East Lancashire Hospitals NHS Trust

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

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East Lancashire Hospitals NHS
NHS Trust

TRUST BOARD PART 1 MEETING

3 MAY 2017, 14:00, SEMINAR ROOM 6, ROYAL BLACKBURN HOSPITAL

AGENDA

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

OPENING MATTERS				
TB/2017/066	**Chairman's Welcome**	Chairman	v	
TB/2017/067	**Open Forum** To consider questions from the public	Chairman	v	
TB/2017/068	**Apologies** To note apologies.	Chairman	v	
TB/2017/069	**Declarations of Interest** To note any new declarations of interest from Directors.	Company Secretary	v	
TB/2017/070	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 29 March 2017.	Chairman	d	Approval
TB/2017/071	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2017/072	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d	Information
TB/2017/073	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2017/074	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information
QUALITY AND SAFETY				
TB/2017/075	**Patient Story** To receive and consider the learning from a patient story.	Director of Nursing	p✓	Information/ Assurance
TB/2017/076	**Corporate Risk Register** To receive an update on the Corporate Risk Register and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Medical Director	d✓	Approval
TB/2017/077	**Board Assurance Framework** To receive an update on the Board Assurance Framework and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Medical Director	d✓	Approval
TB/2017/078	**Serious Incidents Requiring Investigation Report** To receive information in relation to incidents in month or that may come to public attention in month and be assured about the associated learning.	Medical Director	d✓	Information/ Assurance
STRATEGY				
TB/2017/079	**Workforce, Race and Equality Standard Action Plan Report**	Director of HR and OD	d✓	Information/ Assurance
TB/2017/080	**Appraisal Update Report**	Director of HR and OD	d✓	Information/ Assurance

TB/2017/081	**Management of Sickness Absence Report**	Director of HR and OD	d✓	Information/ Assurance
ACCOUNTABILITY AND PERFORMANCE				
TB/2017/082	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed: • Introduction (Chief Executive) • Performance (Director of Operations) • Quality (Medical Director) • Workforce (Director of HR and OD) • Safer Staffing (Director of Nursing) • Finance (Director of Finance)	Executive Directors	d✓	Information/ Assurance
GOVERNANCE				
TB/2017/083	**Freedom to Speak Up/Staff Guardian Role**	Director of HR and OD	p✓	Information/ Assurance
TB/2017/084	**Directors' Register of Interests** To confirm and approve the Directors' Register of Interests for inclusion in the Annual Report 2016/17	Company Secretary	d✓	Approval
TB/2017/085	**Delegation of Authority for Approval of the Annual Report and Accounts 2016/17**	Company Secretary	d✓	Approval
TB/2017/086	**Trust Charitable Funds Committee Update Report** To note the matters considered by the Committee in discharging its duties (April 2017)	Committee Chair	d✓	Information
TB/2017/087	**Trust Board Part Two Update Report** To note the matters considered by the Committee in discharging its duties (29 March 2017)	Chairman	d✓	Information
FOR INFORMATION				
TB/2017/088	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2017/089	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2017/090	**Board Performance and Reflection** To consider the performance of the Trust Board, including asking: • Has the Board focussed on the appropriate agenda items? Any item(s) missing or not given enough attention? • Has the Board agenda the correct balance between formulating strategy and holding to account? • Is the Board shaping a healthy culture for the Board and the organisation? • Are the Trust's strategies informed by the intelligence from local people's needs, trend and comparative information? • Does the Board give enough priority to engagement with stakeholders and opinion formers within and beyond the organisation?	Chairman	v	
TB/2017/091	**Date and Time of Next Meeting** Wednesday 12 July 2017, 2.00pm, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.	Chairman	v	

TRUST BOARD PART ONE REPORT

Item 070

3 May 2017

Purpose Action

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

Summary:

The draft minutes of the previous Trust Board meeting held on 29 March 2017 are presented for approval or amendment as appropriate.

Report linkages

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

Impact

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

Previously considered by: NA

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 29 MARCH 2017

MINUTES

PRESENT

Professor E Fairhurst	Chairman
Mr K McGee	Chief Executive
Mr S Barnes	Non-Executive Director
Mrs M Brown	Acting Director of Finance
Mr M Hodgson	Director of Service Development
Miss N Malik	Non-Executive Director
Mrs C Pearson	Director of Nursing
Mr P Rowe	Non-Executive Director
Mr R Slater	Non-Executive Director
Mr R Smyth	Non-Executive Director
Mr D Wharfe	Non-Executive Director

IN ATTENDANCE

Mr J Bannister	Director of Operations	
Mrs A Bosnjak-Szekeres	Associate Director of Corporate Governance/Company Secretary	
Mr K Griffiths	Director of Sustainability	
Mrs C Hughes	Director of Communications and Engagement	
Miss K Ingham	Company Secretarial Assistant	
Mr K Moynes	Director of HR and OD	
Mr I Johnson	IMS Maxims	Observer/Audience
Mrs G Ferris	Member of the Public	Observer/Audience
Dr I Stanley	Deputy Medical Director	For Dr D Riley
Mr P Magill	Lancashire Telegraph	Observer/Audience
Mrs S Ma		Observer/Audience

APOLOGIES

Dr D Riley	Medical Director
Professor M Thomas	Associate Non-Executive Director

TB/2017/041 CHAIRMAN'S WELCOME

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

TB/2017/042 OPEN FORUM

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

TB/2017/043 APOLOGIES

Apologies were received as recorded above.

TB/2017/044 DECLARATIONS OF INTEREST

Directors noted that that there had been no amendment to the Directors' Register of Interests. Mr Barnes declared an interest in relation to item TB/2017/055: Apprenticeship Levy Report and confirmed that he would not take part in the debate relating to this item.

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

TB/2017/045 MINUTES OF THE PREVIOUS MEETING

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

TB/2017/036: Integrated Performance Report (Safer Staffing) – Mrs Pearson confirmed that the Ward Co-ordinator role was in fact included in the safer staffing figures.

RESOLVED: The minutes of the meeting held on 1 March 2017 were approved as a true and accurate record, pending the aforementioned amendment.

TB/2017/046 MATTERS ARISING

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

TB/2017/047 ACTION MATRIX

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

RESOLVED: The position of the action matrix was noted.

TB/2017/048 CHAIRMAN'S REPORT

Professor Fairhurst reported that Mr McGee had been featured in the HSJ's 'Top 50 Chief Executives 2017' list which is a reflection of his work and the progress that the Trust has

made in recent years. Directors noted that Professor Fairhurst, Mr Rowe and Mr McGee had taken part in the Trust's first 'Safe, Personal and Effective Care' (SPEC) panel to review the evidence presented by the Breast and Gynaecology ward at Burnley General Hospital in their endeavour to be awarded a 'silver ward' status. Professor Fairhurst reported that following the recent CQC visit and report, the Trust had received an overall rating of 'Good'. She congratulated the staff working within the Trust for their continued hard work to achieve the 'Good' rating.

Professor Fairhurst confirmed that she remained involved in the Senior Leadership Forum for the Pennine Lancashire Local Delivery Plan (LDP) and also attends the Chair and Chief Executive Forum for the Lancashire and South Cumbria Sustainability and Transformation Plan (STP) area.

Directors noted that Professor Fairhurst and Mr McGee had been involved in the judging of the organ donation/transplantation art competition that had been run with Witton Park High School to promote and encourage organ donation. Professor Fairhurst reported that Mrs Ditchfield, Organ Donation Nurse, will commence a two year secondment with the national organ donation team, which is a testament to the work that she has done on raising the profile of organ donation across the Trust.

RESOLVED: **Directors received the report provided.**

TB/2017/049 **CHIEF EXECUTIVE'S REPORT**

Mr McGee presented his report and confirmed that Professor Sir Mike Richards was leaving his post as the Chief Inspector of Hospitals. He went on to confirm that both Mr Mackey and Mr Smith were leaving their posts at NHS Improvement and therefore there would be a number of changes at a national level. Mr McGee reported that Mrs Bentley, Head of Patient Services and Mr Davies from the transport team were retiring from their posts over the course of the week and confirmed that he had had the pleasure of thanking them both personally for their service to the Trust and the NHS over many years.

Directors noted that there had been new guidance published in relation to declaring and managing conflicts of interest in the NHS, which featured the need for all clinical and non-clinical staff to declare any work outside of their NHS roles.

Mr McGee highlighted a number of positive pieces of news, including the appointment of Dr Dean as the Clinical Lead for the Royal College of Physicians Quality Improvement Hub. Mr McGee went on to report that the Trust has been awarded accreditation as a Centre of Excellence for Urogynaecology, with this being the only such accreditation in the Sustainability and Transformation Plan (STP) area.

Directors noted that Mrs Erin Bolton was awarded the Nurse of the Year award at the recent

British Journal of Nursing awards. The award is a testament to the work that Mrs Bolton carries out for the Trust.

Mr McGee confirmed that there had been significant discussions over the course of the last month around the operational pressures that the Trust has been under. He reported that whilst there had been significant pressures, the Friends and Family test results remains positive.

Mr McGee highlighted the recommendation by the review panel to award the Breast and Gynaecology Ward at Burnley General Hospital 'SPEC' 'silver ward' status following the review process mentioned in the Chairman's report. Mrs Pearson provided an overview of the assessment process and methodology used. The Board approved the proposal.

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

The Board approved the proposal to award a 'silver ward' status to the Breast and Gynaecology ward at Burnley General Hospital.

TB/2017/050 PATIENT STORY

Mrs Pearson presented the patient story to the Directors on behalf of the patient. She confirmed that the patient's experience had on the whole been positive, but there were some significant areas of learning which spanned across the Trust.

The patient (Mr A) is a 65 year old gentleman who had been admitted to the Trust with a severe chest infection. He had spent time on the Critical Care Unit (CCU) and whilst he did not remember a great deal of his time whilst in the unit his wife commended the care provided, the helpful and patient approach to families and the calm and caring surroundings of the unit.

Once Mr A's condition improved, he was moved to Ward C2 which was noticeably busier than the CCU. Mr A commented that he was unaware of what the various different uniforms worn by the staff on the ward meant and that not all the staff introduced themselves, what they were going to do or gave and explanation of the medication that he was given. Mr A reported that he had found the night staff to be somewhat noisy, which made sleeping difficult at times and he eventually asked the staff to reduce the noise. He commented that the care staff on the ward were nice, but would at times become too task focused and appear to forget that they were dealing with sick people. Mr A was moved to Ward C6 (respiratory ward) and commented that the ward environment was better and he commended the nurse in charge of the day shift. Directors heard that the staff working on the ward did not always interact with Mr A, which left him feeling vulnerable at times. Mr A reported that he had observed a doctor attending to a patient who was clearly in the final days/hours of life and he felt that the doctor was not as compassionate as he could have

been, although this was the only occasion during his episode of care that this was observed. Since discharge from the hospital, Mr A regularly attends the outpatient chest clinic and commented that his consultant always provides clear and comprehensive answers to questions that he may have about his condition/care.

Directors noted that there were a number of lessons to be learnt from Mr A's experience. Mrs Pearson confirmed that the Assistant Director of Nursing within the Integrated Care Group has discussed the support of patients being transferred to medical wards from the CCU at the Divisional matrons' meeting and this issue will also be discussed at the ward sisters' meetings. Directors briefly discussed 'relocation anxiety' which is a known phenomenon for patients who have been treated within the CCU. Dr Stanley provided an overview of the phenomenon and confirmed that work was being undertaken to develop information for patients and their families on this matter. Mrs Pearson confirmed that the issues reported around noise levels at night would also be addressed by Matrons with their ward teams. Directors discussed the possibility of providing patients with 'flight packs' for overnight stays, which included ear plugs and eye masks which would assist their ability to sleep overnight on wards. Mrs Hughes commented that it was good to receive feedback on services by patients and suggested that a collection of patient stories should be developed and shared with the public.

RESOLVED: **Directors received the patient story and noted its contents.**

TB/2017/051 **CORPORATE RISK REGISTER**

Dr Stanley presented the report to Directors and highlighted the proposed reduction in the risk ID 6912: Failure to meet Information Commissioner's Office (ICO) requirements will lead to ICO interventions and financial penalties. It was proposed that the risk rating be reduced from 15 to 12. This reduction is recommended on the basis of there having been no enforcement activity by the ICO in relation to the management of Freedom of Information Requests in the last 12 months.

Mr Smyth commented that he was concerned about the risk being de-escalated based on the lack of regulatory action being taken in the last 12 months. He suggested that the reduction did not address the issues around compliance within the timeframes for response to Freedom of Information (FOI) requests; therefore the underlying problem had not been addressed. Dr Stanley reported that the responsibility for the management of FOI's has now moved to the fully staffed Company Secretariat and the issues around compliance with the 20 working day timeframe are now being addressed. In response to Professor Fairhurst's question, Mrs Bosnjak-Szekeres confirmed that the Company Secretariat was working to identify the exact numbers of outstanding cases and were working closely with colleagues

and the ICO to reduce the number of outstanding cases. She confirmed that the backlog would take around three months to clear but it might be longer. All requests that have been submitted since the Company Secretariat took over the management of FOIs are being responded to in a timely manner and work will continue to identify and reduce the number of outstanding cases. Mrs Brown reported that the Trust would receive an audit visit from the ICO in October and in preparation for this visit the Trust have strengthened a number of elements that will be audited. She confirmed that she was currently the Senior Information Risk Owner (SIRO) and Mrs Bosnjak-Szekeres was the Deputy SIRO for the Trust and as such the Trust was confident that the risk was being managed adequately. Mr Smyth commented that he had received additional assurance and was now content for the Board to accept the proposed reduction in the risk. Directors approved the reduction in the risk rating of risk ID 6912.

RESOLVED: **Directors received the report and approved the recommendation to reduce the risk rating of risk 6912 to 12.**

TB/2017/052 **BOARD ASSURANCE FRAMEWORK**

Dr Stanley provided an overview of the report and confirmed that there had been no proposed changes to the risk scores. Directors noted the updates provided in relation to actions being taken to address risks and additional forms of assurance that had been provided. Mr Rowe thanked Dr Stanley and Mrs Bosnjak-Szekeres for the report and commented that the content of the report provided a great deal of assurance on the risks being managed.

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

TB/2017/053 **SERIOUS INCIDENTS REQUIRING INVESTIGATION REPORT**

Dr Stanley presented the report and provided an overview of the content. He highlighted the increase in the number of grade three pressure ulcers that had been reported and confirmed that this was as a result of the improvements made to the Trust's reporting mechanisms. He provided an overview of the reporting, investigation and confirmation/downgrading of incidents. Directors noted that it was the view of the Trust's Quality Committee that it would prefer to see over reporting and the subsequent downgrading of incidents rather than under reporting.

Dr Stanley provided an overview of the work being carried out in relation to the Duty of Candour (DOC) declarations and confirmed that this was an issue identified at the recent CQC Quality Summit in February. The issue was included on the CQC action plan as a 'must do' action and progress against the action plan is being monitored via the Quality

Committee. Directors noted that there were currently three outstanding DOC declarations that required completion, which was an improvement to the number of cases noted within the report.

Dr Stanley highlighted the themed section of the report which focussed on Venus Thromboembolism (VTE) and confirmed that it is one of the clinical conditions included in the harms reduction work currently being carried out by the Trust. He provided an overview of the processes in place for identification, reporting and management of VTE and also highlighted some of the learning points from previous cases. Directors noted that there has been a significant amount of work carried out through the VTE sub-committee and welcomed the development of a dedicated faculty which will carry out preventative work.

Mr Rowe reported that the Quality Committee had spent a great deal of time discussing the report and a number of the matters included at its last meeting.

In response to Mrs Pearson's comment regarding the development of an electronic system for VTE risk assessments, Dr Stanley confirmed that there were anticipated quality benefits associated with an electronic system versus a paper based system.

Professor Fairhurst asked whether the distinctions between avoidable and unavoidable pressure ulcers were an indication of the acuity of individual patients. Dr Stanley confirmed that there was a number of factors that could contribute to an unavoidable pressure ulcer, such as the type of medication that a person is taking; lack of regular contact with health care services, particularly when frail or in-patients managing conditions that affect mobility and circulation. Directors noted that a significant number of pressure ulcers are identified by staff working in community services and it is the responsibility of these staff to report the ulcer. Therefore the issues around investigation and the determining of whether a pressure ulcer is avoidable/unavoidable remain with the Trust.

Professor Fairhurst suggested that the discussions around pressure ulcers had raised a number of questions about the advice that the Trust gives to patients/the general population to reduce the instances of getting an ulcer. It was agreed that this matter would be progressed by Dr Stanley with the Communications Team outside of the meeting.

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

The information available to patients/the general population in relation to pressure ulcers will be considered by Dr Stanley with the Communications Team outside the meeting.

TB/2017/054 **NATIONAL STAFF SURVEY RESULTS**

Mr Moynes presented the report to the Board and provided an overview of the survey results. He confirmed that the survey had been sent to all staff working in the Trust and

reported that the response rate had been 48%, which was an improvement on the 39% return rate for 2015. Directors noted that the overall results were positive and the best that had been seen within the organisation. Mr Moynes highlighted the key findings of the report, including the further improvements in the staff engagement scores. Directors noted that the staff engagement score is made up of three component questions: staff recommending the Trust as a place to work or receive treatment; staff motivation at work and the ability of staff to contribute to improvements at work.

Mr Moynes reported that the Trust demonstrated lower than average scores in two key areas: the percentage of staff who believe the organisation provides equal opportunities for career progression or promotion and the percentage of staff who have had an appraisal in the last 12 months.

Mr Moynes reported that the Trust was rated third out of 97 Trusts in the league table of Trusts who use Listening into Action (LIA) and was noted to be the top performing non-Foundation Trust.

In response to Mr Barnes's question, Mr Moynes confirmed that significant work has been undertaken, including the development of an appraisal team to improve overall appraisal rates.

Mr Slater asked whether there was a link between the scores relating to appraisal rates and equal opportunities. Mr Moynes agreed that it was likely that there was a link between the responses to the two questions. It was agreed that benchmarking information would be provided to Trust Board members, particularly information relating to the staff Friends and Family Test.

RESOLVED: Directors received the report and noted the information.
Benchmarking information to be provided to the Board.

TB/2017/055 APPRENTICESHIP LEVY REPORT

Mr Moynes presented the report and provided an overview of the content. He informed the Board that the internal processed to prepare for the implementation of the apprenticeship levy were ongoing and he confirmed that there was a drive from the Government to have 3,000,000 apprenticeships nationwide by 2020. The levy for the Trust was in the region of £1,400,000. Directors noted that not all businesses/organisations across the country were subject to the levy, only those who had payroll spend above £3,000,000. Directors discussed the levy, the implications for the Trust and the opportunities for working across organisations for the benefit of the local workforce and services. In response to Mr Slater's question, Mr Moynes reported that degree, masters and PHD level qualifications were included in the apprenticeship, but were capped at £27,000. The apprenticeships are also

available to any existing member of staff as well as staff recruited to the apprenticeship roles. They are also open to anyone irrespective of age and role within the organisation. The Trust had an obligation to facilitate 'day release' for staff undertaking apprenticeships. Directors noted the actions undertaken to date and Mr Moynes confirmed that the Pennine Lancashire Provider Group would continue to work on this matter.

In response to Mr McGee's question, Mr Moynes confirmed that the Trust was unlikely to use the whole levy amount in the new financial year and that there was an expectation that the Trust should discuss the use of the levy with partner organisations.

Professor Fairhurst commented that the Trust had a corporate responsibility to develop the health of the population and therefore this work will have a positive impact, both immediately and in the longer term.

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

TB/2017/056 **FINANCIAL BUDGET APPROVAL**

Mrs Brown referred the Directors to the previously circulated document and provided an overview of the report. She confirmed that the Trust had been set a deficit control total of £863,000 and that the annual pay award has been set at 1%. Directors noted that the proposed budget included a number of estimated costs, such as the Clinical Negligence Scheme for Trusts (CNST) payments, as these costs are still to be finalised.

Directors noted the required level of savings for 2017/18 is £17,800,000 and the Trust had identified the required level of savings.

In response to Mr Wharfe's question, Mrs Brown confirmed that the Trust was cognisant of the possibility that part of the final Sustainability and Transformation Funding (STF) will not be received and will factor this into the financial plan.

Directors approved the plan and requested that the Finance and Performance Committee re-visit the plan to account for the potential non-receipt of STF monies.

RESOLVED: **Directors received and approved the proposed budget for 2017/18.**

TB/2017/057 **INTEGRATED PERFORMANCE REPORT**

Mr McGee introduced the report to the Directors and confirmed that the majority of the report related to activity within the month of February. Directors noted that the winter pressures continued, which has impacted on the flow through the organisation. Mr McGee reported that delayed transfers of care improved slightly in February and the length of stay reduced slightly over the same time period. Directors noted that the format of the report had been revised to reduce the amount of unnecessary information contained and avoid repetition.

a) Performance

Mr Bannister reported that referral to treatment performance continued to be good, with 92.2% of patients being seen within the required timeframes. Directors noted that there had been two 52 week breaches since the last report, both patients have had detailed reviews completed and it was confirmed that both were on complex clinical pathways. There were three patients who had operations cancelled on the day of their planned procedure and, as a result, the Trust breached the 28 day standard in these cases. Mr Bannister reported that there were 17,452 attendances through the emergency department in February. 14,792 were treated/admitted within the required four hours. The overall performance for the month was 84.8% against the 95% target.

Mr Bannister reported that performance against the ambulance handover compliance indicator was achieved at 92.4%. Of the 3,799 patients who were brought into the Trust by ambulance, 2,368 were handed over in less than 15 minutes, with a further 757 handed over between in a time between 15 and 30 minutes.

Directors noted that the performance against the 31 and 62 day cancer targets remained good for the month of January and both targets were met.

b) Quality

Dr Stanley reported that there had been one Methicillin-resistant Staphylococcus Aureus (MRSA) infection detected in the Trust in December 2016, which brings the total number of confirmed cases attributed to the Trust to one for the year 2016/17. Dr Stanley confirmed that the number of cases of Clostridium Difficile (C Diff) remained at 32 for the year to date, against a threshold position of 28; the two cases reported at the Trust Board on the 1 March were not attributed to the Trust.

Directors noted that both the Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) remained within the expected ranges and improvements continued to be seen. Dr Stanley reported that he and Mr Smyth had attended a mortality event in Westminster earlier in the month, which focussed on the new national requirements. It was noted that the Trust's processes are not dissimilar to those now being set at a national level.

Dr Stanley provided an overview of the CQUIN schemes of the coming year. Mr Rowe reported that the CQUIN relating to reduced use of antibiotics had been discussed in detail at the last Quality Committee. The Committee was keen to emphasise that the Trust must not change its practice in relation to reducing the use of specific antibiotics at the expense of the patients in order to fit the requirements of the CQUIN scheme.

Professor Fairhurst asked what was being done at health economy level to address the increase in C Diff cases. Dr Stanley reported that the Trust was seeing increases in the numbers and types of patient groups who are more susceptible to C Diff, such as patients who are alcohol dependent, frail or elderly. Dr Stanley confirmed that there is a regional media campaign around C Diff and work was being carried out in primary care in conjunction with the campaign.

c) Human Resources

Mr Moynes reported that the staff sickness absence figures had improved over the course of the month and stood at 4.82% at the end of February. In relation to the benchmarking information that was requested at the last Trust Board meeting, the Electronic Workforce Information Network (EWIN) system used across the region showed the average sickness absence figures at October 2016 to be 4.97%

Mr Moynes confirmed that the overall staff in post figures had increased slightly since the last meeting. He provided an update in relation to the number of nurses recruited from the Philippines and confirmed that twelve of the recruited nurses have now commenced in post with a further seven scheduled to commence in post in the coming months. Directors noted that the second doctor recruited from India is due to commence in post in the coming week and a further six are due to commence in post between July and September 2017. Overall vacancy figures stand at 6.2%, with the vacancy rate for nurses being 9.9%, which equates to 249 whole time equivalent posts.

Core skills training compliance remains strong with nine of the eleven reporting areas rated as 'green'.

d) Safer Staffing

Mrs Pearson reported that there were 11 areas under the 80% fill rate for registered nurses on day shifts and one area was under the required 80% fill rate for night shift nursing staff. Three of them were due to co-ordinator unavailability. Directors noted that due to the shortages of staff at Blackburn Birth Centre, the number of patients that could be seen was reduced to accommodate the staffing levels. There were three 'red flag' areas highlighted, but no harms were caused as a result.

Mr McGee suggested that the number of nurse vacancies may increase with the removal of the bursary and workforce related issues as a result of the UK leaving the European Union.

e) Finance

Mrs Brown reported that the Trust remained on target to achieve the required year-end

financial position and confirmed that the report showed a further decrease in the spend relating to agency staff. Directors noted that the Trust had agreed and signed off all contracts with local and specialist Commissioners. Mrs Brown provided an overview of the pound for pound matching agreement from the centre and confirmed that the Trust would receive £2,500,000 from the centre under this agreement and therefore the Trust would report a break even position at 31 March 2017.

Mrs Brown went on to provide an overview of the changes to the Sustainability and Transformation Funding (STF) in 2017/18 and confirmed that the Trust had been notified that the appeal submitted against the quarter two funding was not upheld, however the appeal lodged against the quarter three funding has been upheld and the Trust will receive £400,000. Directors noted that the requirements for receipt of the quarter four portion of the STF monies had been revised and was now only based on the achievement of the financial control total; therefore the Trust will also receive £800,000, which will also be matched by the centre. Mrs Brown highlighted the NHS Improvement bonus scheme and confirmed that the Trust would be eligible for additional funds from this scheme, but a final figure is not yet known.

Mr Rowe commented that the report provided overall good news, but the underlying financial position remained difficult and that the Trust should remain focused. Mr McGee commented that the coming year will be challenging, but the Trust was in a much better position than a lot of other Trusts. Professor Fairhurst commented that it was important to recognise the place that the Trust is in and the efforts put in by the Trust staff as a whole.

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

TB/2017/058 FINANCE AND PERFORMANCE COMMITTEE UPDATE REPORT

Mr Wharfe presented the report to Directors and highlighted the discussions that had taken place at the last meeting. He drew Directors attention to the presentations that had been given by the Family Care and Surgical and Anaesthetic Services Divisions in relation to their divisional financial recovery plans. Directors noted that the Committee members had received assurance that the financial improvements that were being made would continue. Mr Wharfe went on to confirm that the Trust financial recovery plan had also been presented and discussed in detail. The discussions around the plan had provided significant assurance that the Trust would meet its required financial control totals for the coming two years.

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

TB/2017/059 QUALITY COMMITTEE UPDATE REPORT

Mr Rowe presented the report and confirmed that a number of the items discussed today had been discussed in detail at the Committee meeting earlier in the month. He commended the medicines strategy to the Board and recommended that the Directors took the time to read it, if they had not done so already.

RESOLVED: Directors received the report and noted its content.

TB/2017/060 AUDIT COMMITTEE UPDATE REPORT

Mr Smyth presented the report and confirmed that the 2017/18 internal audit, external audit and anti-fraud workplans had been presented and approved by the Committee. He confirmed that the STP governance implications had also been discussed at the meeting and it was agreed that this item would be included as a regular item on the Committee's agenda.

RESOLVED: Directors received the report and noted its content.

TB/2017/061 TRUST BOARD PART TWO UPDATE REPORT

The report was presented to the Board for information.

TB/2017/062 ANY OTHER BUSINESS

Professor Fairhurst reported that Mr Rowe would be retiring from his role as Non-Executive Director following a 44 year career within the NHS. She thanked Mr Rowe, both personally and on behalf of the Board for his service to the Trust and for his contributions to the NHS over the course of his career. Mr Rowe thanked Professor Fairhurst for the warm words and thanked Dr Stanley and his colleagues for his efforts to improve the mortality rates within the Trust.

TB/2017/063 OPEN FORUM

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

TB/2017/064 BOARD PERFORMANCE AND REFLECTION

Professor Fairhurst invited comments and observations about the meeting from the Directors. Mr Slater commented that whilst the future of the NHS was challenging the Board meeting had been inspiring.

TB/2017/065 DATE AND TIME OF NEXT MEETING

The next Trust Board meeting will take place on Wednesday 3 May 2017, 14:00, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 072

3 May 2017

Purpose Information

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

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

Report linkages

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2016/291b: Workforce and Organisational Development	A progress update on Workforce, Race and Equality Standard report action plan will be presented to the January and May 2017 Trust Board meetings.	Director of HR and OD	May 2017	Agenda Items May 2017
TB/2017/015: Integrated Performance Report	Mr Moynes will submit a progress report in relation to appraisal rates.	Director of HR and OD	May 2017	Agenda Item May 2017
TB/2017/036: Integrated Performance Report	Mr Moynes to present a paper to the May Trust Board meeting around staff sickness absence.	Director of HR and OD	May 2017	Agenda Item May 2017
TB/2017/050: Patient Story	a) The issues reported around noise levels at night will be addressed by Matrons with their ward teams. b) Explore the possibility of developing a collection of patient stories to be shared with the public.	Director of Nursing Director of Communications & Engagement	May 2017	Oral Report
TB/2017/053: Serious Incidents Requiring Investigation Report	The information available to patients/the general population in relation to pressure ulcers will be progressed by Mr Stanley with the Communications Team outside the meeting.	Director of Communications & Engagement	May 2017	Oral Report
TB/2017/054: National Staff Survey Results	It was agreed that benchmarking information would be provided to Trust Board members, particularly information relating to the staff Friends and Family Test.	Director of HR and OD	May 2017	Oral Report
TB/2017/056: Financial Budget Approval	The Finance and Performance Committee to explore the plan to account for the non-receipt of STF monies.	Director of Finance	May 2017	Oral Report

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 074

3 May 2017

Purpose Information

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

Summary:

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

Recommendation:

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

Report linkages

Related strategic aim and corporate objective	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 anticipated benefits The Trust fails to deliver and develop a safe, competent workforce Partnership working fails to support delivery of sustainable safe, personal and effective care The Trust fails to achieve a sustainable financial position The Trust fails to achieve required contractual and national targets and its improvement priorities Corporate functions fail to support delivery of the Trust's objectives

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

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

National Updates

1. **Stevens: Much left to do as BME staff still more likely to be bullied at work** – Staff from a BME background are still significantly more likely to experience discrimination at work from colleagues and their managers, NHS England's second annual report into racial equality has shown. The Workforce Race Equality Standard (WRES) report found that though progress was being made, there was still a lot of work to be done to ensure the NHS had an equal and diverse workforce across all levels.

2. **Stevens warns of increased operating waiting time 'trade-off' in FYFV update -** Simon Stevens has admitted that some patients may face longer waiting times for non-urgent surgery, and no longer receive certain medications, as "trade-offs" so that improvements can be made to care in other areas. Releasing the much-anticipated 'Next Steps on the NHS Five Year Forward View' report, the NHS England boss set out what many in the sector have already called "an ambitious plan for reform and transformation". However, in order to deliver improvements against a backdrop of increasing demand and "slowly rising" budgets, Stevens said: "Heading into our 70th year, public support for the NHS is as strong as ever but so too are the pressures on our frontline staff.

3. **NHS Litigation Authority rebranded NHS Resolution ahead of upcoming reform -** The NHS Litigation Authority (NHSLA) will change its name to NHS Resolution at the start of April, at the same time as it releases its five-year plan outlining future change, health secretary Jeremy Hunt has announced. Newly formed NHS Resolution will combine the three operating arms of NHSLA, the National Clinical Assessment Service and the Family Health Services Appeal Unit to assist the NHS to resolve litigation concerns fairly, as well as share lessons learnt to improve clinical practice and preserve resources for patient care.

4. **Naylor Review: £10bn needed now to fully finance STP reforms -** A total of £10bn is required to properly fund England STPs and maintain health facilities in the future, an independent report written for the Department of Health has revealed. The report, drawn up by Sir Robert Naylor, former CEO of University College London Hospitals NHS FT, warned that without actual new investment in the NHS estate, there is little chance that sustainability and transformation plans (STPs) will be delivered as facilities would remain as unfit for purpose.

