East Lancashire Hospitals NHS
NHS Trust

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

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TRUST BOARD PART 1 MEETING

26 OCTOBER 2016, 15:00, SEMINAR ROOM 6, ROYAL BLACKBURN HOSPITAL

AGENDA

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

OPENING MATTERS				
TB/2016/282	**Chairman's Welcome**	Chairman	v	15.00
TB/2016/283	**Open Forum** To consider questions from the public	Chairman	v	15.01
TB/2016/284	**Apologies** To note apologies	Chairman	v	15.15
TB/2016/285	**Declarations of Interest** To note any new declarations of interest from Directors.	Company Secretary	v	15.20
TB/2016/286	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 25 May 2016	Chairman	d✓	15.22
TB/2016/287	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda	Chairman	v	15.25
TB/2016/288	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	15.27
ACCOUNTABILITY AND PERFORMANCE				
TB/2016/289	**Integrated Performance Report** To note performance against key indicators and actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed: • Performance • Quality & Safety • Finance • HR • Safer Staffing	Directors	d✓	15.30
STRATEGY				
TB/2016/290	**Workforce and Organisational Development** a) Workforce and Organisational Development Update b) Workforce Race and Equality Standard Report	Director of HR and OD	p d✓	15.40
CLOSING MATTERS				
TB/2016/291	**Any Other Business** To discuss any urgent items of business.	Chairman	v	16.10
TB/2016/292	**Open Forum** To consider questions from the public.	Chairman	v	16.15
TB/2016/293	**Date and Time of Next Meeting** Wednesday 30 November 2016, 14.00, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.	Chairman	v	16.20

East Lancashire Hospitals NHS Trust

TRUST BOARD PART ONE REPORT

Item 286

26 October 2016

Purpose Action

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

Summary:

The draft minutes of the previous Trust Board meeting held on 28 September 2016 are presented for approval or amendment as appropriate.

Report linkages

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

Impact

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

Previously considered by: NA

(286) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST TRUST
BOARD MEETING, 28 SEPTEMBER 2016
MINUTES

PRESENT

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

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Company Secretary	
Mrs J Bradshaw	Patient Relative	For Item TB/2016/251
Mrs M Davey	Assistant Director of Patient Experience	For Item TB/2016/251
Mr M Hodgson	Director of Service Development	
Mrs C Hughes	Director of Communications and Engagement	
Miss K Ingham	Minute Taker	
Mr K Moynes	Director of HR and OD	
Mrs S Nosheen	Quality Improvement Facilitator	For Item TB/2016/251
Mr R Smyth	Associate Non-Executive Director	
Mr G Parr	Shadow Public Governor, Pendle	Observer/Audience
Mr M Wedgeworth	Healthwatch Lancashire	Observer/Audience
Mr P Magill	Lancashire Telegraph	Observer/Audience

APOLOGIES

Miss N Malik	Non-Executive Director
Professor M Thomas	Associate Non-Executive Director

TB/2016/242 CHAIRMAN'S WELCOME

Professor Fairhurst welcomed Directors, Shadow Governors and members of the public to the meeting, in particular Mr Richard Smyth, newly appointed Associate Non-Executive Director who was in attendance at his first Trust Board meeting since his appointment.

TB/2016/243 OPEN FORUM

There were no questions or comments raised at this section of the meeting.

TB/2016/244 APOLOGIES

Apologies were received as recorded above.

TB/2016/245 DECLARATIONS OF INTEREST

Directors noted that there was one update in relation to the Directors' Register of Interests. Professor Fairhurst confirmed that she joined the Learning, Training & Education (LTE) Group as member of the Higher Education Board. There were no declarations in relation to agenda items.

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

TB/2016/246 MINUTES OF THE PREVIOUS MEETING

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

RESOLVED: The minutes of the meeting held on 27 July 2016 were approved as a true and accurate record.

TB/2016/247 MATTERS ARISING

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

TB/2016/248 ACTION MATRIX

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

TB/2016/205: Open Forum – Mrs Bosnjak-Szekeres confirmed that the matter had been resolved and parking related to attendance at the Trust Board meetings would be managed on a case by case basis.

TB/2016/218: Integrated Performance Report – Mr Moynes reported that the figures for the Core Skills Training had improved significantly since the last meeting and the majority of

areas were now rated as green.

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

TB/2016/249 **CHAIRMAN'S REPORT**

Professor Fairhurst reported that she and other Board members had been in attendance at the Trust's annual engagement event and Annual General Meeting (AGM) earlier in the month. She thanked the Communications Team for organising the engagement event and extended her thanks to those members of staff who attended to showcase their services.

Professor Fairhurst also reported that she had had the opportunity to shadow Mr Ed Smith, Chairman of NHS Improvement recently, which she had found to be an interesting learning experience and had provided an excellent opportunity to promote the organisation at a national level.

Directors noted that Professor Fairhurst had led a session earlier in the month on behalf of the Healthcare Finance Management Association (HFMA) with Mr Wood, Director of Finance, who is currently on secondment at Leeds Teaching Hospitals NHS Trust, regarding the experience of the Trust whilst it was in Special Measures. Professor Fairhurst confirmed that she had been able to provide a Non-Executive Director viewpoint, whilst Mr Wood had provided the view from an Executive perspective. The feedback received from the event was very positive.

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

TB/2016/250 **CHIEF EXECUTIVE'S REPORT**

Mr McGee referred Directors to the report and highlighted a number of national and local issues, including the publication of NHS England's Annual Accounts and Annual Report. He went on to confirm that the national planning guidance was due to be published in the coming weeks and was likely to concentrate on strengthening the financial controls throughout the sector. Directors noted that the plans for a seven day hospital pharmacy service had been published.

Mr McGee reported that the Trust's Informatics Department had received an accreditation by the Informatics Service Development Network (ISDN). Directors noted the excellent results of the recent Patient-Led Assessments of the Care Environment (PLACE) assessments of the Trust. Mr McGee confirmed that the development of an elective centre at the Burnley General Hospital site has been approved and it was an important development for the organisation, as it would help to establish the Burnley site as an elective centre, whilst non-elective and emergency activity would be concentrated on the Blackburn site.

Directors noted that Mr John Jackson, a Porter with the Trust, had received the Kate

Granger Award for Compassionate Care at the recent Expo 2016 event. Mr McGee highlighted the achievements of the Infection Prevention and Control Improvement Collaborative and the recent Care Quality Commission (CQC) well-led review.

RESOLVED: Directors received and noted the report provided.

TB/2016/251 PATIENT STORY

Mrs Bradshaw joined the Board meeting and explained that her husband Alan had been admitted to hospital around two and a half years ago. Due to him suffering from Alzheimer's, he found it very challenging and difficult to co-operate with staff. Directors noted that Mrs Bradshaw is a qualified nurse and she had felt that is was right for her to spend as much time with her husband in the hospital as possible and be involved in his care. Mrs Bradshaw explained that she did not feel intimidated by the hospital environment and the staff allowed her to get involved and do whatever she felt was right in helping her husband, as nobody knows Alan as well as she does. Mrs Bradshaw became involved with the One to One Care Collaboration that is concentrating on improving the quality of care though working with the patients' families and carers. She added that she would recommend to all families and carers to be involved in collaborative care.

Mrs Bradshaw stated that it was a real culture change for the nurses to allow family members on the hospital wards outside visiting hours. Although her husband Alan had one to one 'specialing' care, it was just preventing him from harming himself or others and he was relieved every time she came to visit him, as he did not recognise his predicament and did not understand what was happening to him. Mrs Bradshaw reported that she was also involved in the therapeutic work with her husband, which is linked to the partnership model across the five hospital sites. The "Partnership in Care" work is about building partnerships with family members and carers through a collaborative approach to deliver care to those patients needing one to one care in order to ensure better continuity of care. It is a holistic way of providing care, where the staff in collaboration with families and carers understand what patients' needs are and address them. The 'one to one care in partnership' also reduces stay in the hospital and provides a better experience for the patients. It has also reduced spend.

The Board proceeded to watch the video about collaborative care.

Following the video, the Chairman thanked Mrs Bradshaw and the staff involved in the Collaborative Care initiative and invited questions from the Board members. Mr Slater asked how far the hospital has gone to provide personal care. Mrs Bradshaw responded that apart from the experience in the Emergency Department due to the long wait, everyone was kind, but she felt that a positive intervention was required. She went on to give an example when

her husband needed minor day surgery which the surgeon agreed to provide in the environment that her husband could cope with. She expressed that the experience of the day surgery was absolutely amazing and staff were fantastic.

Kevin McGee asked Mrs Bradshaw if she felt that she was also looked after. She responded that she did not feel looked after, but this was due to staff being unprepared and inexperienced in the new ways of collaborative care, but both parties learnt a lot from the experience. Professor Fairhurst noted that the patient story was a good example of both positive and negative experiences. Mrs Pearson added that the Trust has learnt a lot from Mr and Mrs Bradshaw's journey, and it had helped to develop services to ensure that family members and carers can be involved in the care of their loved ones as much as they wish.

RESOLVED: **Directors received and noted the information presented.**

TB/2016/252 **BOARD ASSURANCE FRAMEWORK (BAF)**

Dr Riley presented the report to Directors for review and approval. He confirmed that there had been no changes to the framework since the last meeting and confirmed that the risk score for BAF risk 6: *The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements,* had been changed to reflect the discussions at the previous meeting in relation to the pressures in the emergency department. Directors received the report and noted its contents.

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

TB/2016/253 **CORPORATE RISK REGISTER**

Dr Riley presented the register to Directors and confirmed that there had been two new risks recommended for inclusion in the register (Risk ID 1810: Emergency Department Pressures and Flow and Risk ID 6095: Availability of Mental Health Beds). Following discussion the Directors approved the inclusion of the two risks on the register.

In response to Mr Rowe's question, Dr Riley reported that if the Trust were to commence conducting mental health assessments, there would be a requirement to register with the CQC for the provision of mental health services, which would mean that the Trust would need to undertake significant work in relation to the estate to ensure that it meets the requirements of a mental health provider, such as removal of ligature points, etc. Dr Riley gave an overview of the work being undertaken with the Lancashire Care NHS Foundation Trust to address the issues surrounding the provision of mental health care.

In response to Mr Rowe's comment regarding chemotherapy drug use, Dr Riley confirmed that drug banding was included within the mitigation of the risk.

Professor Fairhurst requested that the Corporate Risk Register be presented before the Board Assurance Framework in the future.

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

ACTION: **Corporate Risk Register to be presented on the agenda before the Board Assurance Framework in future meetings.**

TB/2016/254 SERIOUS UNTOWARD INCIDENTS REQUIRING INVESTIGATION REPORT

Dr Riley referred Directors to the previously circulated report and highlighted the number of falls resulting in a fractured neck of femur. He confirmed that there was no single underlying cause which contributed to the numbers being reported and they were within the acceptable tolerance levels for the Trust. Mrs Pearson provided a brief overview of the falls collaborative that the Trust had been involved in and confirmed that the learning from the work was being rolled out across the organisation. Mr Slater reported that such incidents are reported through the Serious Incidents Requiring Investigation (SIRI) panel, which includes representation from local commissioning organisations. Dr Riley went on to present an overview in relation to performance around duty of candour and confirmed that there had been a small deterioration, however all those cases over the ten day threshold had genuine reasons for missing the deadline and are being actively managed.

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

TB/2016/255 UPDATE ON RECENT DEVELOPMENTS: PENNINE LANCASHIRE AND HEALTHIER LANCASHIRE

Mr McGee reported that at Healthier Lancashire level a case for change was currently being developed, which includes significant information about the delivery of financial savings, health outcomes, overall improvements in performance and workforce development. He confirmed that there were significant opportunities for the Trust, including possibilities to develop existing services further and developing new services for the benefit of the population. Directors noted the positive working relationships that are in place between the Trust and local commissioners. Mr McGee commented that whilst there were opportunities for development, there would be significant changes that would need to take place within the Lancashire and South Cumbria area in order to make the best use of the monies available. He went on to report that Healthier Lancashire had recently put out an advertisement for a Chairman for the Committee in Common.

Mr Hodgson commented that the Trust had recently developed a range of strategies,

including the new Clinical Strategy and Research Strategy which would inform the work of other organisations and help to shape the case for change.

Mr Rowe commented that as a resident within the Lancashire and South Cumbria Sustainability and Transformation Plan (STP) area, he had not been made aware of any of the work being undertaken and asked whether there was a public consultation or information campaign planned. Mr McGee confirmed that there was no such activity at this time, but public involvement was key to the process. Professor Fairhurst commented that it was not just a local issue and that the issue of public engagement had been raised at a recent national event that she had attended.

It was agreed that Mr McGee would continue to keep the Board updated about developments in this area at future meetings.

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

TB/2016/256 **OBTAINING TEACHING STATUS**

Mr McGee referred Directors to the previously circulated report and confirmed that the Trust had an aspiration to become a University Hospital Trust in the future. He reported that the Trust had a good reputation for providing high quality training to staff and students and as such the Trust is keen to adopt a teaching status for both main sites. Directors noted that the name of the Royal Blackburn Hospital and Burnley General Hospitals would change, but the overall name of the Trust would remain as East Lancashire Hospitals NHS Trust for the time being. Directors discussed the proposed change and approved the proposal to change the name of the two main hospital sites.

In response to Mr Wharfe's question, Mr McGee confirmed that the inclusion of the term 'teaching' in the hospitals' names could have a positive effect on the recruitment and attract high quality staff.

Mr Barnes asked why the Trust could not progress with an application to change the overall Trust name. Mr McGee confirmed that this was not currently within the gift of the Trust as obtaining this status was subject an application and regulatory approval. This piece of work will also require legal input and would take place in the future.

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

Directors approved the proposal to include the word 'Teaching' into the names of the two main hospital sites.

TB/2016/257 **INTEGRATED PERFORMANCE REPORT**

Mrs Simpson presented the Integrated Performance Report for the month of August and highlighted the challenges that continue in relation to the delivery of the four hour standard

and delayed transfers of care. Directors noted that there were 143 patients delayed over the month, with 38 of the delays being on the last Thursday of the month. The main reason for delays was the lack of available care packages from local authority partners. Mrs Simpson confirmed that the Trust achieved the 62 day cancer target for July and continued to meet the 18 week referral to treatment standard.

Mrs Simpson provided a brief update in relation to the work being undertaken around the development of the Accident and Emergency Delivery (AED) Board that shall replace the System Resilience Group and confirmed that Mr McGee would chair the (AED) Board for Pennine Lancashire.

Mrs Brown reported that the Trust had reported a month end position of a £1,500,000 deficit at the end of August and this was in line with the plans. Directors noted that there were a number of risks to the financial position, including the continued need to use agency staff over the summer months and the achievement of Safely Releasing Costs Programmes (SRCP). Mrs Brown confirmed that around £10,000,000 in schemes had been delivered which was slightly ahead of the planned position. Mrs Brown confirmed that a number of successful recruitment campaigns had begun to have a positive impact on the need to utilise agency staff.

Mr Rowe commented that local authority providers must recognise that the cost to the organisation in keeping medically fit patients in hospital until care packages are available is often significantly more than the cost of the assessment and care package required and suggested that by leaving patients in acute care setting, they are creating a waiting list at the NHS's expense.

In response to Mrs Sedgley's question, Mrs Pearson confirmed that at times of high demand in the emergency department there are additional staff from back office functions who offer help with non-clinical duties, such as providing food and drinks to those waiting to be seen. In addition, staff in the emergency department provide hourly status updates to patients waiting to be seen.

Professor Fairhurst asked how the Trust worked with housing associations to manage the issue of increased demand on services. Mrs Simpson confirmed that the Trust did not currently have close working relationships with housing associations, but confirmed that this was an area that could and should be developed.

Mrs Pearson provided an update on staffing and confirmed that August had been a difficult month in terms of achieving the required levels of staffing due to it being a peak month for annual leave requests. Directors noted that there would be a number of new staff starting in September, but these staff would require additional support in the form of mentorship and supervision as the majority were newly qualified staff.

Mr Moynes reported that the total number of vacancies in the Trust had reduced with a small number of nurses retiring who will return on a part-time basis. He confirmed that a recruitment campaign has recently been undertaken in India with 37 doctors being interviewed and eight positions offered for posts within the emergency department. It is anticipated that they will be in post in around six months' time following completion of the required tests and registrations. Mr Moynes confirmed that the Workforce Race and Equality Standard report would be presented to the October Board for discussion. Directors noted that flu vaccinations have commenced within the Trust and the national staff survey is due to commence on 4 October for a period of eight weeks and will be available to all staff members within the Trust.

In response to Mr Wharfe's question regarding consultant job planning, Dr Riley referred the Directors to the exception report within the papers. He provided a brief overview of the current situation and the work being undertaken to address the issues. He confirmed that the Trust had procured a software programme called Allocate which will assist in the collation, transparency and auditing of job plans. Directors noted that all job plans will need to be uploaded to the Allocate system within the next six months.

In response to Professor Fairhurst's question regarding appraisers, Dr Riley conformed that a large number of the appraisers in the Trust were involved in the process because they enjoy the work and agreed that it was a time consuming, but rewarding element of the role.

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

TB/2016/258 DOCTORS REVALIDATION REPORT

Dr Riley presented the report to the Board for noting and approval. He provided an overview of the report and expressed thanks to Mrs Schram for compiling the report. Dr Riley highlighted the high levels of compliance with the requirements for revalidation of doctors and confirmed that there were a small number of doctors, who had not completed the revalidation process, but all had valid reasons for this and that monitoring of compliance takes place on a regular basis through the revalidation team.

In response to Mr Slater's question, Dr Riley confirmed that the high level of compliance was partially a measure of engagement, however the revalidation process was a mandatory part of maintaining a licence to practice and if not compliant, the General Medical Council could refuse to renew a doctor's licence.

Mrs Sedgley asked whether the appraisal and revalidation process could highlight any issues in practice of specific individuals. Dr Riley confirmed that evidence of work at specialty level must be provided as part of the revalidation process; however, it is likely that

any issues in capability would be picked up and addressed at the time they arise.

Professor Fairhurst commented that the terms of reference for the Doctors in Difficulty Group did not make reference to the involvement of a Non-Executive Director and asked that Dr Riley liaise with Mrs Bosnjak-Szekeres to determine a form of words which addresses this issue. Directors approved the report for submission.

RESOLVED: **Directors received, noted and approved the report for submission, subject to the amendment to the terms of reference for the Doctors in Difficulty Group.**

ACTION: **Dr Riley to liaise with Mrs Bosnjak-Szekeres to include the reference to the involvement of a Non-Executive Director in the terms of reference for the Doctors in Difficulties Group.**

TB/2016/259 EMERGENCY PLANNING ANNUAL REPORT

Mrs Simpson presented the report to Directors for approval. She provided an overview of the report and highlighted the high levels of compliance against the requirements. Directors noted the three wide scale exercises that the Trust had taken part in over the course of the last year. The report included an overview of the way in which the Trust responded to the recent industrial action by junior doctors. Mrs Simpson reported that the Trust were continuing work to embed the current approach to emergency planning across the organisation and highlighted the need to align the Trust's policy and processes with the new International Organisation for Standardisation (ISO) standard.

Directors approved the report for submission.

RESOLVED: **Directors received, noted and approved the report for submission.**

TB/2016/260 FINANCE AND PERFORMANCE COMMITTEE UPDATE REPORT

Mr Wharfe presented the report to the Board and confirmed that it was an accurate reflection of the meetings held in July and September 2016. He confirmed that there had been an in depth discussion at the July meeting around the need to revise the risk rating of Safely Releasing Costs Programmes (SRCP) and Transformation Programme to more accurately reflect progress against delivery, which had been completed and presented at the September meeting. Directors noted that there had been a presentation from the Programme Management Office around the work being undertaken in relation to the emergency care pathway. Mr Wharfe confirmed that the committee had received a high level of assurance concerning the delivery of SRCP and transformation schemes for 2016/17, but had sought further assurance regarding planning for 2017/18 schemes which would be

presented to the October meeting.

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

TB/2016/261 **FINANCE AND PERFORMANCE COMMITTEE TERMS OF REFERENCE**

Mr Wharfe provided a brief overview of the proposed changes to the committee terms of reference and recommended them to the Board for approval. Following a brief discussion Directors approved the changes and ratified the terms of reference

RESOLVED: **Directors approved the revised terms of reference for the Finance and Performance Committee.**

TB/2016/262 **AUDIT COMMITTEE UPDATE REPORT**

Mrs Sedgley presented the report to Directors and confirmed that it was an accurate reflection of the discussion that had taken place at the last meeting. She highlighted the work that was being undertaken in relation to consultant job planning and confirmed that a further update would be presented in the coming year. Mrs Sedgley escalated a matter to the Board in relation to the lack of Section 75 agreements between the Trust and local authority providers and the impact that this may have on transfers of care and flow within the organisation. Directors noted that the matter would be monitored by the Finance and Performance Committee.

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

TB/2016/263 **QUALITY COMMITTEE UPDATE REPORT**

Mr Rowe confirmed that the infection Prevention and Control Annual Report had been presented to the Quality Committee at its meeting in July. The paper submitted to the Trust Board provided an overview of the report. Mr Rowe highlighted the positive progress made over the course of the year and asked the Board to note that the report had been presented, discussed and approved at the Quality Committee on behalf of the Trust Board.

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

TB/2016/264 **CHARITABLE FUNDS COMMITTEE UPDATE REPORT**

Mr Wharfe presented the report to Directors and confirmed that at the June meeting there had been the annual report presentation by the investment manager from Brewin Dolphin, which had shown that investments had performed well under the current market conditions.

