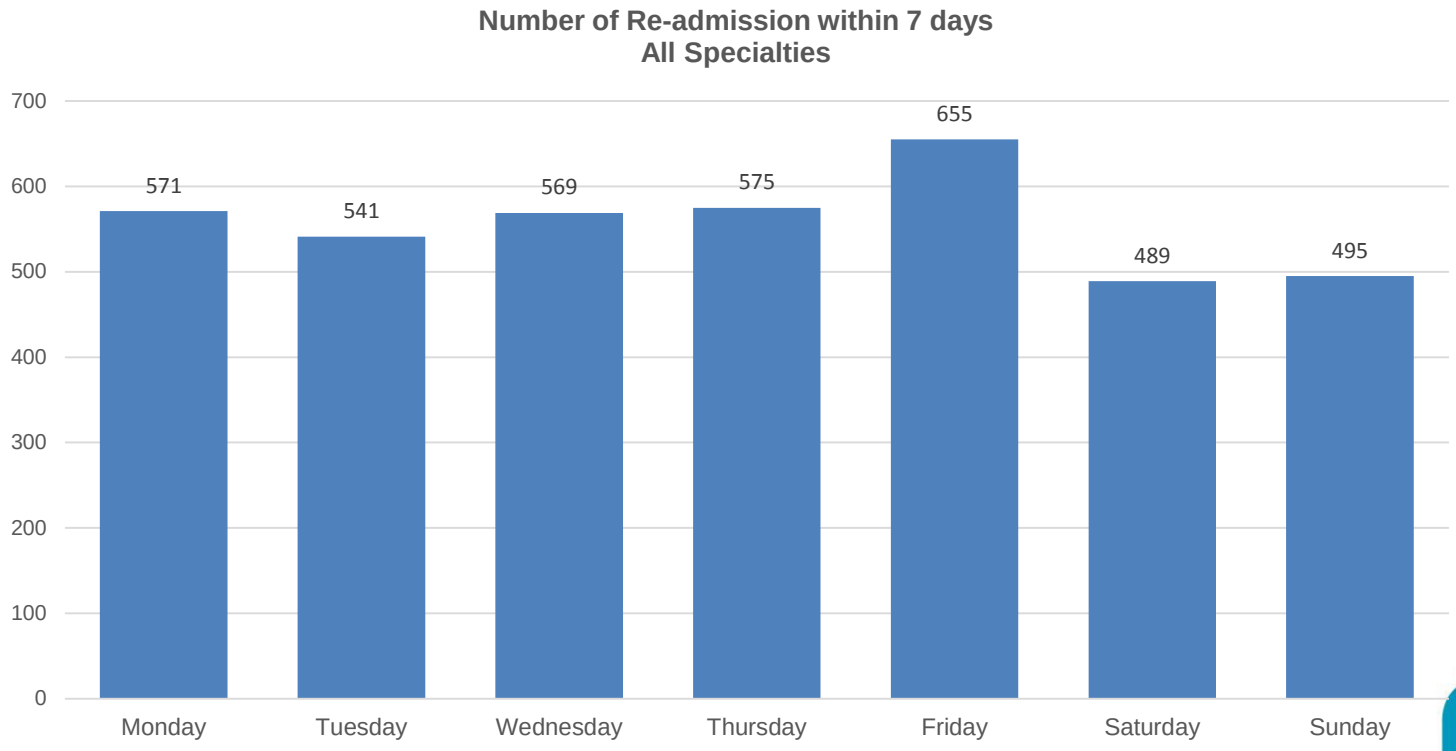
Safe | Personal | Effective

Length of Stay by day of admission 2018



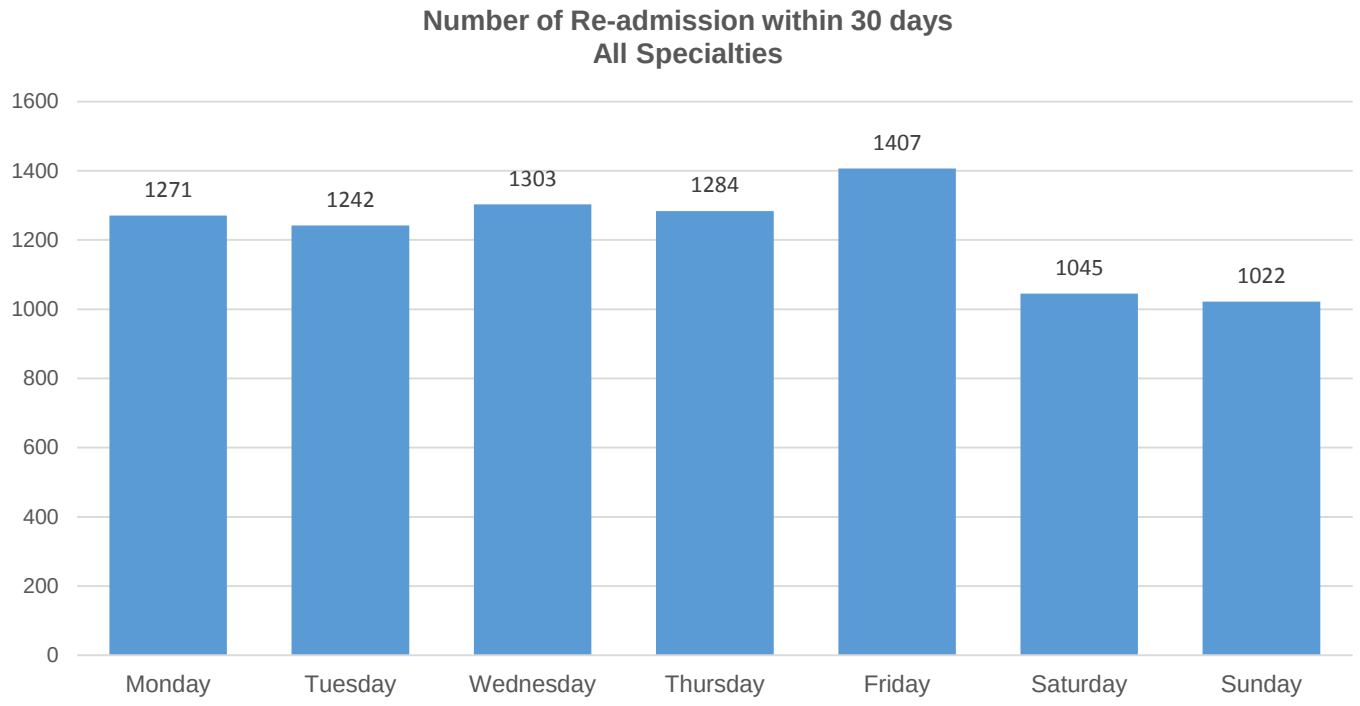
Safe | Personal | Effective

7 day readmissions by day of the week 2018



Safe | Personal | Effective

30 day readmissions by day of admission 2018



Safe | Personal | Effective

7 Day Hospital Services Self-Assessment

Organisation	**East Lancashire Hospitals NHS Trust**
Year	**2018/19**
Period	**Autumn/Winter**