5. **Lords call for independent office to oversee NHS sustainability -** The 'short-sightedness' of successive governments who failed to safeguard a sustainable future for the NHS have been slammed by the House of Lords Select Committee who released a report warning that the Department of Health (DH) had consistently failed to see and implement policies beyond the next few years. In order to fix these problems, the committee made the recommendation for an independent Office for Health and Care Sustainability to be established that will look into health and social care for the next 15 to 20 years and report to Parliament on the impact of changing demographic needs.

6. **Lords report is 'wake-up call' the NHS desperately needs, health leaders say -** Health organisations have welcomed the publication of the House of Lords Select Committee report into the long-term sustainability of the NHS in England, and urged the government to wake up to the severity of the problems the sector is currently facing. The report slammed the failure of successive governments to look more than a few years into the future in creating policies for the NHS, and recommended the establishment of an independent Office for Health and Care Sustainability to scrutinise the government and ensure policies take into consideration the next 15 to 20 years of the NHS, rather than just the next five years.

7. **GPs call for urgent action to stop mass 'haemorrhaging' of doctor numbers -** GPs have called for the NHS to take urgent action to stop a wave of doctors leaving the profession in the next five years, it was announced. Journal (BMJ) has raised significant concerns that many doctors will not stay on as GPs due to the high stress and workload of the job, leading the RCGP to warn that decisive action was needed to encourage GPs to stay in their roles.

Local Developments

8. **A matter of life and death! -** The week started with the announcement that the Trust's Bereavement Care Lead Nurse, Erin Bolton, was named '**Nurse of the Year' by the British Journal of Nursing.** I think it's fair to say that in the past, end of life care at ELHT was not held in high regard. Thanks to the dedication and compassion of Erin and others at our Trust, East Lancashire is now seen as a leader in providing high quality, personal care at such a difficult time in people's lives and I'm so proud that her work has now been recognised at a national level.

9. **New chemotherapy unit opens at Royal Blackburn Teaching Hospital -** Cancer patients are set to benefit from Royal Blackburn Teaching Hospital's new chemotherapy day unit that opened on Monday. The chemotherapy department, which has relocated from a small unit on third floor to a big expansion on top floor of the hospital, comprises of more treatment and consultation rooms along with a large reception and waiting area. There is now also a quiet room in the unit, where patients and their families can reflect as well as be given important information in a comfortable setting.

10. **Urgent Care nurse's compassion earns her Employee of the Month award** - Each month, East Lancashire Hospitals NHS Trust gives a special recognition to one outstanding staff member for going that extra mile. Nurse Practitioner, Becki Slater, has been named March's Employee of the Month. Becki, who works at Burnley General Teaching Hospital's Urgent Care Centre, has been described by her co-workers as a 'professional, calm and dependable nurse' who works with passion and pride, as well as treating everyone she comes across with kindness. Always showing care and compassion, Becki acts as an excellent team leader with her encouragement of healthy and positive working relationships. She also is a terrific role model who guides others in positive directions.

11. **Students' kindness protects lives of youngest patients** - Generous students from Tauheedul Islam Girls High School and Sixth Form College (TIGHS) are helping East Lancashire's youngest and most fragile hospital patients by donating lifesaving medical equipment to the Neonatal Intensive Care Unit (NICU) at Burnley General Teaching Hospital. And last week, a group of Year 12 TIGHS students visited the NICU to meet parents, staff and babies, and hand over six

state-of-the-art pulse-oximeters funded by the school's impressive £3,812 donation and the support of leading medical technology company, Masimo.

12. **Temporary car park change at Royal Blackburn** - Patients and visitors to the Royal Blackburn Teaching Hospital are being advised that, due to unforeseen circumstances, payment for using the hospital's car parks will be cash only for a short period. The change, which comes into effect on Saturday 1st April and is expected to last approximately three months, means that anyone using the hospital's car parks will be unable to use a debit or credit card as a method of payment. Patients, visitors and staff can obtain cash by using the free to use cash machine in the WH Smiths shop located close to the hospital's Main Reception.

13. **Eggs-cellent donation brings Easter cheer to Children's Ward** - Young patients at the Royal Blackburn Teaching Hospital are enjoying a tasty treat thanks to a special delivery of Easter eggs…for the 8th year in a row! Nigel Parker, who lives in Rossendale and is a Manager at the Royal Blackburn Teaching Hospital, generously donates a horde of Easter eggs each year to ensure patients staying on the Children's Ward over Easter don't miss out on the traditional chocolatey treat.

14. **Local artist brings Birth Centre interior to life -** Mums giving birth at the Blackburn Birth Centre now enjoy an even more relaxing environment thanks to the artistic endeavors of a talented local artist. Twenty-three-year-old Holly Riding, from Darwen, spent almost two months visiting the Blackburn Birth Centre where she drew inspiration from childbirth to create five wall murals at the centre on Park Lee Road. "It was a pleasure to work with the midwives to create the new artwork for the interior of the Blackburn Birth Centre," says artist Holly. "It is important to remember that for mothers, this will be one of, if not the most, memorable event in their lives, so I wanted to create artwork which symbolises the everlasting bond between mother and child."

15. **Use of the Trust Seal** – The Trust Seal was applied to a contract for the rooftop lease of the premises at Burnley General Hospital on the 12 April 2017. The parties to the contract are ELHT, EE Limited and Hutchinson 3G UK Ltd and Orange Personal Communications Services Ltd. The contract was signed for

ELHT by the Chief Executive and the Director of Communications and Engagement.

Summary and Overview of Board Papers

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

Summary of Chief Executive's Meetings for March 2017

01/03/17	System Teleconference – RBH
01/03/17	Trust Board – RBH
02/03/17	Telephone call with Common Purpose – RBH
02/03/17	A&E Delivery Board – Nelson
03/03/17	System Teleconference
03/03/17	Lancashire Chief Executives meeting – Royal Preston Hospital
06/03/17	System Teleconference – RBH
06/03/17	Meeting with Chris Clayton from BwD CCG – RBH
06/03/17	Meeting with Dubai Company – RBH
06/03/17	Telephone call with NHSI – RBH
07/03/17	Interviews for the Programme Director – Preston
07/03/17	Health and Wellbeing Board, Blackburn
08/03/17	System Teleconference – RBH
08/03/17	Meeting with Andy Griffiths, Healthwatch Blackburn – RBH
08/03/17	A&E Delivery Board Planning Meeting – RBH
08/03/17	Meeting with GGI – RBH
08/03/17	Board Development Session – Burnley College
09/03/17	TSG Formal Meeting – Nelson
09/03/17	Executives Time Out – Lancashire
10/03/17	Executives Time Out – Lancashire
13/03/17	System Teleconference – RBH
13/03/17	Telephone call with Wearemomentum - RBH
13/03/17	A&E Delivery Board Chairs Meeting – Preston
14/03/17	Meeting with Phil Watson, Chair of Joint Committee of CCG's – RBH

15/03/17 System Teleconference – Warrington
15/03/17 NHS NWLA Board Meeting – Chester
15/03/17 Pennine Lancashire System Leaders Forum – Blackburn
16/03/17 Meeting with Mike Farrar and provider CEO's – Preston
17/03/17 System Teleconference – RBH
17/03/17 NHSI/ELHT Quarterly Review Meeting – RBH
20/03/17 System Teleconference – RBH
20/02/17 ELHT/CCG's Fortnightly Catch Up meeting – RBH
20/03/17 Meeting with Ric Whalley and Steve Wright from Newton – RBH
20/03/17 Meeting with Russ McLean – RBH
21/03/17 Meeting with Mike Wedgeworth - RBH
21/03/17 Joint NHSE/NHSI Improvement Meeting with CEO's – Chorley
22/03/17 System Teleconference – RBH
22/03/17 Programme Board meeting – Lancashire
22/03/17 Meeting with Hempsons Solicitors- RBH
23/03/17 NHS Providers, Chairs and CEO's Meeting – London
24/03/17 System Teleconference – London
27/03/17 System Teleconference – RBH
27/03/17 Meeting with Pam Smith CEO Burnley – Burnley
28/03/17 Meeting with NHSI to sign off report and agree Concordat - RBH
29/03/17 System Teleconference – RBH
29/03/17 Trust Board – RBH
30/03/17 Staff Guardian Interviews - RBH
30/03/17 Meeting with John Heritage – Warrington
31/03/17 System Teleconference – RBH
31/03/17 Regional Action on A&E Improvement Programme - Leeds

Summary of Chief Executive's Meetings for April 2017

03/04/17 System Teleconference – RBH
03/04/17 Extramed Meeting – RBH
03/04/17 GGI Telephone Call – RBH
04/04/17 International Opportunities Meeting – Warwickshire
05/04/17 System Teleconference – RBH
05/04/17 The Children's Society Special Dinner and Discussion – Preston
06/04/17 System Teleconference - RBH
06/04/17 Meeting with CIRCLE Rehabilitation Company – RBH

06/04/17	A&E Delivery Board – Nelson
07/04/17	System Teleconference – RBH
07/04/17	Lancashire Chief Executives Meeting – Preston
07/04/17	Meeting with the HSJ – RBH
07/04/17	Meeting with Chairman and CEO of Blackburn College – Blackburn
07/04/17	GGI Telephone Call - RBH
10/04/17	System Teleconference – RBH
12/04/17	System Teleconference – RBH
12/04/17	Meeting with Kate Holden MP – RBH
12/04/17	ELCCG Telephone Call – RBH
12/04/17	A&E Delivery Board Planning Meeting – RBH
13/04/17	STP Reference Group – Preston
13/04/17	GGI Telephone Call – RBH
13/04/17	CQC Telephone Call – RBH
13/04/17	System Teleconference – RBH
18/04/17	STP Reference Group – Blackpool
18/04/17	Meeting with Amanda Doyle – Blackpool
18/04/17	Programme Board Meeting – Blackpool
19/04/17	System Teleconference – RBH
19/04/17	ELCCG Meeting – Blackburn
19/04/17	Pennine Lancashire System Leaders Forum – Blackburn
19/04/17	Peter Rowe (NED) leaving party – Blackburn
20/04/17	NHS Providers North West – Wrightington
21/04/17	System Teleconference – RBH
21/04/17	Meeting to discuss funding opportunities – RBH
21/04/17	James Friend, special advisor to the Health Secretary – RBH
24/04/17	System Teleconference – RBH
24/04/17	Developing Compassionate Leadership – Buckinghamshire
25/04/17	Developing Compassionate Leadership – Buckinghamshire
26/04/17	System Teleconference – RBH
26/04/17	Telephone Call with Odgers – RBH
26/04/17	Five Steps Meeting with ELCCG – RBH
26/04/17	Meeting on immediate and longer term challenges facing the NHS - Manchester
27/04/17	Pennine Lancashire Transformation Programme – Burnley
27/04/17	Meeting with LTH CEO – Preston

28/04/17 STAR AWARDS

Summary of Chief Executive's Meetings for May 2017

02/05/17 Meeting with Keith Barnes – RBH
03/05/17 System Teleconference – RBH
03/05/17 Trust Board – RBH
04/05/17 A&E Delivery Board – Nelson
05/05/17 System Teleconference – RBH
05/05/17 Lancashire Chief Executives Meeting – Preston
05/05/17 Telephone Call with Haelo – RBH
10/05/17 System Teleconference – RBH
10/05/17 Patient Safety Awards Judging Day – London
10/05/17 Invitation to CHKS Top Hospitals Awards – London
11/05/17 Meetings in London – London
12/05/17 HSJ Invitation to attend round table – London
15/05/17 System Teleconference – RBH
15/05/17 Winter Review Event – Blackpool
16/05/17 A&E Delivery Board Planning Meeting – RBH
17/05/17 System Teleconference – RBH
17/05/17 Programme Board Meeting – Blackpool
17/05/17 Pennine Lancashire Systems Leaders Forum – Blackburn
18/05/17 Developing Compassionate Leaders – Buckinghamshire
19/05/17 System Teleconference – RBH
19/05/17 Meeting with GMAHSN – RBH
19/05/17 Meeting with Sandy Bradbrook – Preston
22/05/17 System Teleconference – RBH
22/05/17 Meeting with Burnley Council CEO – RBH
22/05/17 Meeting with NWAS – RBH
23/05/17 Meeting with the Childrens Society – RBH
24/05/17 System Teleconference – RBH
24/05/17 Meeting to discuss collaboration – RBH
25/05/17 Meeting with Blackburn Council CEO – RBH
26/05/17 System Teleconference – RBH
26/05/17 Team Brief – RBH
26/05/17 Team Brief – BGH

30/05/17	Meeting with ELCCG – RBH
30/05/17	Meeting at Stepping Stones – Blackburn
31/05/17	System Teleconference – RBH

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 076

3 May 2017

Purpose Monitor

Title	Corporate Risk Register
Author	Mrs F Murphy – Head of Legal Services
Sponsor	Dr D Riley, Medical Director

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

Recommendation: Members are requested to

- Receive and review the report
- Approve changes in the Corporate Risk Register

Report linkages

Related aims and duties	Monitoring risk training
	Monitoring quality, safety and governance priorities
	Ensuring lessons learned are disseminated
	Promoting openness and transparency
	Oversight of divisional risk registers
	Oversight of corporate risk registers
	Policy recommendations
	Effectiveness of the divisional governance and risk management arrangements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

(076) Corporate Risk Register Report

Introduction

The Risk Assurance Meeting has delegated responsibility for verifying and monitoring the Corporate Risk Register on a monthly basis. The Risk Manager additionally meets with each Risk Owner or Risk Handler as appropriate to monitor any changes to the risks, the risk management action plans and controls and assurances on an ongoing basis.

A description of each risk is at Appendix 1.

1. **Risks de-escalated from the Corporate Risk Register**

   6912 – Failure to meet ICO requirements will lead to ICO interventions and financial penalties. This item has been de-escalated for management within the Corporate Division.

2. **Risks to be included on the Corporate Risk Register**

   No new risks have been recommended for inclusion on the Corporate Risk Register.

Conclusion

Members are asked to note the assurances provided in relation to the on-going management of the Corporate Risk Register. A full review of the Corporate Risk Register will be undertaken with risk leads on a monthly basis.

Title:	Aggregated Risk – Failure to meet internal and external financial targets in year will adversely impact the Continuity of Service Risk Rating				
ID	7010	Current Status	Live Risk Register – all risks accepted	Opened	25/08/16
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 4 Consequence: 4 Total: 16	Target Rating:	Likelihood: 4 Consequence: 3 Total: 12
Risk Handler:	Allen Graves	Risk Owner:	Michelle Brown	Linked to Risks:	1487 (DCS), 1489 (DCS), 4118 (FC), 6115 (FC), 6229 (ICG), 6230 (ICG), 6487 (ICG), 6509 (FC), 6868 (FC)
What is the Hazard:	Failure to meet the targets will result in the Trust having an unsustainable financial position going forward and the likely imposition of special measures		What are the risks associated with the Hazard:	• Achievement of agreed control total. • Breach of control totals will likely result in special measures, adverse impact on reputation and loss of autonomy • Sustainability and Transformational funding would not be available • Cash position would be severely compromised	
What controls are in place:	• Standing Orders • Standing Financial Instructions • Procurement standard operating practice and procedures • Delegated authority limits at appropriate levels • Training for budget holders • Availability of guidance and policies on Trust intranet • Monthly reconciliation • Daily review of cash balances • Finance department standard operating procedures and segregation of duties		Where are the gaps in control:	Individual acting outside control environment in place	
What assurances are in place:	• Variety of financial monitoring reports produced to support planning and performance • Monthly budget variance undertaken and reported		What are the gaps in assurance:	None identified	

	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		
Actions to be carried out	Action assigned to	Anticipated completion date	Progress Report
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			

Title:	Failure to provide refurbished ward areas due to delays in refurbishment programme impacting on regulatory, contractual & national performance targets				
ID	1660	Current Status	Live Risk Register – all risks accepted	Opened	17/10/12
Initial Rating	Likelihood: 5 Consequence: 4 Total: 20	Current Rating:	Likelihood: 4 Consequence:4 Total: 16	Target Rating:	Likelihood: 3 Consequence: 4 Total: 12
Risk Handler:	Jim Maguire	Risk Owner:	John Bannister	Linked to Risks:	
What is the Hazard:	• Failure to gain access to patient occupied areas for a set period of time without patients being present will not allow PFI partners access to undertake statutory maintenance work, additional refurbishment work and Trust cleaning programs to be undertaken. • Failure to undertake the refurbishment programme at the Royal Blackburn Hospital site will impact on the Trust's ability to achieve regulatory, contractual and national performance targets and achieve a sustainable financial position.		What are the risks associated with the Hazard:	• Backlog maintenance continues to increase having a long and medium term impact on the physical estate and environment and implications for the PFI contract. • Failure to implement the refurbishment programme may lead to suboptimal environments for the delivery of care and an inability to demonstrate compliance with regulatory and contractual requirements. This will impact on the delivery of care, trust performance, the imposition of financial penalties and reputational damage and may result in a requirement to derogate PFI provider from contractual responsibilities.	
What controls are in place:	Refurbishment action plan PFI monitoring meetings		Where are the gaps in control:	Availability of decant ward due to service demands	
What assurances are in place:	Reporting to Estates Divisional Board		What are the gaps in assurance:	None identified	
Actions to be carried out		Action assigned to	Anticipated completion date	Progress Report	
Discussions to be held in relation to likelihood scores within Division to be fed back to Risk Manager for updating					

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

	putting the unassessed patients in to bed/trolley		
What assurances are in place:	• Regular reports to a variety of specialist and Trust wide committees • Consultant recruitment action plan • Escalation policy and process • Monthly reporting as part of Integrated Performance Report • Weekly reporting at Exec Team	What are the gaps in assurance:	None identified
Actions to be carried out	Action assigned to	Anticipated completion date	Progress Report
Current planned actions completed but remains high risk due to variability in demand			
Notes: The Trust continues to experience high levels of demand as indicated in the Integrated Performance Report. Mitigating actions are deployed on a daily basis at an operational level to reduce the risk to patient care.			

Title:	Aggregated risk – Failure to reduce medical locum costs will adversely impact financial sustainability and patient care				
ID	5790	Current Status	Live Risk Register – All risks accepted	Opened	11/09/15
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 3 Consequence: 3 Total: 9
Risk Handler:	Simon Hill	Risk Owner:	Damian Riley	Linked to Risks:	908 (ICG), 4488 (ICG), 5702 (ICG),5703 (ICG), 6487 (ICG), 6637 (ICG), 6930 (ICG)
What is the Hazard:	Gaps in medical rotas require the use of locums to meet service needs at a premium cost to the Trust		What are the risks associated with the Hazard:	• Escalating costs for locums • Breach of agency cap • Unplanned expenditure • Need to find savings from elsewhere in budgets	
What controls are in place:	• Divisional Director sign off for locum usage • Ongoing advertisement of medical vacancies • Consultant cross cover at times of need		Where are the gaps in control:	Availability of medical staff to fill permanent posts due to national shortages in specialties	
What assurances are in place:	• Directorate action plans to recruit to vacancies • Reviews of action plans and staffing requirements at Divisional meetings • Reviews of action plans and staffing requirements at trust Board meetings and Board subcommittees • Reviews of plans and staffing requirements at performance meetings		What are the gaps in assurance:	None identified	
Actions to be carried out		Action assigned to	Anticipated completion date	Progress Report	
Risk mitigation action plans are appended to each of the linked risks and are reviewed by the ICG Division on an ongoing basis with assurances being provided to Divisional meetings.					

Title:	Aggregated risk – Failure to reduce nursing and midwifery agency costs will adversely impact financial sustainability and patient care				
ID	5791	Current Status	Live Risk Register – all risks accepted	Opened	11/09/15
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 3 Consequence: 5 Total: 15	Target Rating:	Likelihood: 4 Consequence: 2 Total: 8
Risk Handler:	Julie Molyneaux	Risk Owner:	Christine Pearson	Linked to Risks:	3804 (ICG), 4640 (SAS), 4708 (DCS), 5789 (ICG), 6487 (ICG), 6637 (ICG), 6930 (ICG)
What is the Hazard:	Use of agency staff is costly in terms of finance and levels of care provided to patients		What are the risks associated with the Hazard:	• Breach of agency cap • Agency costs jeopardising budget management	
What controls are in place:	• Daily staff teleconference • Reallocation of staff to address deficits in skills/numbers • Ongoing reviews of ward staffing levels and numbers at a corporate level • 6 monthly audit of acuity and dependency to staffing levels • Recording and reporting of planned to actual staffing levels • E-rostering • Ongoing recruitment • Overseas recruitment • Internal staff bank • Senior nursing staff authorisation of agency usage • Monthly financial reporting		Where are the gaps in control:	• Unplanned short notice leave • Non elective activity impacting on associated staffing • Break downs in discharge planning • Individuals acting outside control environment	
What assurances are in place:	• Daily staffing teleconference with Director of Nursing • 6 monthly formal audit of staffing needs to acuity of patients • Exercise of professional judgement on a daily basis to allocate staff appropriately • Monthly report at Trust Board meeting on planned to actual nurse staffing levels		What are the gaps in assurance:	None identified	

	• Active progression of recruitment programmes in identified areas		
Actions to be carried out	Action assigned to	Anticipated completion date	Progress Report
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.			

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

		date	
Advertise and interview	Deborah Sullivan	30 Jan 2017	Complete
Recruitment	Deborah Sullivan	01 Feb 2017	Recruitment complete but awaiting move to D5 area for office space for staff before they are commenced in employment.
Notes: The new chemotherapy unit opened on 19th March. Staff have been interviewed and recruited to the establishment. Discussions will take place during the month to reduce the current risk scoring once staff start dates have been confirmed – actions not yet fully confirmed to enable risks to be reduced			

Title:	Aggregated Risk - Failure to secure timely Mental Health treatment (adult and child & adolescent) impacts adversely on patient care, safety and quality				
ID	7067	Current Status	Live Risk Register – all risks accepted	Opened	06/10/2016
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 2 Consequence:3 Total: 6
Risk Handler:	Jill Wild	Risk Owner:	John Bannister	Linked to Risks:	4423 (FC), 2161 (FC) 6095 (ICG)
What is the Hazard:	Mental Health patients with decision to admit may have extended waits for bed allocation.		What are the risks associated with the Hazard:	Impact on 4 hour and 12 hour standards in ED Impact on patient care Risk of harm to other patients Impact on staffing to monitor/ manage patient with MH needs	
What controls are in place:	Frequent meetings to minimise risk between senior LCFT managers and Senior ELHT managers to discuss issues and develop pathways to mitigate risk including; Mental Health Shared care policy, OOH Escalation pathway for Mental health patients, Instigation of 24hrs a day Band 3 MH Observation staff. Ring fenced assessment beds within LCFT bed base (x1Male, x1Female). In Family Care – liaison with ELCAS		Where are the gaps in control:	Unplanned demand ELCAS only commissioned to provide weekday service Limited appropriately trained agency staff available	
What assurances are in place:	Ongoing meetings with LCFT and commissioners Regular review at Divisional and Executive team level		What are the gaps in assurance:		
Actions to be carried out		Action assigned to	Anticipated completion date	Progress Report	
Per linked risks					

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

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 077

3 May 2017

Purpose Approval

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

Summary:
The Executive Directors have reviewed the risks monitored on the BAF and updated the controls, assurances and actions in relation to each risk where appropriate. There are no proposed changes to the risk scores.

Recommendation:

The Trust Board is asked to note the changes and approve the Board Assurance Framework.

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:

(077) Board Assurance Framework

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

a) **Risk 1** – the **risk score remains** 12 (likelihood 3 x consequence 4).

New potential sources of assurance identified include:

i. Trust Safely Releasing Costs Programme (SRCP) and transformation plans for 2017/18 developed and linking to the local delivery plan.

ii. The Director of Service Development leading on the work with the Directors of Strategy from all the providers to develop a work programme for consideration by the Trust's Chief Executive.

New updates include:

i. Pulling together of all the component business cases into one overarching business case for the Local Delivery Plan

ii. Linking our transformation plans with the Local Delivery Plan

iii. The presentation of the 2017-19 transformation and SRCP to the Trust Board in May.

b) **Risk 2 –** the **risk score remains** 12 (likelihood 3 x consequence 4). Updates/actions include:

i. Planning of the Open Day for recruitment for 24 June 2017

ii. First cohort of the Assistant Nurses pilot started in March 2017.

iii. The development of a Workforce Transformation Team is ongoing and it is planned to be fully staffed by the end of May 2017.

c) **Risk 3** – the **risk score remains** 9 (likelihood 3 x consequence 3). Key controls include the development of clinical partnership working events. Potential sources of assurance have been updated to include the Clinical Leaders' engagement event held in April linked to the health improvement priorities.

d) **Risk 4** – the **risk score remains** 16 (likelihood 4 x consequence 4).

Updates relate to the ongoing work on the modelling work regarding potential service configurations that was planned to conclude at the end of quarter 4.

e) **Risk 5 –** the **risk score remains** 16 (likelihood 4 x consequence 4). The section on potential sources of assurance has been updated to include the agreement of the financial recovery plan to the Finance and Performance Committee and the Trust Board.

f) **Risk 6 –**the **risk score remains at** 16 (likelihood 4 x consequence 4). Potential sources of assurance include:

i. The first silver accreditation of a ward under the Nursing Assessment Performance Framework approved by the Trust Board on 29 March 2017 and one more ward ready for silver accreditation.

ii. Improved frequency of the divisional performance meetings linking to the transformation plans.

Updates include:

i. The work continuing to reduce open complaints that are over 40 and 50 days old and a process review to improve response times is underway.

ii. The NHS Improvement/Emergency Care Improvement Plan review has been received and a Concordat to support implementation agreed.

iii. Improvement trajectories to reduce complex care trigger list are in place.

iv. Improvement trajectories for Delayed Transfers of Care to be put in place by May 2017.

Angela Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary, 20 April 2017.

Ref	Principle Director	Strategic Risk *What could prevent these objectives being achieved.*	Risk related to strategic objectives	Key Controls *What controls/ systems, we have in place to assist in securing delivery of our objective.*	Potential Sources of Assurance *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	Initial Risk Score	Risk Tolerance Score	Current Risk Score	Likelihood x Consequence	Annual Risk Score 2017/18				Gaps in Control *Where we are failing to put controls/ systems in place. Where we are failing in making them effective.*	Gaps in Assurance *Where we are failing to gain evidence that our controls/ systems, on which we place reliance, are effective.*	Actions Planned / Update *Dates, notes on slippage or controls/assurance failing.*
										Q1	Q2	Q3	Q4			
BAF/01	Director of Service Improvement	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives	Aligned to Strategic Objectives 1,2,3 and 4.	Integrated transformation plans agreed at organisational level, overarching tracker for transformation and SRCP, Transformation Board meetings (internal and external stakeholders), divisional Transformation Boards report into the Transformation Board that reports into the Finance & Performance Committee. Membership of the Pennine Lancashire Transformation Board (6 workstreams). Transformation/business plans linked to the clinical strategy, high level workforce and estate interdependencies identified. Two year operational plan linking to the transformational plan agreed and submitted to the regulator. Two year contract with commissioners (local and specialist) agreed and signed.	Monthly report demonstrating progress against key targets reported to the Transformation Board and the Finance & Performance Committee Internal Audit significant assurance on transformation reported to the Audit Committee. System Leaders Forum committed to work as an Accountable Care System from 2017/18. Director of Sustainability chairing the system wide (Pennine Lancashire) Finance and Investment Group. Divisional plans developed that are linked to the operational and transformational plans. Economic modelling and forecasting linking with new clinical models. Trust SRCP and transformation plans for 2017-19 have been developed and are linking into local delivery plans. Hosting the Programme Director for the Provider Board who will report to the Chief Executive of ELHT. Director of Service Development leading on the construction of the work programme with the Directors of Strategy from all the providers for consideration by the Chief Executive.	15	10	12	3x4	12				Capacity for delivery of transformation programme Service redesign methodology developed by the Trust (accepted by Pennine Lancashire). Workshops held at system level and plans for ownership due to the changed structures at Pennine Lancashire level are now being put in place. Capacity and resilience building in relation to the service redesign is in early phase.	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.	Using the Transformation Board meetings and our membership on Pennine Lancashire to influence delivery of transformation. Case for change at Pennine Lancashire level agreed, Trust senior leadership involved in the solution design phase which has now been completed. Resources allocated for the delivery of the transformation programme. PMO infrastructure significantly increased and support to build capacity at Divisional level is ongoing. Plans for the service redesign to be driven by the clinical leadership. Update - methodology presented to the Transformation Board and accepted for inclusion into the Pennine Lancashire Transformation Plan. Management of this issue is still ongoing. Economic modelling to be linked to clinical models after quarter 4. A joint clinical leaders event for the Pennine Lancashire health economy was held in February. PMO primary focus on emergency pathway currently as it is identified as an increased risk and is highlighted to the Finance and Performance Committee. Clinical engagement progressed at both Pennine Lancashire and Healthier Lancashire level and the Care Professionals Board is maturing Work on 2017/18 transformation programme, within it specifically the SRCP programme for the forthcoming year completed and presented to the Board in March. May Board to receive the 2 year plan. New Programme Director for Pennine Lancashire appointed in April. Overarching business case made up of the component business cases in the process of being completed.

Ref	Principle Director	Strategic Risk *What could prevent these objectives being achieved.*	Risk related to strategic objectives	Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	Potential Sources of Assurance *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	Initial Risk Score	Risk Tolerance Score	Current Risk Score	Likelihood x Consequence	Annual Risk Score 2017/18				Gaps in Control *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	Gaps in Assurance *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	Actions Planned / Update *Dates, notes on slippage or controls/assurance failing.*
										Q1	Q2	Q3	Q4			
BAF/02	Director of HR/OD	Recruitment and workforce planning fail to deliver the Trust objectives	Aligned to Strategic Objectives 2, 3 and 4.	Transformation plans relating to workforce in place monitored through Transformation Board. Divisional Workforce Plans aligned to Business & Financial Plans, Divisional Performance Meetings, Reports to Finance & Performance Committee. Workforce Controls Group, Population/Person Centric Workforce Planning Methodology.	Performance measures, time limited focus groups with action plans, board and committee reports, regulatory and inspection agencies, stakeholders, internal audit. National staff survey response rate increased in 2016/17 with a good survey outcome. The Trust is third in the country in relation to performacne against key indicators. WRES action plan with timelines in place. Regular reportin to the Board on progress. Work with the Fanshaw Report. Workforce Control Group regularly reports to the Executive on workforce control measures and indicators. Annual report to the Quality Committee. Medical and Non-Medical Agency Group in place. Dashboard presented to the executive monthly.	16	10	12	3x4	12				National recruitment shortages, capacity for delivery of transformation programmes, financial restrictions	Assurances in place in the IPR, Safer Staffing Report and Quality Dashboard. Assurance through the HR governance processes.	'Overseas recruitment campaigns, (the Philippines for nurses and India for Doctors) have been successfully completed. First recruits joined the Trust within the last three months. The Trusts recruitment and retention plan continues to be in place. We continue to embed to the 'Retire and Return' approach. The Trust ensures that all staff are involved, included and engaged with on key changes within the Trust using the Employee Engagement Strategy. WRES progress update report to be presented to the Trust Board in May 2017. The Workforce Transformation Strategy approach has been agreed at the Quality Committee in March 2017. The Strategy addresses the future workforce supply pipeline, opportunities to up skill current staff, introducing new roles, e.g. Physicians Associates and Associate Nurses and establishing new ways of working. This approach will direct the Pennine Lancashire approach to workforce transformation. Workforce Transformation Team in place by the end of May 2017.Recruitment Open Day planned for 24 June targeted at B5/6 band nurses for the Emergency Department, supported by a social media and advertising campaign. First cohort of Associate Nurses pilot started in the Trust in March 2017.