He confirmed that there had been a request to use monies from the charitable funds to support the development of new ‘no smoking’ signage, which had not been approved.

At the July meeting there had been an update in relation to the re-launch of the charity under the new name of 'ELHT & Me'. A proposed plan for the re-launch was presented and agreed with the request that a fundraising strategy be developed for presentation at the December 2016 meeting.

RESOLVED: Directors received the report and noted its contents.

TB/2016/265 TRUST BOARD PART TWO UPDATE REPORT

The report was presented for informational purposes.

TB/2016/266 ANY OTHER BUSINESS

There were no further items of business presented.

TB/2016/267 OPEN FORUM

Mr Wedgeworth commented that funding had been dramatically cut within social care which had affected performance against delayed transfers of care and suggested that acute care Trusts consider the development of intermediate care wards such as the Beachwood Centre in Preston. Mr McGee commented that he had sympathy with local authority colleagues and that the issues being experienced were a reflection of the current system. He confirmed that the Trust was working with other providers to develop solutions to this issue and further information would be provided when available.

Mr Parr commented that the patient story shared earlier in the meeting had been an effective way to share the work that is being implemented and asked whether the collaborative work had been rolled out across all areas of the Trust. Mrs Pearson confirmed that the One to One Care Collaborative had been rolled out across all appropriate areas of the Trust and was closely linked to the Falls Collaborative work which was being undertaken across the organisation.

TB/2016/268 BOARD PERFORMANCE AND REFLECTION

Professor Fairhurst asked Directors whether they felt there had been any areas where adequate assurance had not been received during the meeting. Directors agreed that the forms of assurance received had been adequate. Dr Riley commented that the Board should in conjunction with other organisations develop the public messages around Healthier Lancashire and time be allocated to look at this issue at a future Board meeting.

Mr McGee suggested that the Board would need to consider the balance between day to day business, Healthier and Pennine Lancashire transformational work and planning guidance. Professor Fairhurst suggested that for future meetings, the Board could proceed

with the assumption that members have read the papers and could commence discussions on papers and proposals from the outset of the meetings.

ACTION: **Board to work in conjunction with other organisations to develop the public message around Healthier Lancashire and time to be allocated to consider this matter at a future Board development session.**

TB/2016/269 DATE AND TIME OF NEXT MEETING

The next Trust Board meeting will take place on Wednesday 26 October 2016, 15:00, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 288

26 October 2016

Purpose Action

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

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

Members are asked to note progress against outstanding items and agree further items as appropriate

Report linkages

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

East Lancashire Hospitals NHS
NHS Trust

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
2015/66: Talent Management	Update report to be provided in early 2016 *(this will be covered as part of the Board presentation on workforce in October 2016)*	Director of HR and OD	To be advised	Agenda Item October 2016
2016/133: Action Matrix	Update to be provided in relation to progress with the population centred workforce development *(this will be covered as part of the Board presentation on workforce in October 2016, same as action number 2015/66)*	Director of HR and OD	October 2016	Agenda Item October 2016
2016/155: Information Technology Management (ITM) Strategy	Regular progress reports on implementation of the ITM Strategy to be presented to the Board to ensure that the Board has a timely debate about the allocation of resources.	Acting Director of Finance	To be advised	Agenda Item November 2016 (indicative)
TB/2016/253: Corporate Risk Register	Corporate Risk Register to be presented on the agenda before the Board Assurance Framework in future meetings.	Company Secretary	Ongoing	Oral Report
TB/2016/258: Doctors Revalidation Report	Dr Riley to liaise with Mrs Bosnjak-Szekeres to include the reference to the involvement of a Non-Executive Director in the terms of reference for the Doctors in Difficulties Group.	Medical Director	October 2016	Oral Report
TB/2016/268: Board Performance and Reflection	Board to work in conjunction with other organisations to develop the public message around Healthier Lancashire and time to be allocated to consider this matter at a future Board development session.	Chairman/ Chief Executive	October 2016	Oral Report

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

26 October 2016

Item 289

Purpose Monitoring

Title	Integrated Performance Report (**September 2016)**
Author	Mr M Johnson, Associate Director of Performance and Informatics
Executive sponsor	Mrs G Simpson, Director of Operations

Summary: This paper presents the corporate performance data at September 16

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	No	Financial	No
Equality	No	Confidentiality	Yes

Previously considered by: NA

Board of Directors, Update

Corporate Report

Executive Summary

Referral to treatment 18 week ongoing pathways continue to achieve, although continued pressure in some areas remains a risk.

No MRSA infections have been detected since December 2015.

The number of delayed transfers of care remains above the threshold.

The 62-day cancer treatment measure has failed the standard in August but aim to meet the target cumulatively for Quarter 2.

Accident and Emergency four hour target failed in September 2016 alongside the number of ambulance handover over 30 minutes.

The Trust is reporting a deficit of £1.8m for the period ending 30th September 2016, a further deterioration of £0.3m, in line with expectations at this stage.

Introduction

This report presents the data relating to the period April 16 – September 16 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 and detailed data behind the narrative is graphed in appendix B and is referenced within the text.

SAFE

Infection Control (Graph 1-3)

Current Position

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

There were five Clostridium difficile toxin positive isolate identified in the laboratory in September which were post 3 days of admission. The year to date cumulative figure is 16 against the trust target of 28.

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

Risks

No risks currently identified for MRSA. The five Clostridium difficile identified in September have now put the Trust total of 16 above the year to date trajectory of 14. The total number of Clostridium difficile toxin positive results is rising as a health economy with the pre 3 days also rising.

Forecast Position

Currently the year end position is at risk.

Actions

- Post Infection Review (PIR) of all cases undertaken and discussed across health economy
- Themes/trends from PIR fed back to Divisional Meetings and IC Liaison Group
- IR1s generated on all failures to meet infection prevention policy
- Divisional responsibility highlighted
- Mattress audit being completed monthly on wards and reported through Division
- Actichlor Plus daily cleaning being carried out on high risk areas.
- Monthly hand hygiene audits being undertaken by ICNs
- “Prompt to Protect” is being disseminated to wards, via a rolling programme
- HCAI ward dashboard being published
- Antimicrobial audit being undertaken quarterly and results fed back to Divisions for action

- Surveillance undertaken by ICNs and ribotyping requested on all potential linked cases
- All wards with 2 cases within 28 days supported and closely monitored by ICNs

New Gastroenterologist appointed as C. difficile Lead and MDT ward rounds to recommence along with the Antimicrobial Pharmacist and ICN.

Harm free Care (Graph 4)

Current Position

The Trust remains consistent with the percentage of patients with harm free care at 99.07% for September 2016 using the National safety thermometer tool.

For September 2016 we are currently investigating the following suspected one grade 2 hospital acquired, one grade 2 community acquired and one grade 3 hospital acquired pressure ulcers.

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 September. One reported year to date.

Risks

No risks identified

Forecast Position

No further never events anticipated.

Actions

No action required.

Serious Incidents (Graph 6)

Current Position

The Trust unverified position for incidents reported to the Strategic Executive Information System (StEIS) in the month of September was five incidents. These incidents were categorised as two sub-optimal care of the deteriorating patient, one maternity/ obstetric incident, one diagnostic incident and one adverse media coverage incident.

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.

The report for the adverse media incident will be presented at the Serious Incident Requiring Investigation Panel this month and an action to de-escalate taken, as this has not materialised.

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.

CAS Alerts – non compliance

Current Position

All alerts were acknowledged in time and disseminated to all divisions. Unfortunately, due to an administrative error, whilst all alerts were dealt with in a timely manner, the Department of Health was not notified that all actions had been carried out for three alerts (one in August and two in September) within the required timescale.

Risks

No risks as the delay was administrative

Forecast Position

No further breaches anticipated.

Actions

As a result of this error, controls have been put in place to ensure that senior management oversight is maintained to avoid future errors.

Safe staffing (Graph 7-8)

Current Position

Nursing and midwifery staffing in September 2016 continued to be challenging. The causative factors remained as in previous months, compounded by escalation areas being open. 21 areas fell below an 80% average fill rate for registered nurses on day shifts, which was the same as last month.

Of the 21 areas below the 80% average fill rate, 9 wards fell below the 80% due to coordinator unavailability, which is in addition to the agreed safe staffing levels, two were marginally different than those 9, which left 10 areas of concern.

- B2
- Ward 16
- Hartley Ward
- Marsden Ward
- Reedyford Ward
- CCU
- C4
- C8
- D3
- CCU
- C14

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 DATIX incidents reported the divisions have given assurance that that no harm has been identified as a consequence of staffing. 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. There were two red flag incidents reported relating to less than two registered nurses on duty in month, on investigation this proved to have been inaccurate and there were more than two registered nurses on duty.

Actions

- Extra allocations on arrival shifts continue to be booked. Registered and non-registered.
- Safe staffing conference at 9am 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

- Ward 16, Hartley ward, Marsden ward and Reedyford ward are undergoing a staffing review to determine a potential change to the model of staffing. Their staffing levels presently replicate ward staffing establishments, for ward staffing on the acute wards.

Family Care Division

- 4 incidents were reported within maternity services as red flag incidents; however 2 were excluded as they relate to outpatient services. Of the remaining 2 incidents no harm was caused. A further 11 incidents were reported under the staffing category in relation to staff shortages, none of which were identified as causing harm
- Maternity is currently out to recruitment to backfill to the maternity leave gaps which is approximately 10WTE. These gaps are presently filled by midwives filling bank shifts and rotating staff around the areas according to acuity. Recruitment is ongoing and further interview dates have been arranged.
- On a daily basis midwife staffing levels and workloads are assessed and actions taken to maintain safe services by taking in to account acuity and staffing in all areas.
- **Table outlining the midwife to birth ratios**

Month	Aug 16	Sept 16
If Staffed to full Establishment	1:30.3	1:30.4
Excluding mat leave and vacancies	1:31.5	1:31.9
With gaps filled through staff bank	1:29.7 Staff bank usage 15 WTE	1:28.4 Staff bank usage 21.6
The midwifery staffing/birth ratios calculated using the Birth Rate Plus Tool in August 2016 for the next 6 months		1:29.12

CARING

Friends & Family (Graph 9-12)

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 September the number that would recommend A&E to friends and family increased to 75.8%, whilst the proportion that would recommend inpatient services, increased slightly to 98.4%. Community services would be recommended by 93.1% and maternity 97.8%

Risks

There has been a small decrease in the response rate for inpatients in September to 43.3% from 51.2% in August.

Forecast Position

On target

Actions

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

Complaints (Graph 13)

Current Position

The Trust received 36 new formal complaints in August and 27 in September, compared to 25 new formal complaints in June and 21 in July.

The number of complaints closed in August was 40 and in September 37 were closed.

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 August the number of complaints received is shown as 0.27 Per 1,000 patient contacts. For September the number was 0.22 per 1,000 patient contacts.

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.

Ward Managers have also reported that daily monitoring of Friends and Family Tests on the wards has enabled them to take immediate action when concerns are raised, which has resulted in a reduction of escalation of issues leading to formal complaints.

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.

Divisions have been asked to reduce the numbers of outstanding complaints to less than 50 by end of December. The Customer Relations Team are working with the Divisions to support this.

Patient Experience Surveys (Graph 14)

Current Position

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

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

Overall performance by the Integrated Care Group – Acute decreased to 97% in September. Performance against the information and involvement competencies decreased to 98% in September from 99% in August, and performance against the quality competency decreased to 95% in September from 96% the previous month.

Overall performance by the Integrated Care Group – Community in September was 100% and there was a score of 100% against Dignity, Involvement and Quality.

Surgery – overall performance increased to 98% in September from 97% in August. Performance against the Information, Involvement and Quality competencies all increased slightly in September.

The Family Care Division's overall performance remained at 96% in September. Performance against Information decreased to 94% in September from 97% in August and performance against Quality increased to 98% from 96% the previous month.

Overall performance for the Diagnostic and Clinical Care Directorate in September, increased to 96%. Performance against the Information, Involvement and Quality competencies also increased from the previous month.

Risks

No risks identified

Forecast Position

On track

Actions

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

EFFECTIVE

Mortality (Graph 15-16)

Current Position

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

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

DFI Indicative HSMR - rolling 12 month - Green rating

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

Risks

Our internal CUSUM monitoring of mortality for all coded conditions reveals a trigger for “Cardiac Arrest and Ventricular Fibrillation”. The lower confidence interval is above 99% which triggers an internal review. This is currently underway, but actual numbers are small. At this trigger level, it is characteristic to receive a notice from the CQC in due course asking to see our actions in response to the trigger.

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 with meets monthly to review performance and develop specific action plans for any alerting mortality groups identified.

Delayed Discharges (Graph 18)

Current Position

The number of delays reported against the delayed transfers of care standard has increased and remained above threshold at 5.85%. The failure of this target is multi-factorial, linked to complex discharge processes involving ELHT and partners. However, we now report at individual patient level each category of delay on a daily basis therefore 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 should 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) which has been operational since September 2015 and will require 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.

- Integrated discharge service - This is a developing work stream which 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.
- System Reviews – Audits and improvement events held to identify opportunities for improvement.
- Continuing Health Care – micromanaged to ensure patients are transferred out of hospital as soon as possible when fit for discharge.
- 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.

- Medically Ready Patients

Emergency Readmissions (Reported 1 month behind - Graph 19)

Current Position

The emergency readmission rate is reported at 11.4% in August 2016 compared with 12.8% in August 2015.

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 current trajectory has shown an improvement over the summer months however winter pressures are a risk for this standard.

Actions

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

The Complex Case Management Team observe the front door position 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 (Graph 20)

Current Position

This measures the proportion of patients exceeding the 6 week target for a diagnostic procedure. In September, 0.14% waited longer than 6 weeks.

Risks

No risks identified

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.

CQUIN (Graph 21)

Current Position

The table shows the quarter 1 position as quarter 2 is not yet available. Evidence is being collated and will be available later this month.

Risks

Risks have been identified around the achievement of the sepsis administration of antibiotics from time of arrival.

RESPONSIVE

Accident and Emergency (Graph 22)

Current Position

Overall performance against the Accident and Emergency four hour standard was reported as 82.7%, below the 95% threshold.

There have been two breaches of the 12 hour standard from decision to admit, in September, all mental health patients. A root cause analysis is being completed for each breach. Mental health patient's 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 patients which are resource intensive for the department.

Risks

Full receipt of the sustainability and transformational funding of £12.5m is dependent on the 4-hour target, RTT and cancer 62-day target.

Forecast Position

The performance for September has shown improvement and continued improvement is anticipated.

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 are working daily in the Emergency Department to prevent admissions and have also been deployed across wards to support early discharge.
- Ambulatory Care is operational 08:00-20:00 with referrals being taken up until 18:00. Work is underway on the expansion of this service and a Project Manager has been appointed to facilitate delivery of this. Where staffing permits Ambulatory Care is operational over the weekend to support flow as a precursor to a full business case being developed as part of Phase 2 of our acute medical model.
- Following recruitment sessional GPs are now commencing shifts with the UCC at BGH.
- Work is being undertaken to employ Hospital based GPs undertaking sessions in specialities including UCCs. 3 Hospital based GPs have been employed and are undergoing employment checks.
- Joint working with Lancashire Care Foundation Trust on further development of the Mental Health Pathway. A review of the Mental Health Liaison Service will now be

undertaken including a review of capacity and demand as well as the impact of new initiatives such as 'Street Triage'.

- Mental Health In-Reach service pilot has now been extended for 6 months from 1st May 2016, whilst the above review of the MHLT is undertaken. A review of the 17 MH breaches between November 15 and July 16 is being undertaken jointly with LCFT and ELHT with a report and action plan to the System Resilience Group.
- An external review of the Mental Health Pathway in Pennine Lancashire is being planned and terms of reference are in development – the review will involve the Royal College of Psychiatrists and the Royal College of Emergency Medicine along with NHS England, ELHT and LCFT and commissioners. A formal request with clear objectives has been submitted to the Royal Colleges. This has been agreed by ELHT, LCFT and Commissioners.
- A review of Nurse Staffing in the Emergency Department and Urgent Care Centres has been undertaken. Further work in relation to benchmarking has commenced with an external partner which will be presented to key stakeholders within ELHT in September.
- 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.
- The Executive Team have established a 'flow team' which has a Senior Doctor, Senior Nurse and Senior Manager dedicated to ensuring patients move through the system efficiently and safely.
- The discharge lounge came into operation on 26th July. This facility is available for patients awaiting transport to go home from ED, UCC, STU and Acute Medical Wards.

Diagnostic work across key pathways with the Programme Management Office is being undertaken.

North West Ambulance Service (Graph 23-24)

Current Position

The ambulance handover compliance indicator is reported at 92.9% in September, which is above the 90% threshold.

The number of handovers over 30 minutes has decreased to 714 for September compared to 884 for August.

The validated NWAS penalty figures for September are 155 missing timestamps, 398 handover breaches (30-60 mins) and 48 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 ambulance handover times while the ambulance crew wait with the patient within the department. Increasing patient acuity with patients presenting with complex co-morbidities continues to place considerable demand on ED.

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 for a further 6 months. This role is now being reviewed with NWAS and ELHT clinicians to explore options to expand the role.
- Following the joint workshop held in February with ELHT, NWAS and the CCGs, ELHT are now capturing all HCP referrals, both walk in and NWAS.

Reception capacity has been increased. Staff are in post and currently undertaking training. This supports timely handovers and more efficient transfer of patients from the department.

Referral to Treatment (Graph 25-27)

Current Position

The 18 week referral to treatment % ongoing position has remained at 93.9% at end of September, which is above the 92% standard.

There was one Orthopaedic patient waiting over 52 weeks at the end of September.

Risks

Full receipt of the sustainability and transformational funding of £12.5m is dependent on the 4-hour target, RTT and cancer 62-day target.

Forecast Position

Improvement is expected in this standard and it is anticipated that performance will remain above the national standard of 92%

Actions

It is anticipated that the surgical elective care centre opened in October 2016 will reduce the number of cancelled operations and improve the 18 week position. Regular monitoring of patient tracking lists is undertaken and risks are escalated to senior managers.

Cancer (Graph 28-32)

Current Position

Due to increasing demand and pressures on capacity, the 62 day target of 85% was not achieved in August at 80.8%. At tumour site level, six groups did not meet the 62 day target in August; Colorectal (55.6%), haematology (75.0%), head & neck (70.0%), skin (82.6%), upper GI (75.0%) and urology (72.7%). There were six patients in August treated after day 104.

There were 17.5 breaches of the 62 day standard in August. Reasons for breaches include capacity issues, medical/clinical issues, patient choice and complex pathways.

Risks

Full receipt of the sustainability and transformational funding of £12.5m is dependent on the 4-hour target, RTT and cancer 62-day target.

Forecast Position

September 62 Day Target is forecast to achieve, although still currently being validated.

Actions

Improvements to theatre staffing from November will enable more sessions through increased capacity. Risks are escalated to senior managers and cancer performance is monitored weekly by the director of operations.

Cancelled Operations – 28 Day breach

Current Position

There were three cancelled operations that were not rebooked within 28 days in September. One general surgery and two trauma & orthopaedics. All three of the original procedure dates were cancelled on the day due to bed pressures. One of the patients was not been rebooked within 28 days due to patient having complex comorbidities that require a list to be set up at the Blackburn site. This has proved difficult due to the surgeon not having a list in existence on that site and current bed pressures. The other two patients breached due to bed pressures and emergency patients. They have now been treated.

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 procedure 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.

Length of Stay (Graph 33)

Current Position

Trust non elective average length of stay has increased on last month to 5.0 days for September.

The elective length of stay has decreased on last month to 2.3 days.

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

Risks

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

Forecast Position

Length of stay for elective patients should reduce following the opening of the elective care centre, with more patients treated as day case.

Actions

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 (Graph 37)

Current Position

The Trust sickness absence rate is currently at 4.8% which is above the 4% threshold.
Rates are highest in Estates (currently 6.99%) and Integrated Care Group (currently 6.09%)
There have been unusually high levels of short term sickness (2.56%)
Long Term sickness (2.26%) attributed to anxiety/stress and musculoskeletal problems continue to be the main reasons for sickness absence.

Risks

High sickness rates are a financial risk as bank and agency expenditure increases to cover shifts.

Forecast Position

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

Actions

- Sickness Absence summit held on 22nd June 2016 – Discussion with managers to identify what further support can be offered –managing attendance action plan now finalised
- Sickness Absence Policy review complete and agreed with staff side - trigger levels now more robust and managers have further discretion.
- Tender exercise for employee assistance programme complete, awarded and launched
- Divisional sickness clinics and bespoke training
- Schedule of audits and compliance checks
- Internal Audit of Trust sickness absence procedures – awaiting recommendations
- Review of Mental Health Strategy complete – ODB approved business case for Trust therapy staff and staff now recruited
- Mental Health First Aid training successful pilot which will be rolled out
- Annual training sessions for managers in relation to managing attendance now scheduled

- Continuing provision of Fast physio and Work smart services - Occupational Therapist Wellbeing Practitioner in place who supports recommendations relating to returns to work.
- Additional Physios recruited
- Letters of recognition for staff with no sickness for 2015/6 have been sent out. Further incentive schemes being explored
- Referral of all staff highlighting stress/anxiety and musculoskeletal problems to Occupational Health Services from day one of sickness absence
- Continuing promotion of health & wellbeing initiatives – full health and well-being action plan now developed
- Data Analysis of bank holiday sickness completed – trends highlighted and data provide to managers for action
- Review of all long term sick cases has been undertaken – action plans in place for management of all cases.
- Significant improvement in OH waiting times
- Appointment of health and wellbeing practitioners

Turnover rate and Temporary costs (Graph 38-39)

Current Position

Overall the Trust is now employing 6971 FTE staff in total. This is a net increase of 83 FTE from the previous month. The number of nurses in post at Sep 2016 stood at 2224 FTE which is a net increase of 18 FTE since last month and a net increase of 170 FTE since 1st April 2013. There are a further 105 nurses in the recruitment pipeline. The vacancy rate for nurses now stands at 11.1% (279 FTE)

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

In September the Trust spent £2,484,715 on bank and agency. This is worse than in Sep 2015 (£2,021,322)

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

- Nurse open day held on 17th September 2016 – 9 offers.