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	We are developing ongoing continuous monitoring of time to consultant review as a professional standard within each speciality. We have therefore used this in its current form of monthly samples rather than the NHSE recommended sample, to show ongoing performance. For February 2019 this demontrates that within Medicine 76% of acutely admitted patients are seen by a consultant within 14 hours of admission, with 81% on weekdays and 65.5% at weekends. The target is met for all patients admitted between 8pm and midday, 7 days a week. Consultant job plans have 4 acute physicians on AMU at weekends and 6 on weekdays, their shift finishes at 8.30pm, this would need to be extended to acheive the standard. Whilst this is a reduction from 88% achieved in April 2018, we have increased consultant delivered ambulatory emergency medical care with 20 additional patients per day being discharged within 14 hours, 7 days a week. In Surgery on average 73% of patients had consultant review during weekdays and 66.5% at weekends, an improvement from 47% overall in April 2018. Three additional consultant appointents in surgery will result in further job plan changes and improvements. In Paediatrics 65% of children had consultant review with 14 hours (66% in April 2018), this was 60% at weekends and 66.5% on weekdays. Current consultant staffing in paediatrics focuses on children who can be discharged within 14 hours, and are not able to provide the same level of consultant staffing at weekends as weekdays. Mortality data for 2018 shows crude mortality rate of 6.19% for patients admitted as emergencies on Saturdays, 7.16% for Sunday admssions and 5.9% for weekdays. Length of stay is 4.03 days for Monday admissions, 4.32 for Tuesday to Friday, 4.43 for Saturday and 4.28 for Sunday. Numbers of readmissions was lower at 7 and 14 days for patients admitted on weekend days than week days. In GMC and HEE trainee reports, trainees comment on good or exeptional support out of hours.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	This standard is fully met for all modalities. This is self reported data by each modality.	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes available on site	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	This standard is fully met for all modalities.	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	We are now monioring this with a continuous sample on each ward. With 98.4% of patients having daily consultant review. This falls to 44.5% at weekends. Numbers of patients designated by consultants as not needing review at weekends is 24% on Saturdays and 41% on Sundays. Within medicine Acute Medical Units have full ward rounds at weekends other medical wards have full board rounds on Saturday or Sunday and targetted reviews. Targetted reviews take place within surgical specialities. We believe that there is underrecording of patients not requiring review at weekends, and we are working on more accurate measurement. For patients requiring twice daily review that meet level 2 or 3 criteria, this is acheived 80% of the time on weekdays and 50% of the time at weekends. Consideration to increase consultant staffing by adjusting shift lengths in critical care areas at weekends is under consideration.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency	Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Considerable progress has been made with Standard 3. Multiprofessional assessment occures 7 days per week for acutely admitted patients in assessment units. In addition an acute frailty unit operating 7 days per week was opened in january 2019 and incorporates early comprehensive geriatric assessment. Multiiprofessional weekend review on adult medical wards has been instituted at weekends since November 2018 with therapists and pharmacists as part of enhanced weekend multiprofessional teams. For standard 4 there has been considerable work on multiprofessional handover, particularly exemplified within Medicine, with good practice spreading to otherdepartments within the trust, and the "Blackburn Model" being adopted by a number of other trusts in the North West. This occurs 7 days a week.The trust has further increased multiprofessional community support, in particular instituting a 7 day a week "home first" service in collaboration with community services, social services and volutary sector. As stated above supervision of trainees out of hours has considerably improved over the last few years with reports of good and exceptional support in GMC and HEE recent reports.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	No, the standard is not met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Standards are fully met for vascular patients admitted as emergency. For stroke patients latest SSNAP data from October to Decemcember 2018 shows 81.5% of patients had consultant review including 43.5% before admission, This has improved from 64.1% in in Q2 2018.

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 46

13 March 2019

Purpose Information Assurance

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

Summary: The report sets out the matters discussed and decisions made at the Finance and Performance Committee meeting held on 28 January 2019.

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Finance and Performance Committee Update Report

At the meeting of the Finance and Performance Committee held on 28 January 2019 members considered the following matters:

1. The Committee received an update on the service developments included within the Emergency Care Pathway, specifically the recently opened Ambulatory Emergency Care Unit. The members noted the work that had been undertaken to date to develop the service and others within the pathway which was helping to alleviate pressure on the Emergency Department, facilitate better patient flow through the Trust and improve the overall patient experience. The members also noted the early improvements in relation to activity, access to the service, length of stay in addition to the positive feedback received from patients and professional users such as GPs.
2. The Committee received the Integrated Performance Report, including an overview of the current financial position to the end of December 2018. The average handover time for patients arriving into the emergency department by ambulance reduced to 16 minutes and 45 seconds in December. There were 18 patients who had a trolley wait of more than 12 hours; all were noted to be patients awaiting assessment by mental health services or mental health care beds. There were no patients who waited in excess of 52 weeks for treatment and there were no breaches of the 28 day rebooking limit for patients who had had procedures cancelled.
3. The members received the financial performance report for the month of December 2018 and noted that the Trust had over-performed by £8,700,000 across all specialty areas. Discussions are being undertaken with commissioners to agree payment for the over-performance. The Committee members were asked to review and approve on behalf of the Trust Board a revenue loan application for a total of £3,800,000 to be received over February and March 2019. The Committee approved the application for submission.
4. The Committee received the Sustaining Safe, Personal and Effective Care 2018/19 Report, members noted that the Trust had released £11,600,000 in savings at the end of December 2018 but had used a number of non-recurrent schemes to achieve this position. Committee members received an overview of the work being undertaken as part of the Vital Signs Programme and the work planned for the remaining three months of the 2018/19 financial year, including the Value Stream Analysis (VSA) for the outpatient department.