Ref	Principle Director	Strategic Risk *What could prevent these objectives being achieved.*	Risk related to strategic objectives	Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	Potential Sources of Assurance *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	Initial Risk Score	Risk Tolerance Score	Current Risk Score	Likelihood x Consequence	Annual Risk Score 2017/18				Gaps in Control *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	Gaps in Assurance *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	Actions Planned / Update *Dates, notes on slippage or controls/assurance failing.*
										Q1	Q2	Q3	Q4			
BAF/03	Medical Director	Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways	Aligned to strategic objectives 3 and 4.	Care Professional Group of Pennine Lancashire reporting to the Transformation Steering Group. Care Professionals Group at STP level now also formed. At Pennine Lancashire level health improvement priorities agreed and there is a proposal for a partnership delivery. Governance controls in place feeding into the Clinical Effectiveness Committee and into the Quality Committee. Clinical Partnership working events are planned.	Clinical Effectiveness Committee acting as a governance mechanism for the agreement of the internal pathways and guideline. Stroke pathway already included in the transformation programme. ELHT Transformation Board has urgent care and elective care pathway reporting process. Clinical effectiveness review carried out Pennine Lancashire resource in post working on developing models of care against specific improvement priorities (paediatrics, respiratory and frailty). Health delivery partnerships at Pennine Lancashire level to be established around the health improvement priorities. ELHT have held a number of provider to provider discussions (eg GP federations with the aim of refining the clinical pathways).	9	6	9	3x3	9				Not all pathway developments linked in fully with the transformation programme	No separate programme is place to consolidate internal clinical pathways. Mechanism for prioritisation of pathway development not in place at divisional/ organisational level; however this will be addressed by the Clinical Effectiveness review in quarter 4 Priorities of CCGs to be aligned with priorities for internal pathway redesign (eg stroke).	Prioritisation mechanism to be resolved externally as part of the Pennine Lancashire Health improvement priorities initial assessment being reviewed at Care Professionals Board each month as part of the Pennine Lancashire Transformation Programme. This work is ongoing Across the STP footprint the Medical Directors of the four Trusts agreed to focus on urology, vascular services, stroke, emergency department, interventional radiology and gastrointestinal bleed, and neonatology Pennine Lancashire review of specialist services to serve the population is hoped to conclude in the coming month. Clinical engagement event linked to the health improvement priorities held in April. Some progress made with aligning the CCG with the priorities for the internal pathway redesign (eg Stroke).

Ref	Principle Director	Strategic Risk *What could prevent these objectives being achieved.*	Risk related to strategic objectives	Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	Potential Sources of Assurance *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	Initial Risk Score	Risk Tolerance Score	Current Risk Score	Likelihood x Consequence	Annual Risk Score 2017/18				Gaps in Control *Where we are failing to put controls/systems in place. Where we are failing in making them*	Gaps in Assurance *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are*	Actions Planned / Update *Dates, notes on slippage or controls/assurance failing.*
										Q1	Q2	Q3	Q4			
BAF/04	Chief Executive/ Director of Finance/ Director of Service Improvement	Alignment of partnership organisations and collaborative strategies (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable services by the Trust	3,4,5	Senior Leaders' Forum meets to discuss strategy. Engagement by senior leaders in wider transformation programmes. Regular Board updates and decisions on key actions. Strengthen links between internal transformation and external change processes.	Verbal and written updates, where appropriate Board approvals will be established and permissions will be provided by the Board to let Executives to progress the generations of ideas and options with external stakeholders. The Pennine Lancashire and STP Cases for Change have been published. The solution design phase at LDP level has been completed apart from one workstream, which is due on 27 April. Senior leaders from Trust involved at strategic level. Individual SRO's presented their workstreams at the end of January and that has now developed into the first draft component business case for each workstream which will form the service model proposal on which the public will be consulted. Detailed presentation on the composition of the neighbourhood teams at the System Leaders Forum. Risks regarding the end product of the solution design phase in relation to new models of care reduced. STP governance oversight forms part of the Audit Committee standing agenda for 2017/18. Fostering good relationships with GP practices and Federations eg service pilots and as a result of tenders and general dialogue. These are the most advanced at STP level Pennine Lancashire Memorandum of Understanding agreed by stakeholders.	16	12	16	4x4	16				System leaders agreed a process to develop the governance system for an ACS across Pennine Lancashire; however this is still in the early phase.	Set/prescribed timeline for consultation with public but uncertainty about the detail of the consultation. Lack of unified approach in relation to procurement by Commissioners.	Regular updates provided to Board and the Audit Committee. Pennine Lancashire project solution design phase completed bar one work stream that is due on 27 April 2017. A focused piece of modelling work in progress at Pennine and STP level on potential service configurations to conclude at the end of quarter 4 - this is still ongoing and has not concluded yet. Public consultation on the service model proposal planned for July 2017. New Programme Lead for Pennine Lancashire LDP appointed.

Ref	Principle Director	Strategic Risk *What could prevent these objectives being achieved.*	Risk related to strategic objectives	Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	Potential Sources of Assurance *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	Initial Risk Score	Risk Tolerance Score	Current Risk Score	Likelihood x Consequence	Annual Risk Score 2017/18				Gaps in Control *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	Gaps in Assurance *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	Actions Planned / Update *Dates, notes on slippage or controls/assurance failing.*
										Q1	Q2	Q3	Q4			
BAF/05	Director of Finance	The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework	3,4,5	Ensure suitable controls are in place to maintain budgetary control (income and expenditure). These controls need to extend to effective workforce arrangements. In addition to controls the Trust must ensure that measures are in place to close the financial gap (SRCP), via the Transformation and SRCP schemes effectively monitored by the PMO and the Finance Department and Trust Executives.	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. Financial recovery plans developed and agreed. Financial recovery plan approved by Trust Board March 2017. Governance throgh PMO to be monitored by Finance and Performance Committee.	16	12	16	4x4	16				Additional workforce controls to remain in place. policies and procedures may require amendments where they are no longer fit for purpose. Controls around transformation schemes and SRCP to be monitored by the PMO and the Finance Department with Division to be held to account via the PMO. Gaps in control regarding funding for A&E, RTT, cancer targets and STF Funding - recovery plans underway	Utilise the internal audit programme to test for assurance on core controls, SRCP and transformation plans.	Regular updates to Board and Finance and Performance Committee Finance risk around A&E, RTT, cancer targets and STF funding identified and operational plans to recover are ongoing. Risks in relation to the impact of the changes to CQUIN and STF arrangements for the next two years are being managed and reporting to the Quality Committee and Finance and Performance Committee.

Ref	Principle Director	Strategic Risk *What could prevent these objectives being achieved.*	Risk related to strategic objectives	Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	Potential Sources of Assurance *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	Initial Risk Score	Risk Tolerance Score	Current Risk Score	Likelihood x Consequence	Annual Risk Score 2017/18				Gaps in Control *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	Gaps in Assurance *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	Actions Planned / Update *Dates, notes on slippage or controls/assurance failing.*
										Q1	Q2	Q3	Q4			
BAF/06	Director of Operations/ Director of Nursing/ Medical Director	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements	Aligned to strategic objectives 1, 3 and 4.	Divisional business plans, weekly operational performance meetings, monthly divisional performance meetings feeding into the ODB and Finance and Performance Committee, emergency pathway and elective pathway work linking into the broader Trust wide transformation. Engagement meetings with CQC, quality and safety compliance assessed by each division, divisional assurance boards feeding into the operational sub-committees and the Quality Committee. Nursing Assessment Performance Framework System wide approach as part of the new A&E Delivery Board. Established an emergency pathway improvement programme with agreed priorities and support from NHSI started during the month of January and is ongoing.	IPR reporting to the ODB and at Board/Committee level, regular reporting to the NHSI, monthly integrated delivery meeting with the NHSI and A&E Delivery Board. 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. Good rating overall received from CQC. ED performance improvement action plan aligned with the NHSI Rapid Improvement Collaborative Cancer 62 day target improvement plan underway and having an impact through enhanced operational meetings. In quarter 1 approximately five wards will be potentially eligible for silver accreditation under the Nursing Assessment and Performance Framework following three successive green assessments. First Silver Accreditation of a ward approved by the Trust Board on 29 March 2017. Onve more ward ready for Silver Accreditation. Increased number of assessments under the framework planned all inpatient wards completed in ICG and SAS. Work due on Family Care and Community Services and a plan is in place for 2017/18. Complaints Annual Report shows overall reduction in the number of complaints. Improved frequency of Divisional performance meetings in place from the end of March, linking to the transformational programme for 2017/18. Positive patient survey with improvement areas identified.	15	9	16	4x4	16				Staffing potentially not sufficient to deal with the impact of external environment & high demand, difficulties with discharges. Complaints are a potential source of action by the CQC. Wider system analysis of capacity in primary care and care sector needed.	Risks around some of the national trajectories identified. Recovery plans are being implemented. An increase in non-elective activity and increased length of stay is placing pressure on the elective care. As a result threre has been a reduction in performance against the Referral to Treatment target.	Timeline for the transformation of the emergency pathway plan agreed. Working as part of the Emergency Care Delivery Board to resolve demand issues and participating in the delayed discharge collaborative with the NHSI. Work on reducing the number of complaints, 50+ and 40+ days continues. Completion date planned for the end of December 2016 was revised due to the increase in the number of complaints in November and early December and operational pressures, new completion date agreed for the end of quarter 1 2017/18. Process review to improve response times in underway. Challenges of achieving the four hour standard are being worked on, measures put in place to address performance and action plan has been submitted to NHSI with a view to improve performance and sustain it in the longer term. NHSI/ECIP review received and Concordat to support implementation agreed. Board receives regular SRCP and transformation updates. Work on the Emergency Care Pathway and Model Wards continues including red and green days, discharge to assess and ambulatory emergency care. Recovery plans being implemented around achievement of national trajectories. Improvement trajectory for Delayed Transfers of Care (DTOC) to be put in place from May 2017. Improvement trajectory to reduce complex care trigger list is in place. Nursing Assessment Performance Framework internal audit review due in March 2017 to be reported to the Audit Committee in July. Agreement to increase nurse staffing numbers in the Emergency Department following establishment review.

East Lancashire Hospitals NHS
NHS Trust

TRUST BOARD REPORT

Item 078

3 May 2017

Purpose Information Assurance

Title	Serious Incidents Requiring Investigation Report
Author	Mrs B Jones, Patient Safety Manager
Executive sponsor	Dr D Riley, Medical Director

Summary: This report provides a summary of the Serious incidents and Duty of Candour requirements that have occurred within the Trust in March and April 2017

This report also provides a summary themed analysis of the harm reduction programme on falls and the current quality improvement plans that have either taken place or are in progress aimed at ensuring the risk of falls across the Trust is minimised and appropriately managed

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

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and

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

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

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

Impact

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

Previously considered by: NA

Introduction

This paper provides the Board with:

- **Part 1:**

  An overview of all Serious Incidents Requiring Investigation (SIRIs) that have been reported during March 2017 and April 2017

- **Part 2:**

  A Duty of Candour performance report for March 2017 and April 2017

- **Part 3:**

  Quality improvement projects taking place/completed which are aimed at improving the management and reducing the risk of falls

Part 1: Overview of SIRIS Reported

STEIS SIRIs reported in March and April 2017

There were 9 Strategic Executive Information System (STEIS) events reported in March and April 2017 which is a decrease of 5 compared with the last reporting period. All will undergo Root Cause Analysis (RCA) which will be performance managed by the Trust's SIRI

Please note the processes for StEIS reporting Grade 3 and above pressure ulcers has reverted to previous agreements which is once a pressure ulcer has been verified as grade 3 or above, these are StEIS reported at that stage.

For pressure ulcers concluded as unavoidable, this means all correct procedures, policies and processes were followed and there were no further interventions that could have been carried out to prevent the pressure ulcer occurring. All go through a Root Cause Analysis (RCA) and supporting evidence is shared with commissioners. Unavoidable pressure ulcers are then de-escalated and removed from StEIS.

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

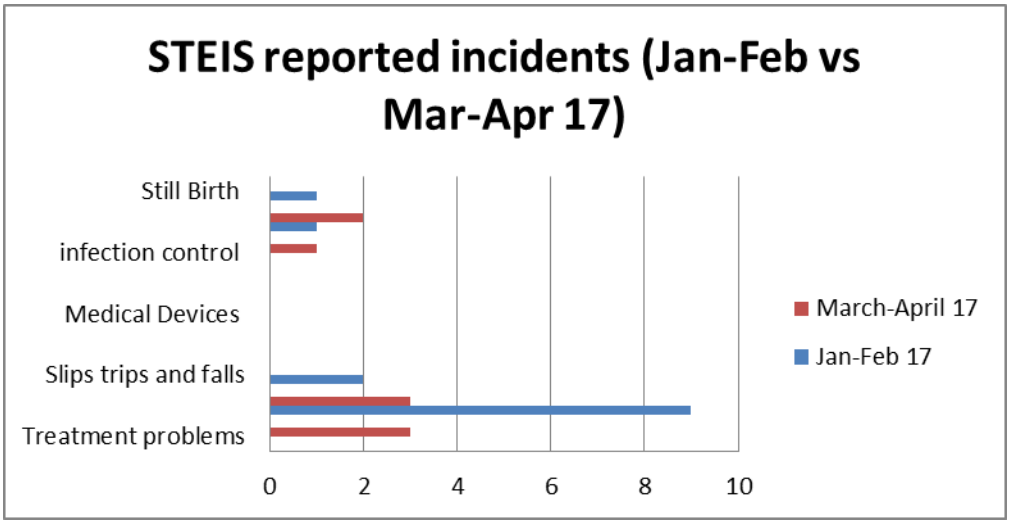
No	Eir1	Division	Ward/ dept.	Description
1	eIR1122944	Community	Residential Home	Grade 3 Pressure ulcer
2	eIR1123456	Medical	Emergency Medicine Dept, Blackburn	12 hour Mental Health Breach
3	eIR1124541	Surgical & Anaesthetic Services	Theatre 6, Blackburn	Wrong site surgery (Never Event)
4	eIR1123317	Family Care	Birth suite BGH	Unexpected deterioration - transfer to neonatal unit
5	eIR1122899	Community	Patients Home	Grade 3 Pressure Ulcer (under investigation)
6	eIR1123730	Surgical & Anaesthetic Services	Ward C14, Blackburn	Grade 3 Pressure ulcer (under investigation)
7	eIR1122624	Family Care	Birth suite BGH	Unexpected deterioration – transfer to Neonatal unit
8	eIR1124109	Surgical & Anaesthetic Services	Ward B20 Blackburn	Infection control outbreak
9	eIR1124783	Medical	Ward B4, Blackburn	Delay in treatment

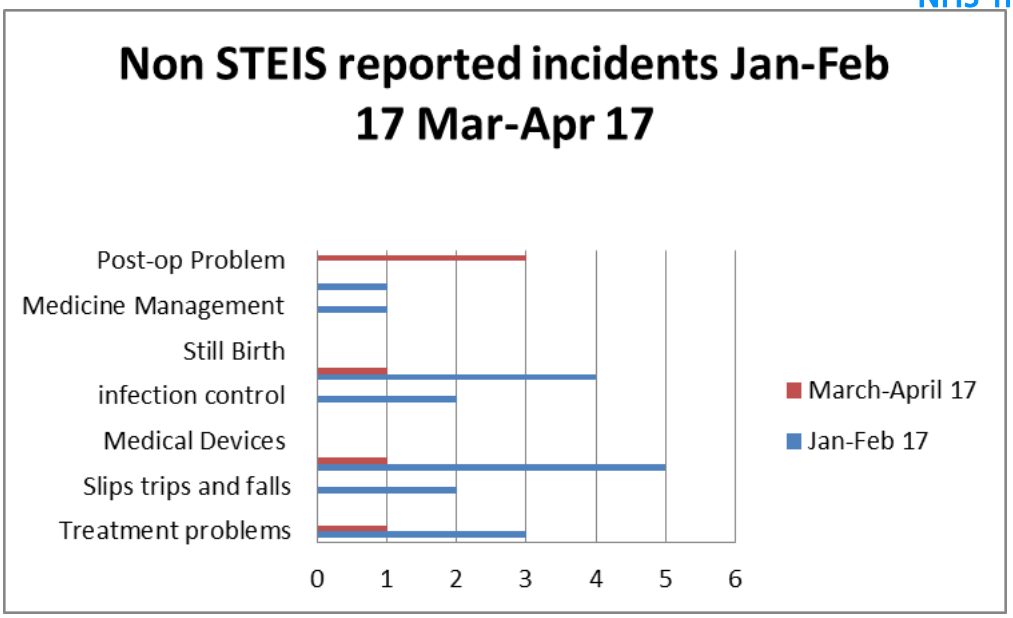
Non STEIS SIRIs reported in March and April 2017

There were 6 non STEIS incidents deemed to be serious incidents requiring investigation in March and April 2017 compared to 22 in the previous reporting period. All will undergo RCA and will be performance managed by the Serious Incident Review Group (SIRG).

No	Eir1	Division	Ward/dept.	Description
1	eIR1122618	Medical	Emergency Dept	Diagnosis/Failure problem
2	eIR1123899	Surgical & Anaesthetic Services	Operating Theatre	Post-op problem
3	eIR1122503	Family Care	Operating Theatre	Post-op problem
4	eIR1122492	Family Care	Operating Theatre	Post-op problem
5	eIR1122493	Family Care	Operating Theatre	Unexpected deterioration - transfer to neonatal
6	eIR1124245	Medical	Ward/Adjacent areas	Treatment problem – (complaint)

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





Part 2: Duty of Candour (DOC) Performance Report

At the time of writing this report on 25th April 2017, there are 9 incidents where Duty of Candour has not been fully served within the 10 day timeline. The progress of these 9 incidents and the incidents awaiting a copy of the DoC letter for assurances is as follows:

The Duty of Candour completion requires:

1. The patient must be informed of the incident and offered an apology
2. A proposed investigation must be provided to the patient/relative
3. Patient must be offered opportunity to receive outcome of the investigation
4. All Duty of Candour conversations with patient should be documented in casenotes
5. A Duty of Candour letter detailing all the discussions and agreements should be sent to the patient.

All 5 steps must be completed for each incident graded moderate or above for Duty of Candour to be recorded as completed.

At East Lancs Hospitals NHS Trust, internal assurances that DoC is completed are sought by a copy of the letter sent to the patient being attached to the Datix system. Therefore, the DoC incidents listed in BLUE on the table below have DoC completed but we are awaiting a copy of the letter to be attached to the Datix system before marking as completed.

At the time of writing this report on 25th April 2017, there are 9 incidents where Duty of Candour has not been fully served within the 10 day timeline. The progress of these 9 incidents and the incidents awaiting a copy of the DoC letter for assurances is as follows:

Ref	Reported	Lead Division	Progress update
eir1124316	07/04/2017	SAS	Patient has been informed of the incident and apology offered in a timely manner. Duty of Candour letter has been sent. We are awaiting a copy of the letter to be attached to the Datix record for assurances.
eIR1122889	10/03/2017	Medical	Patient has been given an apology but has not been informed of investigation or letter sent.
eIR1123281	17/03/2017	Medical	Patient/Patients family not been given an apology or letter written to give apology/need for investigation
eIR1123409	21/03/2017	Medical	Apology has been given to patient and informed of investigation but no letter
eIR1123594	23/03/2017	Surgical & Anaesthetic Services	Apology has been given to patient and informed on investigation but no letter
eIR1123751	27/03/2017	Medical	Nothing filled out on DoC
eIR1123738	27/03/2017	Medical	Nothing filled out on DoC
eIR1124151	04/04/2017	Medical	Apology given to patient but unsure of whether patient has been told of investigation and no letter sent

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

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

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

Part 3: Falls Reduction Quality Improvement Programme

Introduction

Falls Reduction is a component of the Trust's Sign Up to Safety Improvement Plan. The aims of this project are:

1. to reduce the number of inpatient falls with harm by 20% by January 2018 across the organisation and
2. to reduce the number of inpatient falls regardless of harm level by 15% by January 2018 across the organisation.

Falls are one of the highest reported patient safety incidents across the organisation and cost the NHS approximately £2.3billion per year on a national basis. The risk of falling is greater in hospital settings than in the community due to acute illness, increased levels of chronic disease in the hospital population and unfamiliarity of patients with the hospital environment.

The Trust has continued to build on the previously achieved aim of reducing hospital falls by 15% in 2015/16 and has widened the current project to recognise psychological harms from falls in addition to the physical harms patients encounter. The project is being delivered by an organisational wide Falls Faculty which is focussed on ensuring interventions are spread across the organisation effectively, are sustainable and that there is appropriate staff and patient education.

Key achievements/progress:

- Falls monthly incident data continues to be reviewed and circulated at a ward level
- Falls spread matrix created & tracks progress of spread
- Divisional Director of Nursing shared progress/challenges at Nursing and Midwifery forum
- Work on-going to share changes wider at other existing forums
- Falls policy in line with outputs from falls collaborative has been updated and awaiting sign off
- New falls information leaflet completed and in use – still awaiting professional printing
- Falls audit of spread has taken place – "walk the wards" day planned to review sustainability on wards
- Falls collaborative outcome video still in progress which shares a patient and family story of a fall and it also shares guidance on how to ensure all the interventions in the change package should be embedded on the wards

- Printing some material (colour) is difficult for some wards, work is in progress to support this
- Falls thermal technology trial in progress – supporting research and development into falls practice

Outcome performance/measure relating to project aim:

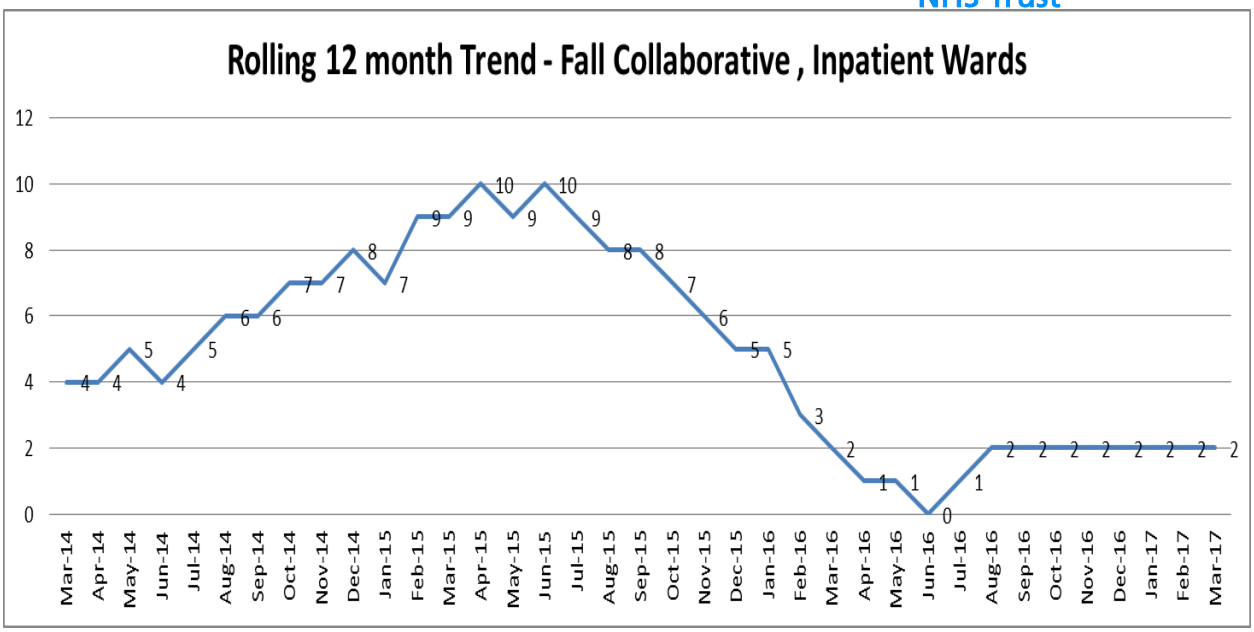
The rates of falls continue to show a downward trend. In January 2017 there were 136 falls in total; comparing to previous January months, this has been the lowest over the past 4 years:

Month and total number of falls	Month and total number of falls
December 2013 (202)	January 2014 (181)
December 2014 (180)	January 2015 (190)
December 2015 (182)	January 2016 (164)
December 2016 (130)	January 2017 (136)

Despite an increase in hospital pressures, the rates of falls in December remained low (131) compared to December 2015 (182) and December 2014 (180).

In January 2017, there were 2 falls with harm: One relates to a fractured neck of femur and the other incident relates to a head injury.

Falls with harm (moderate and above) have been consistently low over the past 4 months, the rates of fractured neck of femurs and falls with head injury have significantly reduced (which has resulted in less Serious Incident Investigations for falls), this would suggest, our most vulnerable and high risk patients are receiving good care.



Future Developments

The Trust is now working with an external partner to scope the possibility of introducing a fall detection and prevention system that uses a thermal imaging sensor and proprietary analytics algorithms to detect the potential risk level of a patient's position in a bed. The system sends out an alert to nearby clinicians if the patient's position is identified as high risk of resulting in a fall or an uncontrolled bed-exit. The sensor is placed on the ceiling above the bed of a patient, where the system monitors the patient's position within the bed by identifying each position in relation to predefined position classifications. Each classification is assigned a risk level by the attending clinician based on the patient's individual fall risk assessment to avoid false alarms. A recommendation on taking this system forward will be made when outstanding issues such as consent and patient environment and patient privacy and dignity issues have been appropriately examined.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

3 May 2017

Item **079**

Purpose **Information**
Action
Monitoring

Title	2017 NHS Workforce Race Equality Standard (WRES) Report
Author	Mr N Makda, Equality & Diversity Manager Lee Barnes, Head of Staff Health Wellbeing & Engagement
Executive sponsor	Kevin Moynes, Director of Human Resources and Organisational Development

Summary:
Board members are asked to note the Workforce Race Equality Standard (WRES) report and the key findings identified. Members are also asked to support the outlined recommendations and action plan.

Report linkages

Related strategic aim and corporate objective (Delete as appropriate)	Put safety and quality at the heart of everything we do Invest in and develop our workforce

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

Legal	Yes	Financial	Yes
Equality	Yes	Confidentiality	No

Previously considered by: N/A

Executive summary

1. This report provides an update to the Trust Board on the Workforce Race Equality Standard (WRES) and the Trust's current performance (1st April 2016 to 31st March 2017) in relation to the prescribed national requirements.

Introduction

2. Almost one in five of the staff working in the NHS is from a black and minority ethnic (BME) background, yet we now know that the treatment and opportunities that they experience in the workplace often does not correspond with the values that the NHS represents. We also know that this has significant adverse impacts on the effective and efficient running of the NHS, including on the quality of care received by all patients.

3. The Workforce Race Equality Standard (WRES), introduced by the NHS was in response to 'The Snowy White Peaks' a report by Roger Kline which provided compelling evidence that barriers and poor treatment of Black Minority Ethnic (BME) staff exists within the NHS.

4. The WRES is a mandatory requirement embedded within the NHS Contract to address the under- representation of Black Minority Ethnic (BME) staff and ensure that all Black and Minority Ethnic (BME) staff are treated fairly, with dignity & respect and their talents valued and developed.

5. The Care Quality Commission has also incorporated the race equality standard into their assessment of whether an organisation is 'Well Led'.

6. Alongside our WRES baseline data the standard requires the Trust to develop their WRES Action Plans that demonstrate continuous improvement against nine indicators of workforce race equality.

7. For the 2016 submission, the Trust was required to:
   a) Submit its 2016 WRES data by 1st August 2016. This was achieved.
   b) Produce a WRES Report which is attached at Appendix 1- this provides a summary of the implications of the data that has been analysed and any additional background including action taken to date.
   c) Produce a WRES Action plan 2017- this is attached at Appendix 3 which outlines proposed actions to be undertaken over the coming year.

2016/17 WRES Highlights

8. The following provides key highlights from the 2016/17 WRES data: -

9. Improved indicators:

a) **WRES Indicator 3: Relative likelihood of BME staff entering the formal disciplinary process compared to white staff.** There has been an improvement from the previous 2 years. The relative likelihood of BME staff entering the formal disciplinary process compared to white staff is 0.54 times greater (ELHT scores in 2014-2016 was 1.4 times greater). This is better than the national average (1.6 times greater) and regional average (1.4 times greater).

b) **WRES Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.** There has been a reduction in the likelihood of BME staff experiencing harassment, bullying or abuse from staff in last 12 months (20% for BME and 22% for white staff) compared to previous year (25% for BME and 23% for white staff). The national average was 25%, when benchmarked ELHT are in the lowest- best 20% for this indicator nationally.

10. Indicators that continue to be a challenge and of key focus:

a) **WRES Indicator 1: Percentage of staff in each of the AFC Bands 1-9 and Very Senior Managers (VSM) (including executive board members) compared with the percentage of staff in the overall workforce.** The staff makeup of the Trust (BME 15%) is still not reflective of the local population (BME 20%). Also BME staff at 8a and above are under-represented and this has not changed in the last 12 months. There are 0% BME staff at Bands 8D, 9 or VSM. A full staff breakdown can be viewed in appendix 2.

b) **WRES Indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts.** BME staff continue to be less likely than White staff to be appointed to roles at the Trust. The relative likelihood of white staff being appointed from shortlisting compared to BME staff is 3.08 times greater (previous year 2.38 times greater). This is significantly worse than the national average (1.6 times greater) and regional average (1.3 times greater).

c) **WRES Indicator 4: Relative likelihood of staff accessing non-mandatory training and continuing professional development (CPD).** BME staff continue to be less likely than White staff to be funded for training. Relative likelihood of white staff being funded for training 1.19 times greater compared to the previous year's score of 1.08 times greater. This is slightly worse than the national average (1.1 times greater) and regional average (1.1 times greater).

d) **WRES Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.** White staff (26%) reported higher levels of harassment, bullying or abuse from patients compared to BME staff (21%). This demonstrated a 1% deterioration for White staff and the figure remained the same in the last 12 months for BME staff. For all staff ELHT was average when compared to the National benchmark data for total staff, however much closer to the best 20% of Trusts for BME staff on this indicator.

e) **WRES Indicator 7: Percentage of staff believing that their Trust provides equal opportunities for career progression or promotion.** There has been a 2% improvement for BME (73%) and a 1% improvement for White staff (86%) on the previous year's scores. However ELHT remains worse than average when benchmarked nationally for this indicator.

f) **WRES Indicator 8: In the last 12 months have you personally experienced discrimination at work from any of the following- manager/team leader or colleagues.** This has remained static in the last 12 months for both BME (14%) & White (6%) staff to perceive they have personally experience discrimination at work from Manager/team leader or other colleagues.

g) **WRES Indicator 9: Percentage difference between the organisations board voting membership and its overall workforce.** At 31 March 2017, the Trust Board membership included 1 voting member Non-Executive Director from a BME Background 9.0%, compared to 91% Board voting members from a white background. This is an improvement on the previous year's representation. However compared to the total Trust BME workforce (15%, Appendix 2 provides a full staff breakdown) there is a 6% difference. The voting membership of the board continues to be under-represented.

WRES Action Plan

11. An action plan has been developed and is detailed in appendix 3, based on:
    a) Subject matter expert support and guidance from Diversity by Design, the Good Governance Institute and the National WRES Implementation Team.
    b) Feedback from the "WRES Big Conversation".
    c) The WRES submission data.
    d) Feedback from WRES working group.
    e) Intelligence from the National Staff Survey and the Quarterly Staff Friends and Family Test.

Recommendations

12. Based on all of the above it is recommended that the Trust focuses on two overarching themes, namely;
    a) Recruitment, Retention and Talent Management.
    b) Culture Change.

13. It is recommended that the Trust Board consider implications of the WRES (Workforce Race Equality Standard) and discuss what the workforce data, including staff survey responses, reveals about the experience of BME staff working in this Trust.

14. It is recommended that the Trust Board receive assurance that the requirements to collect and publish the data have been met.

15. It is recommended that the Trust Board approve and support the WRES action plan, including the priority areas of focus, and continue to demonstrate strong visible leadership and commitment to improve our workforce race equality standard indicators across the organisation.