- Overseas Recruitment (Medical Staff) – Trip to India took place between 21st -27th September. Plans to recruit 15 -20 WTE senior speciality doctors for ED/ Acute Medicine. Offers made to 8 ED Speciality Doctors and Clinical Fellow and 10 Specialty Doctors in Medicine
- Continuing use of medical staffing agencies to target medical vacancies – exclusivity with TTM now agreed
- ED Recruitment national campaign continuing
- Partnering with The Guardian newspaper to develop an attraction piece for health community online
- Project underway to look at reducing recruitment time to hire across the Trust to support reducing the vacancy gap and reduction in bank/agency spend
- Additional OH staff recruited which will support reducing time to undertake pre-employment screening
- Nursing and Midwifery Recruitment Project Group established to drive this agenda
- Recruitment & Retention premium for ED consultants agreed from 1st May. Currently exploring possibility for other specialties
- Implemented RMO model
- Streamline processes implemented for internal bank nurses
- Retention – age profiling exercise underway with view to promoting flexible retirement options to nurses approaching retirement age

- Re-launch of care to make a difference campaign planned including print and social media campaign

- Rolling national campaign for Band 5 Nurse
- Medical Workforce task group in ICG established
- Medical agency group established
- Review of Medical Staffing functions including centralised booking of agency staff – approved and recruitment almost complete – transition to new model complete
- Improving utilisation of Staff flow – now achieved 87%
- Continued roll out of eRostering and improved compliance
- Additional eRostering training dates, and on ward training/refresher sessions
- Restructure of eRostering Implementation Consultants, to be divisionally led, improving working relationships
- Attendance to senior nurses meetings to look at queries and resolves any issues quickly and effectively
- Trust wide agency reduction task group established and action plan in place linked to Lord Carter Recommendations
- Creation of eRostering Optimisation Plan
- Develop with Bank and Informatics a new Ward level scorecard with key indicators
- Audit agreed procedures for the booking of bank and agency shifts and the payment of associated invoices
- Audit agreed procedures for the booking of medical agency locums
- Exec Board agreed rates for Trust locums and established process when divisions request a variation to the agreed rate

- Tiered approach to the booking of temporary staff
- Negotiated competitive rates with local suppliers
- Promotion of flexible retirement
- Retention payments for new nurse recruits
- Policy for buying and selling annual leave
- Introduced weekly pay for bank staff
- Automatic enrolment of new substantive staff on to bank
- Drafting new Bank and Agency Workers Policy to ensure effective use of the temporary workforce
- On-going recruitment to bank
- Established Trust project group to manage bank and agency spend
- PIDS and project plans agreed for transformation programmes aimed at reducing temporary staffing
- Preferred supplier arrangements have been agreed in exchange for more competitive rates.
- Preliminary discussions with local trusts about joint medical staff bank arrangements
- Project plan to establish trust medical bank
- Implemented processes for agreeing breaches to agency rules and robust monitoring processes.
- Ongoing bank recruitment in ED, NICU, Theatres
- Additional resources agreed to speed up the bank recruitment time to hire
- All bank and agency requests over a 4 week period now to be agreed at WCG
- Large scale Bank recruitment with HCAs and A&C with the focus of eliminating both staff groups from agency by 1st September 2016
- Bank, Recruitment and eRostering working together as a group to focus on temporary staffing requests and linking in with Divisions and units and to discuss best practice when rostering and requesting temporary staff
- All agency invoices now being approved centrally through the finance team to ensure the correct rate has been charged and all bookings booked on to Health roster
- Professional Judgement meeting taking place in October to ensure maximum resource efficiency
- Allocate on arrival scheme
- Conversion of Bank HCAS to Fixed term contracts to reduce agency spend

Appraisals & Job Plans (Graph 41-43)

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 September was 40%, 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.

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 - September 2016.

The consultant appraisal rate has increased to 45% from 37% last month. The other medical staff appraisal rate has also improved to 61% from 52% last month.

The AFC appraisal rates continue to be reported as a rolling 12 month figure and are currently at 65% which is below the threshold of 90%

Risks

None identified

Forecast Position

Compliance

Actions

There has been a range of actions to support compliance including:

- Additional PDR and Learning Hub sessions offered to staff from across the organisation
- Bespoke PDR and Learning Hub sessions provided to groups and individual staff undertaken and where requested this had taken place in the workplace.
- A quick PDR Guidance has been made available on the Learning Hub, the Message board and the Learning and Development page of the Intranet
- Flyers have been distributed across the organisation aimed at both Reviewers and Reviewee's detailing what PDR's are and whom to contact for further information
- Staffs are encouraged to consider how PDR's enhance their leadership and management role within their teams/services through various forms of facilitated activities.
- Service support up to the CQC inspection in 2015 was offered to support Divisions in inputting the dates of completed PDRs offered by the Learning and Development department.
- The *Get Ready for Revalidation Awareness Sessions* promotes Personal Development Reviews as a fundamental part of the process
- To promote Talent Management within the organisation we are in the process of implementing a *People Development Strategy* which will incorporate learning and development opportunities accessible to all, integrated within individuals appraisals and enable management of own development in accordance with their aspirations.
- An animated video is being developed which provides an overview of how to carry out an appraisal whilst promoting quality and engagement in the Personal Development Review process
- Work has commenced in making the Appraisal/PDR inputting onto the Learning Hub simpler in readiness for a new template which will be available from 1st January 2017

'Have you had the Conversation' campaign commenced to promote a quality appraisal conversation

Core Skills Training (Graph 45)

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%

Six of the eleven areas are currently below the threshold 'Basic Life Support' (73%), 'Prevent health wrap' (76%), 'Health, Safety and Welfare Level1' (66%), 'Infection Prevention' (64%), 'Information Governance'(92%) and 'Safeguarding adults' (29%).

Risks

No risks identified

Forecast Position

Compliance

Actions

- All new starters complete CST e-learning on induction programme by end of day 2
- Range of communications have continual centrally and via HROD bulletins and within compliance reports and meetings
- Training needs analysis document published on Oli further reinforcing the message of who needs to do what training
- Compliance % and divisional trajectory reports are distributed at the beginning of each month centrally.
- Reports training has been implemented from December 2015 and Managers now have direct access to run real time reports for their departments etc.
- All staff have the function available on learning hub to produce red, amber and green compliance reports for their team/area
- Ward and department support and bespoke support sessions in place
- Facilitated Core Skills e-learning sessions running weekly for staff who cannot access this in the workplace or who need additional IT skills support
- Combined IT skills and facilitated Core Skills e-Learning sessions for Estates and Facilities staff
- Learning Hub sends out reminders to individual and their manager at 90, 60 and 30 days prior to expiry date and also once training has expired.
- Staff prompted around CST when attending other courses
- Other controls – compliance checks in place before funded study leave.
- Responsibilities included in new Nursing and Midwifery leadership programme
- Implementation of the Pay progression policy (May 2014)
- Review of improved reports format to divisions

Financial Position (Graph 46-50)

Current Position

The Trust is reporting a deficit of £1.8m for the period ending 30th September 2016, a further deterioration of £0.3m, in line with expectations at this stage.

Risks

Partial achievement of the sustainability funding

Non-achievement of the Safely Releasing Cost Programme (SRCP)

Continued usage of agency and locum staff over and above the resources available.

Non-achievement of the agency maximum threshold of £10.5m.

Non–achievement of the 3% Qualified nurse agency cap

The cash impact of any non-delivery

Pay Analysis

The Trust pay expenditure for Month 6 was £26.3m of which:-

Agency Expenditure £1.6m in month, £7.6m cumulative to date

Bank Expenditure £1.0m, £5.5m cumulative to date

Overtime Expenditure £0.1m, £0.6m cumulative to date

Trust wide vacancies of 642wte (August 703wte)

Agency Expenditure

Agency expenditure forecast to year end stands at £15.2m which is £4.7m above the Trust target of £10.5m.

Qualified nursing has seen an increase on overall expenditure % for September 4.1% against the target of 3%

Capital expenditure

The Trust investment in capital to the end of September represents 76% of the planned

expenditure for this period.

Better Payment Practice Code (BPPC)

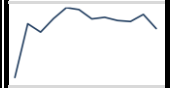
The Trust continues to meet the BPPC target of 95% compliance for non-NHS invoices paid on time to date in terms of both volume and value this month and for the year to date. The value of NHS invoices paid on time is also above target. The number of NHS invoices paid on time remains below target at 93.7% for the year to date.

Safely Releasing Cost Programme

The Trust has identified schemes which total £14.2m for 2016-17 in line with the 3% target established for the Trust to meet its deficit control total of £3.7m.

APPENDIX A – SCORECARD

Safe

		Threshold 16/17	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Monthly Sparkline
M64	CDIFF	28	4	4	5	3	3	1	2	1	2	3	4	1	5	
M65	MRSA	0	0	0	0	1	0	0	0	0	0	0	0	0	0	
M66	Never Event Incidence	0	0	0	0	1	1	0	1	0	0	0	1	0	0	
M67	Medication errors causing serious harm (Steis reported date)	0	0	0	0	0	0	0	0	0	0	1	0	0	0	
C28	Percentage of Harm Free Care	92%	99.4%	99.0%	99.1%	99.2%	99.1%	99.4%	99.1%	99.7%	98.8%	99.1%	99.4%	99.2%	99.1%	
M68	Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	97.4%	98.9%	98.7%	99.1%	99.4%	99.3%	99.1%	99.1%	99.0%	99.0%	99.2%	98.8%		
M69	Serious Incidents (Steis)		3	3	8	10	7	9	7	10	2	6	5	7	5	
M70	CAS Alerts - non compliance	0	0	0	0	1	0	0	0	0	0	0	0	1	2	
M146	Safer Staffing -Day-Average fill rate - registered nurses/midwives (%)	80%	87%	91%	92%	90%	89%	89%	86%	88%	89%	87%	86%	85%	87%	
M147	Safer Staffing -Day-Average fill rate - care staff (%)	80%	105%	105%	109%	105%	105%	105%	107%	110%	114%	116%	118%	126%	121%	
M148	Safer Staffing -Night-Average fill rate - registered nurses/midwives (%)	80%	98%	99%	98%	97%	97%	97%	97%	97%	99%	98%	99%	98%	99%	
M149	Safer Staffing -Night-Average fill rate - care staff (%)	80%	114%	112%	117%	116%	120%	120%	121%	124%	122%	129%	136%	142%	138%	
M150	Safer Staffing - Day -Average fill rate - registered nurses/midwives- number of wards <80%	0	10	6	3	9	8	12	19	16	11	17	15	21	21	
M151	Safer Staffing - Night -Average fill rate - registered nurses/midwives- number of wards <80%	0	0	1	0	0	0	0	0	0	0	1	1	0	1	
M152	Safer Staffing - Day -Average fill rate - care staff- number of wards <80%	0	4	1	1	2	3	4	3	2	0	0	0	0	0	
M153	Safer Staffing - Night -Average fill rate - care staff- number of wards <80%	0	2	1	1	1	3	2	3	2	1	1	1	1	1	

Caring

		Threshold 16/17	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Monthly Sparkline
C38	Inpatient Friends and Family - % who would recommend	92.07%	98.7%	98.2%	98.1%	98.8%	99.1%	96.9%	98.4%	98.6%	97.9%	98.6%	98.5%	98.2%	98.4%	
C40	Maternity Friends and Family - % who would recommend	91.86%	94.9%	94.1%	95.8%	92.6%	93.4%	95.5%	96.6%	96.4%	96.7%	95.9%	95.8%	97.0%	97.8%	
C42	A&E Friends and Family - % who would recommend	74.90%	84.7%	83.2%	83.9%	85.1%	78.3%	80.8%	76.5%	80.4%	75.7%	76.3%	75.0%	73.9%	75.8%	
C44	Community Friends and Family - % who would recommend	88.62%	91.6%	94.6%	93.9%	93.7%	94.4%	93.7%	93.7%	94.0%	94.9%	94.3%	93.6%	94.3%	93.1%	
C15	Complaints – rate per 1000 contacts	0.4	0.2	0.2	0.2	0.2	0.3	0.3	0.2	0.3	0.2	0.2	0.2	0.3	0.2	
M52	Mixed Sex Breaches	0	0	2	0	0	0	0	0	0	0	0	0	0	0	

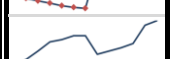
Effective

		Threshold 16/17	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Monthly Sparkline
M73	Deaths in Low Risk Categories - relative risk	Outlier	65.2	68.8	68.6	68.5	75.5	75.6	70.4	67.8	71.6					
M74	Hospital Standardised Mortality Ratio - Weekday (DFI Indicative)	Outlier	103.1	100.2	100.9	98.6	96.4	94.8	94.9	96.1	96.1					
M75	Hospital Standardised Mortality Ratio - Weekend (DFI Indicative)	Outlier	106.5	106.9	104.0	101.6	101.9	101.7	101.6	106.5	102.0					
M54	Hospital Standardised Mortality Ratio (DFI Indicative)	Outlier	104.0	101.9	101.7	99.4	97.8	96.6	97.0	99.1	97.6					
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Outlier	1.06			1.06			1.06							
C16	Emergency re-admissions within 30 days		12.65%	12.7%	13.4%	13.3%	13.3%	12.6%	12.8%	12.3%	13.0%	13.2%	11.0%	11.4%	13.0%	
M89	CQUIN schemes at risk	0	0			3			2							

Responsive

		Threshold 16/17	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Monthly Sparkline
C2	Proportion of patients spending less than 4 hours in A&E	95%	94.8%	93.6%	94.4%	94.5%	88.2%	90.0%	87.8%	88.5%	85.5%	85.5%	84.3%	77.9%	82.7%	
M62	12 hour trolley waits in A&E	0	0	0	1	2	0	1	0	2	3	3	7	9	2	
C1	RTT admitted: percentage within 18 weeks	95%	85.0%	85.3%	85.0%	86.3%	82.5%	83.2%	81.2%	78.5%	80.4%	79.2%	73.7%	79.0%	76.2%	
C3	RTT non- admitted pathways: percentage within 18 weeks	90%	97.5%	96.3%	97.5%	95.9%	95.3%	95.6%	96.3%	94.4%	94.4%	95.0%	93.8%	94.9%	94.9%	
C4	RTT waiting times Incomplete pathways	92%	96.7%	95.9%	94.6%	93.9%	94.5%	95.2%	95.6%	94.8%	93.7%	94.7%	95.7%	93.9%	93.8%	
C37.1	RTT 52 Weeks (Ongoing)	0	0	0	0	0	0	0	0	1	2	1	1	0	1	
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1%	0.1%	0.0%	0.1%	0.1%	0.2%	0.2%	0.2%	0.2%	0.1%	0.2%	0.3%	0.3%	0.1%	
C18	Cancer - Treatment within 62 days of referral from GP	85%	85.9%	93.2%	89.2%	91.0%	93.7%	86.6%	88.4%	85.6%	82.8%	81.6%	87.8%	80.8%		
C19	Cancer - Treatment within 62 days of referral from screening	90%	95.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%	96.4%		
C20	Cancer - Treatment within 31 days of decision to treat	96%	100.0%	100.0%	100.0%	100.0%	98.3%	100.0%	98.9%	100.0%	98.4%	99.1%	99.4%	96.3%		
C21	Cancer - Subsequent treatment within 31 days (Drug)	98%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	100.0%		
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94%	100.0%	97.4%	100.0%	100.0%	99.0%	97.3%	94.1%	97.1%	100.0%	97.8%	97.7%	97.5%		
C24	Cancer - seen within 14 days of urgent GP referral	93%	96.4%	96.3%	96.7%	96.7%	97.6%	95.5%	95.6%	95.2%	95.1%	94.3%	95.4%	93.9%		
C25	Cancer - breast symptoms seen within 14 days of GP referral	93%	94.7%	97.1%	93.0%	97.2%	96.4%	97.3%	93.6%	95.2%	94.1%	93.0%	97.5%	96.6%		
M9	Urgent operations cancelled for 2nd time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
C27a	Not treated within 28 days of last minute cancellation due to non clinical reasons - actual	0	0	0	0	0	0	0	0	0	1	0	1	1	3	
M55	Proportion of delayed discharges attributable to the NHS	3.5%	3.6%	3.6%	3.0%	4.2%	4.4%	4.8%	4.8%	4.3%	4.4%	4.6%	5.5%	4.5%	5.8%	
M90	Average LOS elective and daycase		2.8	2.4	2.9	2.8	2.9	3.0	2.8	2.8	2.6	2.9	2.3	3.0	2.3	
M91	Average LOS non-elective		4.4	4.6	4.6	4.6	4.6	4.6	4.9	4.8	5.0	5.0	4.5	4.9	5.0	

Well led

		Threshold 16/17	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Monthly Sparkline
C31	NHS England Inpatients response rate from Friends and Family Test	16%	45.9%	49.1%	43.7%	49.8%	48.9%	48.5%	50.1%	45.9%	54.0%	50.5%	47.7%	51.2%	43.3%	
C32	NHS England A&E response rate from Friends and Family Test	4%	25.0%	25.4%	23.0%	23.7%	21.1%	21.7%	22.2%	21.8%	19.8%	19.7%	20.5%	21.5%	21.1%	
M77	Trust turnover rate	12%	9.7%	9.6%	9.5%	9.4%	9.3%	9.2%	8.7%	8.9%	8.9%	9.0%	9.0%	9.4%	9.6%	
M78	Trust level total sickness rate	3.75%	4.81%	4.91%	4.93%	4.74%	4.81%	4.74%	4.45%	4.5%	4.5%	4.9%	4.9%	4.8%		
M79	Total Trust vacancy rate	5%	5.2%	6.8%	6.5%	7.5%	7.8%	7.1%	7.3%	8.0%	6.7%	7.7%	8.0%	7.3%	6.2%	
M80.1	Mandatory Training	95%	89.0%	92.0%	93.0%	90.0%	89.0%	85.0%	82.0%							
M80.2	Safeguarding Children	80%	84.0%	85.0%	86.0%	86.0%	87.0%	87.0%	88.0%	88.0%	88.0%	90.0%	91.0%	93.0%	92.0%	
F8	Temporary costs as % of total paybill	4%	8%	8%	8%	8%	8%	9%	9%	7%	7%	8%	9%	10%	10%	
F9	Overtime as % of total paybill	0%	1%	0%	1%	0%	0%	1%	0%	1%	0%	0%	0%	0%	0%	
F1	Cumulative Retained Deficit for breakeven duty (£M)	(3.7)	(8.2)	(8.8)	(9.5)	(10.1)	(10.8)	(11.2)	(11.5)	(0.3)	(0.6)	(0.9)	(1.2)	(1.5)	(1.8)	
F2	SRCP Achieved % (green schemes only)	100.0%	46%	49%	54%	60%	62%	64%	64%	52%	54%	56%	59%	71%	74%	
F3	Liquidity days	>(14.0)	(13.2)	(12.7)	(13.2)	(13.5)	(14.0)	(14.4)	(5.0)	(5.3)	(5.9)	(5.6)	(5.5)	(5.8)	(6.2)	
F4	Capital spend v plan	85%	75%	72%	71%	71%	72%	71%	90%	93%	91%	79%	73%	75%	76%	
F5	FSSR (Continuity of risk rating)	3	2	2	2	2	2	2	3	2	2	3	3	3	3	
F6	FSSR - Liquidity rating	2	3	2	2	2	1	1	3	3	3	3	3	3	3	
F7	FSSR - Capital Servicing Capacity rating	1	1	1	1	1	1	1	3	1	1	2	2	2	2	
F10	FSSR - I&E Margin	3			1	1	1	1	4	2	2	2	2	2	2	
F11	FSSR - I&E Margin variance from plan	4			4	4	4	4	4	2	2	3	3	4	3	
F12	BPPC Non NHS No of Invoices	95%	96.0%	96.0%	95.9%	95.9%	95.7%	95.5%	95.5%	96.8%	96.3%	96.0%	96.2%	96.4%	96.3%	
F13	BPPC Non NHS Value of Invoices	95%	94.5%	94.8%	94.8%	95.1%	95.3%	95.2%	95.4%	98.2%	96.7%	95.7%	95.8%	96.2%	96.0%	
F14	BPPC NHS No of Invoices	95%	95.4%	95.6%	95.5%	95.6%	95.2%	95.0%	95.0%	95.3%	95.3%	93.2%	93.7%	93.4%	93.7%	
F15	BPPC NHS Value of Invoices	95%	96.4%	97.0%	96.6%	96.6%	96.6%	96.6%	96.4%	99.5%	95.8%	95.9%	96.6%	96.6%	97.0%	