5. The Committee received the combined reference costs report for the Trust for the year 2017/18 and noted that the Trust had a score of 97 against an average of 100; therefore the Trust is performing better than the average in terms of financial efficiency.

6. The Committee members received an update on the Trust's business planning process and financial planning assumptions for the coming year. This included detailed activity, financial and workforce plans. In addition, members considered suggested performance trajectories which are required to be included in the final plan submission. The final planning submission is due on 4 April. Due to the timeline for the submission the Committee members discussed the arrangement for the delegation of authority by the Board to approve the final plan. This will be presented to the Board on 9 March.

7. Members received an overview of the planning guidance and key dates, key features of the NHS 10 Year Plan, alignment of the Trust's Clinical Strategy to the planning day themes and 10 Year Plan, the next steps in relation to the development of work across the Trust and Integrated Care Partnership. Members noted the financial assumptions that had been made to date, including pay inflation, reduction in market forces factor (MFF) and a £400,000 reduction in income. The members also received an overview of the proposed blended payment proposal and the proposed 50% reduction in the value of Commissioning for Quality and Innovation (CQUIN) schemes.

8. The Committee members received the first iteration of the Workforce Report which focused on sickness rates, bank and agency usage and absence management. Members received an overview of the 'hire to retire' VSA that was underway within the Trust including the mapping out of the end to end employee lifecycle; as a result there have been refinements to the Trust's exit processes. Members noted that staff sickness continues to be an issue for the Trust with 5.54% of staff being off sick in December 2018. The main factors for staff being off sick were noted to be stress, anxiety, Musculoskeletal (MSK) issues and flu for this period, although it was noted that this is a relatively constant theme for sickness over the year. The Committee members noted that the Trust has been recognised as a hub for workforce transformation with funding being received from NHS England for a dedicated workforce transformation clinician. It was agreed that a deep dive into workforce transformation would be presented to the next meeting.

9. The Committee received an update report on tenders; the Trust's Costing Strategy the Lancashire Procurement Cluster response to Brexit Planning update; and the minutes of the Contract and Data Quality Board for information.

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 28 February 2019.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 47

13 March 2019

Purpose Information
Assurance

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

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

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Audit Committee Update

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

1. The internal audit reports listed below were presented to the Committee:
   a) Policy Management - **Limited Assurance**
   b) Enhanced Care Risk Assessment Process – Substantial Assurance
   c) Accident and Emergency Standard Reporting – Substantial Assurance
   d) Cyber Essentials Certification Gap Analysis – no rating given

   Members noted that the management response to the Policy Management report would be presented to the next meeting of the Committee.
2. The Committee received the management response update in relation to the recent Theatre Stock Management audit. Members noted the action plan that had been put in place to address the nine recommendations in the audit report including the development of an inventory system to improve stock management and allow staff to make up theatre procedure packs, track expiry dates and allow more staff to be available to support clinical staff. It was agreed that a further update on progress and the implementation of the new electronic stock management system would be provided to the Committee in July 2019.
3. The Committee received an update on the Information Commissioners Office (ICO) desktop review which had been carried out in November 2018. The Committee noted that the ICO had issued a formal closing report to the Trust after conclusion of the desktop review. Members noted that other than the outstanding actions from the initial audit review in late 2017 there had been no further actions requested as a result of the most recent review. However a number of recommendations had been made for consideration around data protection governance; training and awareness; and security and personal data.
4. The Committee received the progress report from external auditors and noted that the independent examination of the Trust's Charitable Fund accounts had been completed. The interim findings of the main Trust accounts audit would be presented to the Committee in April 2019 with the final report being presented at the meeting in May 2019 prior to formal submission to the regulator on 29 May 2019.
5. Members received the Anti-Fraud Service Progress Report and noted the progress being made in relation to referrals and investigations. The Committee noted the fraud awareness raising that had taken place with staff groups across the Trust.