2017 Workforce Race Equality Standard Report Appendices

1. Appendix 1 Workforce Race Equality Indicators 1st April 2016-31st March 2017
2. Appendix 2 Indicator 1 - Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.
3. Appendix 3 WRES action plan 2017/18

Appendix 1 – Workforce Race Equality Indicators 1st April – 31st March 2017

	Indicator	Data for reporting year (2017)	Data for previous year (2016)	Narrative – the implications of the data and any additional background explanatory narrative
	For each of these four workforce indicators, the Standard compares the metrics for White and BME staff.			
1	***Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.***	Detailed information refer to appendix 2	Detailed information refer to appendix 2	***The staff makeup of the Trust (15%) is still not reflective of the local population (20%).*** BME representation at 8a and above either no change/deterioration in figure in the last 12 months. For non-clinical staff, BME staff were clearly over-represented at Band 6 and not represented at all among very senior management. For clinical staff, BME staff were clearly over-represented at Band 5 and not represented at all above Band 8C. Among medical staff, there was a clear over-representation of BME staff at the non-consultant career grades
2.	Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts.	**3.08 times greater**	2.38 times greater	Of all indicators, the greatest of concern. BME staff continue to be less likely than White staff to be shortlisted/appointed to roles at the Trust. ***The relative likelihood of white staff being appointed from shortlisting compared to BME staff is 3.05 times greater***
	Indicator	**Data for reporting year (2017)**	**Data for previous year (2016)**	**Narrative – the implications of the data and any additional background explanatory narrative**

3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*	2015-2017 0.54 times more likely	2014-2016 1.40 times more likely	An improvement from the previous 2 years ***the relative likelihood of BME staff entering the formal disciplinary process compared to white staff is 0.54 times greater (2014-2016 was 1.4 times greater)***
4	Relative likelihood of White staff accessing non-mandatory training and CPD as compared to BME staff	2017 1.19 times more likely	2016 1.08 times more likely	BME staff continue to be less likely than White staff to be funded for training. Relative likelihood of white staff being funded for raining 1.19 times greater compared to the previous year 1.08 times greater.
	For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for White and BME staff			

5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White 2016 26%	BME 2016 21%	White 2015 25%	BME 2015 21%	Fairly static between the two years but is still higher than the Trust would expect. Although BME staff still report high levels of harassment, bullying or abuse from patients te percentage was higher for White Staff in figures in the last 12 months.
	Indicator	**Data for reporting year (2017)**		**Data for previous year (2016)**		**Narrative – the implications of the data and any additional background explanatory narrative**

6	KF 19 [26]. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	**White 22%**	**BME 20%**	**White 23%**	**BME 25%**	Slight reduction in the likelihood of BME staff experiencing harassment, bullying or abuse from staff in last 12 months (20% for BME and 22% for white staff) compared to previous year 25% for BME and 23% for white staff. Small variance between White & BME Staff.
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion	**White 86%**	**BME 73%**	**White 85%**	**BME 71%**	This has improved for both from the previous year for both BME (73%) and White staff (86%) "Believing that the Trust provides equal opportunities for career progression or promotion". Last year 71% for BME and 85% white staff.
8	Q17b. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleague	**White 6%**	**BME 14%**	**White 6%**	**BME 14%**	This has remained fairly static, no change/deterioration in figure in the last 12 months for both BME (14%) & White (6%) staff to ***personally experience discrimination at work from Manager/team leader or other colleagues.***
	Indicator	**Data for reporting year (2017)**		**Data for previous year (2016)**		**Narrative – the implications of the data and any additional background explanatory narrative**
	Boards representation indicator For this indicator, compare the difference for White and BME staff					

9	**Percentage difference between the organisation's Board Executive voting membership and its overall workforce. Note: Only Executive voting members of the Board should be included when considering this indicator.**	**White** 2016 **94%**	**BME** 2016 **6%**	**White** 2015 **0%**	**BME** 2015 **0%**	***At 31 March 2017, the Board voting membership included 1 Non-Executive Director from a BME Background 9.0%, compared to 91% White Board members. This is a difference of 6% as 15% BME workforce*** ***Breakdown of Board Members;*** ***9 Executive Directors with 5 voting members*** ***6 Non-Executive Directors with voting membership*** ***2 Associate Non-Executive Directors (without voting membership)***

Appendix 2 - Indicator 1 - Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.

	Non-Clinical Staff					Clinical Staff					All Staff				
Payband	**White**	**BME**	**Total**	**White**	**BME**	**White**	**BME**	**Total**	**White**	**BME**	**White**	**BME**	**Total**	**White**	**BME**
				%	%				%	%				%	%
Non-contracted hours	10	9	19	52.6%	47.4%	3	1	4	75.0%	25.0%	13	10	23	56.5%	43.5%
Band 1	124	32	156	79.5%	20.5%	0	0	0	0.0%	0.0%	124	32	156	0.0%	0.0%
Band 2	856	133	989	86.6%	13.4%	552	82	634	87.1%	12.9%	1408	215	1623	86.8%	13.2%
Band 3	405	53	458	88.4%	11.6%	563	55	618	91.1%	8.9%	968	108	1076	90.0%	10.0%
Band 4	393	32	425	92.5%	7.5%	135	10	145	93.1%	6.9%	528	42	570	92.6%	7.4%
Band 5	189	46	235	80.4%	19.6%	1212	253	1465	82.7%	17.3%	1401	299	1700	82.4%	17.6%
Band 6	145	58	203	71.4%	28.6%	1008	88	1096	92.0%	8.0%	1153	146	1299	88.8%	11.2%
Band 7	95	22	117	81.2%	18.8%	412	17	429	96.0%	4.0%	507	39	546	92.9%	7.1%
Band 8A	68	9	77	88.3%	11.7%	129	3	132	97.7%	2.3%	197	12	209	94.3%	5.7%
Band 8B	33	2	35	94.3%	5.7%	19	1	20	95.0%	5.0%	52	3	55	94.5%	5.5%
Band 8C	20	1	21	95.2%	4.8%	5	1	6	83.3%	16.7%	25	2	27	92.6%	7.4%
Band 8D	9	0	9	100.0%	0.0%	4	0	4	100.0%	0.0%	13	0	13	100.0%	0.0%
Band 9	6	0	6	100.0%	0.0%	0	0	0	0.0%	0.0%	6	0	6	0.0%	0.0%
VSM	19	0	19	100.0%	0.0%	1	0	1	100.0%	0.0%	20	0	20	100.0%	0.0%
Medical: Consultants	0	0	0	0.0%	0.0%	149	123	272	54.8%	45.2%	149	123	272	54.8%	45.2%
Medical: Non-consultant career grades	0	0	0	0.0%	0.0%	49	89	138	35.5%	64.5%	49	89	138	35.5%	64.5%
Medical: Trainee grades	0	0	0	0.0%	0.0%	52	76	128	40.6%	59.4%	52	76	128	40.6%	59.4%
TOTAL	**2372**	**397**	**2769**	**85.7%**	**14.3%**	**4293**	**799**	**5092**	**84.3%**	**15.7%**	**6665**	**1196**	**7861**	**84.8%**	**15.2%**

Appendix 3: WRES Action Plan 2017/18

	Indicator	Action planned	Responsible for action	Completion Date
1	**Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.**	• Deep dive by collecting and analysing staff data to identify where the specific blocks to talent are in the Trust and then Pilot an area where there is an under-representation, by review of HR/OD policies, processes, utilise positive action to recruit diversity. • Make Managing Difference/ Unconscious Bias training mandatory for all recruiting managers via inclusion in recruitment training accompanied with change in the process. • Increase representation of BME staff by 2% in all areas where there is under-representation • Develop partnership working with CCG's, Local council, Job Centre, NHS Trusts on shared initiatives i.e. WRES	WRES Working Group/ with support from Diversity by Design	March 2018
2	**Relative likelihood of staff being appointed from shortlisting across all posts.**	• Critically **examine recruitment** processes by piloting an area of under-representation including; ○ Rejecting non-diverse shortlists; ○ Change in process, challenging and sifting out selection bias; (needs to be designed out) ○ Drafting job specification & PS in a more inclusive way; (focus on a combination of excellence – e.g level of skill etc. – and then crucially on the personal attributes (identity, background, experiences) the person brings – e.g the difference they bring. ○ Skills mix creating opportunities for different skills, backgrounds and attributes, not just the chosen few ○ Re-design recruitment materials to specify Trusts desired values and behaviours	WRES Group with support from Diversity by Design	March 2018

	Indicator	Action planned	Responsible for action	Completion Date
2	*(Continued from previous page)* **Relative likelihood of staff being appointed from shortlisting across all posts.**	• Recruitment panel members must have completed Unconscious Bias training accompanied with a change in process of shortlisting and interviewing • Spot checks / audits of vacancies, analysis by banding	Employment Services/ Equality and Diversity Manager	Ongoing
3	**Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.**	• Dealing with difference training to build confidence in managers in resolving disputes/incidents/problems so that they feel able to deal with BME colleagues in the same way as white colleagues • Unconscious bias training for disciplinary/appeal panels • The development of Diversity Ambassadors who review Disciplinaries	Equality & Diversity Manager	February 2018
4	**Relative likelihood of staff accessing non-mandatory training and CPD.**	• Identify reasons/rationale why BME staff are refused funding for non-mandatory training and CPD	Equality & Diversity Manager	January 2018
5	**KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.**	• High profile bullying and harassment campaign with executive leadership on tackling bullying and harassment.	All divisions	March 2018
6	**KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**	• Review of Bullying & Harassment policy • Encourage all staff to first pursue informal mechanisms to resolve issues i.e. Mediation, fair treatment champions, staff side, staff guardian, etc.	Bullying & Harassment working group	November 2017

	Indicator	Action planned	Responsible for action	Completion Date
7	**KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.**	• 2 way mentoring- build into the objectives of all managers above band 5 including VSM to mentor BME colleagues to share experience, in how to manage mixed groups of staff and improve opportunities so that BME colleagues have access to internal/informal networks (this way we are not recruiting/promoting from the same pond)	All Senior managers	March 2018
8	**Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? B) Manager/team leader or other colleagues**	• Tougher sanctions for those who are found to be discriminating, this will act as a deterrent. • Integrate diversity within the performance management processes, including measuring employees on their ability to work well with others and measuring managers on their ability to drive and implement diversity initiatives. Measurements for managers in their appraisals. 360 from staff contributing to measurement of achievement of the 'soft' targets e.g behaviour etc. • Continue with employee engagement activities so that views are sought out; staff are listened to and see that their opinions count and make a difference to Safe Personal Effective care.	Equality & Diversity Manager Staff Engagement Team	March 2018 Ongoing
9	**Percentage difference between the organisations' Board voting membership and its overall workforce.**	• Senior executives must take accountability by ensuring executive sponsorship for this target; consider using positive action for next Board member recruitment. • Explore the introduction of a 'reciprocal mentoring scheme' for BME staff to be paired up with members of the Exec/managers that report directly to the Exec team. • Explore succession planning that considers positive action for all board and senior positions and development of the talent pool generally.	Trust Board Executive Team/Senior Managers	May 2017

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

3 MAY 2017

Item 080

Purpose **Information**
Action
Monitoring

Title	Appraisal update report
Author	Linda Whitfield Head of Workforce Education and Development
Executive sponsor	Kevin Moynes, Director of Human Resources and Organisational Development

Summary:
This paper aims to inform the Trust board on the actions taken with regard to the Trust's history of poor compliance rates and make recommendations on the actions necessary to improve appraisal rates.

A regular, meaningful appraisal is essential in terms of engaging and valuing our staff and maximising their contribution to delivering Safe, Personal and Effective Care

Report linkages

Related strategic aim and corporate objective (Delete as appropriate)	Put safety and quality at the heart of everything we do Invest in and develop our workforce

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

Legal	No	Financial	No
Equality	Yes	Confidentiality	No

Previously considered by:

Executive summary

1. The paper aims to inform the Trust board on the actions taken to date with regard to the challenges of achieving the Trust target of 90%.
2. A number of recommendations are identified aimed at improving the uptake of quality Appraisals.
3. A regular, meaningful Appraisal is essential in terms of engaging and valuing our staff and maximising their contribution to delivering Safe, Personal and Effective Care.

Key actions taken to date

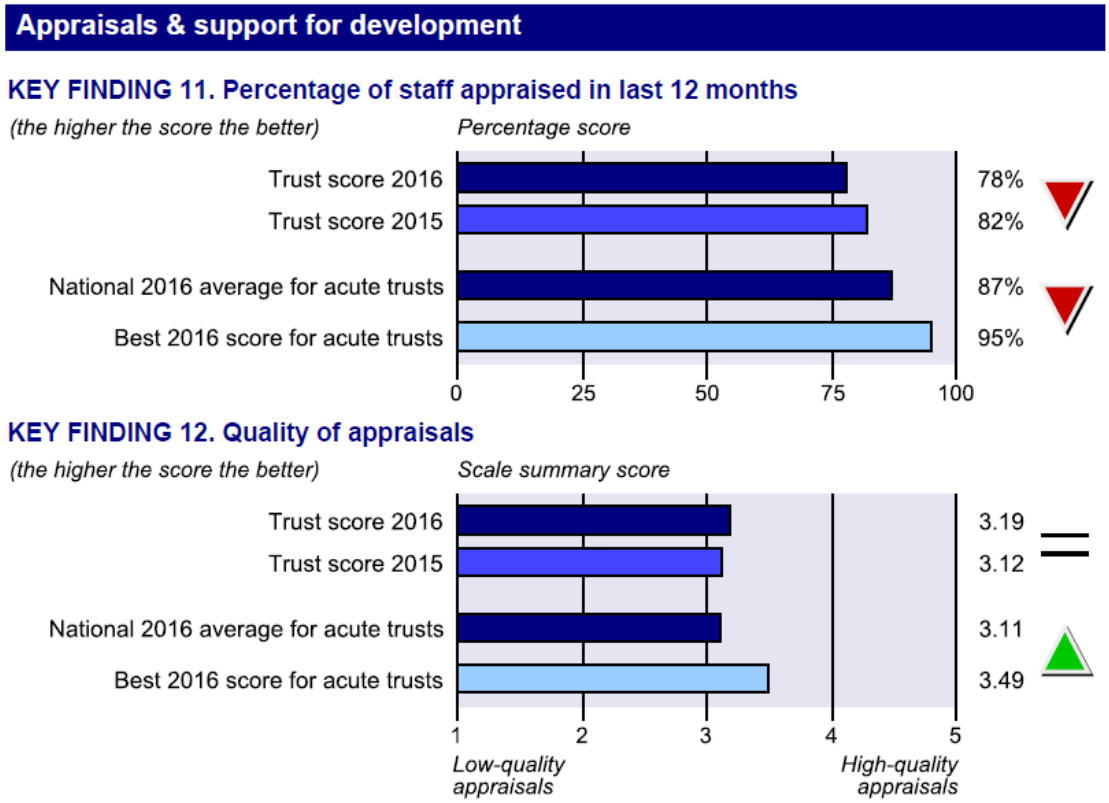
4. Over the past 12 months the Trust has listened to staff feedback and introduced a number of supportive actions with the aim of improving performance, for example, developing the 'Learning Hub', with improved online access to Appraisal documentation and materials and completely moving away from a paper based, complex and cumbersome approach.
5. The Learning Hub now includes '*Your Learning and Development Journey'* incorporating an e-portfolio and simplified Appraisal template. This now meets the requirements of staff who need to revalidate to maintain their professional registration.
6. As a result, the Appraisal process is now central to every individuals '*Learning and Development Journey'.* This approach also highlights the vast array of development opportunities available to staff.
7. Ward based and site specific training has been delivered to over 290 staff with an additional 51 having attending Appraiser awareness since the launch in December 2016.
8. The Appraisal Policy and guidance document (currently known as the Personal Development Review Policy) is being reviewed.
9. All staff receive a personal reminder to book their Appraisal at 60 and 30 days before their due date.
10. The Divisions can now accurately see the level of engagement with Appraisal, which will enable them to support areas with low engagement. See Appendix 1, Current Divisional Performance.
11. The '*Have you had the Conversation'* campaign started in October 2016 and the importance of undergoing Appraisal is discussed at local and corporate induction.

12. The Trust is currently meeting with the 'Best Performing Trusts' based on the 2016 National Staff Survey results.

Current performance

13. Despite a number of approaches and changes to the Appraisal process over time, the Trust has found meeting the Appraisal target (90%) challenging for a number of years.
14. Even though there is some recognition of the fact, that the Trust is carrying a number of vacancies, notably in nursing, and that staff are working under considerable operational pressures; however, simply put, historical and current performance is unacceptable going forward.
15. Current completion rates range have ranged from 56-59% for more than a year with 73% being the highest completion rate.
16. It is clear from benchmarking information, that other Trusts of similar size and make up have continued to achieve 90% plus. In fact, the highest performing Trust has over 15,000 staff.
17. The key findings from the 2016 NHS staff survey (table 1) shows the Trust performance for Appraisal completion is in the 'worst 20%' for uptake, with the national average for Acute trusts being 87% and the best performing Trust, 95%.The Trust is above average for the quality of Appraisals.
18. There has been a renewed focus since the staff survey results and early indicators are good, showing a 5% increase in March 2017 which equates to 400 more appraisals. Considering operational pressures this is a good start.
19. A more detailed update can be found in Appendix 2, Appraisal Update

Table 1 NHS Staff Survey 2016



Recommendations

20. All Clinical Divisions are set an Appraisal trajectory target of 87% by Sept 2017 (the national average for Acute Trusts) and 90% by December 2017.
21. All Corporate Divisions are set an Appraisal trajectory target of 90% by Sept 2017 and 95% by December 2017.
22. The Appraisal target be a focus in future Divisional Performance meetings
23. The Appraisal target to be a focus in Appraisal with the Chief Executive and the Directors leading Corporate Divisions.
24. The current Appraisal policy does allow for the suspension of pay progression to be considered, if there is non-compliance with Appraisal, which is a contractual obligation. However, the recommendation would be at this point, to consider this at a later date, following the approach recommended in this paper.

Kevin Moynes
Director of Human Resources and Organisational Development
24th April 2017

Appendix 1 – Current Divisional Performance and trajectory

End of March 2017 Data includes all staff on ESR (with the exception of Bank only staff, Medical & Dental Staff and New Starters)							
	Target	% Compliance as at 3 Apr 17	% Compliance as at 28 Feb 17	Trend analysis		Target for Sept 2017	Target for Dec 2017
Diagnostics & Clinical Support	90%	62	61	⬆	1	87%	90%
Estates & Facilities	90%	74	71	⬆	3	87%	90%
Family Care	90%	76	68	⬆	8	87%	90%
Finance & Informatics	90%	86	85	⬆	1	90%	95%
Governance	90%	84	80	⬆	4	90%	95%
HR & OD	90%	85	79	⬆	6	90%	95%
Integrated Care Group	90%	51	45	⬆	6	87%	90%
Research & Development	90%	59	64	⬇	-5	90%	95%
Surgical and Anaesthetics Services	90%	54	46	⬆	8	87%	90%
Trust Headquarters	90%	49	50	⬇	-1	90%	95%
Total		62	**57**	⬆	5	**88.5%**	**92.5%**

Appendix 2 **Appraisal Update**

Rationale ***(Safe)***

Since the introduction of Agenda for Change (AfC) there has been low compliance in completing Appraisals (2015 & 2016 the highest AfC compliance has only reached 73%)
Feedback from staff state there has been a reluctance and anxiety in regard to inputting Appraisal information onto the system.
This is due to time constraints and the level of detail that has been required, which has also impacted on the quality of the Appraisal.
Evidence for this is from feedback received in training, coaching, leadership programmes and is also reflected in staff survey reports.

In helping inform the Appraisal conversation we are encouraging staff to take ownership of their own development, aiming to create 7000+ leaders. The NHS Leadership Academy Healthcare Leadership model© has been fully incorporated into the new Leadership programmes. (People Development Strategy)

Evidence indicates that coaching promotes the identification of personal development, therefore the **GROW** model has been incorporated into the Appraisal discussion which will support implementation of the talent management process
This project plan and outcomes are included in the *HR&OD Enabling Workstream re Workforce Transformation Plan*

Implementation and engagement ***(Personal)***

- ✓ **HRDMB 11th July 2016 and monthly via Ops report**
- ✓ **HRDMB SMT meetings**
- ✓ **HRDMB Team Brief 2nd August 2016**
- ✓ **Presented to Family Care QSB, DCS DMB & DCS education board, Practice Education network and now included in Nursing and Midwifery Leadership programme all by end of August 2016**
- ✓ **Presented and demonstrated to CEO, Chair, NEDs and Executives at AGM 14th September 2016**
- ✓ **Discussed with SAS Deputy Chief Nurse and Patient Safety Lead by October 2016**
- ✓ **Discussed with HRBPs 3rd November 2016**
- ✓ **Formal launch (invite sent to CEO , Chair, Head of HR OD and Deputy Medical Director/Education & Quality) 5th December 2016**
- ✓ **JNCC 15th December 2016**
- ✓ **Range of communications, poster displays and information produced to support launch**

Controls ***(Effective)***

- HR&OD Enabling Workstream Operational Plan and associated project plan: *Developing Leadership and People Management Capability*
- IPR reports (changed from December 2016 now to focus on Divisional actions to address non-compliance)
- Monthly compliance report sent to Divisions and included in Trust Workforce report

The Journey so far:

- Investment in an Education Development team to deliver Leadership, Management and a range of OD interventions including Appraisal training. All team members in place January 2017
- Designed, developed and invested '*Learning and Development Journey'* available on the Learning Hub for all staff launched 5th December 2016
- Development of the Learning Hub Appraisal to simplify the recording of Appraisal and enable the option for **all** staff to build an e-portfolio for practice related feedback, CPD and personal reflection similar to the Nursing and Midwifery Revalidation area of the Learning Hub in place January 2017
- Within the new Learning Hub Appraisal there is now the opportunity for both the Appraisee and Appraiser to input objectives and comments on progress made throughout the Appraisal year from January 2017
- Launched 'Have you had the Conversation' and supported Video to encourage and engaged the importance of the conversation October 2016
- In the last 2 years 367 Appraisers have been trained focussing on the conversation whilst ensuring development opportunities and evidencing competency with in role and linking to service/team objectives an additional 39 have been trained since the launch in December 2016
- Delivery of ward based and site specific training to over 269 staff since launch in December 2016
- Importance of engagement with Appraisal Included in all Leadership training and aligned to NMC Revalidation
- Development of the RAG rated Appraisal reports and inclusion in the *Required Learning* area of the individuals Learning Hub. This provides email reminders to the individual and their manager to advise on due and overdue dates
- Presented to ICG Divisional Management team in February 2017

Feedback:

Feedback from all presentations, launches and training events have been positive this has included the simplified template, the drive for the importance of the conversation and inclusive career opportunities and progression

Additional information:

Outstanding 2016 Appraisal dates not inputted by Divisional appraisers added in by Learning Hub team (182 have come through and been uploaded since offer made on 1st January 2017)
One individual has commented that she has worked for the Trust for 29 years and has been waiting for this for her and her team. We will be working with this individual as a case study
We have received a successful Leadership Academy talent management bid to support BME staff and have linked this into the BME Big Conversation outcomes
We are expected to see outcomes of the project from April 2017 onwards with the 2017 staff survey being measure of engagement. Focused case studies will also form part of the Evaluation strategy

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

3 MAY 2017

Item 081

Purpose Information
Monitoring

Title	Management of Sickness Absence
Author	Emma Schofield, Head of Human Resources Paula Reed, HR Business Partner
Executive sponsor	Kevin Moynes, Director of Human Resources & Organisational Development

Summary:
This report outlines the Trust's performance in relation to sickness absence, includes analysis of the current position and sets out a proactive strategy to support managers in responding to the sickness absence rates across the Trust and monitor actions by managers and our HR team.

Recommendation: The Board are recommended to note the contents of the report and receive regular updates on progress.

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

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

Legal	No	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

Cost to Trust of excessive sickness absence (sick pay and agency costs for cover).

Aim

1. The aim of this report is to update the Trust Board on current performance in relation to sickness absence and to outline the proactive strategy and actions put in place to support managers in their role in managing sickness absence across the Trust.

Background and Context

2. The link between a healthy workforce and good organisational outcomes is well-documented. In the NHS, the most notable contributors have included Dame Carol Black, 'Working for a Healthier Tomorrow' (2008), Lord Darzi, 'High Quality Care for All' (2009) and Dr Steve Boorman, 'NHS Health and Wellbeing' (2009). All make very clear the link between improved staff health and wellbeing and improved patient care.

3. Most recently Lord Carter's Review of operational productivity and performance in English NHS acute hospitals identified significant and unwarranted variation in costs and practice which, if addressed, could save the NHS £5bn. Of these savings up to £2bn comes from the workforce budget, including reducing agency spend and absenteeism. Continuing high sickness rates may also have a detrimental impact on the Trust's achievement of expenditure ceilings on agency and locum staff set by NHS Improvement.

Current Position

4. The sickness absence rate at the end of March 2017 stood at 4.45%, a reduction from 4.82% in February 2017. While this rate is the lowest since May 2016 when it stood at 4.53%, March and April absence rates tend to be slightly lower due to a seasonal impact of holidays. An annual summary is shown at Appendix 1.

5. Rates remain highest in Estates & Facilities (5.87%) and ICG (5.37%), although ICG has demonstrated reductions from 7.05% in October 2016. Based on average salary costs, it is estimated that a 1% reduction in the sickness absence rate reflects a saving of 49k with an associated 19k reduction per 1% in bank and agency costs. The peak of absence was in January 2017 at 5.36% and March Trust data reflects an associated cost saving of 71k across the Trust. A schedule demonstrating the absence rates by Division is shown at Appendix 1.

6. While there has been a reduction in sickness absence, the following statistics reflecting the period April 2016 to March 2017 (a rolling 12 month period) are concerning and need to be addressed:
    - 125 597 FTE working days have been lost due to sickness absence.
    - This reflects 11,437episodes of absence.
    - The average number of days lost per employee at the Trust is 16.07, in the private sector it is 6.3 days, in the public sector it is 8.5 on average. (Source CIPD Absence Survey 2016).
    - The estimated cost to the Trust for the 12 month rolling period is £9,915,258.

7. The Trusts rates have deteriorated year on year since 2013/4 when the absence rate stood at 4.00%. This followed a sustained period of improvement. This trend is mirrored in the NHS both nationally and regionally. The Trusts May to October 2016 average sickness rate (4.87%) was worse than the NHS England average (4.01%) and NW Regional average (4.66%). NHS benchmarking data from December 2016 is still not available so it is not possible to provide any further comparative analysis. The most reported reasons for sickness absence continue to be anxiety/stress and MSK conditions. This mirrors the position across the public and private sector as described in the 2016 CIPD Absence Survey.

Strategy to Support Managers in Reducing Sickness Absence

8. In response to the monthly reports demonstrating the levels of sickness absence, a Sickness Management Summit, facilitated by HR was held in June 2016. Over 50 managers shared their experiences of managing sickness absence. They were asked their views about why sickness absence had increased and were consulted about what further support they required to help them manage absence more effectively. In addition to this a bespoke workforce diagnostic was carried out in the ICG division to inform the development of a workforce change programme (Project Elevate) which underpins the divisions' strategy. One element of this project is focused on managing a reduction in sickness absence rates for ICG to a target of 5% by the end of July 2017.

9. All the supportive interventions identified through the Summit and the ICG diagnostic relating to absence have been compiled into an action plan, Support for Managers:

Reducing Sickness Absence, focussing on the following areas which we believe will help managers to have a positive impact on the reduction of sickness absence:

- Policy, Procedures and Compliance
- Data, Intelligence and Systems
- Improving People Management Capability
- Engagement and Communication
- Performance Management, Reward & Incentives
- Occupational Health and Wellbeing Services
- Effective Employee Relations
- ICG Action Plan

A number of actions have already been implemented by the HR team and the Trust is starting to see the benefits of these. Feedback from managers has been positive and in February 2017 the first reduction in absence rates across the Trust for 9 months was realised.

Policy, Procedures and Compliance

10. The CIPD recommends that effective absence practice needs to be underpinned by a clear sickness absence policy that sets out the organisation's expectations in terms of attendance and highlights procedures that will be applied in dealing with absence.

11. The Trust's revised sickness absence policy makes a clear statement of the standards of attendance expected by the Trust. It confirms 'triggers' for action and procedures for investigating and managing absence when triggers are reached. A review of the sickness policy was undertaken in 2016 where the triggers for follow up action were strengthened. The policy has also been updated to state that employees are required to attend Occupational Health appointments and sickness related meetings. The policy also gives managers more discretion to act where absence is persistent but triggers are not necessarily activated. The policy was agreed with the Trade Unions on 7th September 2016 and managers were briefed on the changes.

12. The Internal Audit team were commissioned to audit our sickness absence procedures. Their findings and recommendations were already anticipated and were included in the Support for Managers: Reducing Sickness Absence Action Plan.

13. Rates Benchmarking has been undertaken against NW Trusts to compare the approaches taken in managing sickness absence. Where different practice has been identified, this has been considered and if helpful, added to the action plan.

Data, Intelligence and Systems

14. Lord Carter's review highlighted the need to improve the collection of data in relation to sickness absence management to support better monitoring. The Workforce Information Team is responsible for the production and analysis of data to support sickness management and currently provides data for Divisional Management Boards and the Integrated Performance Report. Good progress has been made to improve the level of insight this data provides, but it is recognised that further improvements can be made, particularly in relation to data provided to Divisions to assist them to manage sickness absence more effectively.

15. The Workforce Analyst is currently working with divisions to improve the monthly data pack. The HR team is also working with the Performance & Information Department to improve data on triggers and long term absence along with their workforce analytical capabilities. Data currently presented to the Trust Board and Finance & Performance Committee will also be reviewed.

16. Once we have realised the improvements in absence data reporting and metrics, it will be possible to review the impact of the new triggers.

Improving People Management Capability

17. CIPD research shows that there is significant correlation between reducing sickness absence rates and line manager capability. The HR Department have been running sickness management training courses for line managers aimed at giving managers the technical understanding of the policy and procedures and the softer skills needed to manage difficult conversations. However, feedback from managers at the Sickness Absence Summit was that this should be supplemented by more coaching and bespoke methods reflecting their specific issues.

18. One key output of Project Elevate was to improve the sickness absence training provided to managers by HR. The training has been re-written and is currently being delivered to all managers across ICG. This material is now available for delivery to all Divisions as needed and will form part of HR's annual people management training schedule. The Estates and Facilities team have recently scheduled bespoke dates where training will be delivered to their managers as a priority. The overarching principle of Project Elevate is to pilot interventions within ICG and then scale up across the Trust.

19. In order to ensure that highest quality of training is both developed and delivered for managers, all members of the Operational HR team have now attended a Masterclass in group training techniques. A 'task and finish' group has been established to redesign the suite of people management training and to refocus the delivery methods and media. On completion the training materials for delivery will be made up of face to face courses, bite sized training sessions, coaching guides, manager guides and 'How Do I' briefs. All with the intension of improving accessibility and quality.

20. The Divisional Senior HR Business Partners have also identified the hotspot areas in their divisions and have now allocated a HR lead to each area, so managers have a key point of contact. This will be supported by the introduction of the 'Engaging Managers' programme which will develop manager's softer skills when dealing with staff in these situations.

21. In recent years the HR Department has developed a sickness management 'toolkit' aimed at supporting line managers to manage absence effectively. This guidance document has been reviewed and updated to make it easier to use. The template letters and forms have also been updated. These new documents were launched to tie in with the new training for managers designed initially for ICG.

Engagement and Communication

22. There is an evidence base to show that there is a link between engagement and the health and wellbeing of staff. The Trust has a clear engagement strategy in place, overseen by the Employee Engagement Sponsor Group. All divisions have held big conversations and have engagement action plans in place. The HR Department, with input from the Occupational Health & Wellbeing Team are developing a communication

strategy to promote health and wellbeing and to promote personal responsibility to stay well and in work. This commenced with the marketed launch of the new Employee Assistance Programme which the Trust has recently retendered.

Performance Management, Reward and Incentives

23. The Trust's sickness absence target is currently 3.75% which for some areas, in the short to medium term is unrealistic. There is a need to set realistic targets for improvement based on current levels at a divisional and directorate/department level. The HR Senior Management Team is working with Divisional Management Teams to agree these which will be managed via the divisional performance meetings and delivery against these targets will be overseen by the Operational Delivery Board. Recognising that a focus effort on reducing sickness absence is required, it is proposed that an overall target for the Trust of 4.3% (national average) by October 2017 (6 months) is agreed. This is being proposed as a new Trust target. A proposed trajectory to meet this trajectory is shown at Appendix 2.