East Lancashire Hospitals NHS
NHS Trust

APPENDIX B – GRAPHS

Safe | Personal | Effective

SAFE

Chart 1 - C Difficile actual against threshold

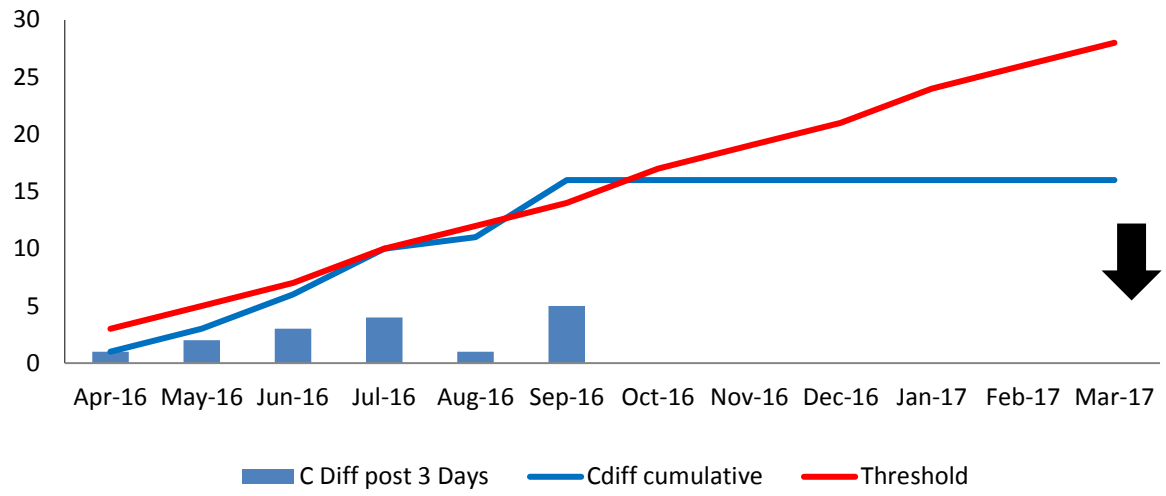


Chart 2 - Safe Infection Control - C Diff per 100,000 occupied bed days

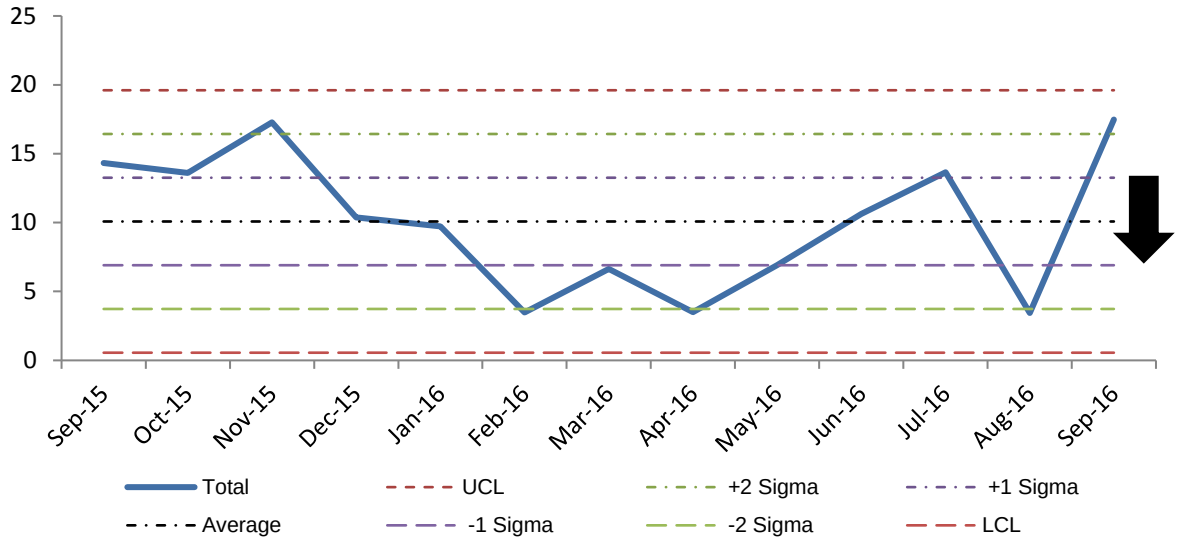
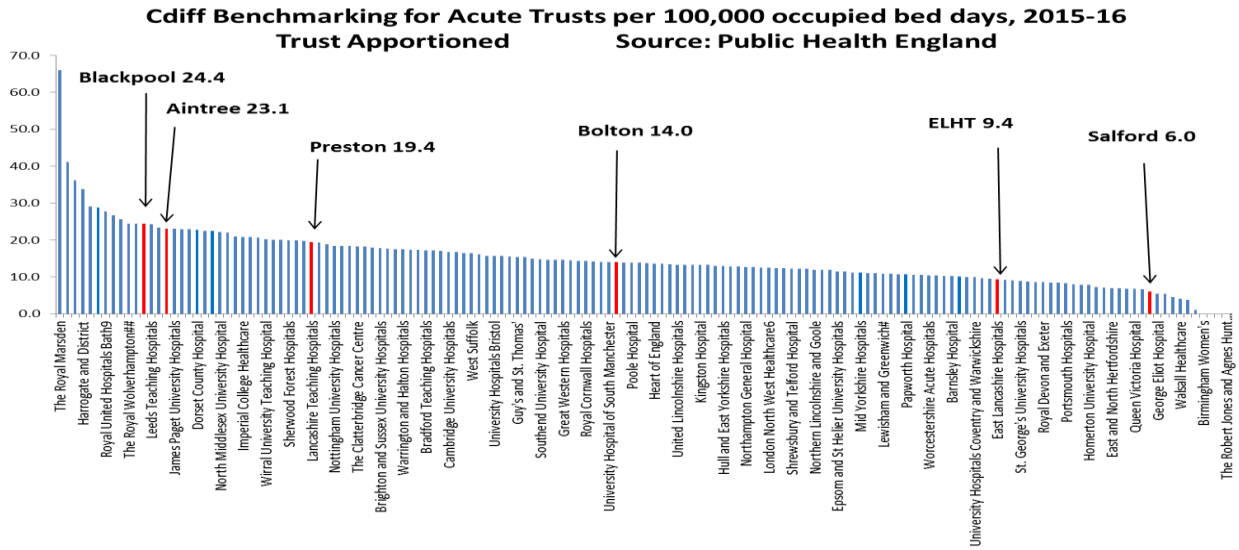


Chart 3 - C Diff benchmarking



SAFE

Chart 4 - % Harm Free Care from safety thermometer

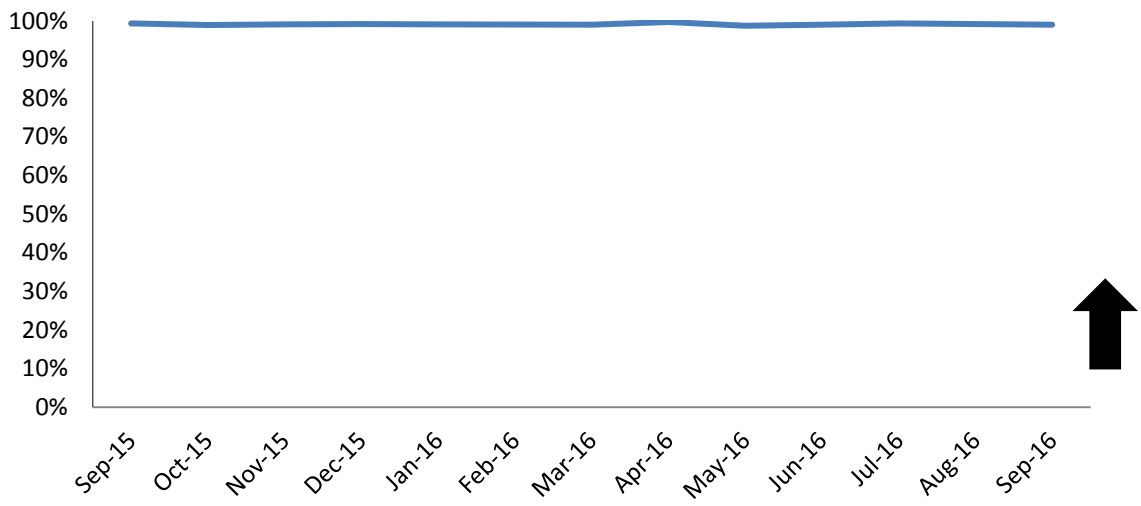


Chart 5 - VTE assessment

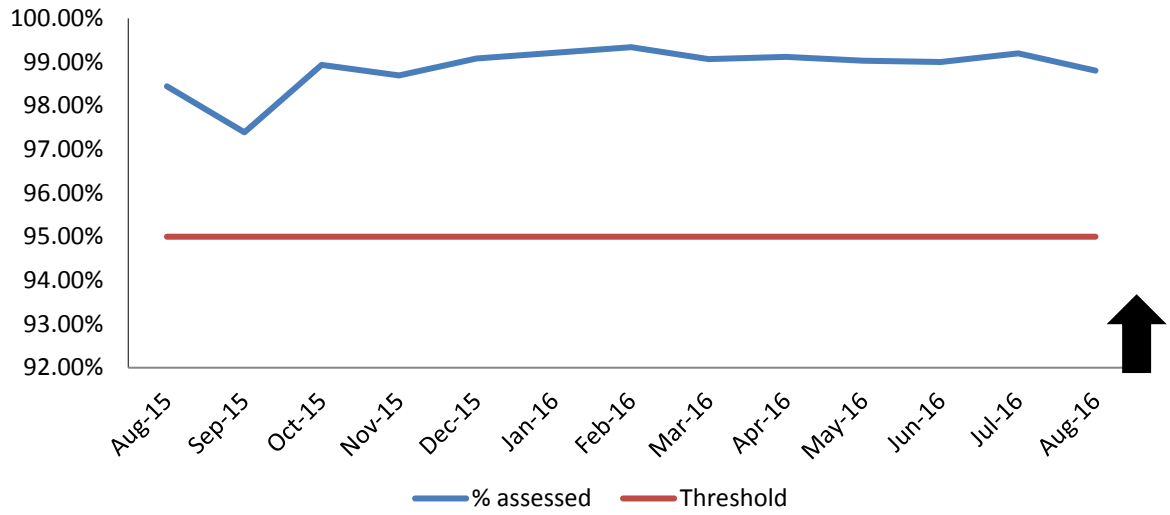
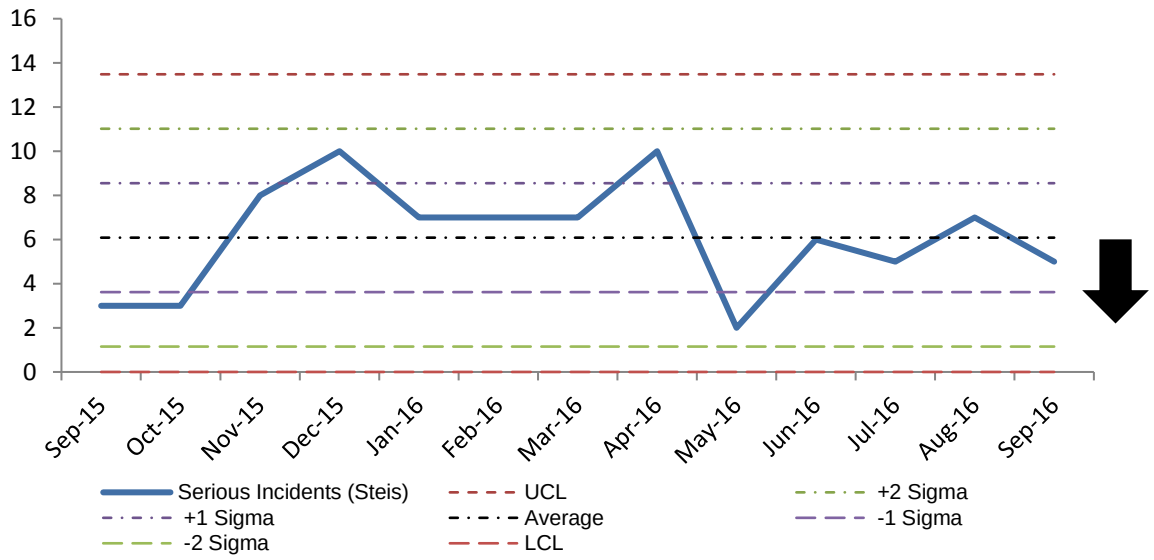


Chart 6 - Serious Incidents



SAFE

Chart 7 - Registered Nurses/Midwives

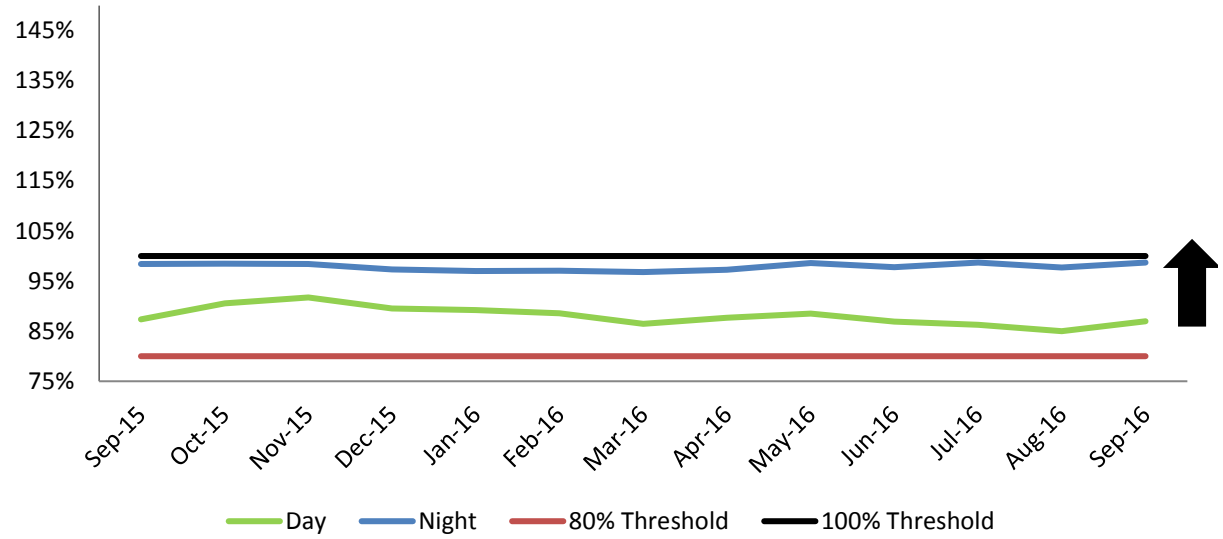
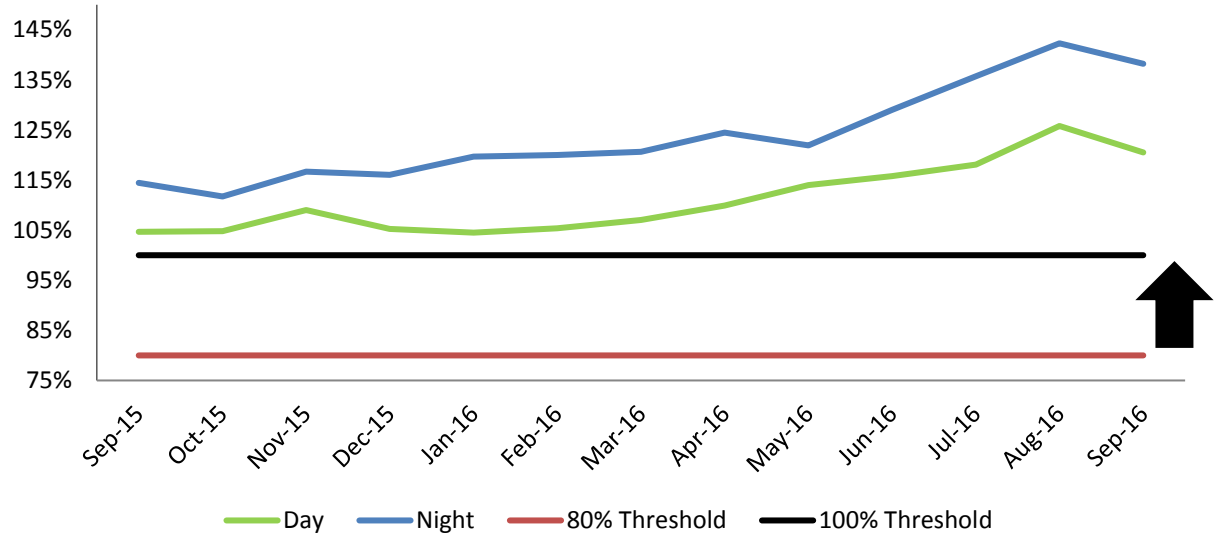