6. In addition to the regular Anti-Fraud Progress Report the Committee received an update on the actions being undertaken to address the recommendations made following the NHS Counter Fraud Authority (CFA) inspection visit that took place in quarter one of the 2018/19 year. They noted that of the nine recommendations that were made one had been completed, six were actions that would be ongoing over the course of the year and a further two remained partially implemented. The two partially implemented actions related to the development and implementation of an e-learning package which had been developed but not yet rolled out and the introduction of an awareness raising slide for use at corporate induction.
7. The Committee received and approved the reviewed and revised accounting policies and noted the timetable for the production, agreement and submission of the Trust's annual accounts and annual report.
8. The Committee received an update on the number of staff who has completed their declarations of potential or actual conflicts of interest since the launch of the online system in September 2018 and the minutes of the Information Governance Steering Group.

Kea Ingham, Assistant Company Secretary, 1 March 2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 48

13 March 2019

Purpose Information
Assurance

Title	Trust Charitable Funds Committee Update Report
Author	Miss K Ingham, Corporate Governance Manager/Assistant Company Secretary
Executive sponsor	Mr S Barnes, Non-Executive Director

Summary: The report sets out the matters discussed and decisions made at the Trust Charitable Funds Committee meetings held on 24 January 2019.

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

(48) Trust Charitable Funds Committee Update Report

Trust Charitable Funds Committee Update

At the meeting of the Trust Charitable Funds Committee held on 24 January 2019 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.

1. The Committee received the applications to use funds report and noted that there had been one request for funds in excess of £20,000 since the last meeting, which was for a monitor totalling £33,920, which was approved by the Committee. The remainder of the items of expenditure were within the delegated responsibility from the Committee and did not require approval at Committee level.
2. The Committee were updated on the work of the Fundraising Manager, including the £1 Million appeal. Within the report there was a summary of the various fundraising activities that had taken place and further events planned to maximise participation and income generation.
3. The Committee were asked to approve the draw-down of £250,000 from the investment portfolio held and managed by Brewin Dolphin for the purchase of defibrillators in the amount of £500,000. The Committee approved this request in line with the recommendation.
4. The Committee also received the Investment Performance Report and the Fund Performance and Utilisation Report.

Kea Ingham, Assistant Company Secretary, 4 March 2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 49

13 March 2019

Purpose Information

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

Summary: The list of matters discussed at the Remuneration Committee held on 9 January 2019 are presented for Board members' information.

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Remuneration Committee Information Report

1. At the meeting of the Remuneration Committee held on 9 January 2019 members considered the following matter:

   a) 2018/19 Annual pay Increase for VSM Staff

Kea Ingham, Assistant Company Secretary, 28 February 2019

East Lancashire Hospitals
NHS Trust

TRUST BOARD REPORT

Item 50

13 March 2019

Purpose Information

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

Summary: The report details the agenda items discussed in closed session of the Board meetings held on 9 January 2019.

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Trust Board Part Two Information Report

1. At the meeting of the Trust Board on 9 January 2019, the following matters were discussed in private:
   a) Round Table Discussion: Care Quality Commission Feedback
   b) Round Table Discussion: Themes from the Planning Day
   c) Round Table Discussion: NHS Long Term Plan
   d) Round Table Discussion: Brexit
   e) Sustaining Safe, Personal and Effective Care 2018/19 Update Report
   f) Tender Update
   g) Finance and Performance Update
   h) Serious Untoward Incident Report
   i) Doctors with Restrictions
2. The matters discussed were private and confidential and/or identified individuals and/or were commercially sensitive at this time and so the decision was taken that these items should not be discussed in the public domain. As these items progress, reports will be presented to Part 1 of Board Meetings at the appropriate time.

Kea Ingham, Assistant Company Secretary, 28 February 2019