24. The Trust currently recognises individuals who do not take sick leave in any given year. Letters from the Chief Executive to over 2,500 staff have been sent out recognising this achievement. Feedback from managers on this recognition process has varied. Many managers felt staff attendance is expected, while others felt reward for good attendance could be improved through further developing financial individual or team based incentives.

25. Rewarding staff for not taking sick leave can be counterproductive and lead to presenteeism. Such rewards may encourage people to attend when they are not well. The HR Team are currently exploring whether these recognition letters for 100% attendance should continue further and recommendations will follow. While the absence rates may be less than ideal, it is important to recognise that we are also appropriately supporting a number of staff who have long-term medical conditions, in order to either return to or stay in work.

Occupational Health & Wellbeing Services

26. Access to Occupational Health & Wellbeing (OH) services and the application of health

and wellbeing interventions are key to improving the wellbeing of staff and improving attendance. Safe Effective Occupational Health Services (SEQOHS) is a set of standards and a process of accreditation that aims to help to raise the overall standard of care provided by occupational health services, thus helping to make a meaningful difference to the health of people of working age. The OH services received full SEQOHS accreditation in July 2013 and have continued to preserve their accreditation.

27. Key Performance Indicators (KPI) for access for all OH services ensures that staff are seen quickly and by the appropriate speciality. Having KPI leads to rapid access to rehabilitation and occupational health treatment for employees and enables them to return to work more quickly, or to stay in work rather than taking sick leave.

28. Musculoskeletal problems are one of the highest reasons for sickness absence in the organisation and rapid access to physiotherapy and ergonomics services is essential in maintaining staffs Health and Wellbeing.

    a. The Work Smart Ergonomic Service is a systematic ergonomics function that aims to remove risk factors that lead to musculoskeletal injuries and allows for improved human performance and productivity.

    b. OH Physiotherapy services help employers and staff to establish safe working practices and manage health issues. OH Physios seek to prevent as well as treat problems, which can have benefits such as reduced sickness absence and improved staff retention.

    c. Stress and mental health issues are the other highest cause of sickness absence at the Trust and rapid access services for therapy has a positive impact on the health of the organisation.

    d. Mental Health First Aid (MHFA) is an educational course which teaches people how to identify, understand and help a person who may be developing a mental health issue. In the same way as we learn physical first aid, Mental Health First Aid teaches you how to recognise those crucial warning signs of mental ill health. MHFA training is being delivered across the Trust. The

purpose of this intervention is to support the organisation in tackling mental wellbeing. We aim to certify 100 MHFA trained staff by the end of 2017. This function will reduce stigma associated with Mental Health conditions and educate employees how to help support staff with mental wellbeing concerns.

e. Data shows that one of the highest reasons for stress related illness at the Trust is financial concerns. OH and HR have recently introduced a Credit Union to help assist staff.

f. OH has a workplace mediation service, as breakdown in working relationships can contribute or cause people to feel unwell at work. Workplace Mediation is a confidential, informal and voluntary process whereby an impartial mediator facilitates communication between those in dispute to assist them in developing mutually acceptable agreements to improve their future working relationship and help them to return to work or remain in work.

29. Ensuring staff are given appropriate and timely fitness to start work advice is imperative for the organisation. OH ensure substantive staff, bank staff and volunteer staff are approved as fit to begin work as soon as possible. This reduces time to hire, as well as providing any recommended adjustments that may need to be considered.

30. Immunisations and vaccinations of staff is an essential part of the work that OH complete and recent initiatives have seen audits of the organisation's vaccination status to ensure staff are up to date with their vaccines. This initiative will work alongside the infection prevention committee, divisions and departments to support staff in receiving their necessary vaccines to assist them in staying safe at work, protecting the patients they are caring for as well as protecting those people they care about.

31. The flu campaign is run by the OH service. OH offer free flu vaccines to staff to help protect patients, families and colleagues. The 2016/2017 campaign saw the Trust finish as the second acute trust in the country for vaccination of Frontline Healthcare workers with **85.6%** of the organisation receiving vaccination against flu. This is the highest number of flu vaccinations ever achieved by the Trust. Having staff vaccinated against.

A full Occupational Health & Wellbeing Services action plan structured around key wellbeing areas is in progress.

Effective Employee Relations

32. Best practice in tackling sickness absence includes developing a holistic approach to absence by linking attendance to good employment relations, employee engagement, good management, flexible working and effective employment procedures. All organisations see a spike in bullying and harassment complaints when more robust implementation of policy is introduced and difficult conversations happen. There is some evidence of this at the Trust. The introduction of our new Mediation Service is an excellent tool to support both managers and employees. Whilst mediation does not work in all situations, the types of cases referred to above tend to achieve a high degree of resolution which can also reduce the time taken off sick by employees citing stress at work when this relates to a breakdown in a relationship. The HR Team are also undertaking the following actions to ensure that the employment policies and procedures support effective attendance management:
    - An review of flexible working, special leave and annual leave policies.
    - A review of processes and procedures that support staff who have experienced bullying and harassment.
    - A review of disciplinary and grievance procedures to ensure there is suitable emphasis on informal resolution of disputes.
    - Implementing and monitoring of a new mediation service and trained mediators.
    - Developing a new suite of people management training.

33. The recent purchase of an Employee Relations Tracker system has been made with a view to improving quality of data in relation to all employee relations activity, including sickness absence management. This will help to drive improvement in the management of people matters and provide a greater level of insight in terms of how robustly sickness absence is being managed across the Trust.

ICG Action Plan

34. Approval was given (as an 'invest to save') to recruit a dedicated fixed term HR Business Partner to support delivery of the project. A new member of staff joined the HR team in

February 2017 and the savings made to date in reducing sickness absence have already paid for the post along with the fixed term Senior HRBP who was assigned to Project Elevate.

35. Recognising that the increased focus on sickness absence and the additional resource is a short term measure, discussions have been had to identify how the required focus will be sustained longer term. This will be done through a combination of allocated management time for ward managers and a separate proposal (work in progress) regarding the establishment of more ward clerk hours on all ICG wards. One of their responsibilities will be to support Ward Managers with the administration associated with people management.

36. All Ward Managers within ICG have now been given management time away from their clinical duties to focus on their management responsibilities, including sickness absence management. This is known locally as a 'management day' and actions expected on these days include:
    - 6 week rota compliance
    - Plan to reduce hours owed
    - Monitor sickness and ensure compliance to policy
    - Improve staff morale through management of health & wellbeing and clinical supervision
    - Ensure 14% compliance with annual leave
    - Reduce outstanding IR2's, complaints, RCA's, PDR's
    - Improve staff competency through CMT
    - Ensure key information is shared with staff

37. The combination of support measures detailed in this paper, the provision of management time, clear guidance on how to use management time and the KPIs expected are designed to support managers in achieve their people management responsibilities.

Next Steps

38. The HR Team are currently developing a dataset which will demonstrates the scale of absence across Directorates and how cases are being managed. This intelligence will be mapped against ESR data to ensure that while support is provided to our Managers, we are also able to demonstrate that sickness absence procedures are being implemented consistently across Divisions.

39. The HR/OD Directorate will continue to oversee implementation of the action plan and will specifically look to roll out successful interventions (post pilot) from Project Elevate into the other Divisions and Corporate Services. Line managers will be required to ensure that the Sickness Absence Policy is followed in all cases, ensuring an appropriate balance between both support and action for their staff.

40. A communications plan will be rolled out to keep attendance management a key focus, ensuring that the impact of sickness absence along with the extensive support to help colleagues stay in work or return to work is publicised.

41. Interventions which are developed as part of Project Elevate, which have a positive impact will continue to be rolled out across the Trust either following the pilot or sooner where appropriate.

Conclusion

42. The Trust Board is asked to note the contents of the paper and will update the Board on a quarterly basis.

Recommendations

43. That Trust Board is asked to support the proposed trajectory to achieve 4.3% by October 2017.

Appendix 1: Sickness Absence Analysis

Actual % v Current Trust Target of 3.75%

Division	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
ELHT	4.46%	4.53%	4.86%	4.91%	4.83%	4.95%	5.14%	5.11%	5.21%	5.36%	4.82%	4.45%
Corporate	2.27%	2.83%	2.51%	2.86%	2.86%	3.32%	4.23%	3.28%	2.12%	3.02%	3.16%	2.54%
Estates & Facilities	8.26%	8.40%	7.17%	6.97%	6.99%	5.44%	4.50%	5.18%	6.02%	5.91%	6.18%	5.87%
Family Care	3.45%	3.50%	4.40%	4.94%	4.42%	4.38%	4.67%	4.33%	4.76%	4.70%	3.90%	3.83%
ICG	5.21%	4.88%	5.91%	6.03%	6.09%	6.71%	7.05%	6.93%	6.96%	6.73%	5.40%	5.37%
Diagnostic & Clinical Services	3.10%	3.75%	3.57%	3.18%	3.17%	3.34%	4.03%	3.72%	4.13%	4.32%	4.25%	3.51%
Surgical	4.42%	4.31%	4.71%	4.90%	4.75%	4.86%	4.48%	5.10%	4.90%	5.49%	5.14%	4.58%

Annual Breakdown for the Trust

Year	% Sickness Absence	FTE Days Lost	Episodes	Estimated Cost
2016/17	4.96%	125,597	11,437	£9,915,258
2015/16	4.85%	121,347	9,805	£9,270,517
2014/15	4.79%	117,966	9,387	£9,419,567
2013/14	4.00%	94,359	8,249	£7,562,349
2012/13	4.16%	91,334	10,703	£7,401,154
2011/12	4.18%	97,400	10,864	£7,444,261
2010/11	4.41%	92,764	10,198	£7,094,606

Appendix 2 Breakdown of Proposed Trajectory by Division

The proposed target is 4.3% by the end of October 2017.

	ACTUAL												TBC	PROPOSED TARGETS					
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
ELHT	4.46%	4.53%	4.86%	4.91%	4.83%	4.95%	5.14%	5.11%	5.21%	5.36%	4.82%	4.45%		4.40%	4.38%	4.36%	4.35%	4.34%	4.30%
CORPORATE	2.27%	2.83%	2.51%	2.86%	2.86%	3.32%	4.23%	3.28%	2.12%	3.02%	3.16%	2.54%		2.54%	2.54%	2.54%	2.53%	2.53%	2.52%
ESTATES AND FACILITIES	8.26%	8.40%	7.17%	6.97%	6.99%	5.44%	4.50%	5.18%	6.02%	5.91%	6.18%	5.87%		5.80%	5.86%	5.85%	5.83%	5.82%	5.78%
FAMILY CARE	3.45%	3.50%	4.40%	4.94%	4.42%	4.38%	4.67%	4.33%	4.76%	4.70%	3.90%	3.83%		3.80%	3.81%	3.81%	3.81%	3.80%	3.80%
INTEGRATED CARE GROUP	5.21%	4.88%	5.91%	6.03%	6.09%	6.71%	7.05%	6.93%	6.96%	6.73%	5.40%	5.37%		5.30%	5.15%	5.00%	5.00%	5.00%	5.00%
DIAGNOSTIC & CLINICAL SERVICES	3.10%	3.75%	3.57%	3.18%	3.17%	3.34%	4.03%	3.72%	4.13%	4.32%	4.25%	3.51%		3.51%	3.50%	3.48%	3.48%	3.48%	3.47%
SURGICAL	4.42%	4.31%	4.71%	4.90%	4.75%	4.86%	4.48%	5.10%	4.90%	5.49%	5.14%	4.58%		4.56%	4.55%	4.55%	4.53%	4.52%	4.50%

	Item	
	Purpose	~~Information~~ ~~Action~~ Monitoring

Title	Integrated Performance Report for the period to **March 2017**
Author (Name and job title)	Mark Johnson - Associate Director of Performance and Informatics
Executive sponsor (Name and job title)	John Bannister – Executive Director of Operations
Summary: This paper presents the corporate performance data at March 2017	
Report linkages	
Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice Become a successful Foundation Trust
Related to key risks identified on assurance framework	The Trust fails to deliver and develop a safe, competent workforce Partnership working fails to support delivery of sustainable safe, personal and effective care The Trust fails to achieve a sustainable financial position The Trust fails to achieve required contractual and national targets and its improvement priorities Corporate functions fail to support delivery of the Trust's objectives

Impact (delete yes or no as appropriate and give reasons if yes)			
Legal	~~Yes~~/No	Financial	~~Yes~~/No
Equality	~~Yes~~/No	Confidentiality	Yes/~~No~~
Previously considered by:			Not applicable

Board of Directors, Update

Corporate Report

Executive Overview Summary

Significant operational pressures continued in March due to the level of demand for beds. The Trust saw an increase in the number of delayed discharges of medically fit patients and the non-elective length of stay has also increased in March. The emergency department saw an increase in the ambulance handover times. This increased pressure has impacted the flow through the hospital, causing delays in the emergency department for patients waiting for beds.
Despite all the pressures, the 18 week referral to treatment targets for March have been achieved, however the 62 day cancer target was not achieved.

The Trust is reporting achievement of its control total for the financial year 2016-17. Once confirmation of the STF incentive monies has been received, we are likely to achieve of minimum of a £1.5m surplus. The Trust is placed in segmentation 2 by the Regulator under the Single Oversight Framework which is a reflection of the excellent overall performance of the organisation.

SAFE
There have been no further confirmed MRSA infections reported in March. One MRSA infection was reported in December, putting the Trust above the zero threshold. This is the first MRSA infection since December 2015.

No further clostridium difficile post 3 day infections were reported in March, resulting in a year end trust total of 32 for the year above the annual trajectory of 28.

There have been ten serious incidents reported in March, compared with five in February and is above the average of six. Four of these were in Obstetrics.

Nursing and midwifery staffing in March 2017 continued to be challenging. 6 areas fell below an 80% average fill rate for registered nursed on day shifts, an improvement on previous month and 1 area for registered midwives on night duty.

CARING
Friends and Family recommendation rates remain high and the complaints rate is within target.

EFFECTIVE
The latest Summary Hospital Mortality Indicator (SHMI) has remained within expected levels at 1.05 as published in March 2017. Full payment has been received for quarter 3 CQUIN, however risks have been identified against three of the schemes in quarter 4.

RESPONSIVE

Delayed discharges have remained at 5.2% in March. Continued high demand levels have impacted flow through the hospital, caused delays in the emergency department for patients waiting for beds, resulting in 5 '12 hour trolley waits' (patients waiting longer than 12 hours for a bed from decision to admit).
The number of ambulance handovers over 30 minutes increased to 840. The ELHT acute four hour standard was reported at 80.8% and the Pennine A&E Delivery Board four hour standard was reported at 83.5%

Referral to treatment 18 week ongoing pathways continue to achieve at 92.3%, although there is continued pressure in a number of specialties placing the overall performance at risk. There was one confirmed patient still waiting for treatment over 52 weeks at the end of March.

There were no 'on the day' cancelled operations not rebooked within 28 days in March and the diagnostic 6wk standard continues to be met.

The 62 day target is on track to achieve the quarter and full year position, however the February position was just below the 85% threshold at 83.7%

WELL LED

The trust sickness absence rate remains above the threshold although has reduced in February to 4.8% The vacancy rate whilst still above the threshold at 6.1% has reduced.

We have finished the financial year ahead of our control total and, once confirmation of STF incentive monies is received, are likely to achieve a minimum of a £1.5m surplus for the year.

We have achieved more efficiency savings than we planned throughout the year (101%), with 73% being recurrent (£10.2m).

We have met all 4 Better Payment Practice Code (BPPC) targets.

Our Finance and Use of Resources Metric remains at a 2, an improvement on our planned score of 3, (1 being the best level of performance and 4 being in financial special measures).

We have delivered 85% of our capital plan.

Introduction

This report presents the data relating to the period April 16 – March 2017 and follows the NHS Improvement Single Oversight Framework. The narrative provides details on specific indictors under the five areas; Safe, Caring, Effective, Responsive, Well Led. A summary of performance is included in a scorecard at Appendix A.

SAFE

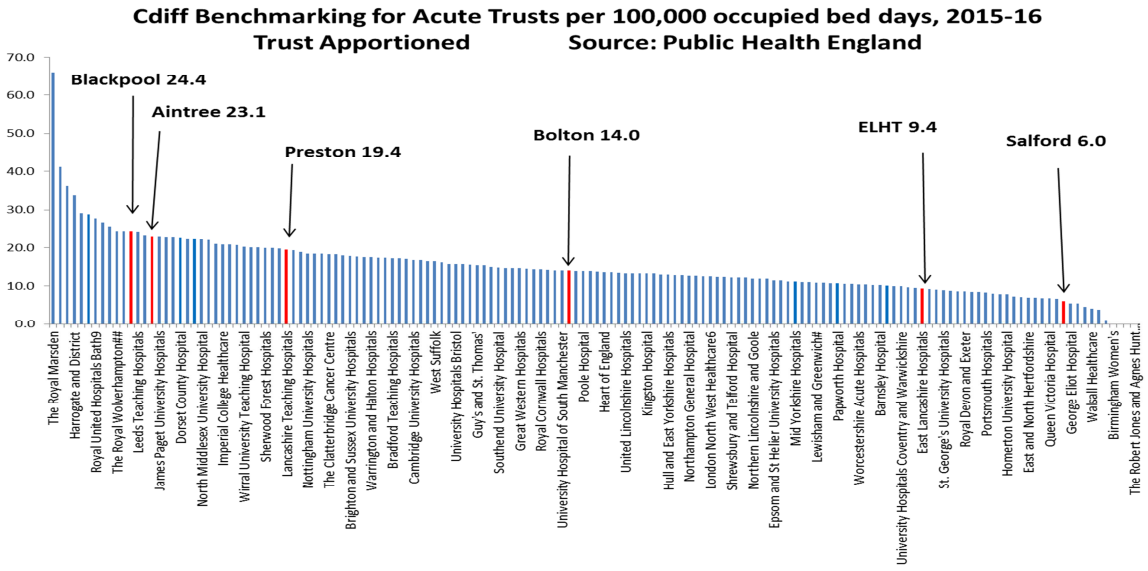
Infection Control (M64/M65)

Current Position

There have been no further confirmed MRSA infections reported in March. There was one MRSA infection detected in December post 2 days of admission on the Children's Medical Unit. The year to date total attributed is one, which is above the threshold of zero.

There were no Clostridium difficile toxin positive isolates identified in the laboratory in March which were post 3 days of admission. The year to date cumulative figure is 32 against the trust target of 28.

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



Risks

The MRSA target has now breached the zero threshold.

The cumulative total Clostridium difficile identified is now at 32 which is above the annual trajectory of 28.

Forecast Position

Year end threshold has been breached.

Actions

Actions on-going as reported previously.

Harm free Care (C28)

Current Position

The Trust remains consistent with the percentage of patients with harm free care at 99.3% for February 2017 using the National safety thermometer tool.

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

Risks

No risks identified

Forecast Position

Above target for harm free care

Actions

The Trust has a quality improvement approach and an established pressure ulcer steering group meeting monthly, to review performance and progress the initiatives to reduce pressure ulcers. This work is monitored through the patient safety and risk assurance committee.

Never events

Current Position

There were no never events reported to Steis in March. One reported year to date.

Risks

No risks identified

Forecast Position

No further never events anticipated.

Actions

No action required.

Serious Incidents (M69)

Current Position

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

StEIS Category	No. of Incidents
Information Governance Breach	1
Slips Trips and Falls	1
Sub Optimal Care of the Deteriorating Patient	1
Maternity/Obstetrics	3
Maternity/Obstetrics – Baby only	1
Pressure Ulcer Grade 3	1
Commissioning Incident – Mental Health Breach	1
Pressure Ulcer Grade 3	1

The four maternity and obstetric incidents reported were in relation to two stillbirths and two babies born in poor condition admitted to NICU. On review of the incidents within Division and when the 2 stillbirths were mapped against the Saving Babies Lives Care Bundle issues have been identified in relation to compliance with the care bundle, the growth charts and the referral and management process. All staff working in the antenatal clinic, and the community midwifery setting have now had one to one training in the use of the Customised Growth Chart, the measuring of the symphysis fundal height and the referral process for women when concerns are identified. Midwives working in antenatal inpatient services have also received this 1:1 training, however there are some staff within this who still require training and a plan is in place to ensure these staff are trained and support is being provided from other areas to provide the training. All Central Birth Suite midwives are now being trained with a planned completion date of the 31st July 2017.

Risks

At the time of reporting any immediate risks to patient safety have been managed – the Investigations are on-going and any further risk to patient safety and the Trust will be managed and escalated appropriately.

Forecast Position

Current trajectory demonstrates approximately six incidents per month.

Actions

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.

Central Alerting System (CAS) Alerts – non compliance (M70)

Current Position

Full compliance reported as all alerts were dealt with within the required timescale.

Risks

None

Forecast Position

100% Compliance

Actions

None required

Safe staffing (M146 – M153)

Current Position

Nursing and midwifery staffing in March 2017 continued to be challenging. 6 areas fell below an 80% average fill rate for registered nursed on day shifts, an improvement on previous month and 1 area for registered midwives on night duty.

The causative factors remain as in previous months, compounded by escalation areas being open. Of the 6 areas below the 80% average fill rate, 4 of those wards fell below the 80% due to coordinator unavailability, which is in addition to the agreed safe staffing levels, leaving 2 areas of concern.

Daylight Shifts

- Reedyford
- Hartley Ward

Night Shifts

- Blackburn Birth Centre

Blackburn Birth Centre has had difficulty this month staffing to the planned requirements due to sickness and maternity leave. To maintain safety and mitigate the risk numbers of women at any one time in labour have been reduced in line with the safe staffing.

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

There were 4 red flag incidents reported, 2 related to less than 2 registered nurses on duty, on investigation one of these was an inaccurate recording, the other related to day case unit where one nurse was looking after 5 patients, no harm was identified. The other 2 related to missed meal breaks.

The safer care acuity tool is being utilised much more effectively to support the movement of staff, however it is acknowledged that this remains an iterative process as confidence and ability to use the system embeds.

Actions taken:

- Extra allocation on arrival shifts continue to be booked. Registered and non-registered.
- Safe staffing conference at 10 am followed up with meetings throughout the day where required to ensure safe staffing, with contingencies agreed for weekends and out of hours.
- Extra health care assistant shifts are utilised to support registered nurse gaps
- On-going active recruitment/open days

Family Care March 2017

Maternity

Month	Aug 16	Sept 16	Oct 16	Nov 16	Dec16	Jan 17	Feb 17	March 17
Staffed to full Establishment	1:30.3	1:30.4	1:30.25	1:30.6	1:30.1	1:29.23	1:28.83	1:29.22
Excluding mat leave and vacancies	1:31.5	1:31.9	1:30.60	1:31.2	1:31	1:30.86	1:30.33	1:30.47
With gaps filled through ELHT Midwife staff bank	1:29.7	1:28.4		1:29.4	1:29.2 Usage 13.31WTE weekly	1:29.44 Bank Usage 10.10WTE	1:29.47 Bank Usage 6.165 WTE	1:29.32 Bank usage 8.225 WTE

The midwife/birth ratios calculated using the Birth Rate Plus Tool from the 1st March 2017 to the 31st August 2017 (predictive) is 1:28.85.

The staffing figures do not reflect how many women were in labour or acuity of areas.

Within Maternity Services whilst all gaps are sent through to Bank 30% are unfilled.

Seventeen incidents were reported within Maternity Services as “Red Flag” incidents in March in the red flags report on Datix and 22 incidents were reported under the staffing category.

However on further analysis and cross referencing as the incidents appeared in both the staffing and red flags report, 5 incidents were red flag incidents 4 of which were excluded

as they occurred in Antenatal Clinic and not an inpatient area, therefore there was 1 red flag incident within Maternity Services in March and 17 staffing incidents.

No harm was caused by any of the red flag or staffing incidents reported and the appropriate actions and escalation occurred.

Maternity continue to have staffing gaps due to retirement, sick leave and maternity leave. Interviews took place on the 17th March and 14 WTE midwifery post were recruited too.

Acuity is assessed twice daily at the safety huddles on Central Birth Suite, the huddles review the whole picture across maternity services and staff are moved accordingly to ensure safe staffing. Bank staff are used to ensure safety.

NICU

NICU safely staffed to the level of acuity in March. NICU had recruited to all vacancies, however 1 has subsequently withdrawn.

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. The fill rate for HCA on night duty was 51.6%. This did not compromise patient care or safety as the registered nurse to patient ratio was maintained.

Paediatrics

Paediatrics continues to have staffing gaps due to vacancies and maternity leave, bank and agency are used to mitigate the risk and ensure safe staffing.

There are a number of student nurses ready to start but this will not be until the summer time.

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

CARING

Friends & Family (C31-C32)

Current Position

These metrics reflect national measurement methodology, which measures the proportion of patients that would recommend the Trust to friends and family. The latest Trust development authority thresholds have been included where available.

In March the number that would recommend A&E to friends and family was slightly down on last month at 79.6%. The proportion that would recommend inpatient services was also slightly down on last month at 97.0%. Community services would be recommended by 92.8% and maternity 96.9%

Risks

The response rate for inpatients in March was 47.0% and the A&E response rate was 22.1% for March, however there are no national targets for this.

Forecast Position

On target

Actions

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

Complaints (C15)

Current Position

The Trust received 41 new formal complaints in March compared to 32 in February and 38 in January.

The number of complaints closed in March was 32.

ELHT is targeted to achieve a threshold of at or less than 0.4 formal complaints per 1,000 patient contacts – made up of inpatient, outpatient and community contacts. The Trust on average has approximately 115,000 patient contacts per calendar month and reports its performance against this benchmark. For March the number of complaints received is shown as 0.3 Per 1,000 patient contacts.

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

Risks

No risks identified

Forecast Position

On track

Actions

There is a continued presence of Customer Relations Staff across both sites, in addition to contact by phone, email, letter or face to face being made by the Customer Relations Team to resolve concerns quickly and prevent escalation, where possible.

All complaints are triaged by the Customer Relations Team and, wherever possible, early contact is made. Any issues which can be resolved immediately are identified and dealt with. Any outstanding issues following this are highlighted for investigation and response if necessary. However, a number of complaints have been withdrawn in these circumstances, as once the complainant has the opportunity to discuss issues and immediate concerns are satisfactorily resolved, it is often felt by the complainant to be unnecessary to continue with the formal complaint process.

Weekly complaint monitoring meetings are in progress to review complaint management progress.

Patient Experience Surveys

Current Position

The table demonstrates divisional performance from the range of patient experience surveys for March 2017. The threshold is a positive score of 90% or above for each of the 4 competencies.

The Divisional performance from the range of patient experience surveys is above the threshold of 90% for all of the 4 competencies in March 2017.

Overall performance by the Integrated Care Group – Acute remains at 97% in March. Performance against the Dignity, Information and Involvement competencies remain at 99%, performance against the Quality competency decreased to 96% in February and remains at 96% in March.

Overall performance by the Integrated Care Group – Community decreased to 99% in February and remains at 99% in March. The performance against Dignity and Quality remains at 100%, with performance against the Information competency decreasing to 99% in February; this remains at 99% for March. The performance against the Involvement competency increased from 99% in February to 100% in March.

The overall performance within Surgery increased to 98% in February and decreased to 97% in March. Performance against the Dignity competency decreased to 98% in February and remains at 98% in March, Information increased to 99% in February, however decreased to 97% in March. The performance against the Involvement competency decreased to 98% in February and remains at 98% in March and Quality competency decreased to 96% in February and then increased to 98% in March.

The Family Care Division's overall performance increased to 98% in February, however this decreased to 96% in March. Performance against Dignity competency decreased to 98% for February and remains at 98% in March. Performance against Information decreased to 96% in February and decreased further to 94% in March. Performance against the Involvement competency was 98% in February and increased to 99% in March and Quality increased to 98% in February with a decrease to 96% in March.

Overall performance for the Diagnostic and Clinical Care Directorate decreased to 95% in February and remains at 95% in March. Performance against the Dignity and Quality decreased to 95% in February and increased to 97% in March. The Involvement competency increased from at 98% in February to 99% in March, and the Information competency decreased to 94% in February and then increased to 95% in March.

Table 2: Patient Experience

March 2017 Totals		Overall	Dignity	Information	Involvement	Quality
	No.	%	%	%	%	%
Trust	2386	97	98	97	99	97
Integrated Care Group - Acute	651	97	99	99	99	96
Integrated Care Group - Community	326	99	100	99	100	100
Surgery	282	97	98	97	98	98
Family care	464	96	98	94	99	96
Diagnostic and Clinical	411	95	97	95	99	97

Risks

No risks identified

Forecast Position

On track

Actions

Ongoing monitoring of these measures. No specific actions required to improve performance.

EFFECTIVE

Mortality (M73-M53)

Current Position

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

No further learning disability related deaths since January 2017

DFI Indicative HSMR - rolling 12 month

The latest indicative 12 month rolling HSMR (January 16 – December 16) is reported 'as expected' at 97.0 against the monthly rebased risk model.

Risks

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

Forecast Position

The SHMI and HSMR trajectories are showing regular improvement and the forecast is for both to remain with expected levels.

Actions

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.

CQUIN (M89)

Current Position

The table shows the Quarter 3 position for which the Trust has received full payment. The quarter four position is currently being collated and will be available in next month's report.

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

Risks

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

- Latest published data for the 1% reduction in antibiotic consumption per 1000 admissions CQUIN is on track for the overall reduction required and for Carbapenems but consumption of piperacillin/taxobactam is 4.6% up on agreed baseline. Payment is based on the final annual position reported after Quarter 4.
- Risk has been identified around achievement of the Hepatitis C CQUIN, which is a specialised commissioner CQUIN.
- Achievement of the quarter 4 milestone of 90% for antibiotic review

Forecast Position

Achievement of the nationally mandated Quarter 4 milestones for sepsis and reduction in total antibiotic consumption will prove challenging in addition to the risk around Hepatitis C.

Actions

All CQUIN schemes have been assigned clinical and managerial leads and are managed by the divisional teams. Monitoring and updates are provided through the Trust's Clinical Effectiveness Committee and Contract and Data Quality Steering Group.

RESPONSIVE

Accident and Emergency (C2/C2ii/M62)

Current Position

Overall performance against the ELHT Accident and Emergency four hour standard was reported as 80.8%, below the 95% threshold. The performance against the Pennine A&E Delivery Board four hour standard was reported as 83.5%

The number of attendances during the month was 17,950 and of these 14,987 were treated and left the department within 4 hours. (Pennine A&E Delivery Board)

Only 6 out of 139 reporting trusts with type 1 departments achieved the standard on all types for January. (National data reported one month behind)

There were 5 breaches of the 12 hour trolley wait standard from decision to admit during March. All were mental health breaches. Mental Health demand and the timely availability of mental health beds remain an issue. Rapid review timelines are completed in accordance with the NHS England Framework and a root cause analysis will be undertaken.

Risks

- Medical staffing gaps continued during the month with sickness and cancellation of locum shifts. This had a serious impact on flow. Support from across divisions continued and alternative internal pathways were put in place where possible although this was limited.
- There was a high level of short notice nurse staffing sickness throughout March which had a significant impact on ED/UCC and on the wards.
- Surges in ambulance attendances have continued with high numbers of arrivals in short period of time leading to delays.
- Mental Health demand and the timely availability of mental health beds remain an issue. There continues to be significant numbers of attendances in relation to Mental Health which are resource intensive for the department. During February there were five 12 hour Mental Health breaches waiting for a mental health bed.
- Bed pressures continue. At times admissions have exceeded discharge levels across both surgery and medicine – high acuity patients within medicine and surgery have impacted on the number of discharges which in turn caused delays in bed availability resulting in increased length of stay in ED causing delayed first assessments. At times the ED and UCC have been over capacity by 50-75% causing patients to be nursed on corridors which impacted on the ability to assess patients in a timely way.
- Increasing patient acuity with patients presenting with complex co-morbidities has continued to place considerable demand on the emergency department. High

numbers of patients needing senior decisions/reviews from Doctors due to acuity. This in turn causes delays at times and has halted flow as each decision needed to go through a Consultant.

- Full receipt of the sustainability and transformational funding of £11.3m in 2017/18 is dependent on achievement of the 4-hour target and the financial control total.

Forecast Position

Performance is expected to show improvement during April with continued improvement into May.