Chart 8 - Care Staff



CARING

Chart 9 - Friends & Family A&E

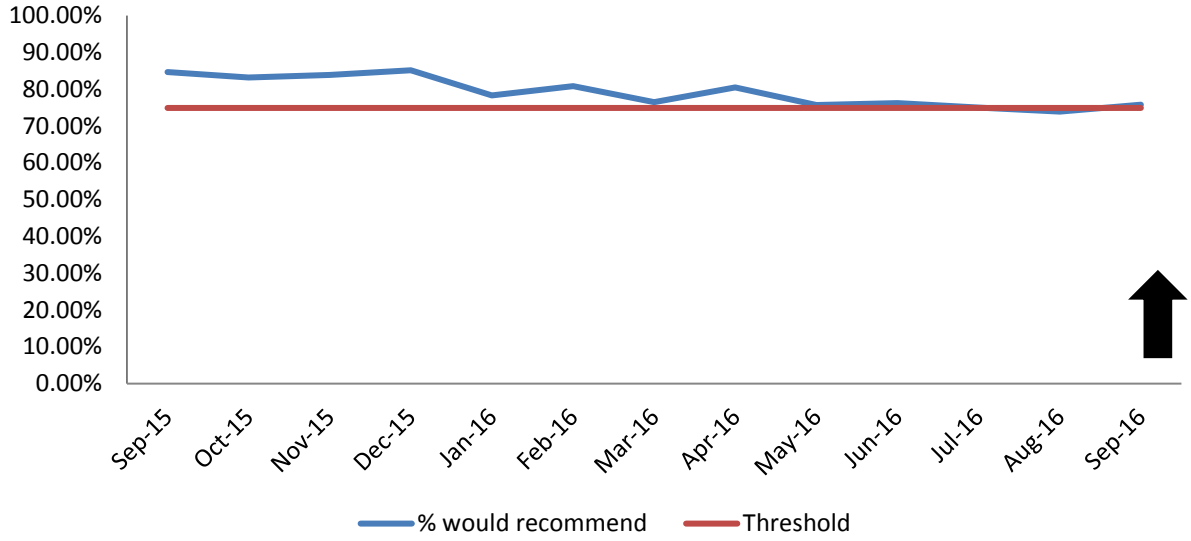


Chart 10 - Friends & Family Community

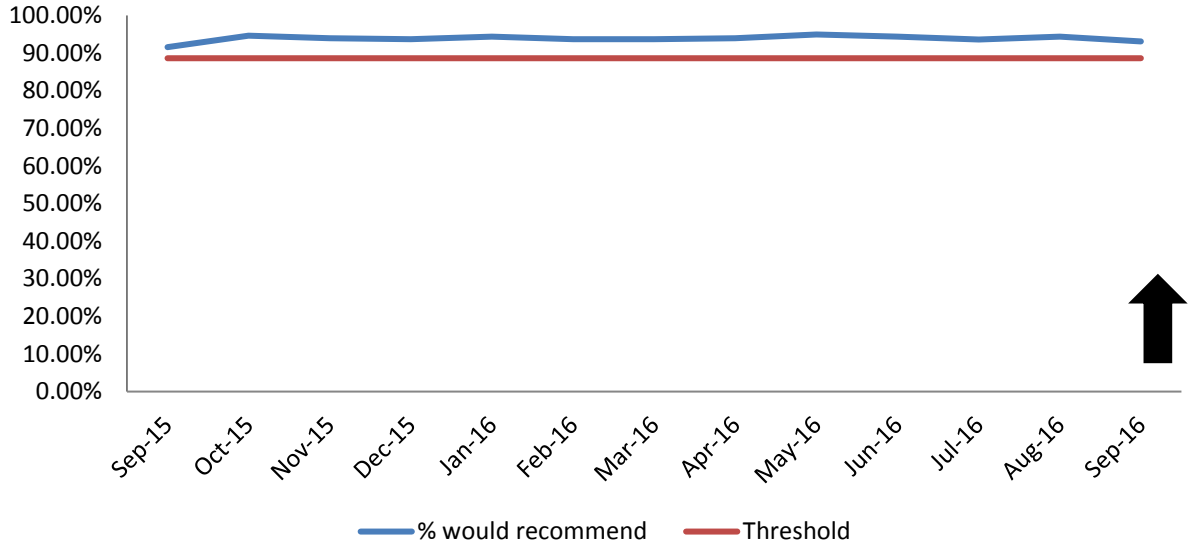
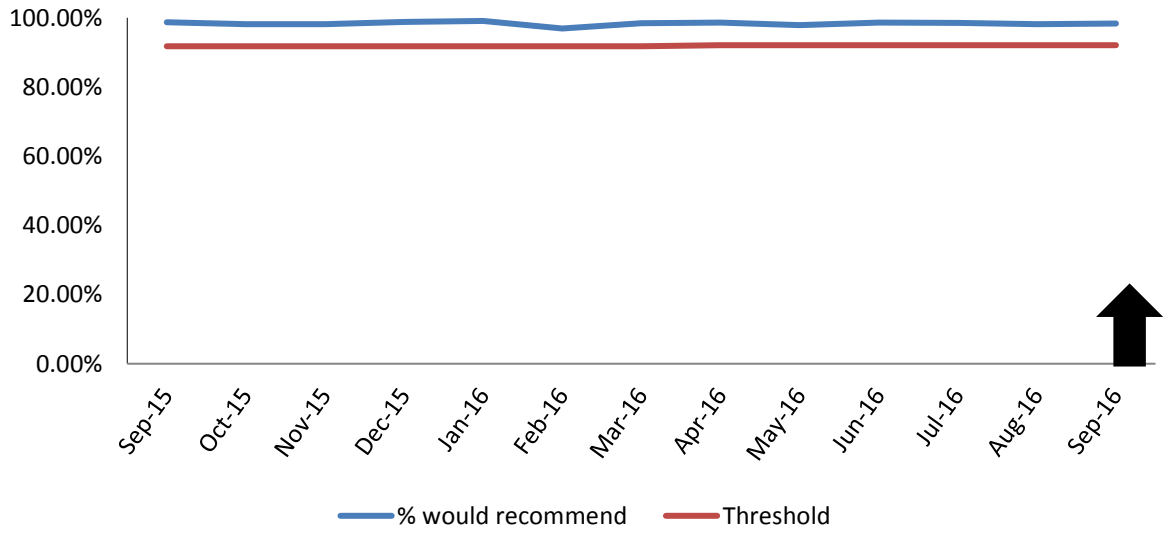
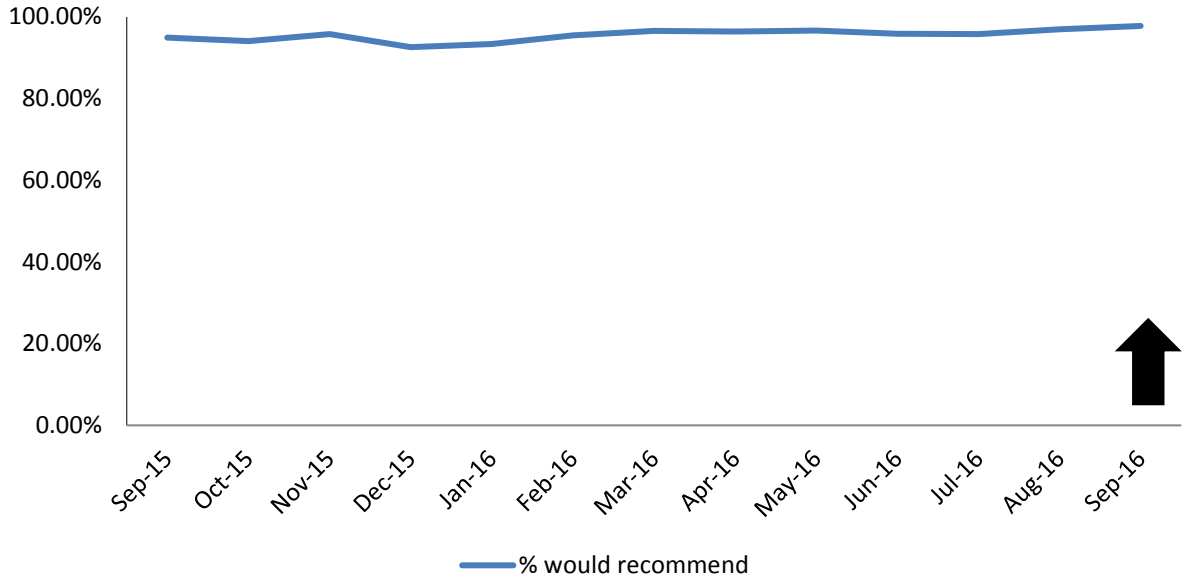


Chart 11 - Friends & Family Inpatient



CARING

Chart 12 - Friends & Family Maternity



CARING

Chart 13 - Complaints per 1000 contacts

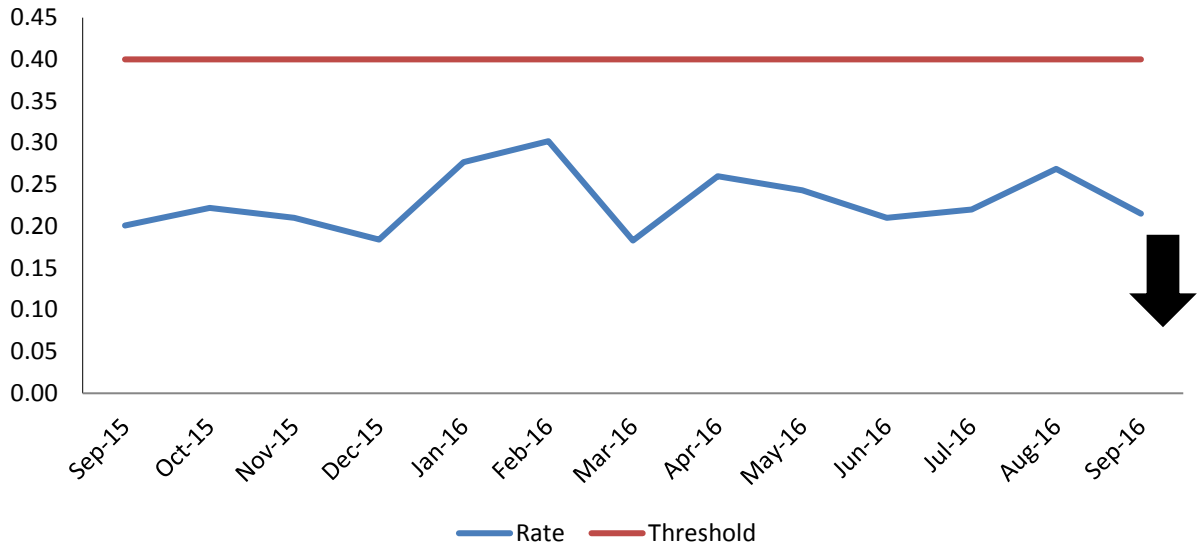


Chart 14 - Patient Experience

September 2016 Totals	Overall		Dignity	Information	Involvement	Quality
	No.	%	%	%	%	%
Trust	2463	97%	99%	97%	99%	97%
Integrated Care Group - Acute	620	97%	99%	98%	98%	95%
Integrated Care Group - Community	418	100%	100%	99%	100%	100%
Surgery	450	98%	99%	98%	99%	99%
Family care	506	96%	99%	94%	99%	98%
Diagnostic and Clinical	450	96%	95%	96%	99%	97%

EFFECTIVE

Chart 15 - Dr. Foster Indicative HSMR monthly Trend

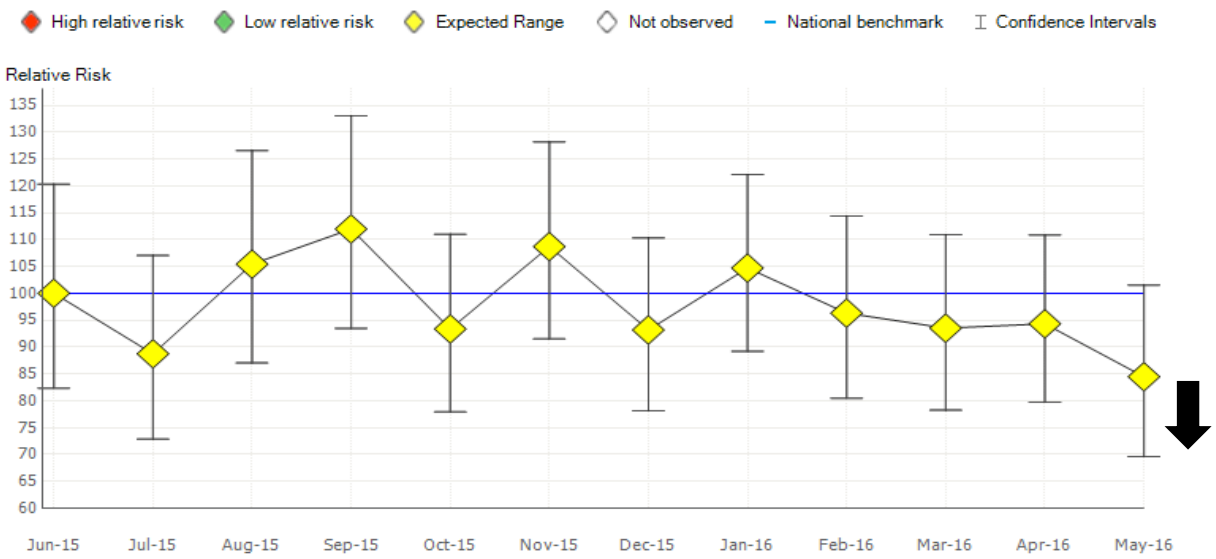


Chart 16 - SHMI Published Trend

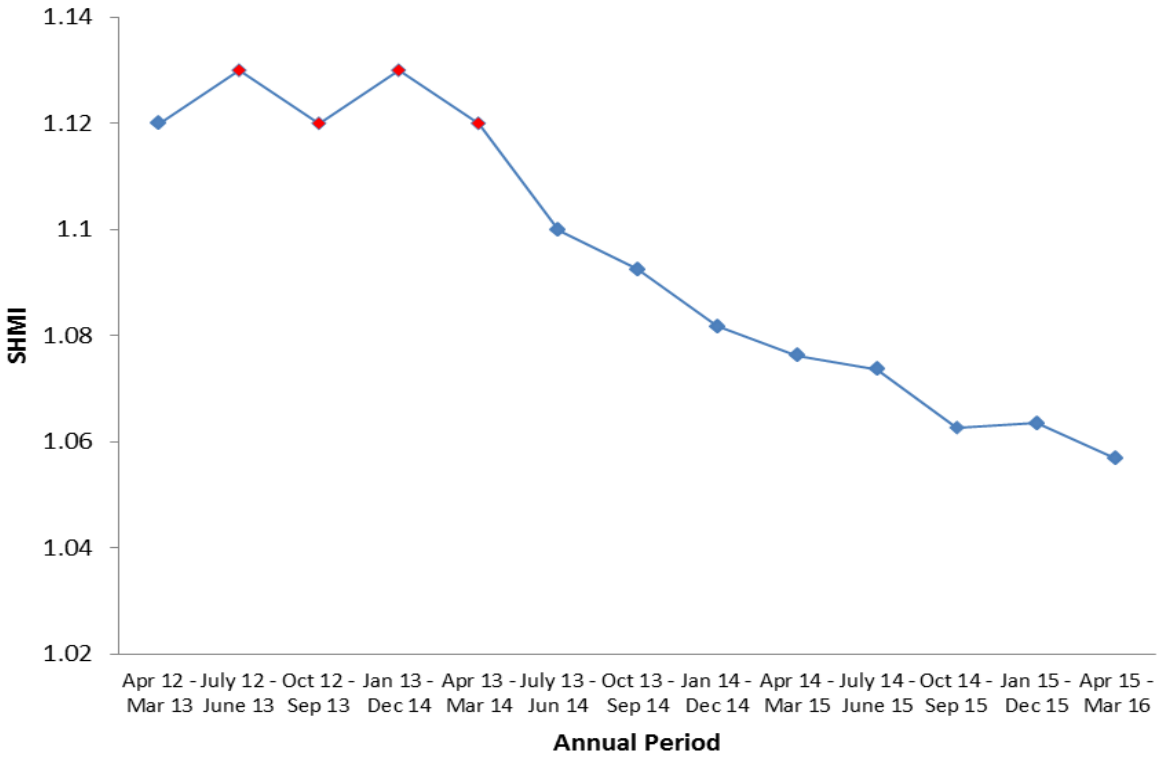


Chart 17 - DFI Indicative HSMR rolling 12 month

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

EFFECTIVE

Chart 18 - Delayed Discharges per 1000 bed days

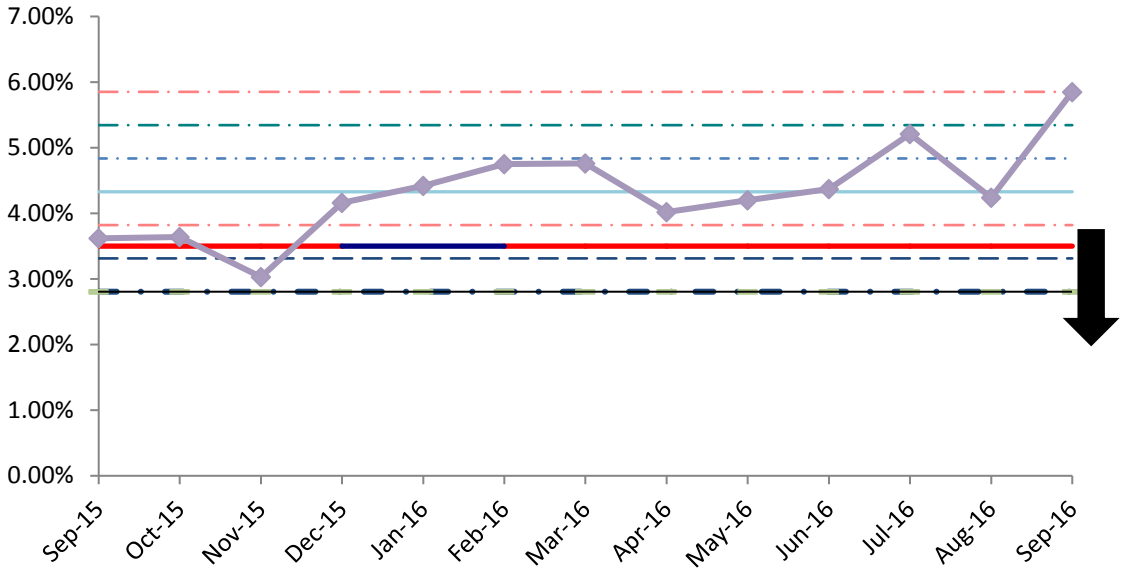


Chart 19 - Emergency Readmissions

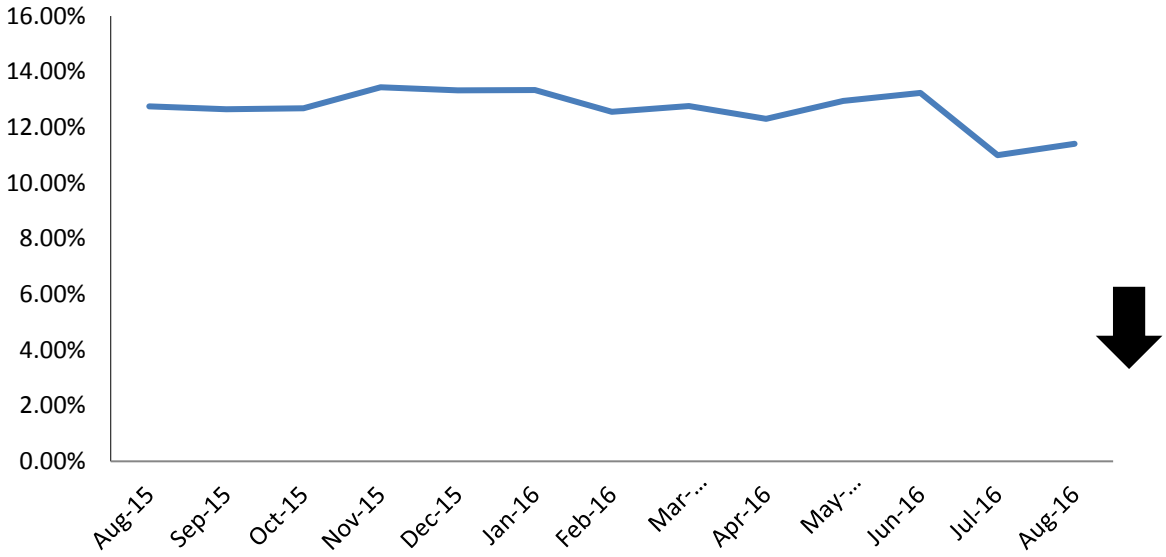


Chart 20 - Diagnostic Waits

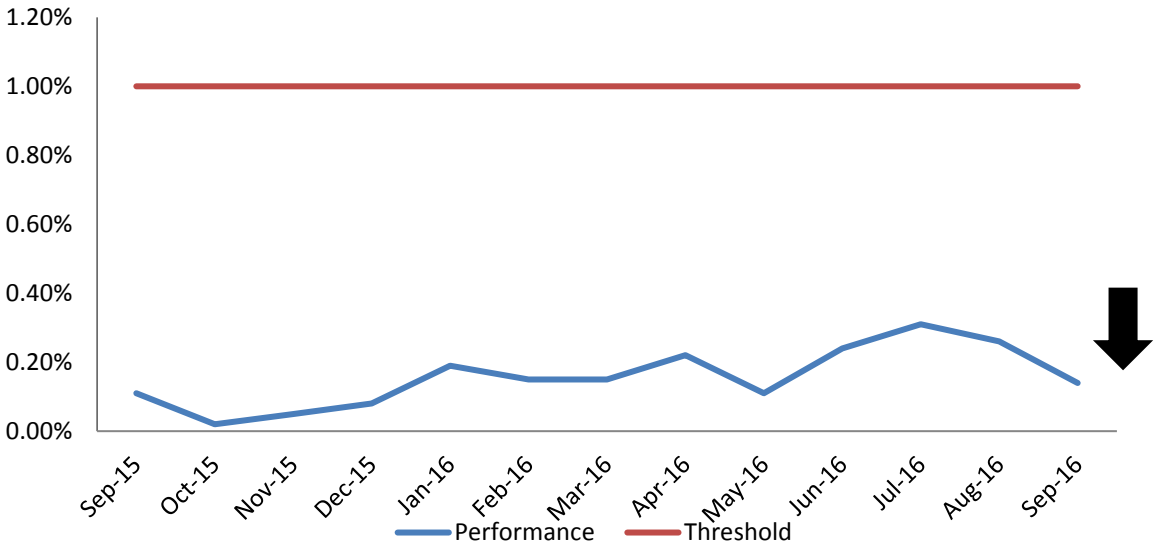


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Chart 21 - Commissioning for Quality and Innovation (CQUIN)