Actions

- Our winter escalation ward is open to support additional demand and is being reviewed in order to plan for the next few weeks.
- Micro-management clinical flow 24/7 with an 8am cross organisational Operational Performance meeting on a daily basis considering issues from the previous 24 hours.
- Intensive Home Support Teams continue to work daily in the Emergency Department to prevent admissions and have also been deployed across wards to support early discharge.
- Operational times for Ambulatory Care have been increased from November 2016. The service is now provided 7 days a week and the impact will is being monitored. A Business Case has also been drafted which supports this continuing going forward.
- We now have a regular number of GPs coming forward to offer sessions in UCCs. These support the existing workforce. A hospital based GP in UCC commenced in post in December 2016.
- Overseas recruitment took place in September 2016. Posts have been offered and work continues to finalise and arrange start dates.
- A review of the 12 hour MH breaches has been undertaken. A paper and Action Plan were presented at SIRI panel. A fishbone analysis was undertaken and the Action Plan updated. The Action Plan will be monitored through the LCFT and ELHT Quality Meetings.
- An external review of the Mental Health Pathway in Pennine Lancashire took place at the end of November. This involved the Royal College of Psychiatrists and the Royal College of Emergency Medicine along with, ELHT and LCFT and commissioners. Formal feedback has been received and is being reviewed.
- A review of Core Nurse Staffing in ED/UCC has been undertaken and recruitment has commenced based on initial feedback.
- The Transformation Programme for the Emergency Care Pathway has now been agreed and key projects commenced: including Review of Rapid Assessment and Treatment Model in ED, Review of the Urgent Care Model including Triage, MSK pathway from Triage.
- A stranded patient metric is being used to assess the position in relation to complex discharges and DTOC.
- We continue to utilise the Discharge Lounge for patients awaiting transport to go home from ED, UCC, STU and Acute Medical Wards.
- Following a test of change for direct orthopaedic attendances from GPs, AVH MIU, BUCC and Rossendale MIU where patients were reviewed in Ambulatory Care by the Orthopaedic team, patients will now be directed straight to STU.

- The streaming model has been reviewed and clearly defined protocols to support the clinical decision making at initial presentation are now in place. Work continues to review and refine the streaming model with support from sessional GPS and UCC lead GP. A Rapid Improvement piece of work is planned at Burnley UCC w/c 3rd April.
- NHS Improvement visited ELHT twice in February to review the Emergency Pathway and work with us on areas of potential improvements. The report following this is due in April 2017.
- A review of breach analysis and utilisation of EPTS is underway.
- The Transitional Care Unit (TCU) was opened in January to support the decompression of ED to improve flow and reduce the number of patients waiting on corridors therefore improving patient experience. A SOP was developed and is in place.

North West Ambulance Service (M81/M82)

Current Position

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

The number of handovers over 30 minutes increased to 840 for March compared with 674 for February. 1269 handovers were within 15 minutes of arrival and a further 1159 were 15-30 minutes.

The validated NWAS penalty figures for February are reported as;- 180 missing timestamps, 426 handover breaches (30-60 mins) and 98 handover breaches (>60 mins).

Risks

- Royal Blackburn continues to be the busiest site in the North West for ambulance attendances. Surges in ambulance arrivals continue to cause pressure in the department especially in times of limited patient flow due to low bed availability within the Trust.
- Surge patterns continue with high numbers of arrivals in short time periods leading to delays.
- Congestion within the department at time of pressure leads to reduction in space to offload arriving ambulance patients. This impacts handover times.
- Increasing patient acuity with patients presenting with complex co-morbidities continues to place considerable demand on ED.
- Timely availability of medical and surgical beds has impacted on the length of stay in ED which has therefore resulted in Delayed First Assessments and overcrowding. Demand has exceeded capacity.

Actions

- Rapid Handover procedure for UCC patients has been agreed and introduced. This has seen a rise in the number of appropriate patients being taken to UCC.
- Fortnightly operational meetings continue with NWAS/ED/AMU with representation from the CCG.
- The Ambulance Liaison Officer role is now embedded and has been extended up to end of March 17. This role is now being reviewed with NWAS and ELHT clinicians to explore options to expand the role.
- Reception capacity has been increased. Staff are in post and this is supporting timely handovers and more efficient transfer of patients from the department.
- Rapid Assessment of Treatment (RAT) Process in ED had been reviewed and made leaner to improve the timeliness of assessment and to improve flow to enable an improvement in handover times.
- Process mapping of handover process undertaken jointly with ELHT/NWAS including RAT process in February.

Referral to Treatment (C1/C3/C4/C37.1)

Current Position

The 18 week referral to treatment (RTT) % ongoing position has been achieved with 92.3% patients waiting less than 18 weeks to start treatment at end of March, which is an improvement on last month (92.2%) and above the 92% target.

The total number of on-going pathways has increased slightly to 25,807 from 25,779 last month. There has been a further reduction of patients waiting over 18 weeks at the end of the month to 1979 from last month's 2004.

The median wait has increased slightly in March to 6.1 weeks from 6.0 in February.

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

There was one confirmed patient waiting over 52 weeks at the end of March.

The latest published figures from NHS England show a slight improvement of the ongoing standard nationally, with 89.9% of patients waiting less than 18 weeks to start treatment in January, compared with 89.7% in December.

Risks

Operational pressures are still a risk and routine operations are being cancelled due to lack of beds. Pressures exist in the system with increasing demand and lack of capacity in some areas.

Forecast Position

It is anticipated that performance will remain above the national standard of 92%

Actions

Regular monitoring of patient tracking lists is undertaken and risks are escalated to senior managers.

Additional outpatient and theatre sessions are undertaken where possible and subject to bed availability, to manage demand and nurse clinics set up.

Cancer (C18-C25/ C36)

Current Position

The 62 day target is on track to achieve the quarter and full year position, however the February position was just below the 85% threshold at 83.7%

The 62 day target is not monitored nationally by tumour group and is included here for information only. At tumour site level, four groups did not meet the 62 day target in February; Colorectal (83.3%), Urology (81.0%), Head & Neck (57.1%) and Upper GI (69.6%). There were five patients in February treated after day 104 and these 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.

Risks

Cancer Services are under pressure to manage cancer targets alongside the 18 week referral to treatment target and the 4hr target. The cancer targets are being micromanaged to maintain compliance.

Forecast Position

Compliance forecast for March, subject to validations.

Actions

Risks are escalated to senior managers and cancer performance is monitored through weekly cancer patient tracking list (ptl) meetings, Surgery and Integrated Care Group (ICG) performance weekly meetings and the director of operations weekly performance monitoring meeting.

Cancelled Operations – 28 Day breach (C27a)

Current Position

There were no ‘on the day’ cancelled operations not rebooked within 28 days in March.

Risks

Financial penalties are imposed on the Trust for breaches of the standard at the Payment by Results tariff of the procedure.

Forecast Position

No further breaches anticipated.

Actions

Regular monitoring of patients that had procedures cancelled on the day to ensure dates are offered within the 28 days. Risks are escalated to senior managers and reviewed weekly by the director of operations.

Delayed Discharges (M55)

Current Position

The number of delays reported against the delayed transfers of care standard has been maintained at 5.2% however still remains above the threshold of 3.5%. This equates to an average of 43 beds lost per day. The top three reasons for the delays are 'Awaiting completion of assessment' (36%), 'Awaiting domiciliary package of care' (17.7%) and 'Awaiting Public Funding' (14.5%).

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

There is now daily reporting at individual patient level in each category of delay so that any trends or specific issues can be escalated for resolution to the relevant partners. The Integrated Discharge Service operational team are attending an allocation meeting at regular points in the day to progress cases and ensure we are prioritising our work in accordance with organisational clinical flow demands. Progress is reported across the IDS hub as required to expedite any barriers to progressing transfers of care.

Risks

The increase in delayed discharges will add further pressure to patient flow and the 4 hour target as available bed capacity is reduced.

Forecast Position

The actions being taken aim to reduce the number of delayed discharges.

Actions

A systematic 'micro-management' of all patients who are medically fit for discharge is now well embedded alongside partner agencies with daily meetings taking place to monitor this cohort of patients.

As a health economy, we now have a work stream to develop and implement a fully Integrated Discharge Service (IDS), It requires on-going refinement with partner organisations. This service has been co-produced with our commissioners and partner health and social care provider agencies. It is one of the major facets of our Community Services Transformation Programme alongside Intensive Home Support, Integrated Neighbourhood Teams and Frailty Pathway development. The key strands of work to improve delayed discharges are:

- Integrated discharge service - This will ultimately result in the delivery of a fully integrated discharge service including a trusted assessor role to support ELHT front door areas and wards. The service has been developed to use the 'Assess to Admit' and 'Discharge to Assess' principles of care. This service needs to be fully resourced with further operational permissions from across the system to be effective in managing the delayed transfers of care to a satisfactory level.
- Continuing Health Care – micromanaged to ensure patients are transferred out of hospital as soon as possible when fit for discharge. We still need to work on this outward pathway to ensure that we are able to progress discharge without the need for long term decision to be made from an acute episode. System wide local agreements needs to be made to see a new way of working which would prevent delay.
- Home of Choice - Our allocation service is supporting families to make timely choices for onward care. Working daily with Care Home Selection service to ensure that we are fully updated on progress and that actions to facilitate discharge are completed in a timely manner. We are waiting to have a home of choice policy that is agreed by the wider health and social system and operational by September 2017.
- Home first is now operational, a discharge to assess scheme ensuring that assessment after acute episode are undertaken at home and patients are left at home with relevant care and reviewed on day 3/day 5. This scheme has been hugely successful, however more capacity is needed to meet the demand of patients requiring this style of service.
- Medically Ready Patients – operational plan in place to reduce medically fit for discharge number to below 79 by the end of March 2017. By the end of March we remain in a position where the medically optimsed for discharge patients is above 79.

Emergency Readmissions (Reported 1 month behind – C16)

Current Position

The emergency readmission rate is reported at 12.3% in February 2017 compared with 12.6% in February 2016.

Risks

Readmissions add further pressures to bed capacity and the need to shorten length of stay to release capacity also increases the risk of readmission.

Forecast Position

The forecast is for this to improve over the summer months.

Actions

Development of pathways to increase the role of community services, particularly for paediatrics and the elderly.

The Complex Case Management Team work within the ED and assessment units, to ensure that if care in the community has failed this can be reviewed by our duty teams if further admission to the hospital is not required.

Diagnostic Waits (C17)

Current Position

This measures the proportion of patients exceeding the 6 week target for a diagnostic procedure. In March, 0.4% (34 patients) waited longer than 6 weeks, which has increased slightly from last month (0.3%) however is still under the threshold of 1%.

Nationally, 1.7% of patients were waiting over 6 weeks at the end of December.

Risks

No risks

Forecast Position

On track

Actions

Diagnostic patient tracking lists are monitored weekly and any breach risks are escalated to senior managers to ensure all are accommodated where possible.

Length of Stay (M90/M91)

Current Position

The Trust non elective average length of stay has increased to 4.7 days in March, compared to 4.6 in February.

The elective length of stay (excluding daycase) has decreased on last month to 2.3 from 2.5.

Dr Foster benchmarking shows the Trust length of stay to be below the expected when compared to national casemix adjusted, for elective and slightly higher than the expected for non-elective.

Table 3 – Average Length of Stay VS expected, January 16 - December 16, Dr. Foster

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	58,459	9,962	48,497	3.4	2.6	-0.8
Emergency	53,467	53,467	0	4.9	4.9	0.1
Maternity/Birth	14,336	14,336	0	2.2	2.5	0.3
Transfer	182	182	0	10.8	33.7	22.9

Risks

Long length of stay increases bed occupancy which at high levels puts pressure on other standards ie 4hr target and cancelled operations.

Forecast Position

The trend in non-elective length of stay appears to be increasing and is now slightly above the expected according to the DR. Foster casemix adjusted rate.

Actions

The action plan for delayed discharges will also reduce the average length of stay.
Divisional monitoring of length of stay and use of benchmarking software to identify outliers.

WELL LED

Sickness (M78)

Current Position

The sickness absence rate decreased from 5.36% in January 2017 to 4.82% in February 2017. This is higher than the previous year (4.74%).
Long term sickness currently stands at 3.00% and short term sickness at 1.81%.

Risks

High sickness rates are a financial risk as bank and agency expenditure increases to cover shifts. The level of short term sickness is unusually high. Long Term sickness attributed to anxiety/stress and musculoskeletal problems continue to be the main reasons for sickness absence.

Forecast Position

Improvement due to intervention and actions but countered by expected seasonal increases over the winter period

Actions

- Corporate and Divisional action plans in place
- Sickness Absence Policy review complete and agreed with staff side – trigger levels now more robust and managers have further discretion.
- New Employee Assistance Programme launched
- Divisional sickness clinics and bespoke training taking place
- Internal Audit of Trust sickness absence procedures complete and recommendations being implemented
- Data Analysis of bank holiday sickness underway for Christmas and new year period– trends will be highlighted and data provided to managers for action
- ICG Divisional project aimed at reducing sickness including recruitment of 'Divisional Sickness Absence Taskforce'
- Full review of sickness absence action plan underway and update will come to Trust Board in May

Turnover rate and Temporary costs (M77/F8)

Current Position

Overall the Trust is now employing 7086 FTE staff in total. This is a net increase of 23 FTE from the previous month. The number of nurses in post at Mar 2017 stood at 2290 FTE

which is a net increase of 16 FTE since last month and a net increase of 236 FTE since 1st April 2013.

There are a further 126 nurses in the recruitment pipeline.

The vacancy rate for nurses now stands at 9.1% (228 FTE)

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

In February 2017 the Trust spent £2,183,837 on bank and agency. This was less than in February 2016 (£2,368,912) and more than in January 2017 (£2,127,294).
Total expenditure to date for 2016/17 is £24,648,629

Risks

Risk of not meeting NHSI targets, impact on staff engagement, attendance and patient care

Forecast Position

No change to vacancy rate. Forecast to not meet NHSI target (£10.5 million)

Actions

- Improving utilisation of Staffflow – now achieved 96%
- Additional eRostering training dates, and on ward training/refresher sessions
- Trust wide agency reduction task groups (medical and Non –Medical) and Executive Oversight Group established
- Each division now has an allocated eRostering expert lead/single point of contact, resulting in increased familiarity with their roster and therefore improved engagement.
- The 16/17 professional judgement meetings were concluded in November 2016. This resulted in required changes to the establishment, which will be documented in a separate paper for agreement.
- A proposal to change the annual leave allowance to a fixed percentage was agreed and so this will come into effect from the 1 April 2017 (updated policy has been agreed). This will have a positive impact in terms of being able to manage/flat line the 22% headroom across the year.
- A 60 unit role out plan has been developed for 2017/18 which will continue to see the Allocate tool being rolled out across the Trust. In December the Domestic workforce (299 WTE) were moved onto the eRoster and are now being paid via this tool. Several more units are now being progressed including, Catering, Portering, Therapies and multiple units within ICG and Family Care.
- A review of the eRoster training modules and the introduction of some eLearning modules are now complete and available via the Learning Hub. Customer feedback

has been used to inform this review. This has also included 400 domestics being trained to use Employee on Line.

- Full implementation of the Safecare.
- Reduce additional duties above demand/agreed staffing level. A full reconciliation has been done between the three systems which capturing the establishment (ESR, Ledger and eRoster), demonstrating that all three are aligned. However the actual levels at which the majority of wards are staffing to, is beyond the budget and the roster template that was agreed. Therefore further work is required in order to understand and address the reasons for this.
- Implementation of the Kendal Bluck recommendations within ED, including the harmonisation of shift patterns and the implementation of a seasonal roster.
- To review the way in which 1:1's are managed, given the month on month increase to establish whether there is a more efficient/cost effective way to identify and manage this required resource.
- Re-introduction of the Nurse Confirm and Challenge meetings (chaired by the Deputy Director of Nursing) to address areas of concern highlighted on the eRostering Dashboard (now that the draft dashboard has been developed). Oversight of this will be via the Executive Oversight Committee from January 2017 onwards.
- Reviewing the way in which the Allocate on Arrival process works to ensure that its managed in the most cost effective and efficient way, now that Safecare has been implemented and can be used to identify and manage the movement of staff.
- Promotion of medical staff bank – 30 more doctors active on bank since April 2016
- Centralisation of all medical locum bookings now complete
- 22 Candidates in the pipeline and have been offered the Intensive ILETS training, 6 of which have passed and are in the CBT process.
- 18 doctors recruited from India in pipeline – 1st doctor to start in February 2017 with rest scheduled to start in Spring
- ED Recruitment national campaign continuing
- Project continuing to look at reducing recruitment time to hire across the Trust to support reducing the vacancy gap and reduction in bank/agency spend
- Social media project group established to support recruitment
- ED and Family Care open day's being planned for Spring 2017
- Attendance at the RCN jobs fair in February
- Currently reviewing and implementing new HMRC tax rules and NHSI rules on locums

Appraisals & Job Plans (M80)

Current Position

The 2015/16 year end job plan completion rate was 80%. The 2016/17 job planning round was re-launched in May, with a window of June to August to undertake the reviews. The current completion figure for 2016/17 at the end of March was 79%, including reviews that have taken place since January 2016. The Deputy Medical Director is working closely with the Divisional Directors to ensure that job plans are undertaken.

A new electronic job planning system has been purchased and is in process of being implemented.

Table 4 – Job Plans

	2015	2016 (YTD)
Trust Total	80%	79%
Integrated Care Group	66%	56%
Surgery	75%	90%
Family Care	100%	79%
Diagnostics & Clinical Support	84%	85%

There has been a new system implemented (MyL2P) to capture the appraisal rates for consultants and career grade doctors. The completion rates reported from this system are cumulative year to date, April – March 2017 and reflect the number of reviews completed that were due in this period.

The consultant appraisal rate has increased to 99% and the other medical staff appraisal rate has remained at 99%.

The AFC appraisal rates continue to be reported as a rolling 12 month figure and have increased in March to 62% from last month (57%), however is still below the threshold of 90%

Risks

None identified

Forecast Position

Compliance

Actions

There has been a range of Trust wide actions to support compliance as reported previously, which are on-going. In addition, the divisions have developed their own action plans as follows:

Divisional

- Reminder e-mails to managers of non-compliant staff
- Scoping exercise currently being undertaken to look at the numbers of appraisals managers are doing and whether this is a cause for under performance. The results of this will be fed back to individual Directorates.
- Promotion of “have you had the conversation” via Divisional newsletter and other communications channels to encourage staff to come forward to ask their manager for an appraisal.
- Appraisals are a standard item on the agenda and discussed at the various DMB meetings as well as the individual business meetings that are held with managers.

- Senior HRBP part of HR&OD Working Group currently looking at ways to help support Divisions in increasing appraisal compliance.
- Monthly meetings with all ward managers covers appraisal rates– Learning Hub information shared and signposted

Core Skills Training

Current Position

From April 2016, the core mandatory training has been replaced by a core skills framework consisting of eleven mandatory training subjects. Training is via a new suite of e-learning modules and knowledge assessments on the learning hub. The threshold has been set at 80% for all areas except Information Governance which has a threshold of 95%

All of the eleven areas are currently above target for training compliance, with the exception of two modules which are currently below the threshold 'Basic Life Support' (77%) and 'Information Governance' (86%).

The Trust's mandatory training programme was audited by the Mersey Internal Audit Agency in October 2016, following previous reviews in 2013/14 & 2014/15, which had given a limited assurance opinion. The report gave a 'Significant Assurance' for the learning system but a 'Limited Assurance' of the mandatory training compliance levels. An action plan to address the findings and recommendations from this audit has been developed. Progress against the action plan is being monitored by the Trust's Audit Committee.

Table 5 – Core Skills Training Compliance –March 2017

	Target	Compliance at end March 17
Basic Life Support	80%	77
Conflict Resolution Training Level 1	80%	93
Equality, Diversity and Human Rights	80%	94
Fire Safety	80%	86
Health, Safety and Welfare Level 1	80%	89
Infection Prevention	80%	89
Information Governance	95%	86
Prevent Healthwrap	80%	81
Safeguarding Adults	80%	84
Safeguarding Children	80%	88
Safer Handling Theory	80%	92

Risks

Divisions are reporting difficulties in accessing basic life support classroom training due to sessions being fully booked. This has been recognised by the Clinical Activities Support Team who are looking at increasing the capacity and number of sessions available. Staff are also able to access this training through a cascade trainer in their ward/department where available.

There are also some difficulties in releasing staff for training due to staffing levels.

Forecast Position

Continued achievement of target for the compliant modules and compliance is expected to be achieved in the two areas below target.

Actions

There has been a range of Trust wide actions to support compliance as reported previously, which are on-going. In addition, the divisions have developed their own action plans as follows:

Divisional

- Compliance rates reported and monitored through divisional and directorate management meetings.
- Managers to invoke the managing performance or pay progression policy on non-compliance.
- Circulation list of 'non-compliant' staff to managers
- Analysis of low compliance directorates
- Targeted support for low compliance directorates.

Financial Position (F1-F15)

Executive summary

1. The Trust is reporting achievement of its control total for the financial year 2016-17. Once confirmation of the STF incentive monies has been received, we are likely to achieve of minimum of a £1.5m surplus.
2. This is a further improved position from that reported in February 2017 and reflects the continued achievement of our financial targets this year, through our divisional recovery plans, the impact of a change to accounting for annual leave and the resulting impact of the finance incentive scheme, announced during

January 2017. It is important to reflect also that this has been achieved whilst the Trust has been under significant operational pressures.

3. The annual SRCP target of £14.0m was achieved in full in year, with £14.2m of savings (£10.4m being on a recurrent basis with £3.8m being carried forward into the 2017-18 financial year).
4. We have met all 4 Better payment practice code targets in year.
5. Our Finance and Use of Resources Metrics remains at a 2, an improvement to our planned score of 3, (1 being the best level of performance and 4 being in financial special measures).

STF Finance Incentive Scheme

6. As previously communicated, the Trust will benefit from the new 'STF Finance Incentive scheme' where for every £1 improvement to a Trusts control total, NHS Improvement will match fund this, in cash, to the Trust on the understanding that it will be used to improve the Trusts outturn position and, in turn, improve our cash position going into 2017-18.
7. Table 6 below shows the movement in our financial outturn and our current likely final position. A number of issues have resulted in this improvement, these being:
   i. Initially we assumed we would lose £1.2m of STF funding related to our 4 hour standard performance. We worked to bridge this gap internally so that we could maintain our cash balances, in effect improving our underlying financial performance in year.
   ii. In January, incentive funding was introduced which would match our £1.2m improvement.
   iii. In February we reported that our annual leave accrual (£1.3m) would be released and matched by the Finance incentive STF funding resulting in a forecast breakeven position.
   iv. Towards the end of March we were then notified that our appeal in relation to the 4 hour performance STF funding had been upheld for qtr 3 (rejected at qtr 2), a further improvement of £390,000.
   v. For qtr 4, STF guidance was changed to be paid on achievement of the financial control total only. Again a further improvement for the Trust of £390,000.
   vi. During 2016-17, we saw an unplanned financial pressure relating to a national change in discount rates for provisions. This resulted in a cost to us

of £471,000. In March, NHSI announced that for Trusts that had managed this pressure internally, they would match fund this also with incentive funding, a further gain to us of £471,000.

vii. Finally we exceeded our planned target by £0.1m which is likely to be matched by the NHSI Finance Incentive scheme.

viii. NHSI have announced that there may be a further bonus payment for Trusts who have achieved their financial position. We will be notified of this figure on the 24th April 2017, at which point our financial position may improve further.

Table 6 – Movement from the initial plan to outturn

	£m	
2016-17 Planned Control Total	**-16.2**	**deficit**
Planned STF Funding - non recurrent	12.5	
2016-17 Planned Outturn	-3.7	deficit
Anticpated loss of NHSI Core STF A&E Access standard	-1.2	
Internal decision to improve our financial position to cover	1.2	
NHSI Finance incentive STF to match improved financial performance	1.2	
Release of the annual leave accrual	1.3	
NHSI Finance incentive STF to match the release of the annual leave accrual	1.3	
Planned Revised Control total at 28th February 2017	**0**	**breakever**
NHSI Core STF - Q3 A&E Access Standard	0.4	
NHSI Core STF - Q4 Control total standard	0.4	
NHSI Finance Incentive STF - change in the discount rate	0.5	
Increased surplus	0.1	
NHSI Finance incentive STF to match the increased surplus	0.1	
2016-17 Actual Outturn	**1.5**	**surplus**

Finance and Use of Resources metrics (Chart 1)

8. Our planned metrics score of 3 for the year represented a potential support need for the Trust in relation to its financial position. We have seen an improved working capital position year as a result of our improved financial position and some slippage on our capital schemes which means that an overall score of 2 has been achieved for the year. However, agency spend continues as the only metric behind plan, with performance for the year 43% above the ceiling set.
9. While liquidity days are expected to fall at year end, our breakeven forecast means that an overall score of 2 has been maintained at year end.

2016-17 Divisional performance

10. The divisional performance to the 31st March 2017 is shown in Chart 6 and Chart 7.
11. Cumulatively to the end of month 12 the Trust's clinical divisions have a net overspend of £5.6m (previous month £5.3m), with overspends against the non-achievement of the SRCP of £0.3m (previous month £0.4m). This has been off-set by an improvement in the non-clinical position.

Agency expenditure

12. Agency staffing spend for month 12 was £1.3m, taking it to a cumulative total of £15.0m over the 12 months, an improvement of £500,000 on our forecast position. Overall we have exceeded our external agency spend target of £10.5m by £4.5m. We have continued to reduce our administration agency and are working towards zero tolerance for the use of agency for any non-clinical posts including health care assistants.
13. The 2017-18 target is £13.0m, a reduction of £2m.

Income

14. The Trust's final position agreed with our host and associate commissioners shows a cumulative over performance of £3.2m. The Trusts actual month 12 activity shows a high activity month with an increase of £1.7m. For the full year, we have finished close to the final position agreed with our commissoners. An analysis of the Trusts performance by POD shows an improved position in day case and elective activity, outpatient activity, non-elective activity and adult critical care. The main area behind plan in month 12 is Rehabilitation.

Safely Releasing Cost Programme (SRCP)

15. The Trust has identified £14.2m schemes against the annual £14.0m SRCP target (101%). £3.8m of this will be carried forward as a pressure into 2017-18. Table 7 shows the breakdown by Division for 2016-17 and 2017-18. The position is reported in further detail in the Sustaining Safe, Personal and Effective Transformation paper.

STATEMENT OF FINANCIAL POSITION (SOFP)

Summary

16. Overall the total assets employed at the end of the reporting period are £175.9m which is an increase of £8.1m, largely as a result of the £1.0m in-month retained surplus and £5.8m of revaluation adjustments. In line with our accounting polices, we undertook a desktop valuation to reflect changes to indices at the end of the year, hence the revaluation impact.

Non-Current Assets, including Capital Expenditure

17. The value of non-current assets has increased by £8.6m to £294.5m, mainly as a result of the revaluation adjustments and £4.2m of capital expenditure. The Trust has invested £12.3m in capital during 2016/17, which equates to the targeted level of 85% of planned expenditure.
18. The Trust has invested £8.9m in capital in 2016-17 plus the PFI expenditure resulting in £12.3m expenditure against a plan of £14.4m which represents 85% of the planned expenditure for the financial year.

Current Assets

19. The value of current assets at the end of the reporting month equates to £44.4m, an increase of £0.5m in month. There has been an increase in cash of £7.4m, although this is largely offset by a £7.1m reduction in trade and other receivables. System debt has fallen by £7.0m with NHS debt falling by more than 50% to £5.9m. Within this overall movement, there have been similar reductions in NHS debt not yet due, as well as NHS debt overdue by less than and more than 90 days. It is pleasing to report that these reductions include a £1.0m fall in the level of debt with both of the Trust's two main commissioners.
20. The only other significant change to receivables is the elimination of the £1.5m prepayment to NHSLA, which was reported last month. As a result of these changes, there has been a small reduction in impairment provisions and total net debt overdue by more than 90 days has fallen from 49.7% to 38.5%.

Liabilities

21. Current liabilities have reduced by £0.6m, largely due a reduction in NHS revenue payables. Current liabilities have reduced by £0.6m with increases in capital and NHS related payables largely offset by a £4.4m reduction in non-NHS revenue related payables. The increase in capital creditors is in line with expectations given the level of expenditure incurred this month with the remaining increase

largely attributable to a £1.1m increase in deferred income. The main reason for the reduction in non-NHS creditors is a £1.2m reduction in the PDC dividend accrual following payment of the second instalment in March and the removal of the annual leave accrual. The long term element of the PFI liability, which is the main component of non-current liabilities, has decreased by £0.3m.

Better Payment Practice Code (BPPC)

22. The Trust has achieved all four BPPC targets for the year.

Conclusion

23. It is pleasing to note that despite the considerable operational pressure being experienced by the Trust, the Trust has exceeded its financial control total as a result of our recovery plans, Core STF funding and the Finance Incentive STF funding.

Charts

Chart 1 - Finance and Use of Resources metrics

Area	Metric		Actual YTD Performance	Score	Forecast outturn Performance	Score
Financial sustainability	Capital service capacity		1.6	3	1.6	3
	Liquidity (days)		(6.3)	2	(9.4)	3
Financial efficiency	I&E margin		0.3%	2	0.0%	2
Financial control	Distance from financial plan		1.1%	1	0.0%	1
	Agency spend		43.0%	3	(100.0%)	1
Total				2		2

Metric	Definition	Weighting	Scoring 1	2	3	4 [1]
Capital service capacity	Degree to which the provider's generated income covers its financial obligations	20%	> 2.5x	1.75 - 2.5x	1.25 - 1.75x	< 1.25x
Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	20%	> 0	(7) - 0	(14) - (7)	< (14)
I&E margin	I&E surplus or deficit / total revenue	20%	> 1%	1% - 0%	0% - (1%)	<=(1%)
Distance from financial plan	Year-to-date actual I&E surplus / deficit in comparision to year-to-date plan I&E surplus / deficit	20%	>= 0%	(1%) - 0%	(2%) - (1%)	<=(2%)
Agency spend	Distance from provider's cap	20%	<= 0%	0% - 25%	25% - 50%	> 50%

Chart 2 - Break Even Duty

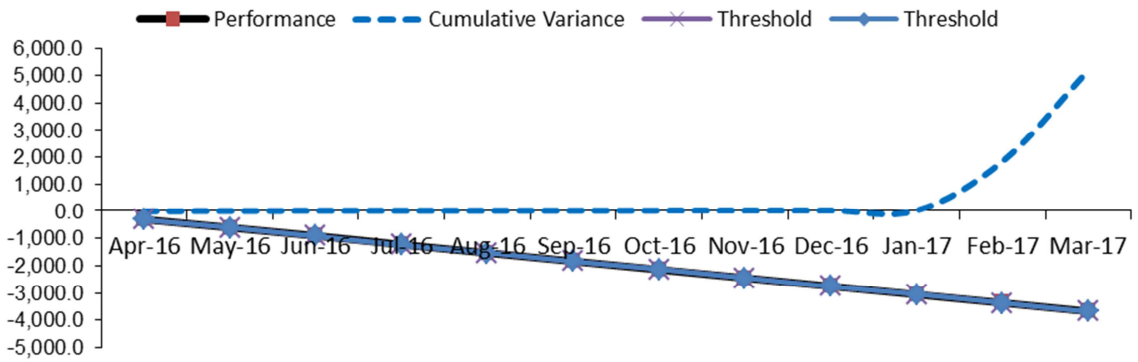


Chart 3 - Income and Expenditure variances

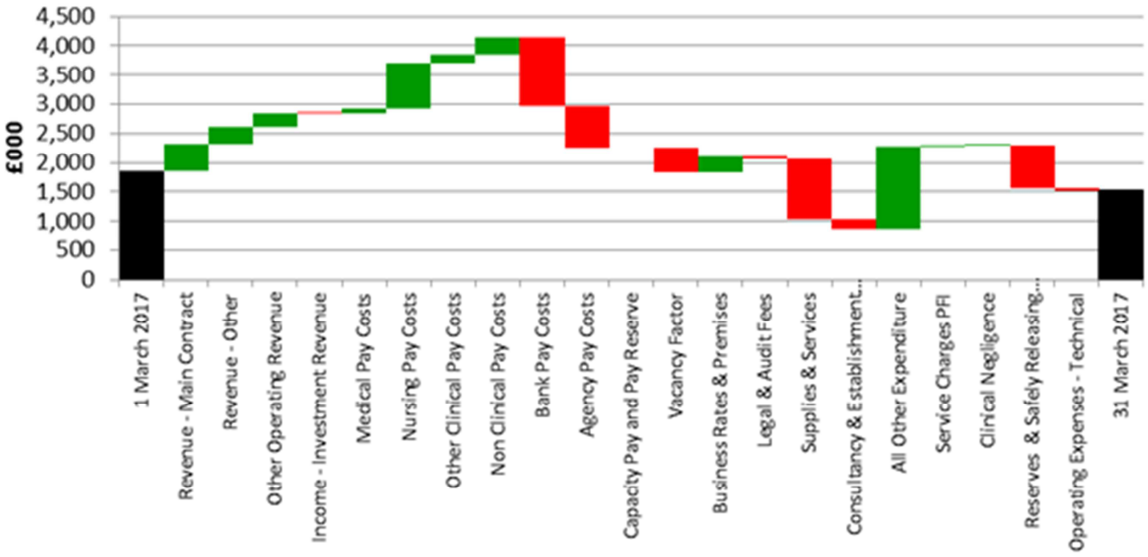


Chart 4 – Better Payment Practice Code (BPPC)

	Performance Target %	Actual in month	Actual YTD	Comments
Non NHS - No. of invoices	95.0%	96.4%	96.7%	Meeting target
Non NHS - Value of invoices	95.0%	96.2%	96.7%	Meeting target
NHS - No. of invoices	95.0%	93.2%	95.8%	Meeting target
NHS - Value of invoices	95.0%	96.7%	98.6%	Meeting target

Chart 5 – Total Trust Savings

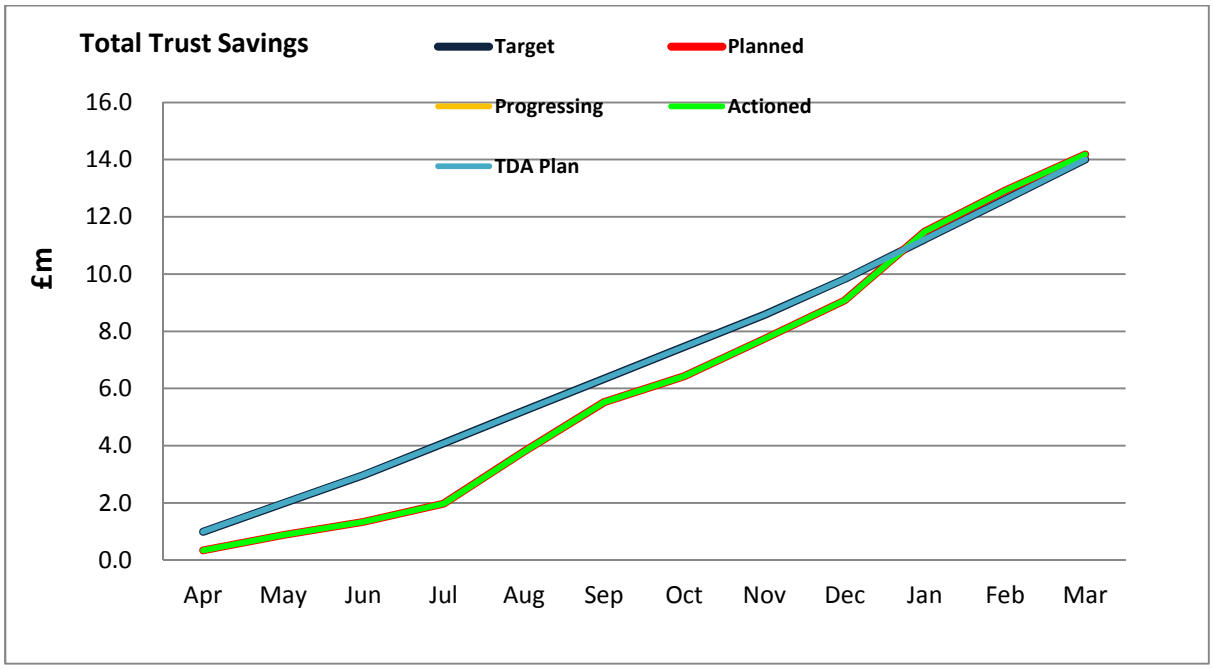


Chart 6 - Statement of Comprehensive Income by Division to 31st March 2017

	In Month			Annual Budget	In Month			Cumulative		
	Est Funded	Wte Worked	Wte Contracted	£000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Income										
Revenue from Patient Care Activities - Main Contract				427,734	36,252	36,728	476	427,734	428,225	491
Revenue from Patient Care Activities - Other				6,272	(1,772)	(1,476)	296	6,272	6,370	98
Other Operating Revenue				40,475	6,934	7,167	233	40,475	41,298	824
Total Income				**474,480**	**41,415**	**42,419**	**1,004**	**474,480**	**475,893**	**1,413**
Expenditure										
Clinical Divisions										
Integrated Care Group	2,324.0	2,515.9	2,052.1	(115,861)	(10,266)	(10,657)	(391)	(115,861)	(117,122)	(1,261)
Surgery and Anaesthetic Services	1,610.0	1,686.2	1,467.9	(93,299)	(8,268)	(8,694)	(426)	(93,299)	(97,512)	(4,214)
Diagnostic and Clinical Support	1,583.1	1,515.9	1,502.3	(100,617)	(9,783)	(9,614)	169	(100,617)	(99,610)	1,007
Family Care Division	994.7	988.2	897.7	(57,928)	(4,898)	(5,101)	(204)	(57,928)	(60,100)	(2,172)
Sub Total	**6,511.8**	**6,706.1**	**5,919.9**	(367,705)	(33,214)	(34,066)	(852)	(367,705)	(374,344)	(6,640)
Non-Clinical Divisions										
Estates and Facilities	717.8	728.1	655.5	(37,827)	(3,043)	(2,965)	79	(37,827)	(37,351)	477
Corporate Services	515.8	499.7	499.3	(37,284)	(3,831)	(3,517)	315	(37,284)	(35,839)	1,445
Research and Development	0.0	32.4	33.5	(1,489)	(60)	(60)	(0)	(1,489)	(1,489)	0
Reserves	0.0	0.0	0.0	(8,623)	4,371	3,545	(826)	(8,623)	0	8,623
Total Expenditure	**7,745.4**	**7,966.4**	**7,108.1**	**(452,928)**	**(35,777)**	**(37,062)**	**(1,285)**	**(452,928.30)**	**(449,023)**	**3,905**
EBITDA : Earnings before interest, taxation, depreciation and amortisation				**21,552**	**5,638**	**5,357**	**(280)**	**21,552**	**26,870**	**5,318**
Depreciation				(10,290)	(701)	(736)	(35)	(10,290)	(10,325)	(35)
Amortisation				(1,603)	(276)	(276)	0	(1,603)	(1,603)	0
Impairments				230	0	0	0	230	230	(0)
Investment Revenue				256	21	10	(12)	256	168	(88)
Other Gains and (Losses)				(54)	0	0	0	(54)	(54)	0
Finance Costs				(9,097)	(760)	(761)	(1)	(9,097)	(9,097)	(0)
Dividends payable on Public Dividend Capital (PDC)				(4,483)	(488)	(488)	(0)	(4,483)	(4,483)	0
Retained (deficit) for the year				**(3,488)**	**3,434**	**3,106**	**(328)**	**(3,488)**	**1,707**	**5,195**
Other Adjustments for break-even duty										
Donated asset reserve elimination				42	(68)	(68)	1	42	43	1
Non IFRIC12 (Impairments)/ Impairment reversals				(230)	0	0	0	(230)	(230)	0
IFRIC12 (Impairments)/ Impairment reversals				0	0	0	0	0	0	0
Retained (deficit) for Break-even duty				**(3,676)**	**3,365**	**3,038**	**(327)**	**(3,676)**	**1,520**	**5,196**

Chart 7 - Financial Position by Divisional Variances to 31st March 2017

Division / Directorate	Cumulative Variance						
	WTE Variance	Income	Pay	Non-Pay	SRCP	Expenditure	Total
		£000	£000	£000	£000	£000	£000
Integrated Care Group	(115)	(195)	(3,791)	2,137	783	(870)	**(1,065)**
Surgery and Anaesthetic Services	(46)	49	(1,438)	(1,306)	(1,043)	(3,787)	**(3,738)**
Diagnostic and Clinical Support	77	586	108	606.7148	123	838	**1,424**
Family Care Division	35	(6)	(761)	(987)	(221)	(1,968)	**(1,974)**
Sub-total Clinical Divisions	**(49)**	**434**	**(5,881)**	**451**	**(358)**	**(5,788)**	**(5,354)**
Estates and Facilities	10	(254)	228	214	(43)	398	**144**
Chief Executive	(19)	6	(15)	(78)	45	(49)	**(43)**
Finance, Informatics and Procurement	13	38	799	(894)	540	444	**483**
HR and OD	5	148	451	197	(105)	543	**691**
Clinical Care & Governance	4	0	180	12	0	192	**192**
Reserves	0	36	0	5,663	0	5,663	**5,700**
Research and Development	0	(0)	(0)	0	0	0	**0**
Sub-total Non-Clinical Divisions	**12**	**(26)**	**1,642**	**5,114**	**436**	**7,192**	**7,166**
Subtotal	**(37)**	**409**	**(4,240)**	**5,565**	**78**	**1,404**	**1,812**
Depreciation	0	0	0	(0)	0	(0)	**(0)**
Amortisation	0	0	0	(0)	0	(0)	**(0)**
(Impairments)/Reversal of Impairments	0	0	0	(0)	0	(0)	**(0)**
Investment Revenue	0	(77)	0	0	0	0	**(77)**
Other Gains and (Losses)	0	0	0	0	0	0	**0**
Finance Costs	0	0	0	1	0	1	**1**
Dividends payable on Public Dividend Capital (PDC)	0	0	0	0	0	0	**0**
Sub-total before Impairments	**(37)**	**332**	**(4,240)**	**5,566**	**78**	**1,405**	**1,737**
Other Adjustments for break-even duty						0	**0**
Donated asset reserve elimination	0	0	0	0	0	0	**0**
Non IFRIC12 (Impairments)/ Impairment reversals	0	0	0	0	0	0	**0**
IFRIC12 (Impairments)/ Impairment reversals	0	0	0	0	0	0	**0**
Retained Surplus / (Deficit) for Break-even duty	**(37)**	**332**	**(4,240)**	**5,566**	**78**	**1,405**	**1,737**
Planned Deficit	0	0	0	110	0	110	**110**
Total including planned deficit	**(37)**	**332**	**(4,240)**	**5,677**	**78**	**1,515**	**1,847**

Chart 8 - Expenditure analysis to 31st March 2017

	In Month			Annual	In Month			Year to date		
	Est Funded	Wte Worked	Wte Contracted	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Pay Expenditure										
Registered Nursing, Midwifery & HV	2,495.5	2,230.4	2,306.0	102,672	8,316	7,569	747	102,672	92,068	10,604
Scientific, Therapeutic & Technical	887.3	829.8	847.6	36,533	2,900	2,777	123	36,533	34,409	2,125
Support to clinical staff - AHP	1,009.2	953.4	995.5	24,256	1,889	1,871	18	24,256	24,000	256
Support to clinical staff - Nursing	308.9	286.3	287.5	7,271	571	548	23	7,271	6,928	343
NHS Infrastructure Support staff	2,246.4	2,091.3	2,134.3	61,380	4,883	4,582	301	61,380	56,736	4,644
Consultants	288.7	274.5	271.6	41,114.6	3,441.1	3,394.9	46	41,115	39,830	1,284
Career and Staff Grades	165.3	131.0	127.6	12,179.9	1,103.5	928.0	176	12,180	11,126	1,054
Trainee Grades	330.4	330.7	137.0	18,600.2	1,586.1	1,710.4	(124)	18,600	18,173	427
Bank - Nursing	0.8	130.9	0.0	784.6	199	515	(316)	785	3,956	(3,171)
Bank - Support to Clinical Staff - AHP	1.4	365.0	0.0	1,203.2	232	812	(580)	1,203	5,852	(4,649)
Bank - NHS Infrastructure Support staff	0.0	137.2	0.0	190.6	25	295	(270)	191	2,594	(2,404)
Bank - Scientific, Therapeutic & Technical	0.0	7.5	0.0	(0.1)	0	22	(22)	(0)	123	(124)
Agency - Nursing Qualified	1.2	116.6	0.0	995	186	665	(479)	995	5,335	(4,340)
Agency - Other Clinical	0.1	20.4	0.0	495	77	50	27	495	2,095	(1,600)
Agency - Non Clinical	(0.3)	7.8	0.0	186	26	20	5	186	269	(83)
Agency - Medical and Dental	10.6	53.5	0.0	2,644	264	528	(264)	2,644	7,332	(4,688)
Capacity Pay and Pay Reserve	0.0	0.0	0.0	0	0	0	0	0	0	0
Vacancy Factor	0.0	0.0	0.0	(4,917)	(409)	0	(409)	(4,917)	0	(4,917)
Total Pay Expenditure	**7,745.4**	**7,966.4**	**7,107.1**	**305,588.3**	**25,289.4**	**26,288.0**	**(998.5)**	**305,588.3**	**310,826.3**	**(5,238.0)**
Non-Pay Expenditure										
Purchase of Healthcare Non-NHS				649	56	55	2	649	917	(268)
Supplies & Services Clinical				69,191	7,032	8,027	(995)	69,191	72,397	(3,206)
Supplies & Services General				5,776	582	607	(25)	5,776	6,052	(276)
Consultancy Services				258	38	137	(99)	258	535	(277)
Establishment				5,970	545	616	(71)	5,970	5,880	90
Transport				2,112	254	254	(0)	2,112	2,213	(101)
Service Charges PFI				6,419	534	512	22	6,419	6,396	23
Business Rates				2,496	(96)	(12)	(84)	2,496	2,543	(48)
Premises				17,565	1,755	1,399	356	17,565	16,952	613
Hospitality				(5)	(2)	1	(3)	(5)	6	(11)
Legal Fees				676	90	92	(2)	535	557	(23)
Audit Fees				78	18	66	(48)	219	230	(11)
Clinical Negligence				18,159	1,513	1,513	0	18,159	18,159	0
Education and Training				991	122	215	(93)	991	832	159
All Other Expenditure				8,179	2,377	872	1,505	8,179	4,477	3,702
Research & Development				49	(36)	(36)	(0)	49	49	0
Total Non-Pay Expenditure				**138,563**	**14,783**	**14,319**	**464**	**138,563**	**138,197**	**366**
Reserves & Safely Releasing Cost Programme				8,735	(4,295)	(3,545)	(750)	8,777	0	8,777
Total Expenditure including Reserves & Red Rated saving scheme's				**452,886**	**35,777**	**37,062**	**(1,285)**	**452,928**	**449,023**	**3,905**
Operating Expenses - Technical				25,526	2,225	2,261	(36)	25,296	25,331	(35)
Total Expenditure				**478,412**	**38,002**	**39,323**	**(1,320)**	**478,224**	**474,354**	**3,870**

Chart 9 - Agency Staffing Costs

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Agency 1617 outturn
													£000
Medical staff													
Consultants	200	211	238	220	323	288	229	270	228	158	138	167	2,670
Career and staff grades	78	99	308	263	331	258	320	357	289	345	345	336	3,329
Trainee Grades	311	185	18	94	43	116	86	168	133	98	56	26	1,334
Total Medical	**589**	**495**	**564**	**577**	**697**	**662**	**635**	**795**	**650**	**601**	**539**	**529**	**7,333**
Nursing staff													0
Qualified	248	236	246	282	443	560	511	495	610	498	541	665	5,335
Unqualified	74	87	134	186	231	177	150	40	36	36	34	33	1,217
Total Nursing	**322**	**323**	**380**	**468**	**674**	**737**	**661**	**535**	**646**	**534**	**575**	**698**	**6,552**
Other Clinical/Scientific													0
AHP	132	119	109	80	-22	85	64.5	105	0	-47	-23	-3	599
Scientific	13	22	27	36	34	18	42	20	19	23	6	19	278
Unqualified clinical / scientific	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Other Clinical	**145**	**141**	**136**	**116**	**12**	**103**	**107**	**125**	**19**	**-24**	**-17**	**16**	**877**
Total Clinical	**1056**	**959**	**1080**	**1161**	**1383**	**1502**	**1402**	**1455**	**1315**	**1111**	**1096**	**1243**	**14,762**
Non Clinical													0
Administrative and clerical	39	12	29	6	-5	-8	-3	12	-4	-110	1	-1	-32
Estates	0	0	0	0	0	1	5	3	0	0	0	1	10
Managerial	23	25	21	42	33	17	21	19	1	29	11	19	262
Other	11	4	10	12	-4	0	-6	0	1	1	0	1	29
Total Non clinical	**73**	**41**	**60**	**60**	**24**	**10**	**17**	**34**	**-2**	**-80**	**12**	**20**	**269**
Grand Total	**1129**	**1000**	**1139**	**1221**	**1407**	**1512**	**1419**	**1489**	**1313**	**1031**	**1109**	**1263**	**15,031**

Chart 10 - Statement of Financial Position as at 31st March 2017

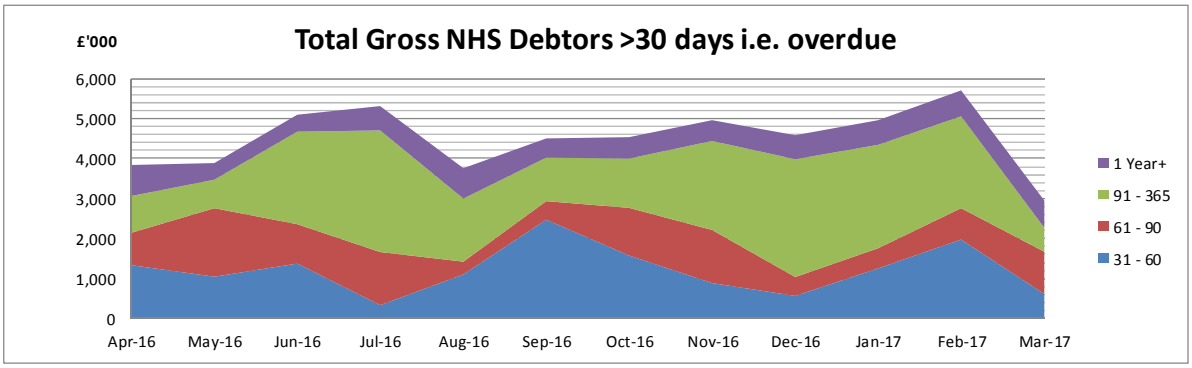
	Year to date movement			In Month		Year end
	Closing 31st March 2016	As at 31 March 2017	Year to date Movement	Prior Month	In-month Movement	Forecast
	£000	£000	£000	£000	£000	£000
Non-Current Assets:						
Property, Plant And Equipment	282,650	288,842	6,192	280,974	7,868	285,287
Intangible Assets	4,605	4,263	(342)	3,567	696	4,605
Trade And Other Receivables	1,172	1,182	10	1,363	(181)	1,172
Total Non-Current Assets	**288,427**	**294,287**	**5,860**	**285,904**	**8,383**	**291,064**
Current Assets:						
Inventories	2,450	2,442	(8)	2,173	269	2,450
Trade And Other Receivables	21,021	18,523	(2,498)	25,662	(7,139)	21,021
Cash And Cash Equivalents	32,165	23,423	(8,742)	16,036	7,387	25,933
Total Current Assets	**55,636**	**44,388**	**(11,248)**	**43,871**	**517**	**49,404**
Total Assets	**344,063**	**338,675**	**(5,388)**	**329,775**	**8,900**	**340,468**
Current Liabilities:						
NHS Trade Payables	(3,042)	(7,823)	(4,781)	(5,686)	(2,137)	(3,042)
Non-NHS Revenue Payables	(45,071)	(32,873)	12,198	(37,306)	4,433	(45,108)
Non-NHS Capital Payables	(4,963)	(3,362)	1,601	(632)	(2,730)	(4,963)
Borrowings / DH Loan	(200)	(200)	0	(200)	0	(200)
Other Financial Liabilities - PFI	(3,347)	(3,194)	153	(3,219)	25	(3,202)
Provisions For Liabilities And Charges	(229)	(1,097)	(868)	(907)	(190)	(914)
Total Current Liabilities	**(56,852)**	**(48,549)**	**8,303**	**(47,950)**	**(599)**	**(57,429)**
Net Current Assets/(Liabilities)	**(1,216)**	**(4,161)**	**(2,945)**	**(4,079)**	**(82)**	**(8,025)**
Total Assets Less Current Liabilities	**287,211**	**290,126**	**2,915**	**281,825**	**8,301**	**283,039**
Non-Current Liabilities						
Borrowings / DH Loan	(1,600)	(1,400)	200	(1,400)	0	(1,400)
Other Financial Liabilities - PFI	(111,867)	(108,445)	3,422	(108,718)	273	(108,437)
Provisions For Liabilities And Charges	(4,575)	(3,880)	695	(3,896)	16	(3,904)
Total Non-Current Liabilities	**(118,042)**	**(113,725)**	**4,317**	**(114,014)**	**289**	**(113,741)**
Total Assets Employed	**169,169**	**176,401**	**7,232**	**167,811**	**8,590**	**169,298**
Financed By Taxpayers Equity						
Public Dividend Capital	174,173	174,214	41	174,214	0	174,214
Retained Earnings	(44,932)	(40,277)	4,655	(46,332)	6,055	(44,844)
Revaluation Reserve	39,928	42,462	2,534	39,929	2,533	39,928
Total Taxpayers Equity	**169,169**	**176,399**	**7,230**	**167,811**	**8,588**	**169,298**

Chart 11 - Statement of Cash Flows as at 31st March 2017

Cash Flow Statement	As at 31st March 2016 £000	Previous month £000	As at 31 March 2017 £000	Forecast £000
Operating Activities				
Operating Surplus/(Deficit)	18,011	10,828	15,173	12,060
Depreciation and amortisation	9,878	10,915	11,927	11,846
Impairments and reversals	3,096	(230)	(230)	(230)
Donated assets received credited to revenue but non cash	(192)	(117)	(214)	(140)
Interest paid	(8,611)	(8,380)	(9,145)	(9,048)
Dividend paid	(5,682)	(1,702)	(3,432)	(4,393)
(Increase) in inventories	(202)	277	8	0
Decrease/(Increase) in trade and other receivables	(6,573)	(7,824)	(776)	(3,264)
(Decrease)/Increase in trade and other payables	3,752	(7,413)	(8,467)	0
(Decrease)/Increase in provisions	1,311	43	221	(34)
Net cash inflow from Operating Activities	**14,788**	**(3,603)**	**5,065**	**6,797**
Cash Flows from Investing Activities				
Interest received	178	158	168	256
(Payments) for property, plant and equipment	(7,447)	(9,090)	(9,120)	(9,617)
Proceeds from disposal of property, plant and equipment	137	130	140	130
(Payments) for intangible assets	(129)	(288)	(1,261)	(1,411)
Proceeds from disposal of intangible assets	0	0	0	0
(Payments) for investment with DH	0	0	0	0
(Payments) for other financial assets	0	0	0	0
Proceeds from disposal investment with DH	0	0	0	0
Proceeds from disposal of other financial assets	0	0	0	0
Net cash outflow from Investing Activities	**(7,261)**	**(9,090)**	**(10,073)**	**(10,642)**
Net cash inflow before Financing	**7,527**	**(12,693)**	**(5,008)**	**(3,845)**
Cash Flows from Financing Activities				
Public dividend capital received	30	41	41	41
Public dividend capital repaid	(3,700)	0	0	0
New capital investment loans	0	0	0	0
Other capital receipts	0	0	0	0
Capital investment loans repayment of principal	(850)	(200)	(200)	(200)
Capital element of finance lease and PFI	(1,826)	(3,277)	(3,575)	(3,575)
Net cash outflow from Financing Activites	**(6,346)**	**(3,436)**	**(3,734)**	**(3,734)**
Decrease in cash	**1,181**	**(16,129)**	**(8,742)**	**(7,579)**
Cash at the beginning of the year	**30,984**	**32,165**	**32,165**	**32,165**
Cash at the end of the financial period	**32,165**	**16,036**	**23,423**	**24,586**

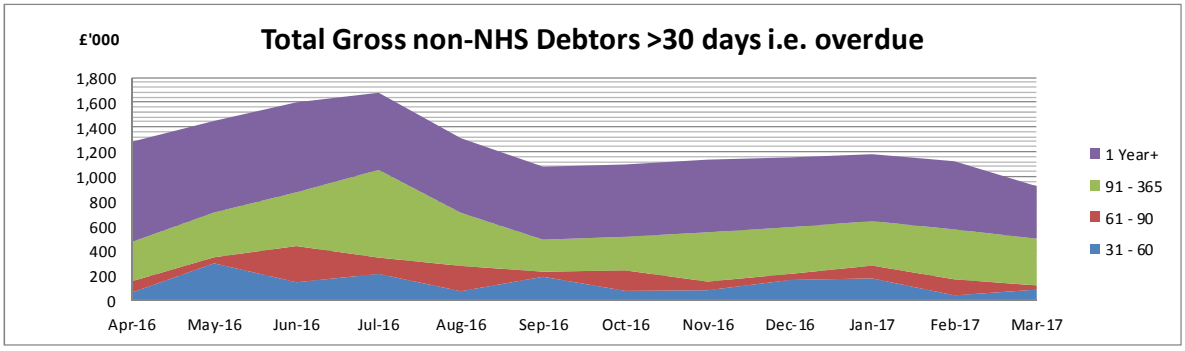
Chart 12 - Debtors Report as at 31st March 2017

Gross debtors	Not Due	No. of days overdue				Total overdue debt	
	0 - 30	31 - 60	61 - 90	91 - 365	1 Year+	M12	M11
	£'000	£000	£000	£000	£000	£000	£000
NHS	2,988	613	1,056	603	680	2,952	5,703
% of total debt	50.3%	10.3%	17.8%	10.2%	11.4%		
Non-NHS	682	83	35	377	424	919	1,122
% of total debt	42.6%	5.2%	2.2%	23.5%	26.5%		
Total gross debtors	**3,670**	**696**	**1,091**	**980**	**1,104**	**3,871**	**6,825**



Top five NHS Gross Debtors by value	No of	No. of days overdue				Total overdue debt	
		31 - 60 £'000	61 - 90 £'000	91 - 365 £'000	1 Year+ £'000	M12 £'000	M11 £'000
Blackburn with Darwen CCG	12	5	628	47	0	**680**	1,671
East Lancashire CCG	14	263	37	44	6	**350**	1,375
Nhs England - Y54 - Cheshire & Mersey - Q75	31	38	16	293	249	**596**	558
Central Manchester Univ Hospital Ft	8	0	287	6	114	**407**	478
Nhs England	9	0	0	0	252	**252**	252
Balance	197	307	88	213	59	**667**	1,264
Total Gross Debtors	**271**	**613**	**1,056**	**603**	**680**	**2,952**	**5,703**

The overdue balance includes debt with NHS England North West Commissioning Hub which has reduced in month from £357K to £12K.



Top five non-NHS Gross Debtors by value	No of	No. of days overdue				Total overdue debt	
		31 - 60 £'000	61 - 90 £'000	91 - 365 £'000	1 Year+ £'000	M12 £'000	M11 £'000
Blackburn With Darwen Borough Council	28	(2)	3	12	149	**162**	285
Acces to Work	5	0	0	23	0	**23**	23
Burnley College	2	0	0	55	0	**55**	55
Graham Curran	1	0	0	0	40	**40**	40
Stanley Moody	2	0	0	22	0	**22**	22
Balance	1,276					**617**	637
Total Gross Debtors	**1,314**	**83**	**35**	**377**	**424**	**919**	**1,062**

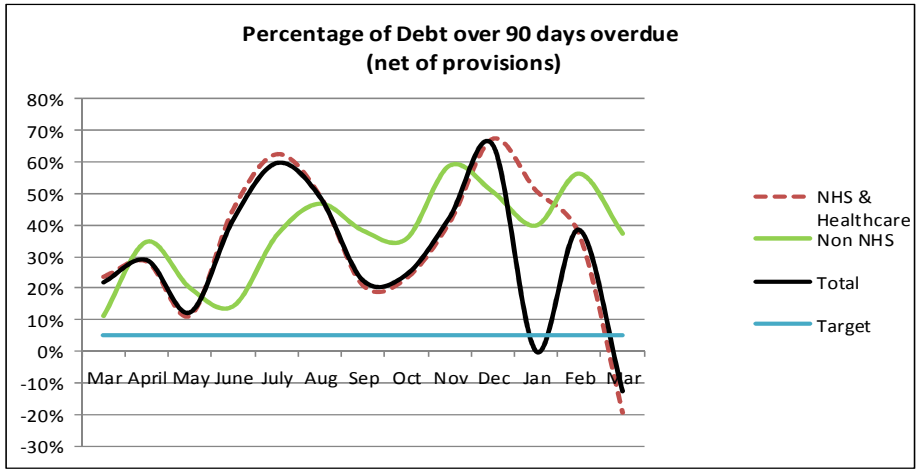
Chart 13 - Debtors Report as at 31st March 2017

NHS	M12 2016-17 £	M11 2016-17 £
NHS debtors overdue	2,952,028	5,703,119
Over 90 days	1,282,986	2,942,390
% debt over 90 days	43.46%	51.59%
Total provision *	(1,554,064)	(1,325,128)
Total NHS debt after provision	1,397,964	4,377,991
Net debt over 90 days	**(271,078)**	**1,617,262**
Net % NHS debt over 90 days	**-19.39%**	**36.94%**
NHS memorandum items		
Credit notes >90 days	22	22

Non NHS	M12 2016-17 £	M11 2016-17 £
Non NHS debt overdue	918,641	1,121,371
Over 90 days	800,663	955,616
% debt over 90 days	87.16%	85.22%
Total provision *	(730,393)	(741,780)
Total Non NHS debt after provision	188,248	379,591
Net debt over 90 days	**70,270**	**213,836**
Net % Non NHS debt over 90 days	**37.33%**	**56.33%**
Non NHS memorandum items		
Awaiting write off	(5,027)	(5,027)
Paying installments	(151,577)	(144,326)

Total		
Total debt after provisions	1,586,212	4,757,582
Total debt overdue by 90 days after provisions	(200,808)	1,831,098
% Net debt over 90 days	**-12.66%**	**38.49%**

* The Trust only provides for specific debt overdue by less than 90 days.