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

EFFECTIVE

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

RESPONSIVE

Chart 22 - A&E 4 hour standard % performance, including National average

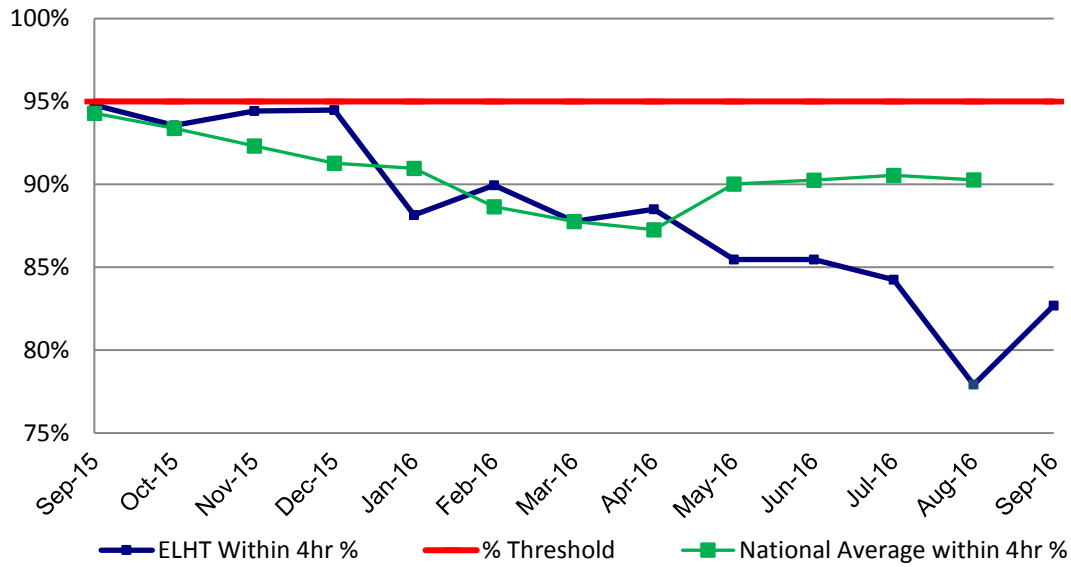


Chart 23 - Handovers

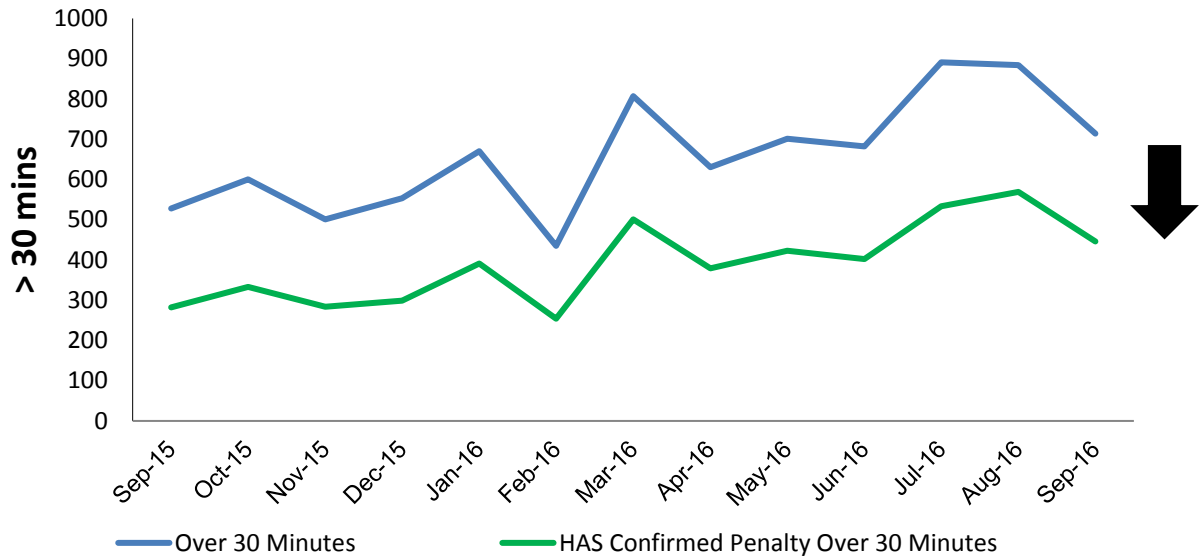
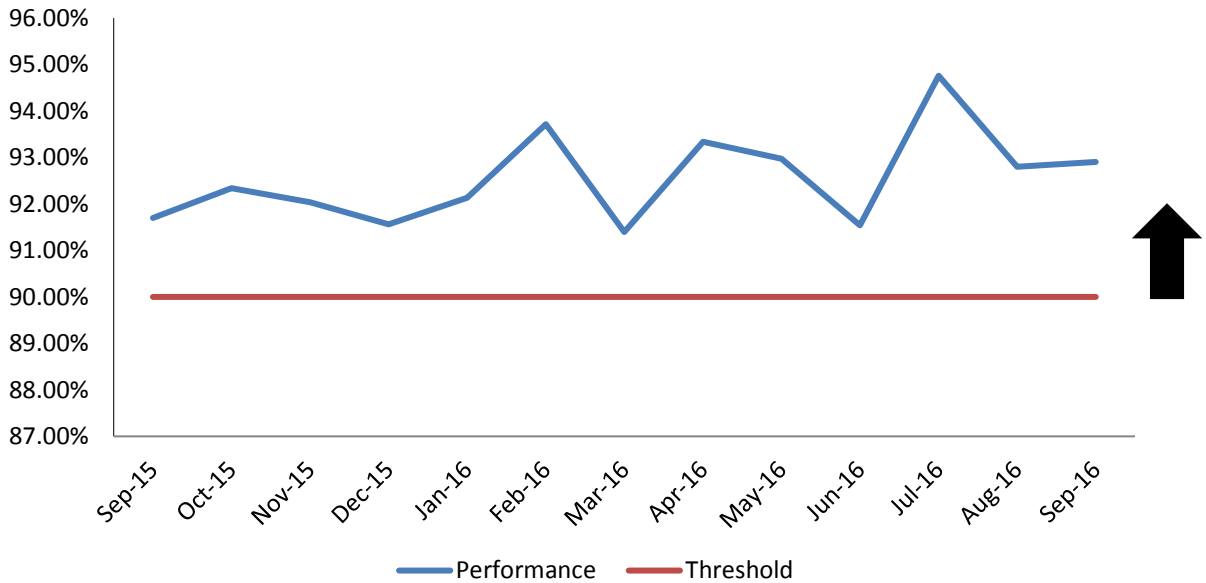


Chart 24 - HAS Compliance



RESPONSIVE

Chart 25 - RTT Ongoing

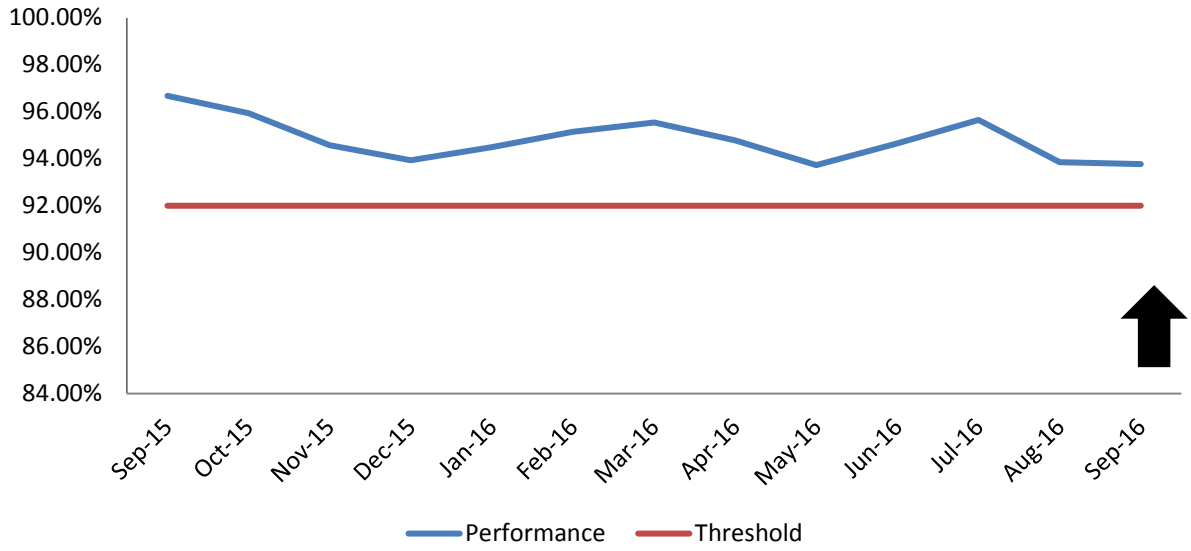


Chart 26 - RTT Ongoing 0-18 Weeks

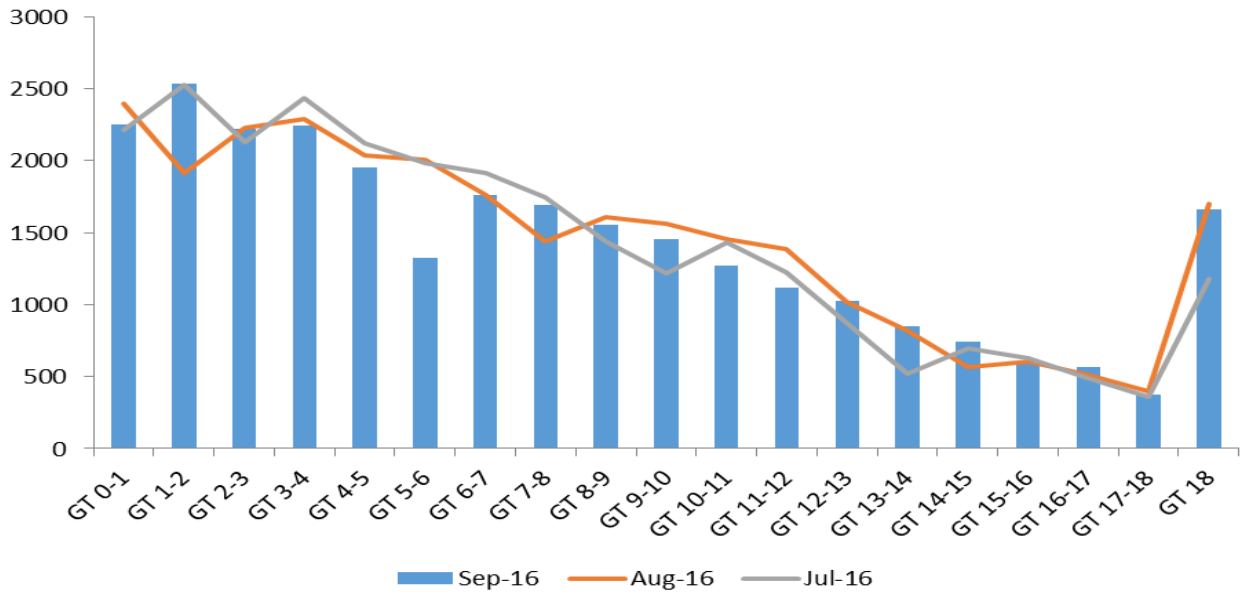
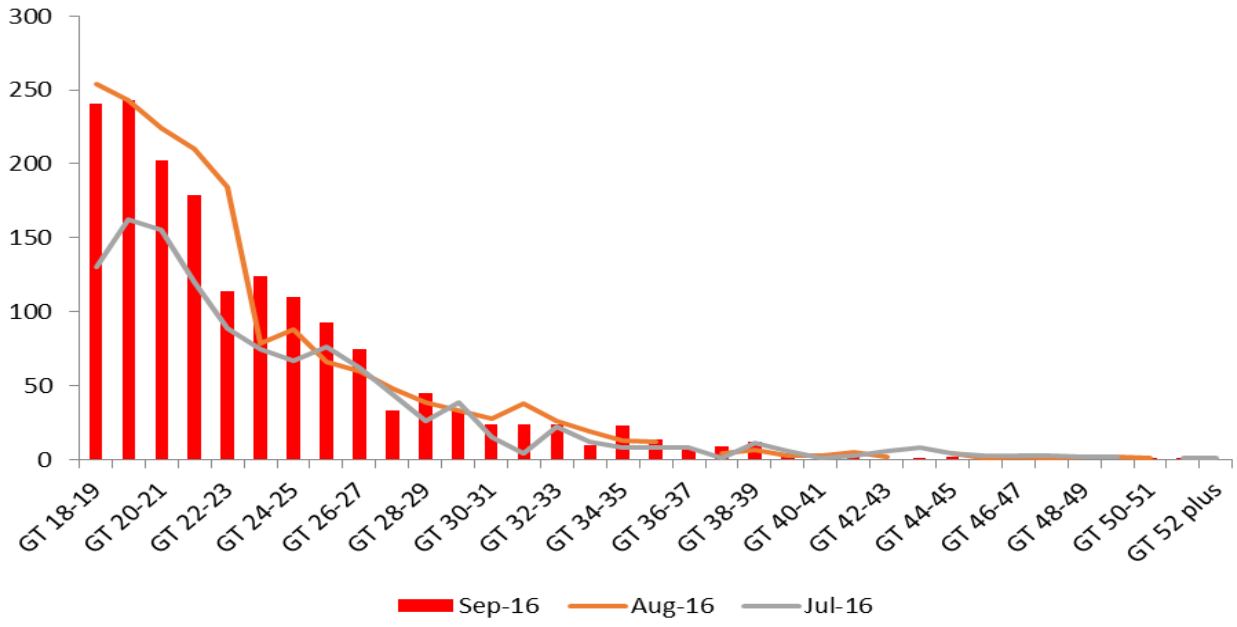


Chart 27 - RTT Over 18 weeks



RESPONSIVE

Chart 28 - Cancer 2 Week

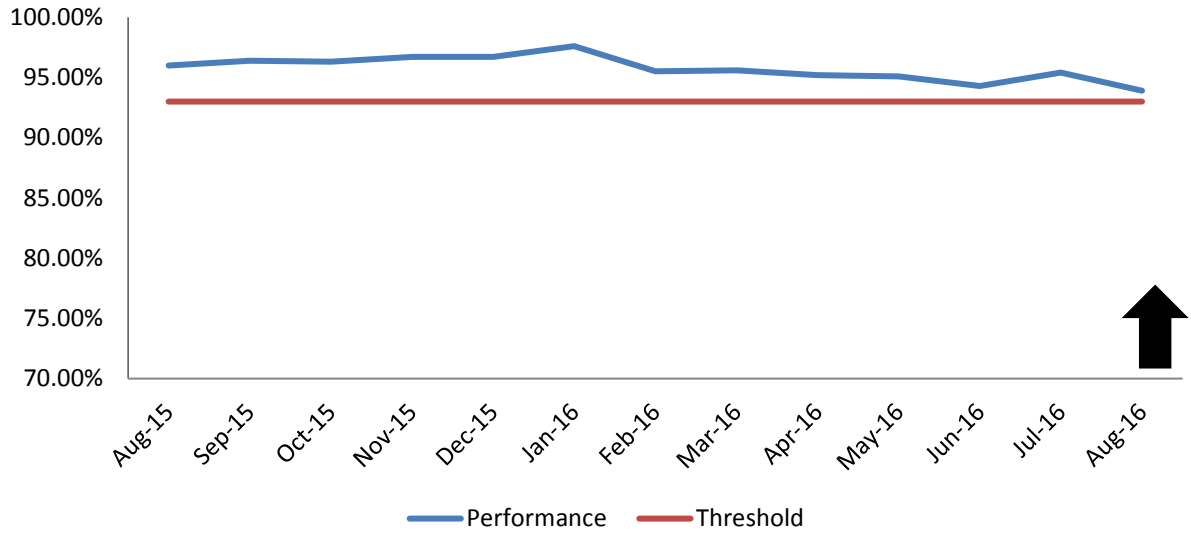


Chart 29 - 62 Day

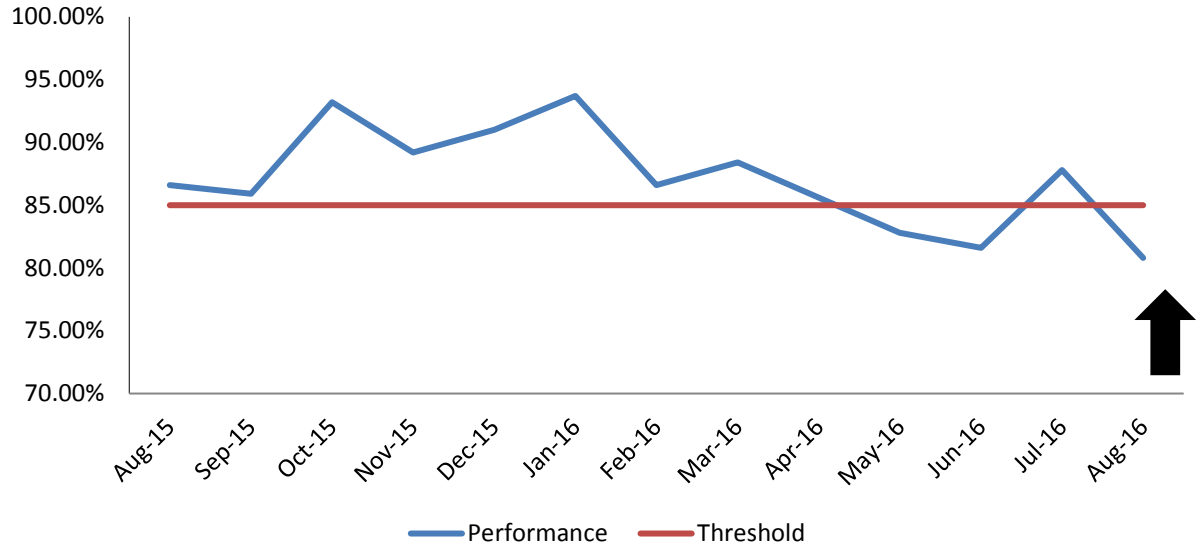
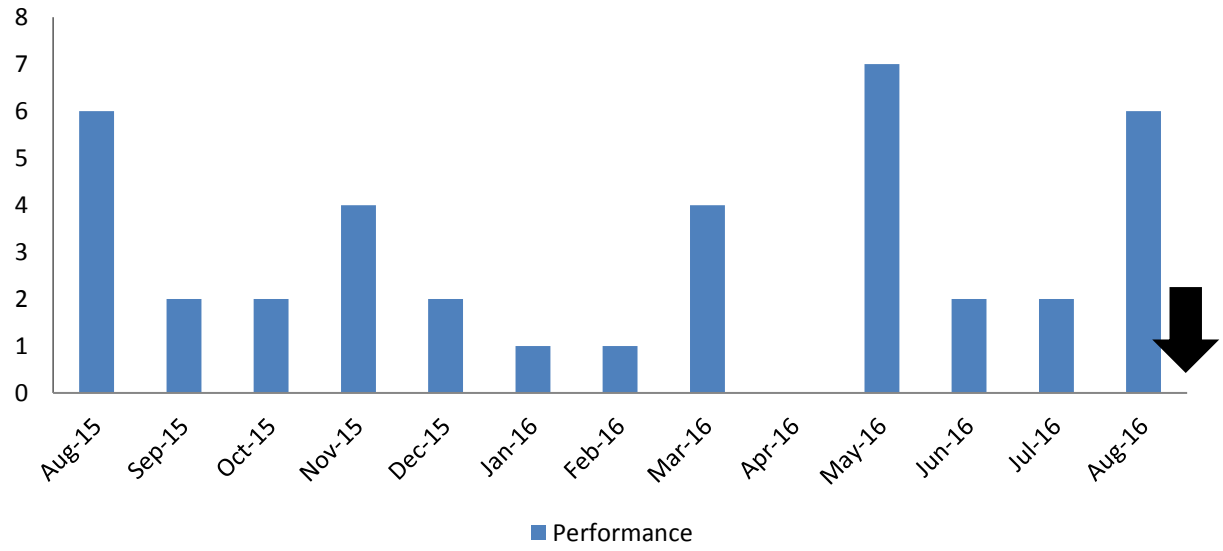


Chart 30 - Cancer Patients Treated > Day 104

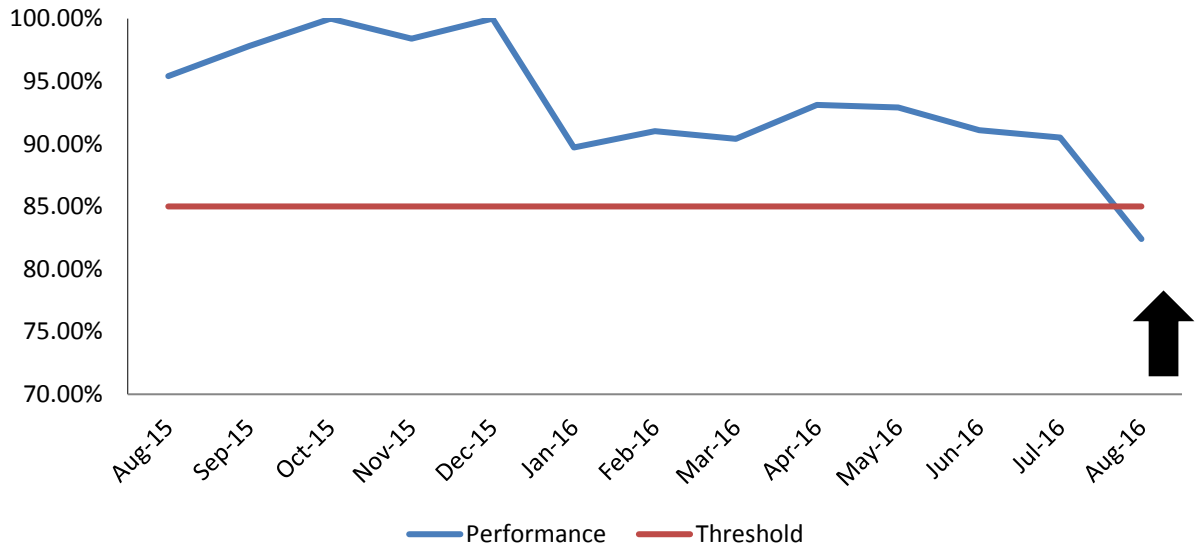


RESPONSIVE

Chart 31 - 62 Day by Tumour Site

Tumour Site	Q1	Jul-16	Aug-16
Breast	98.1%	100.0%	100.0%
Colorectal	71.4%	71.4%	55.6%
Gynaecology	86.2%	100.0%	100.0%
Haematology	79.3%	100.0%	75.0%
Head & Neck	64.9%	83.3%	70.0%
Lung	84.9%	92.3%	100.0%
Other	100%		100.0%
Skin	89.0%	100.0%	82.6%
Upper GI	58.5%	78.6%	75.0%
Urology	85.0%	75.0%	72.7%

Chart 32 - 62 Day Consultant Upgrade



RESPONSIVE

Chart 33 - Average Length of Stay

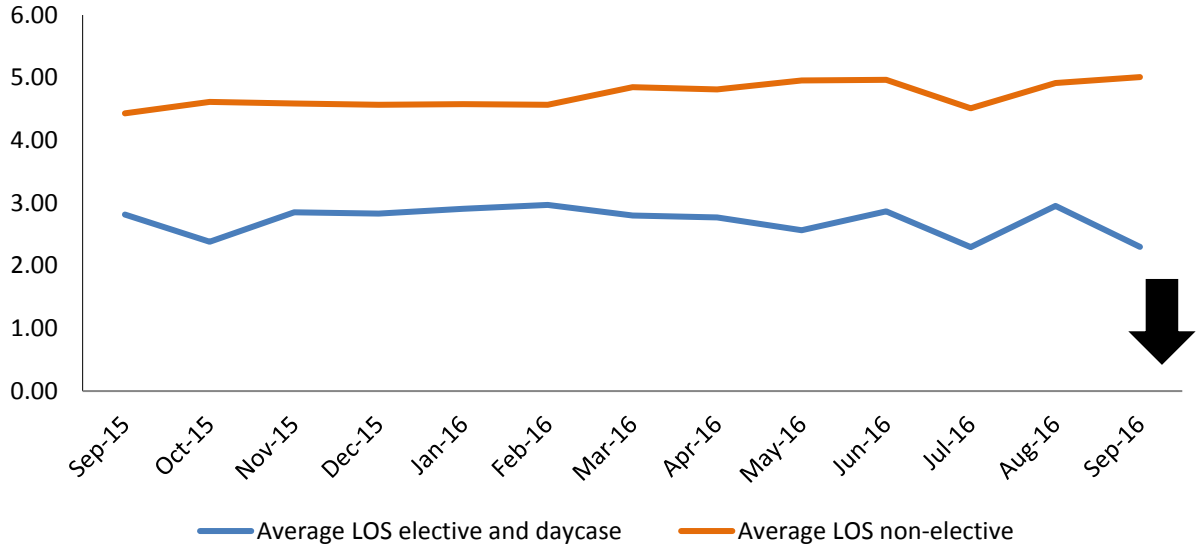


Chart 34 - Average Length of Stay VS expected, July 15 - June 16, DFI

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	57,059	9,922	47,137	4.0	2.8	-1.2
Emergency	54,178	54,178	0	5.2	4.9	-0.3
Maternity/Birth	14,559	14,559	0	2.2	2.5	0.3
Transfer	202	202	0	10.4	30.9	20.5