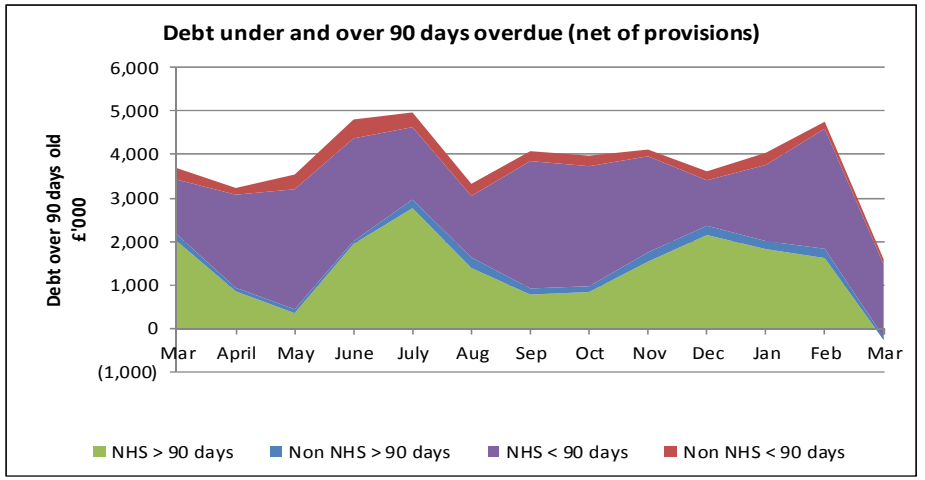


Chart 14 - Capital Spend as at 31st March 2017

Scheme	Annual Plan Opening Plan £'000	Annual Plan Adjustments to Plan £'000	Annual Plan Revised Plan £'000	Actual/Forecast Actual spend to date £'000	Under/ (Over) Spend £'000
Total Building Infrastructure Schemes	5,759	(51)	5,708	3,622	2,086
Other Schemes	250	(50)	200	(12)	212
Total Maintenance and Statutory Compliance	250	0	250	154	96
Total Equipment	1,705	50	1,796	1,996	(200)
Total Information Technology	2,879	(200)	2,679	2,563	116
Total Fees	400	0	400	457	(57)
Donated Assets	100	0	100	214	(114)
Total Capital Expenditure (Non IFRIC 12)	**11,344**	**(251)**	**11,134**	**8,993**	**2,141**
Total PFI Life Cycle Costs	3,264	0	3,264	3,264	0
Charge against Capital Resource Limit including IFRS Impact	**14,608**	**(251)**	**14,398**	**12,257**	**2,141**

Capital Resource Limit (CRL)	
Capital Resource Limit (CRL)	
Allocation	10,136
PFI Allocation	3,264
PDC-Fibroscanner	41
Loan re IT	0
	0
TOTAL	**13,441**
Charge against CRL	
Capital Expenditure (Non IFRIC12)	8,993
Capital Expenditure (IFRIC12)	3,264
Less Donated Asset	(214)
Net Book Value of Asset disposals	(194)
TOTAL	**11,850**
(Over) / Under spend against Limit	**1,591**

Capital Expenditure Performance	**£'000**
Planned expenditure to 31st March 2017	14,398
Actual expenditure to 31st March 2017	12,257
% of plan achieved to date	**85%**

APPENDIX A – SCORECARD

Safe

		Threshold 16/17	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Monthly Sparkline
M64	CDIFF	28	1	2	1	2	3	4	1	5	5	4	2	3	2	0	
M64.1	Cdiff Cumulative from April	28	27	29	1	3	6	10	11	16	21	25	27	30	32	32	
M65	MRSA	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	
M66	Never Event Incidence	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	
M67	Medication errors causing serious harm (Steis reported date)	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	
C28	Percentage of Harm Free Care	92%	99.4%	99.1%	99.7%	98.8%	99.1%	99.4%	99.2%	99.1%	99.3%	99.2%	98.9%	99.1%	99.3%		
M68	Maternal deaths	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	99.3%	99.1%	99.1%	99.0%	99.0%	99.4%	99.1%	99.0%	99.0%	98.5%	98.4%	98.7%	98.4%	97.2%	
M69	Serious Incidents (Steis)		9	7	10	2	6	5	7	5	4	8	6	8	5	10	
M70	CAS Alerts - non compliance	0	0	0	0	0	0	0	1	2	0	0	0	0	0	0	
M146	Safer Staffing -Day-Average fill rate - registered nurses/midwives (%)	80%	89%	86%	88%	89%	87%	86%	85%	87%	90%	90%	90%	90%	89%	89%	
M147	Safer Staffing -Day-Average fill rate - care staff (%)	80%	105%	107%	110%	114%	116%	118%	126%	121%	123%	118%	112%	111%	114%	114%	
M148	Safer Staffing -Night-Average fill rate - registered nurses/midwives (%)	80%	97%	97%	97%	99%	98%	99%	98%	99%	101%	99%	97%	99%	99%	100%	
M149	Safer Staffing -Night-Average fill rate - care staff (%)	80%	120%	121%	124%	122%	129%	136%	142%	138%	134%	130%	122%	127%	128%	125%	
M150	Safer Staffing - Day -Average fill rate - registered nurses/midwives- number of wards <80%	0	12	19	16	11	17	15	21	21	9	5	5	7	11	6	
M151	Safer Staffing - Night -Average fill rate - registered nurses/midwives- number of wards <80%	0	0	0	0	0	0	0	0	0	0	0	0	0	1	3	
M152	Safer Staffing - Day -Average fill rate - care staff- number of wards <80%	0	4	3	2	0	1	1	0	1	1	1	3	4	1	1	
M153	Safer Staffing - Night -Average fill rate - care staff- number of wards <80%	0	2	3	2	1	1	1	1	1	1	1	2	1	1	1	

Caring

		Threshold 16/17	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Monthly Sparkline
C38	Inpatient Friends and Family - % who would recommend	92.07%	96.9%	98.4%	98.6%	97.9%	98.6%	98.5%	98.2%	98.4%	98.5%	97.7%	98.5%	98.1%	97.9%	97.0%	
C31	NHS England Inpatients response rate from Friends and Family Test		48.5%	50.1%	45.9%	54.0%	50.5%	47.7%	51.2%	43.3%	43.2%	40.8%	51.2%	53.2%	47.4%	47.0%	
C40	Maternity Friends and Family - % who would recommend	91.86%	95.5%	96.6%	96.4%	96.7%	95.9%	95.8%	97.0%	97.8%	97.3%	96.2%	98.3%	97.4%	97.9%	96.9%	
C42	A&E Friends and Family - % who would recommend	74.90%	80.8%	76.5%	80.4%	75.7%	76.3%	75.0%	73.9%	75.8%	76.7%	75.7%	76.1%	76.0%	81.8%	79.6%	
C32	NHS England A&E response rate from Friends and Family Test		21.7%	22.2%	21.8%	19.8%	19.7%	20.5%	21.5%	21.1%	20.8%	17.9%	19.1%	21.3%	21.2%	22.1%	
C44	Community Friends and Family - % who would recommend	88.62%	93.7%	93.7%	94.0%	94.9%	94.3%	93.6%	94.3%	93.1%	92.5%	92.8%	92.8%	91.9%	93.1%	92.8%	
C15	Complaints – rate per 1000 contacts	0.4	0.3	0.2	0.3	0.2	0.2	0.2	0.3	0.2	0.2	0.4	0.3	0.3	0.3	0.3	
M52	Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

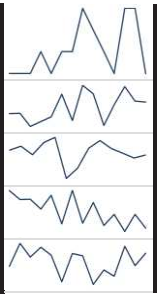
Effective

		Threshold 16/17	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Monthly Sparkline
M73	Deaths in Low Risk Categories - relative risk	Outlier	75.6	70.4	67.8	71.6	77.3	81.1	85.1	82.7	86.5	82.7	91.6				
M74	Hospital Standardised Mortality Ratio - Weekday (DFI Indicative)	Outlier	94.8	94.9	96.1	96.1	95.9	96.3	97.7	97.0	98.7	95.6	96.2				
M75	Hospital Standardised Mortality Ratio - Weekend (DFI Indicative)	Outlier	101.7	101.6	106.5	102.0	100.2	98.3	97.7	98.3	97.0	99.1	99.4				
M54	Hospital Standardised Mortality Ratio (DFI Indicative)	Outlier	96.6	97.0	99.1	97.6	97.0	96.8	97.7	97.4	98.3	96.5	97.0				
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Outlier		1.06			1.04			1.05							
C16	Emergency re-admissions within 30 days		12.6%	12.8%	12.3%	13.0%	13.2%	11.0%	11.6%	12.7%	13.1%	12.6%	12.4%	12.1%			
M89	CQUIN schemes at risk	0		2			0			3			1			3	

Responsive

		Threshold 16/17	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Monthly Sparkline
C2	Proportion of patients spending less than 4 hours in A&E	95%	90.0%	87.8%	89.3%	86.4%	86.4%	85.2%	79.3%	83.9%	84.1%	79.8%	77.3%	75.3%	79.9%	80.8%	
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	95%	90.0%	87.8%	89.3%	86.4%	86.4%	85.2%	79.3%	83.9%	84.1%	79.8%	77.3%	81.2%	84.8%	83.5%	
M62	12 hour trolley waits in A&E	0	1	0	2	3	3	7	9	2	3	3	0	16	7	5	
M81	HAS Compliance	90%	93.71%	91.40%	93.34%	92.97%	91.54%	94.76%	92.80%	92.91%	92.96%	92.82%	91.77%	91.12%	92.39%	92.17%	
M82	Handovers > 30 mins ALL	0	435	807	630	701	682	891	884	714	909	954	1190	1402	674	840	
M82.6	Handovers > 30 mins ALL (NWAS Confirmed Penalty)	0	254	501	379	423	402	533	569	446	590	604	776	940	376	524	
C1	RTT admitted: percentage within 18 weeks	95%	83.2%	81.2%	78.5%	81.8%	79.2%	73.8%	79.0%	76.2%	78.1%	72.5%	75.3%	71.3%	70.7%	69.8%	
C3	RTT non- admitted pathways: percentage within 18 weeks	90%	95.6%	96.3%	94.4%	94.4%	95.0%	93.8%	92.4%	92.0%	93.9%	92.7%	93.2%	91.3%	92.5%	92.0%	
C4	RTT waiting times Incomplete pathways	92%	95.2%	95.6%	94.8%	93.7%	94.7%	95.7%	93.9%	93.9%	92.7%	92.9%	92.0%	92.0%	92.2%	92.3%	
C37.1	RTT 52 Weeks (Ongoing)	0	0	0	1	2	1	1	0	1	1	1	0	3	2	1	
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1%	0.2%	0.2%	0.2%	0.1%	0.2%	0.3%	0.3%	0.1%	0.1%	0.2%	0.1%	0.4%	0.3%	0.4%	
C18	Cancer - Treatment within 62 days of referral from GP	85%	86.6%	88.4%	85.6%	82.8%	81.6%	87.8%	80.8%	86.5%	85.4%	93.6%	89.4%	87.6%	83.7%		
C19	Cancer - Treatment within 62 days of referral from screening	90%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%	96.4%	96.9%	91.9%	95.8%	100.0%	100.0%	100.0%		
C20	Cancer - Treatment within 31 days of decision to treat	96%	100.0%	98.9%	100.0%	98.4%	99.1%	99.4%	96.3%	98.9%	99.0%	99.0%	98.8%	98.9%	98.8%		
C21	Cancer - Subsequent treatment within 31 days (Drug)	98%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94%	97.3%	94.1%	97.1%	100.0%	97.8%	97.7%	97.5%	94.3%	100.0%	94.7%	100.0%	95.9%	100.0%		
C24	Cancer - seen within 14 days of urgent GP referral	93%	95.5%	95.6%	95.2%	95.1%	94.3%	95.4%	93.9%	94.3%	95.1%	95.7%	96.9%	94.0%	97.3%		
C25	Cancer - breast symptoms seen within 14 days of GP referral	93%	97.3%	93.6%	95.2%	94.1%	93.0%	97.5%	96.6%	98.7%	98.9%	95.6%	95.3%	98.8%	100.0%		
C36	Cancer 62 Day Consultant Upgrade	85%	91.0%	90.4%	93.1%	92.9%	91.1%	90.5%	82.4%	92.0%	83.3%	95.6%	94.1%	93.6%	89.3%		
C25.1	Cancer - Patients treated > day 104		1	4	0	7	2	2	6	3	1	3	4	2	5		
M9	Urgent operations cancelled for 2nd time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

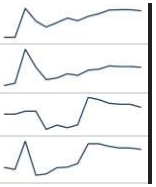
C27a	Not treated within 28 days of last minute cancellation due to non clinical reasons - actual	0	0	0	0	1	0	1	1	3	2	1	0	3	3	0
M55	Proportion of delayed discharges attributable to the NHS	3.5%	4.8%	4.8%	4.3%	4.4%	4.6%	5.5%	4.5%	5.8%	5.5%	4.3%	5.1%	5.8%	5.2%	5.2%
C16	Emergency re-admissions within 30 days		12.6%	12.8%	12.3%	13.0%	13.2%	11.0%	11.6%	12.7%	13.1%	12.6%	12.4%	12.1%	12.3%	
M90	Average LOS elective (excl daycase)		3.0	2.8	2.8	2.6	2.9	2.3	3.0	2.4	2.7	2.3	2.5	2.2	2.5	2.3
M91	Average LOS non-elective		4.6	4.9	4.7	4.8	4.7	4.4	4.7	4.7	4.4	4.5	4.5	4.8	4.6	4.7



Well led

		Threshold 16/17	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Monthly Sparkline
C31	NHS England Inpatients response rate from Friends and Family Test	16%	48.5%	50.1%	45.9%	54.0%	50.5%	47.7%	51.2%	43.3%	43.2%	40.8%	51.2%	53.2%	47.4%	47.0%	
C32	NHS England A&E response rate from Friends and Family Test	4%	21.7%	22.2%	21.8%	19.8%	19.7%	20.5%	21.5%	21.1%	20.8%	17.9%	19.1%	21.3%	21.2%	22.1%	
M77	Trust turnover rate	12%	9.2%	8.7%	8.9%	8.9%	9.0%	9.0%	9.4%	9.6%	9.3%	9.2%	9.2%	9.2%	9.1%	9.1%	
M78	Trust level total sickness rate	3.75%	4.74%	4.45%	4.5%	4.5%	4.9%	4.9%	4.8%	5.0%	5.1%	5.1%	5.2%	5.4%	4.8%		
M79	Total Trust vacancy rate	5%	7.1%	7.3%	8.0%	6.7%	7.7%	8.0%	7.3%	6.2%	6.1%	5.7%	6.7%	6.5%	6.5%	6.1%	
M80.3	Appraisal (AFC)	90%	72.0%	73.0%	71.0%	66.0%	64.0%	62.0%	65.0%	65.0%	64.0%	60.0%	59.0%	59.0%	57.0%	62.0%	
M80.3!	Appraisal (Consultant)	90%	96.0%	96.0%	n/a	12.0%	21.0%	28.0%	37.0%	45.0%	50.0%	94.0%	95.0%	92.0%	96.0%	99.0%	
M80.4	Appraisal (Other Medical)		96.0%	98.0%	n/a	16.0%	31.0%	45.0%	52.0%	61.0%	72.0%	99.0%	95.0%	94.0%	99.0%	99.0%	
M80.2	Safeguarding Children	80%	87.0%	88.0%	88.0%	88.0%	90.0%	91.0%	93.0%	92.0%	91.0%	93.0%	93.0%	90.0%	90.0%	88.0%	
M80.2:	Information Governance Toolkit Compliance	95%	85.0%	93.0%	95.0%	94.0%	95.0%	94.0%	94.0%	92.0%	92.0%	92.0%	92.0%	91.0%	89.0%	86.0%	
F8	Temporary costs as % of total paybill	4%	9%	9%	7%	7%	8%	9%	10%	10%	9%	10%	9%	8%	8%	11%	
F9	Overtime as % of total paybill	0%	1%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
F1	Cumulative Retained Deficit for breakeven duty (£M)	(3.7)	(11.2)	(11.5)	(0.3)	(0.6)	(0.9)	(1.2)	(1.5)	(1.8)	(2.1)	(2.4)	(2.7)	(3.0)	(1.5)	1.5	
F2	SRCP Achieved % (green schemes only)	100.0%	64%	64%	52%	54%	56%	59%	71%	74%	75%	81%	87%	99%	101%	101%	
F3	Liquidity days	>(14.0)	(14.4)	(5.0)	(5.3)	(5.9)	(5.6)	(5.5)	(5.8)	(6.2)	(6.6)	(6.9)	(7.1)	(7.1)	(6.1)	(6.3)	
F4	Capital spend v plan	85%	71%	90%	93%	91%	79%	73%	75%	76%	80%	76%	74%	67%	77%	85%	
F16	Finance & Use of Resources (UoR) metric - overall	3									3	3	3	3	2	2	
F17	Finance and UoR metric - liquidity	3									2	2	3	3	2	2	
F18	Finance and UoR metric - capital service capacity	3									4	4	4	3	3	3	
F19	Finance and UoR metric - I&E margin	3									3	3	3	3	3	2	
F20	Finance and UoR metric - distance from financial plan	1									1	1	1	1	1	1	
F21	Finance and UoR metric - agency spend	1									3	3	3	3	3	3	

F12	BPPC Non NHS No of Invoices	95%	95.5%	95.5%	96.8%	96.3%	96.0%	96.2%	96.4%	96.3%	96.5%	96.6%	96.8%	96.8%	96.8%	96.7%
F13	BPPC Non NHS Value of Invoices	95%	95.2%	95.4%	98.2%	96.7%	95.7%	95.8%	96.2%	96.0%	96.5%	96.6%	96.8%	96.8%	96.8%	96.7%
F14	BPPC NHS No of Invoices	95%	95.0%	95.0%	95.3%	95.3%	93.2%	93.7%	93.4%	93.7%	97.0%	96.7%	96.3%	96.2%	96.2%	95.8%
F15	BPPC NHS Value of Invoices	95%	96.6%	96.4%	99.5%	95.8%	95.9%	96.6%	96.6%	97.0%	99.2%	99.2%	98.9%	98.7%	98.7%	98.6%



East Lancashire Hospitals NHS Trust

THE STAFF GUARDIAN JOURNEY

Safe | Personal | Effective

Vision for the Role

- In post from September 2015
- Worked to establish a culture of confidence in raising concerns without fear or consequence.
- Supported the workforce in raising concerns and issues on patient safety.
- Firm foundations now in place

National Guardian Office

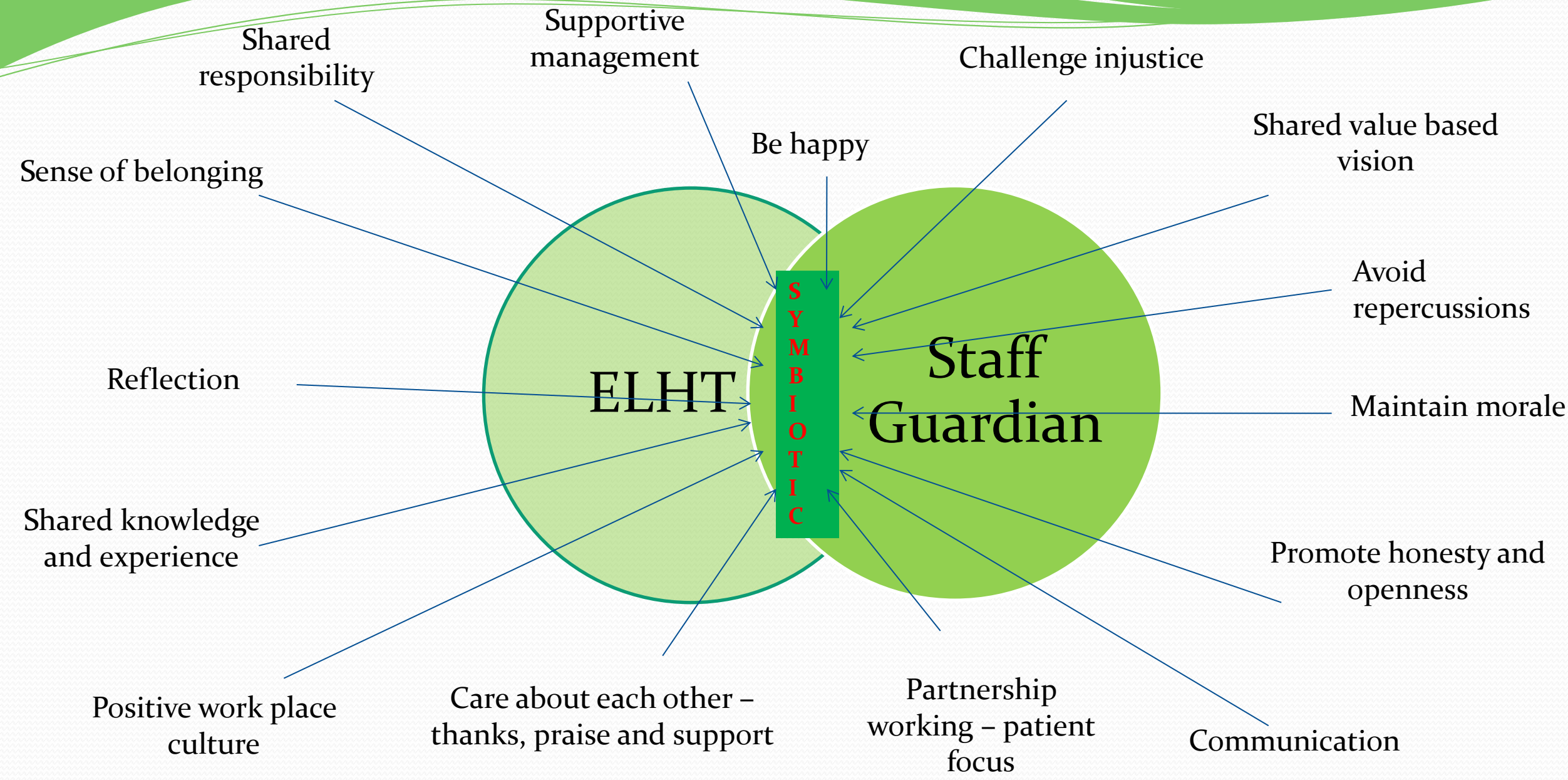
- Established in April 2016
- Dr Henrietta Hughes - National Guardian practicing GP 1 day per week.
- National Guardian - 4 days per week.
- ELHT involved in national work programme.

Staff Raising Concerns

- Nobody speaks if nobody listens. Managers need to listen to what staff have to say.

- 85 resolved concerns – 4 still on-going – 40 sign posts

- Themes – indicated that managers needed support in people management. Developed and introduced engaging managers programme.


Shared responsibility
Supportive management
Challenge injustice
Shared value based vision
Sense of belonging
Be happy
Avoid repercussions
Reflection
ELHT
SYMBIOTIC
Staff Guardian
Maintain morale
Shared knowledge and experience
Promote honesty and openness
Positive work place culture
Care about each other – thanks, praise and support
Partnership working – patient focus
Communication

Going Forward

- Communication regarding the change
- An increase in the number of concerns raised
- A network of Champions will be embedded
- “if you see it, say it” culture
- Staff Charter

Going Forward

- Continue to improve Health and Wellbeing for staff
- Host the Regional Network event
- Continue to give assurance to the Board that there is a culture of speaking out safely within ELHT
- EVERY patient is delivered safe personal effective care

East Lancashire Hospitals NHS
NHS Trust

TRUST BOARD PART 1

Item 084

3 May 2017

Purpose Action

Title	Directors' Register of Interests
Author	Mrs A Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary
Sponsor	Professor E Fairhurst, Chairman

Summary: Section 5 of the Trust's Standing Orders describes the duties and obligations of Board Members in relation to declaring interests. All Board Members have recently been asked to review and update their interests and this report provides the up to date entries in the Register. The Register is available for public inspection and it is presented annually to the Trust Board for approval and inclusion in the Trust's annual report.

Recommendation: The Board is asked to approve the presented Register of Director's Interests and authorise its inclusion into the Trust's annual report for 2016/17.

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

(084) Directors' Register of Interests

DIRECTORS' REGISTER OF INTERESTS 2016/17

Name and Title	Interest Declared	Date last updated
Professor Eileen Fairhurst Chairman	Professor at Salford University - until 31.12. 2017. Trustee, Beth Johnson Foundation - until 31.3.2017. Chairman of Bury Hospice – from 23.1.2017. A member of the Learning, Training & Education (LTE) Group Higher Education Board from September 2016.	26.4.2017.
Kevin McGee Chief Executive	Positive Nil Declaration	26.4.2017.
Stephen Barnes Non-Executive Director	Chair of Nelson and Colne College Member of the National Board of the Association of Colleges - from 2.3.2017 Vice Chair of the National Council of Governors of the Association of Colleges - from 2.3.2017	20.4.2017.
Naseem Malik Non-Executive Director (appointed 1 September 2016)	Independent Assessor- Student Loans Company- Department for Education- Public Appointment Fitness to Practice Panel Chair - Health & Care Professions Council (HCPC) - Independent Contractor Investigations Committee Panel Chair - Nursing & Midwifery Council (NMC) - Independent Contractor Member of the Law Society Fellow of The Royal Society of Arts 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	25.4.2017.

Name and Title	Interest Declared	Date last updated
	from 2004 until 2010. Relative (first cousin) is a GP at Darwen Health Centre (GP Practice) Relative (brother-in-law) is a Mental Health Nurse who works at Lancashire Care NHS Foundation Trust	
Peter Rowe Non-Executive Director (***retired 31 March 2017***)	Director – Rowe Creative Ltd	
Elizabeth Sedgley Non-Executive Director (***retired 3 February 2017***)	Accountant for various local firms	
Richard Slater Non-Executive Director	Positive Nil Declaration	19.4.2017.
David Wharfe Non-Executive Director	Positive Nil Declaration	19.4.2017.
John Bannister Director of Operations (from 1 December 2016)	Positive Nil Declaration	25.4.2017.
Michelle Brown Acting Director of Finance (from 10 June 2016 to 2 April 2017)	School Governor at St Catherine's RC Primary School, Leyland Husband works for North West Ambulance Service as an Emergency Technician	19.4.2017.
Keith Griffiths Director of Sustainability (from 6 November 2016)	Positive Nil Declaration	25.4.2017.
Martin Hodgson Director of Service Development	Positive Nil Declaration	20.4.2017.
Christine Hughes Director of Communications and Engagement	Positive Nil Declaration	25.4.2017.
Kevin Moynes Director of Human Resources & Organisational Development	Governor of Nelson and Colne College	25.4.2017.
Christine Pearson Director of Nursing	Positive Nil Declaration	20.4.2017.

Name and Title	Interest Declared	Date last updated
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 employee - GP in Dyneley House Surgery, Skipton Sister is an employee of pharmaceutical company Novartis	19.4.2017.
Gillian Simpson Director of Operations (***retired 15 January 2017***)	Spouses business (Simpsons Furniture, Colne) – provides cots for NICU at BGN	
Professor Michael Thomas Associate Non-Executive Director (appointed 1 September 2016)	Vice-Chancellor of UCLAN	1.9.2016.
Michael Wedgeworth Associate Non-Executive Director (appointed 1 April 2017)	Honorary Canon of Blackburn Cathedral in 2003 Assistant Priest at Blackburn Cathedral since 1995 Member of the Lancashire Health and Well-Being Board since 2011 Elected Public Governor at Lancashire Care Foundation Trust and Chair of the Patient Experience Group until April 2017 Chair of Healthwatch Lancashire since 2015 Healthwatch Representative on NHS governing bodies and Trusts since 2015 Member of the Lancashire and South Cumbria Sustainability and Transformation Programme Board and its workstream on Acute and Specialised Services since 2015 Board member of North West Connected Healthy Cities	26.4.2017.
Jonathan Wood Director of Finance	Positive Nil Declaration	20.4.2017.

Name and Title	Interest Declared	Date last updated
(from 30 June 2016 to 3 April 2017 on secondment at Leeds Teaching Hospitals NHS Trust)		

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

26 April 2017

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 085

3 May 2017

Purpose Action

Title	Delegation of Authority to the Audit Committee
Author	Mrs A Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary
Executive sponsor	Mr J Wood, Director of Finance

Summary:

The report sets out the proposal for the delegation of authority by the Board to the Audit Committee for the approval of the annual report, audited accounts, annual governance statement and quality accounts for 2016/17.

Report linkages

Related strategic aim and corporate objective	n/a
Related to key risks identified on assurance framework	n/a

Impact

Legal	Yes	Financial	No
The Trust would be in breach of its regulatory obligations should it omit to submit its audited accounts to the Department of Health by the given deadline.			
Equality	No	Confidentiality	No

Previously considered by: n/a

(085) Delegation Of Authority

Background

1. The Trust's Standing Orders and the Reservation and Delegation of Powers describe the Board's authority to receive and approve the annual report and accounts.
2. Section 1.3 of the Standing Orders states the Trust's powers to delegate and make arrangements for delegation. Section 4.3 describes the delegation from the Board to the Committees.
3. The deadline for the submission of the annual report and audited accounts for 2016/17 is on the 1 June 2017. According to the annual plan presented by the Trust's external auditors, Messrs Grant Thornton at the last Audit Committee meeting on the 6 March 2017, the reporting of the audit findings and signing of the financial statements opinion will occur on the 30 May. Thus, it would not be possible to present the final audited accounts for approval to the Board at its meeting on the 12 July. In previous years, the Board has delegated the authority to the Audit Committee to approve the audited accounts in order to ensure that they were submitted by the prescribed timelines. The recommendation below is based on the approach taken by the Board in the past.

Recommendation

4. The Board is asked to delegate the authority to the Audit Committee to approve the annual report and audited accounts for 2016/17, the annual governance statement and the quality accounts at its meeting on the 26 May 2017 and to authorise the Chairman of the Audit Committee and the Director of Finance with the submission of the audited accounts and relevant documents to the Department of Health on the 1 June 2017.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 086

3 MAY 2017

Purpose Information Assurance

Title	Trust Charitable Funds Committee Update Report (April 2017)
Author	Miss K Ingham, Company Secretarial Assistant
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 meeting held on 3 April 2017

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

(086) Trust Charitable Funds Committee Update Report

Trust Charitable Funds Committee Update: 3 April 2017

1. At the last meeting of the Trust Charitable Funds Committee held on Monday 3 April 2017 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.
2. The Committee briefly discussed the need to open discussions with Brewin Dolphin (Investment Company) in relation to the fees paid and the performance of the Fund. Committee members noted that whilst it was uncommon for the investment company not to return a profit on investments it was reflective of the market over the period of time that had been discussed. It was agreed that the Investment Manager would be invited to the next meeting to discuss this matter further and present an up to date position.
3. The Committee received an application to use the charitable funds for the purchase of furniture for the Trust's Chemotherapy Unit. The total amount that was requested was £36,747.75 (plus VAT) and therefore there was a requirement for the Committee to discuss and approve the request. Following a discussion the Committee agreed the use of the Fund for this purpose.
4. The Committee received the investment report and noted the overall performance of the funds for the nine month period to 31 December 2016. There was a small increase in the value of the portfolio of £23,000 bringing the total value of the fund to £2,156,100. The Committee members discussed the performance of the fund and suggested that market testing could be carried out in relation to the use of an Investment Company.
5. The Committee received a report relating to the performance and utilisation of the funds. It was noted that the total expenditure for the period to 31 December 2016 was £502,000, which was slightly lower than the same period in 2015/16.
6. The Committee received a brief update in relation to the proposed Fundraising Strategy, including the proposed Job Description for the Fundraising Manager role. Members noted that the role was currently out to advert; the Committee members were keen to be involved in the recruitment process for the Fundraising Manager. The Committee members expressed their desire to see tangible progress following the successful candidate being recruited into the post.
7. The Committee received a number of the Charity's governing documents as requested at the last meeting. Members discussed the practicalities of moving the 'Albert Bertwistle' fund into the main fund whilst maintaining the principles of the bequest, to use the fund for the Burnley General Hospital site.

8. Members also discussed the use of the Trust's charitable fund to offer staff long service awards and pay for retirement buffets for staff. Non-Executive members were in favour of using the fund for long service awards but were less comfortable about using the funds to facilitate retirement gatherings. It was agreed that income streams such as the staff lottery and staff gym would be used to pay for such benefits rather than to use the donations from individuals for this purpose.
9. The Committee received the initial results of the Committee Self-Assessment survey, it was agreed that once all Committee members and attendees at the meetings had submitted their responses the results would be shared again with members.

Kea Ingham, Company Secretarial Assistant, 10 April 2017

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 087

3 May 2017

Purpose Information

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

Summary: The report details the agenda items discussed in Part 2 of the Board meetings held on 29 March 2017.

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

Report linkages

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

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

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: n/a

Trust Board Part Two Information Report: 29 March 2017

1. At the meeting of the Trust Board on 29 March 2017, the following matters were discussed in private:

   b) Round Table Discussion: Local Delivery Plan, Sustainability and Transformation Plan and Provider group Update

   c) Sustaining Safe, Personal and Effective Care 2016/17 Update Report

   d) Finance Reports: Financial Recovery Plan/Transformation 2017/18

   e) Finance Reports: Tendering and Contracting Offer Update

   f) Serious Untoward Incident Report

   g) Doctors with Restrictions

   h) Board Dates for the Next 12 Months

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, Company Secretarial Assistant, 10 April 2017