Chart 35 - Friends & Family A&E Response Rate

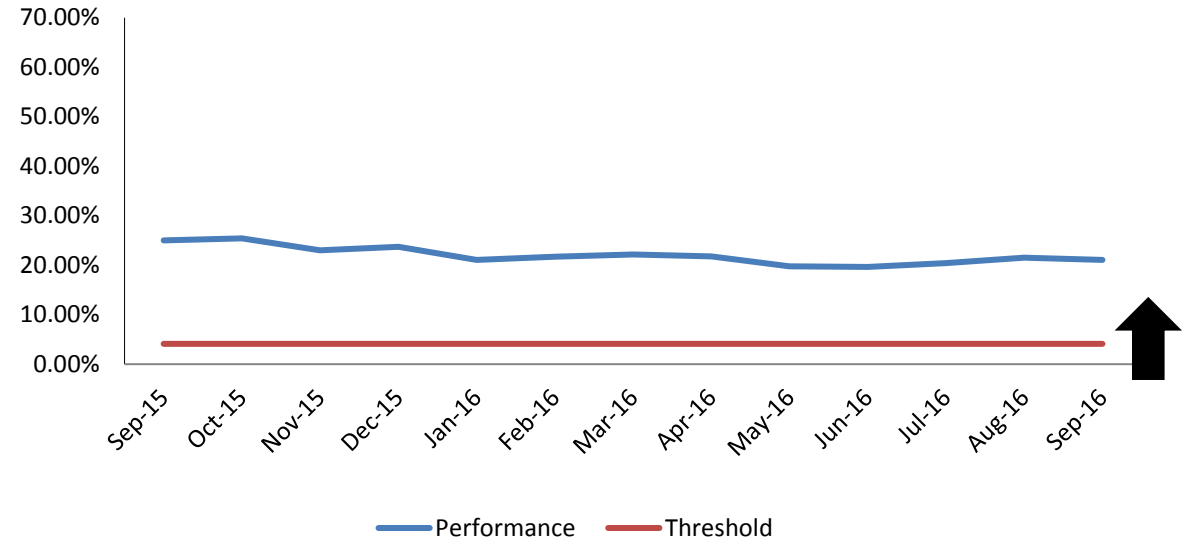


Chart 36 - Friends & Family Inpatient Response Rate

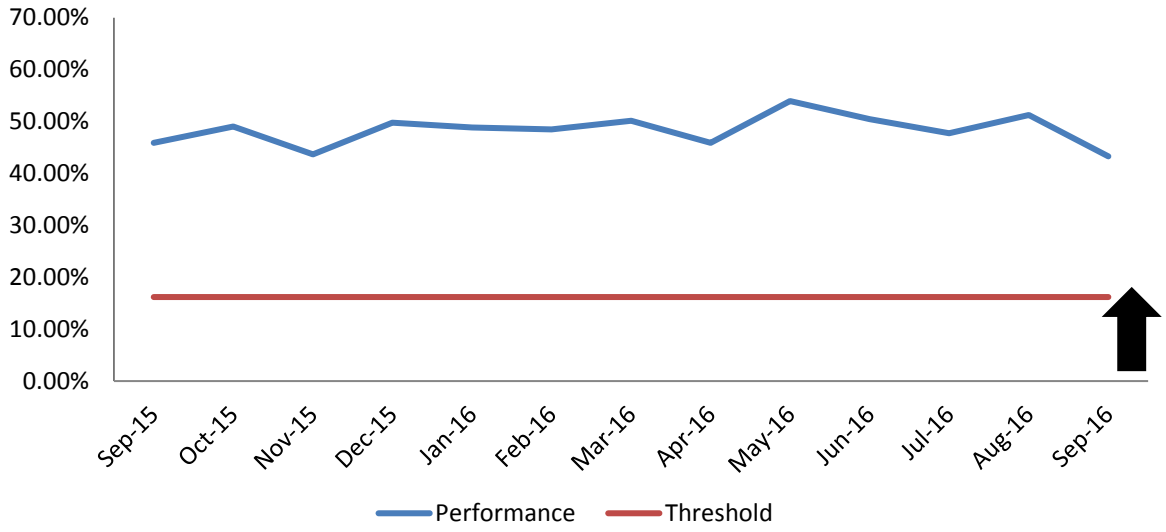


Chart 37 - Sickness

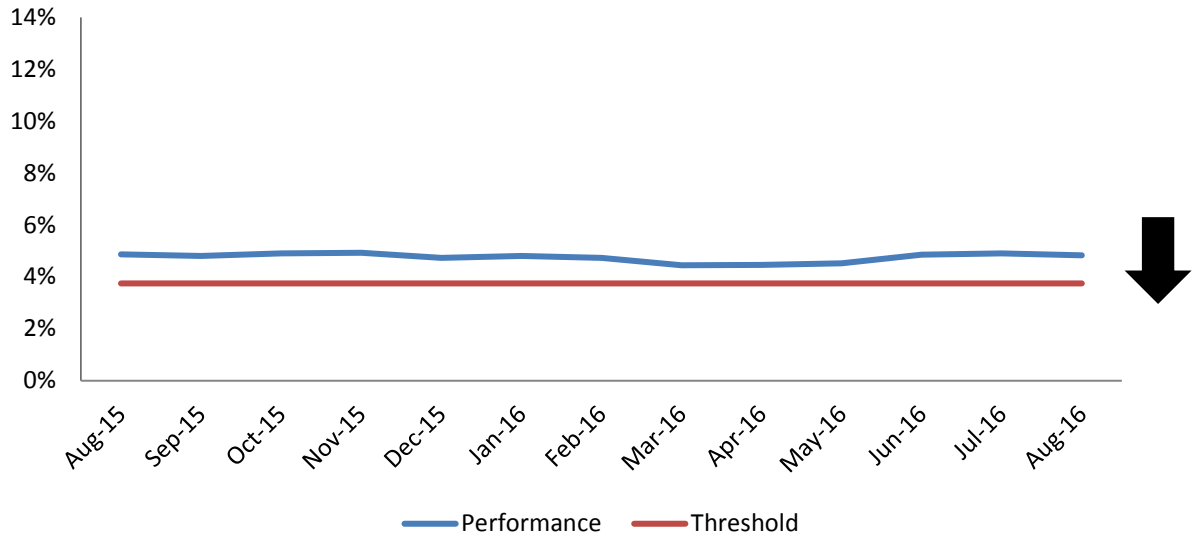


Chart 38 - Turnover Rate

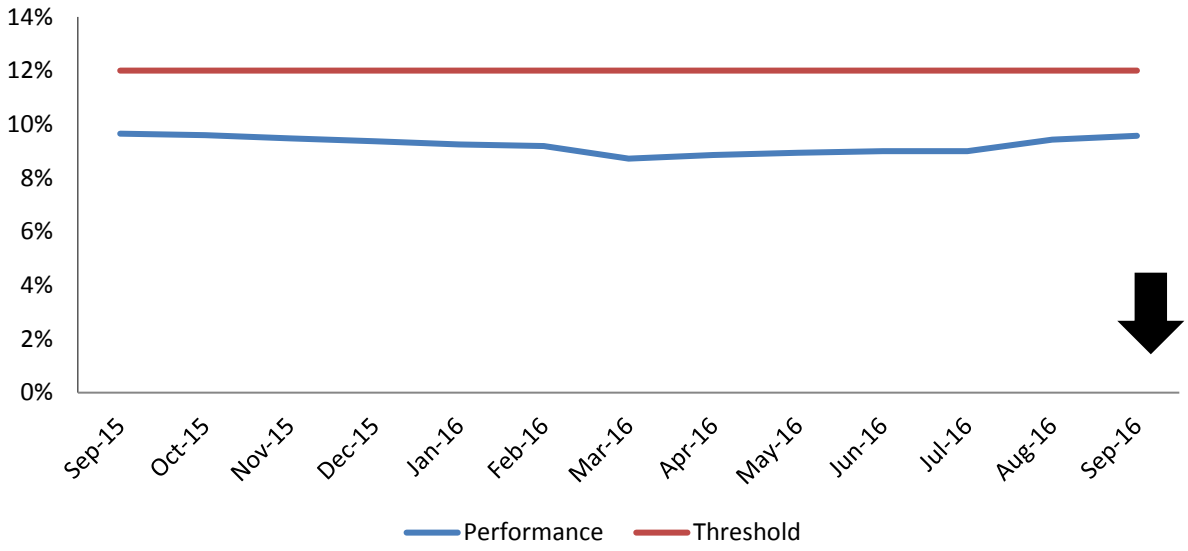
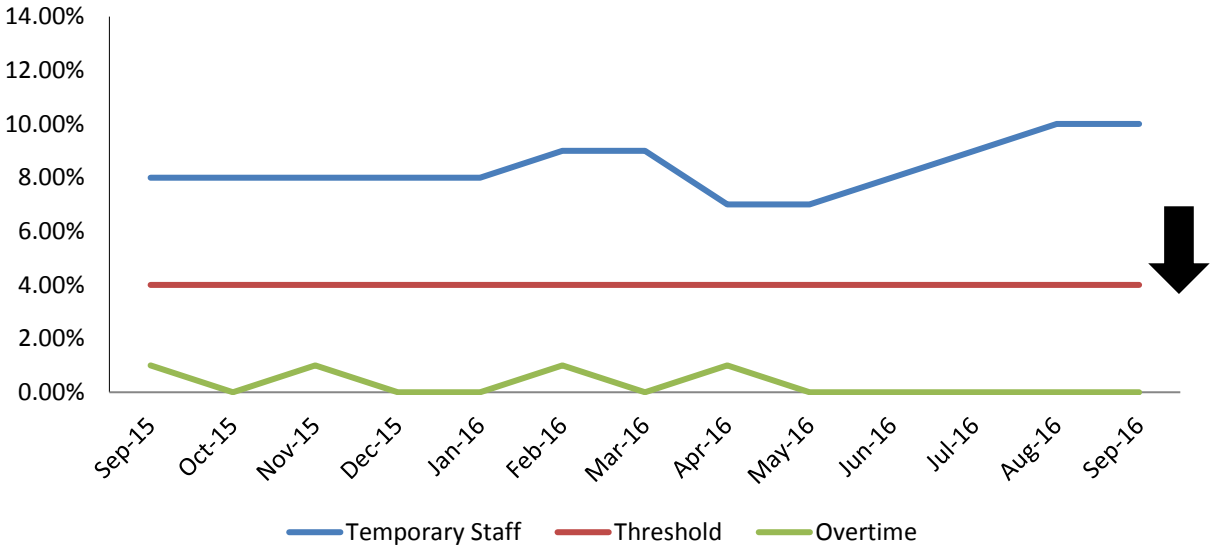


Chart 39 - Temporary costs and overtime as % total paybill



WELL LED

Chart 40 - Vacancy Rate

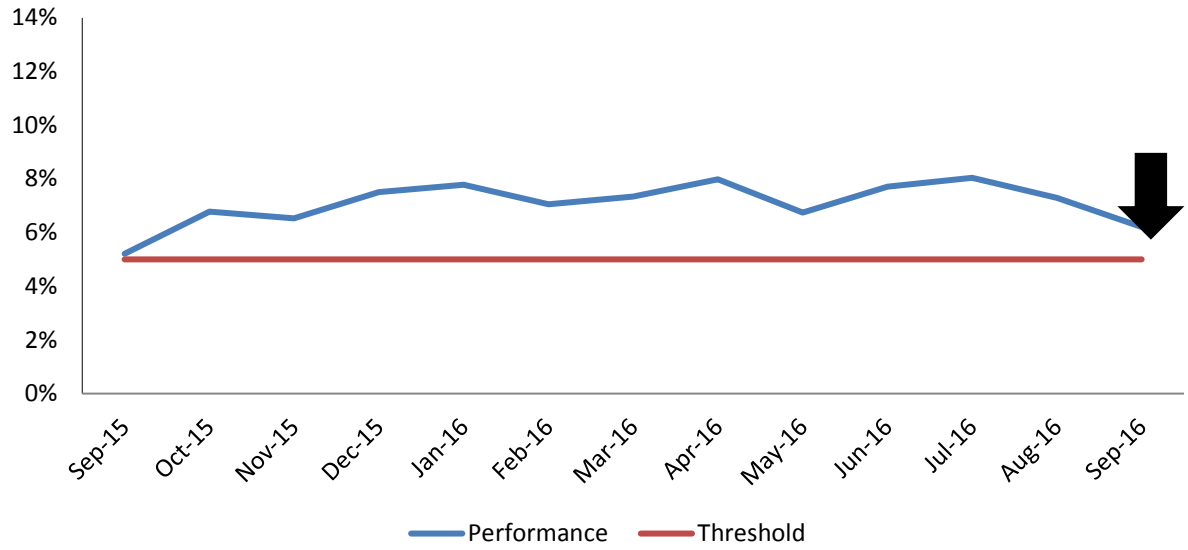


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Chart 41 - Appraisals, Consultant & Other Medical (April 15 - Sep 16)

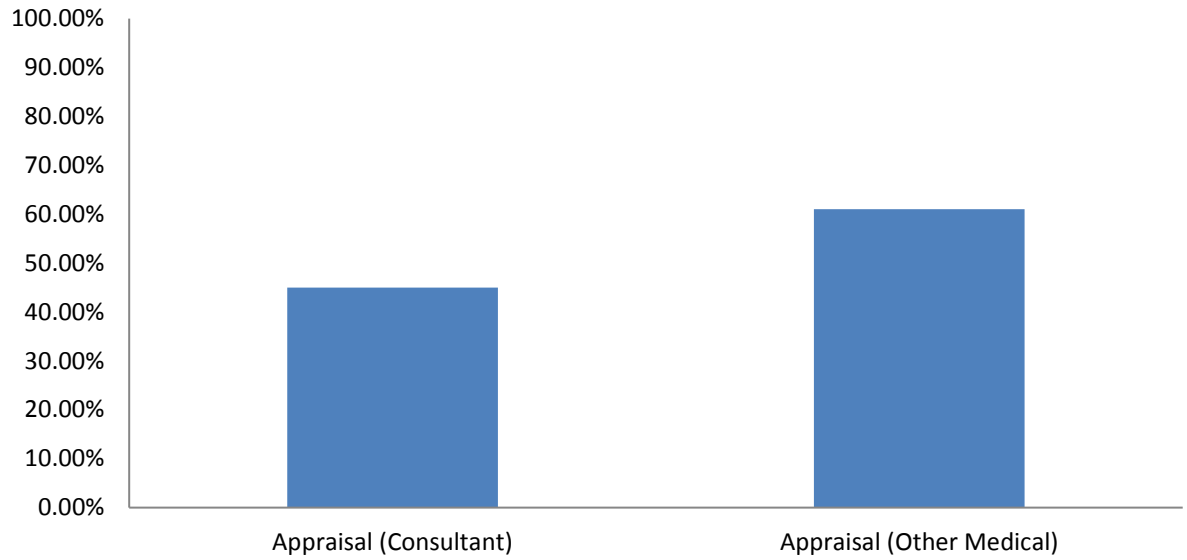

Chart 42 - Appraisals AFC

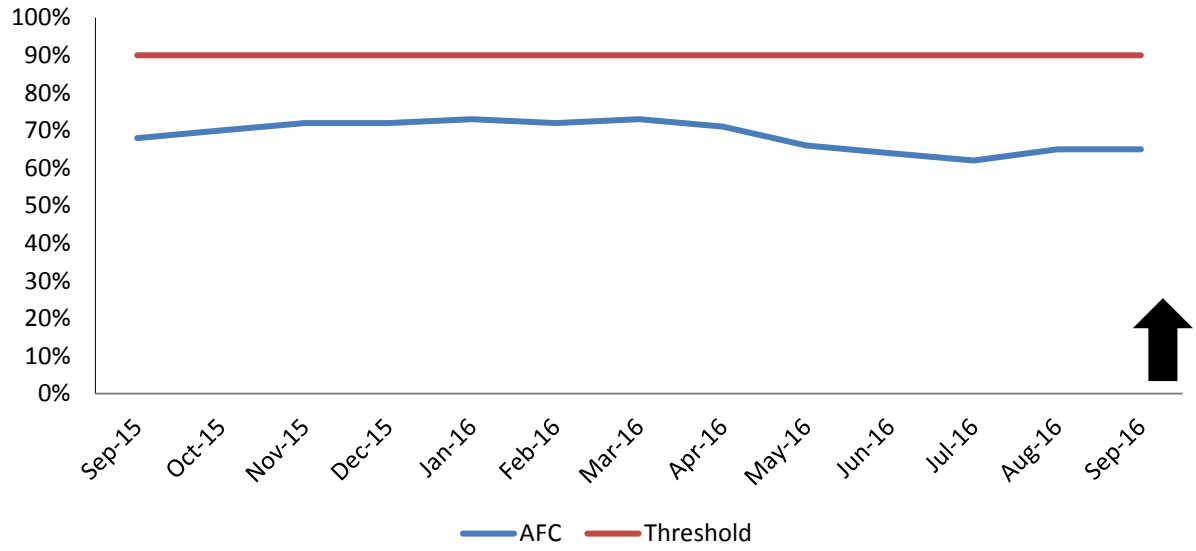

Chart 43 - Job Plans

	2015	2016 (YTD)
Trust Total	80%	40%
Integrated Care Group	66%	2%
Surgery	75%	47%
Family Care	100%	35%
Diagnostics & Clinical Support	84%	80%

WELL LED

Chart 44 - Information Governance Kit

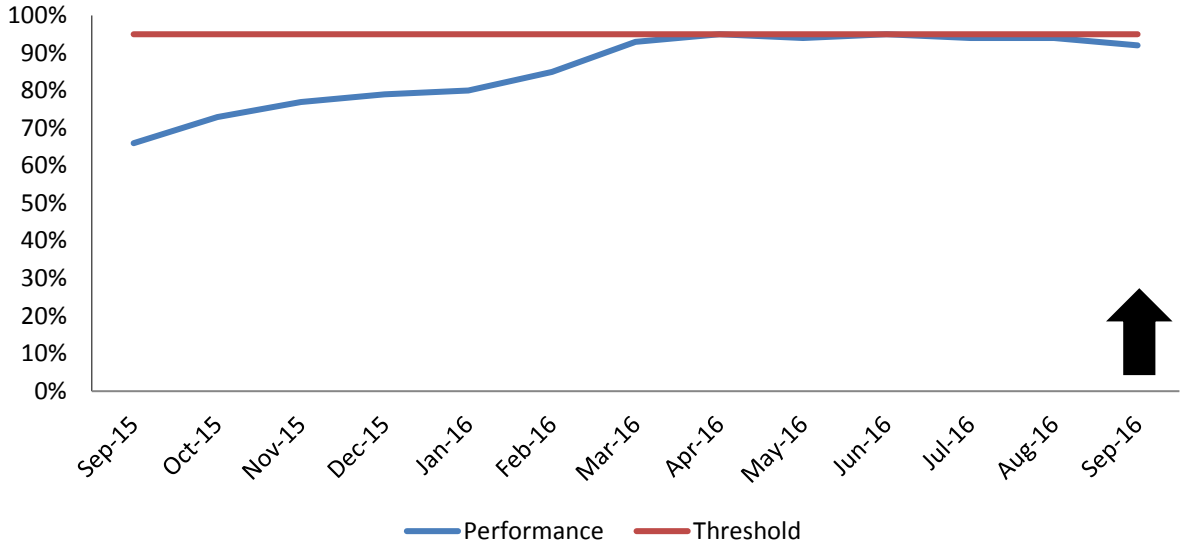

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Chart 45 - Core Skills Training % Compliance

Overall Trust Core Skills Training Compliance (Excluding New Starters and FY1/2 only) End of September 2016											
	Basic Life Support	Conflict Resolution Training Level 1	Equality, Diversity and Human Rights	Fire Safety	Health, Safety and Welfare Level 1	Infection Prevention	Information Governance	Prevent Healthwrap	Safeguarding Adults	Safeguarding Children	Safer Handling Theory
Target	**80%**	**80%**	**80%**	**80%**	**80%**	**80%**	**95%**	**80%**	**80%**	**80%**	**80%**
435 Chief Executive	-	85	85	83	60	58	94	84	55	94	83
435 Diagnostics & Clinical Support	80	93	93	86	71	68	94	92	61	94	93
435 Estates & Facilities	-	83	**76**	68	56	58	96	86	54	90	84
435 Family Care	**72**	92	93	81	70	67	93	64	57	87	90
435 Finance & Informatics	-	96	97	91	83	83	98	80	76	99	96
435 Governance	-	98	100	88	87	87	94	94	83	100	96
435 HR & OD	88	93	93	88	74	74	94	96	74	92	91
435 Integrated Care Group	**72**	89	89	80	63	60	89	87	53	93	89
435 Research & Development	54	97	100	89	91	82	100	89	63	100	89
435 Surgical & Anaesthetics Services	**70**	87	88	**77**	63	61	90	66	52	93	87
Compliance as at 30 Sep 1616	**73**	**89**	**89**	**80**	**66**	**64**	92	**76**	**57**	**92**	**89**
Compliance as at 31 Aug 16	**71**	**89**	**89**	**81**	**50**	**48**	94	**74**	**29**	**93**	**88**
Trend analysis from Aug 16 to Sep 16	⬆	-	-	⬇	⬆	⬆	⬇	⬆	⬆	⬇	⬆
	2	**0**	**0**	**-1**	**16**	**16**	**-2**	**2**	**28**	**-1**	**1**

Chart 46 - Break Even Duty

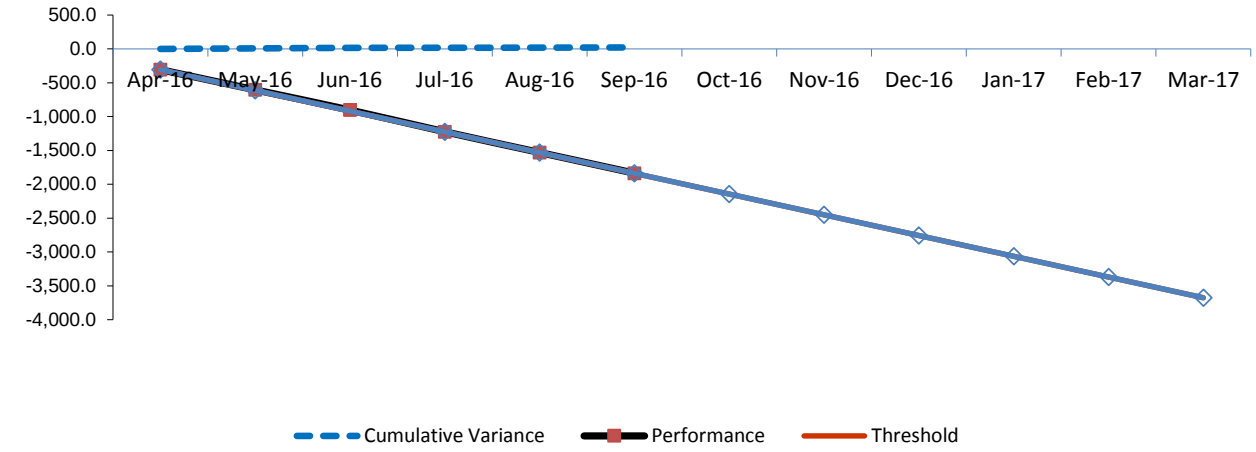


Chart 47 - Bridge Analysis - income and expenditure variances

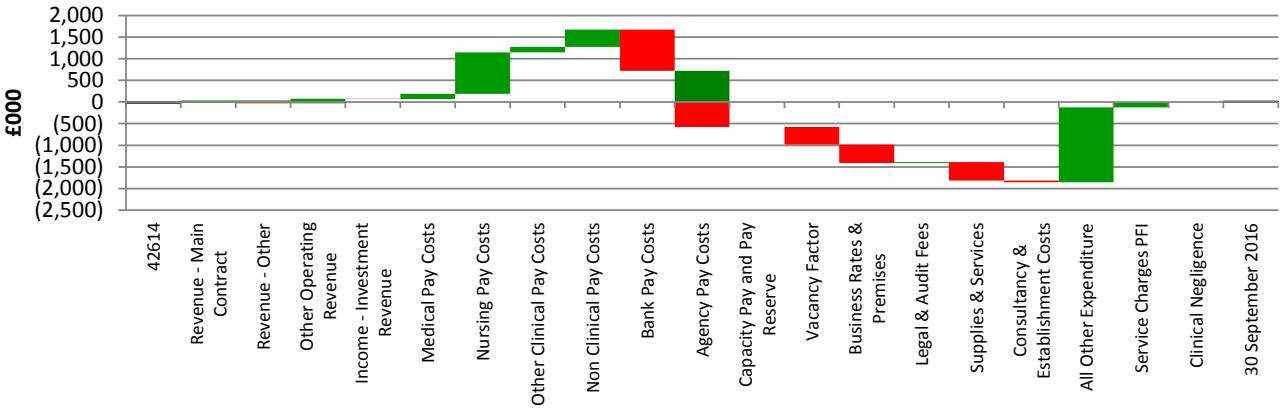


Chart 48 - Better Payment Practice Code (BPPC)

	Performance Target %	Actual in month	Actual YTD	Comments
Non NHS - No. of invoices	95.0%	97.1%	96.3%	Meeting target
Non NHS - Value of invoices	95.0%	97.8%	96.0%	Meeting target
NHS - No. of invoices	95.0%	92.4%	93.7%	Behind Target
NHS - Value of invoices	95.0%	96.9%	97.0%	Meeting target

Chart 49 - Gross Overdue Debtors

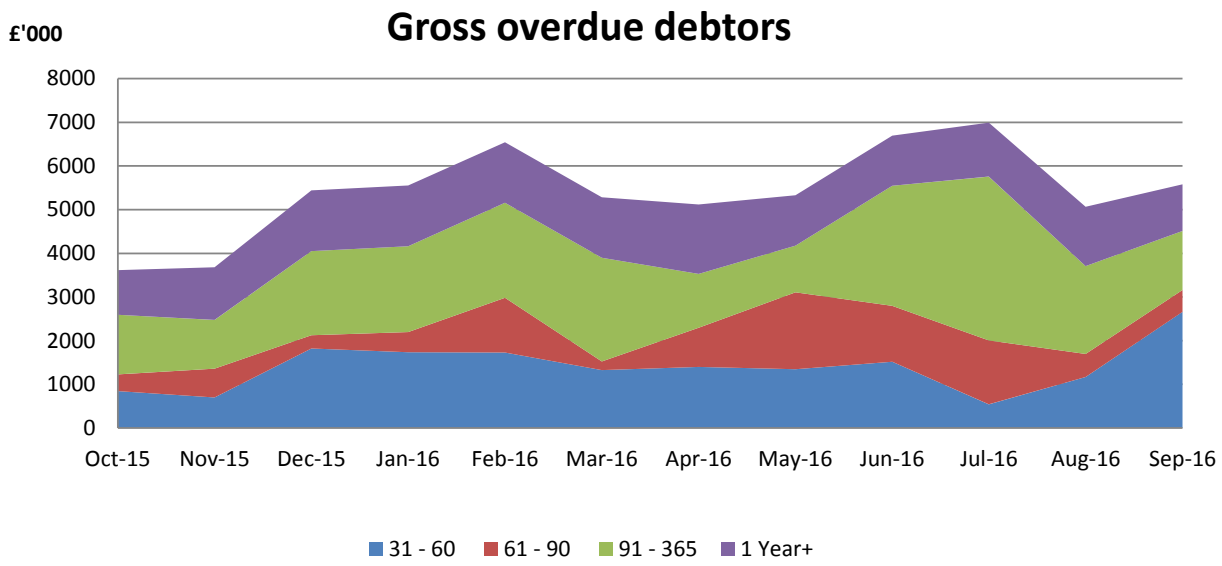
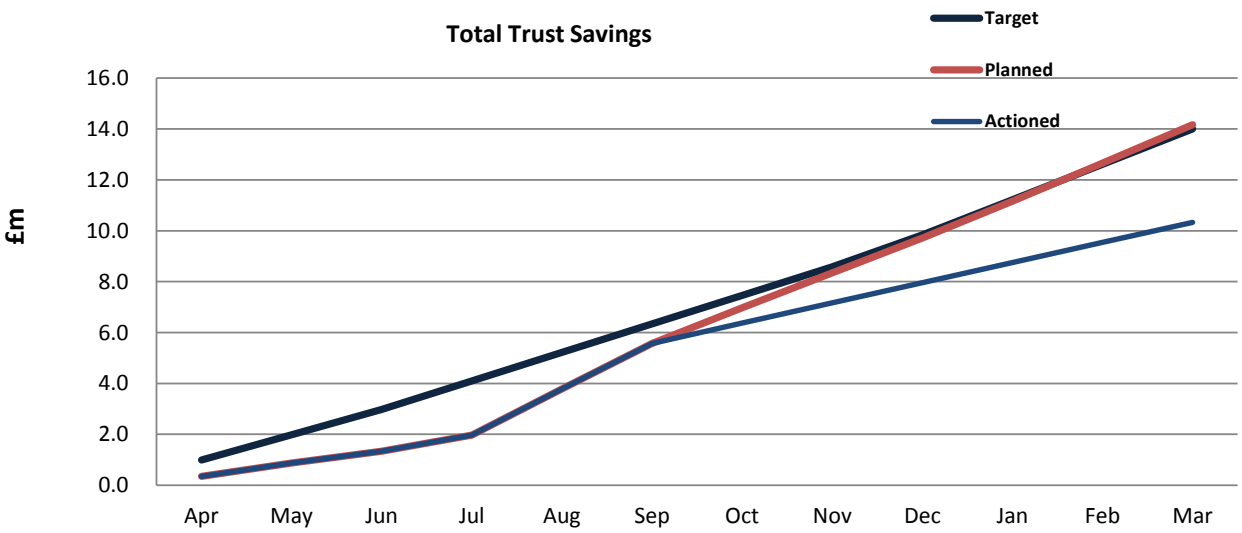


Chart 50 - Total Trust Savings



East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 290b

26 October 2016

Purpose Information
Action

Title	Workforce Race Equality Standard Report
Author	Mr N Makda, Equality & Diversity Manager
Executive sponsor	Mr K Moynes, Director of Workforce & Education

Summary:

This paper outlines the Trust's performance against the Workforce Race Equality Standard (WRES) for 2015/16 and the action plan which is being delivered over a nine month period. A further review of performance is required in April 2017.

The Board is asked to note the WRES report and agree the action plan outlined within Appendix 1.

Report linkages

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

	delivery of sustainable services by the Trust
	The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.
	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	No
Equality	Yes	Confidentiality	No

Previously considered by: NA

Introduction

1. This paper outlines the Trust's performance against the Workforce Race Equality Standard (WRES) for 2015/16 and the action plan which is being delivered over a period of nine months. A further review of performance is required in April 2017.

Background

2. There have been a number of approaches within the NHS, in past years, to tackle issues of inequity in the workforce, however this is the first time that a set of measurable indicators (Workforce Race Equality Standard) have been developed to help organisations to improve the representation and experience of Black Minority Ethnic Staff at all levels of the organisation and track progress.
3. The WRES aims to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.
4. The first WRES report produced by NHS England can be found here: https://www.england.nhs.uk/wp-content/uploads/2014/10/WRES-Data-Analysis-Report.pdf
5. This is derived from the national NHS Staff Survey (WRES indicators 4-8).

The evidence that Black and Minority Ethnic staff are less favourably treated in the NHS is indisputable.

6. One in five nurses, more than one in three doctors and one in six of all NHS staff are from black and minority ethnic (BME) backgrounds. Analysis of NHS workforce and NHS staff survey data across England shows that:
   a) White shortlisted job applicants are, on average, much more likely (1.74 times more likely) to be appointed than are Black and Minority Ethnic (BME) shortlisted applicants.
   b) The proportion of NHS Board members and senior managers who are BME is significantly smaller than the proportion of the NHS workforce or local communities that are from BME backgrounds.
   c) BME NHS staff members are much more likely to be disciplined than White staff members.
   d) NHS staff survey data shows that BME staff are more likely than White staff to experience harassment, bullying or abuse from other staff (but not from patients, relatives of the public); are more likely to experience discrimination at work from

colleagues and their managers; and are much less likely to believe that the Trust provides equal opportunities for career progression.

7. The challenge to ensure black and minority ethnic (BME) staff are treated fairly and their talents valued and developed is one that **all** NHS organisations need to meet because:
   a) Research shows that unfair treatment of BME staff adversely affects the care and treatment of all patients
   b) Talent is being wasted through unfairness in the appointment, treatment and development of a large section of the NHS workforce
   c) Precious resources are wasted through the impact of such treatment on the morale, discretionary effort, and other consequences of such treatment
   d) Research shows that diverse teams and leaderships are more likely to show the innovation, and increase the organisational effectiveness, the NHS needs
   e) Organisations whose leadership composition bears little relationship to that of the communities served will be less likely to deliver the patient focussed care that is needed
8. The workforce race equality standard mixes challenge and support. The NHS standard contract requires providers to provide evidence of year on year progress; it is included within the CQC's "well led domain"; and the data will be published and benchmarked. The intention is to prompt root cause analysis to understand how to close the gap between White and BME staff treatment.

Workforce Race Equality Standard (WRES)

9. The WRES comprises nine standards against which the Trust is required to assess its performance:
   a) four standards cover the comparison of white and black, minority and ethnic (BME) staff metrics held within the Electronic Staff Record (ESR)
   b) four standards cover the comparison of white and BME staff responses within the annual NHS staff survey results for 2015
   c) one standard covers an assessment of whether our Board ethnicity is representative of the local population it serves.
10. NHS providers (including ELHT) must publish data against nine metrics summarising the gap between the treatment and experience of white and BME staff in the NHS – and then demonstrate year on year improvements in grade composition, appointments, disciplinary action, access to career development, bullying, and board composition.

Conclusion

11. Examination of the data currently available in support of the Trust's position against the WRES indicates further work is required both in terms of addressing data quality and establishing a better understanding what appears to be detrimental treatment of black, minority and ethnic (BME) staff across a number of areas.

12. The WRES provides guidance to the NHS on how to achieve better equality outcomes for our BME staff. Understanding the data and its implications for our BME staff is a great first step in making the difference that all our staff, patients and communities need and deserve.

Recommendations

13. The Board is asked to note the WRES report plan and agree the action plan seen in Appendix 1, with a full review in April 2017.

Kevin Moynes, Director of HR and Organisational Development, October 2016

Appendix 1. Workforce Race Equality Indicators & 2016 WRES Action Plan

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	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.	ESR workforce data	ESR workforce data	BME staff are employed in higher proportions in lower pay bands 1-4. BME staff are highly underrepresented in senior Management roles.	• To develop a WRES task & finish group • Undertake further detailed data analysis to identify any specific directorates, departments, job roles and pay bands where BME staff are poorly represented at senior level. Work with senior managers in those areas to develop action plans to identify the underlying reasons and potential solutions. • Big conversation event for BME staff to identify issues and concerns	Equality & Diversity Manager WRES task & finish Group Engagement Team/ Equality & Diversity Manager	July 2016 August 2016 Sep 2016

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Responsible for action	Completion Date
2	Relative likelihood of staff being appointed from shortlisting across all posts.	Relative likelihood of White staff being appointed from shortlisting compared to BME staff is 2.23 times greater.	White staff are 2.25 times more likely to be appointed from shortlisting than BME staff.	White people are 2.23 times more likely to be Appointed following shortlisting than BME people, yet both are equally likely to be shortlisted. This suggests any inequities are likely to exist within the face to face elements of the recruitment process.	• To introduce a random sample audit of recruitment processes e.g. interviews, etc. to enable identification of and action to address areas of poor practice. • Introduce unconscious bias training for recruiting managers, including sharing WRES findings • Send surveys to previous candidates about their experience of the interview. • Carry out further data analysis to establish whether there are particular directorates, departments, job roles and pay bands where BME staff are more or less likely to be appointed from shortlisting. Use this information as the basis for further action planning.	WRES task & finish Group Equality & Diversity Manager/ Recruitment Resourcing Manager WRES task & finish Group	October 2016 October 2016 Nov 2016

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Responsible for action	Completion Date
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	The relative likelihood of BME staff entering the formal disciplinary process compared to White staff is 1.4 times greater.	This indicator is based on data from a two year rolling average of the current year and the previous year	Data shows that BME staff are 1.4 times more likely to be subject to formal disciplinary procedures when compared with White staff (based on a rolling two year average of closed cases)..	• Engage with BME staff to gain greater understanding of this issue and seek feedback on how we can apply the disciplinary policy more consistently and fairly. This would include seeking feedback on: a) How well they feel the organisation deals with disciplinary matters generally. b) The main reasons they feel staff from BME backgrounds are disciplined. c) Aspects of the disciplinary processes they felt might place BME staff at a disadvantage. d) Suggested ways to improve the situation for BME staff. e) Ways to help improve the situation for managers	WRES task & finish Group	January 2017

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Responsible for action	Completion Date
					• To publicise the disciplinary policy and procedure further to ensure staff are aware of the expectations of them in terms of conduct and that they understand the potential consequences of failure to comply • Share an overview of this disciplinary data with line managers and to work with them to try and encourage them to address conduct issues earlier and at a more informal level where appropriate	Employee Relations Team	Nov 2016

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Responsible for action	Completion Date
4	Relative likelihood of staff accessing non-mandatory training and CPD.	Relative likelihood of White staff accessing non mandatory training/CPD is 1.079 times greater.	No data available last year due to new system development.	It is important to improve the reliability of the training data to obtain a clearer and more accurate picture of staff access to training. BME staff (across ELHT) report a lack of access to development opportunities that they feel will make a difference to their own career trajectories. BME staff are employed in higher proportions in lower pay bands 1-4 where external training/ attendance at conferences etc. is less frequently identified as part of personal development.	• Advertise & promote non-mandatory training and CPD to BME staff. • Encourage more BME staff to access the diverse leader's leadership programme. • Review the recording of all training on learning hub and assesses the options to increase data recording of all training and development by ethnicity. • Once the data is more robust, further analysis to be taken to understand where there may be pockets of under-representation (either by BME or White staff) in terms of accessing non-mandatory training and to identify departments, roles or job bands where review and action is required?	Workforce Education Team Equality & Diversity Manager Learning Hub Team Equality & Diversity Manager	Ongoing Dec 2016 Sep 2016 April 2017

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Responsible for action	Completion Date
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White 25% BME 21%	White 28% BME 32%	There has been a reduction in Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. Addressing bullying and harassment is an area that the Trust is working on for all staff.	• A refreshed communication campaign to all service users and visitors to the Trust regarding the Trust's zero tolerance approach to bullying, harassment, abuse and violence. • Review mechanisms available to staff to report incidents to ensure that these are easy to access, quick and simple to use and that appropriate responses are received by staff who report to ensure that they are aware of action taken. Publicise these to encourage staff to report issues	WRES task & finish Group	Dec 2016

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Responsible for action	Completion Date
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White 23% BME 25%	White 23% BME 31%	There has been a reduction in Percentage of BME of staff experiencing harassment, bullying or abuse from staff in last 12 months. BME staff report, proportionately, more negative experiences of bullying, harassment and discrimination that White staff, yet discrimination of any kind is an issue to address with the entire workforce.	• Develop the Bullying & Harassment task & finish group. • Undertake a refreshed communication campaign to staff regarding bullying and unacceptable behaviours, re-emphasising the zero tolerance approach. • Publicity campaign for fair treatment champions, Staff Guardian and Mediation service. • In areas where bullying is identified as an issue, implementing a programme of anti-bullying training, which sets out the Trust's expectations regarding acceptable behaviours and incorporate an element of assertiveness and/or resilience training to give staff some tools and to help them feel more confident in addressing or reporting behaviours which make them uncomfortable.	Employee Relations Team/ Equality & Diversity Manager Equality & Diversity Manager/ Communications Team Equality & Diversity Manager	Sep 2016 Oct 2016 Ongoing

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Responsible for action	Completion Date
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White 85% BME 71%	White 81% BME 73%	Within ELHT BME staff are more likely to report that they do not feel the Trust offers equal opportunities in career progression.	• To gather data on promotions/acting up opportunities and to consider this data by ethnicity and its implications. • Develop a system of mentorship by the members of the leadership team, with specific encouragement to BME staff. • Staff survey findings to be explored in focus groups with BME staff. The issues raised from the focus groups to be discussed with managers. • Identifying positive role models for BME staff who can inspire others. • All vacancies inc. internal, acting up opportunities to be advertised widely.	ESR Team/ Equality & Diversity Manager Equality & Diversity Manager/Senior managers Engagement Team/Equality & Diversity Manager WRES task & finish Group/Senior managers Recruitment Team/ All Line Managers	Dec 2016 March 2017 Dec 2016 Jan 2017 Sep 2016

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Responsible for action	Completion Date
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	White 6% BME 14%	White 6% BME 18%	In the last 12 months there was a 4% reduction in BME staff personally experience discrimination at work from Manager/team leader or other colleagues. Communicating with BME staff, hearing stories and providing opportunities for shared learning are key to identifying the root cause of inequality. Quantitative data can help to identify priorities but in depth qualitative discussion is needed to find long term solutions. Additional there is power in identifying positive role models for BME staff who can inspire others.	• Equality & Diversity master class including unconscious bias for all staff. • Identifying positive role models for BME staff who can inspire others.	Equality & Diversity Manager WRES task & finish Group/Senior managers	Ongoing Jan 2017

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Responsible for action	Completion Date
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	100% white 0% BME	100% white 0% BME	There is one Board member from a BME background within the Trust.	• Review the development opportunities available to staff (both formal and informal) which would support promotion and career progression into senior roles. • Ensure that the process for appointment of Non-Executive Directors encourages diverse applicants	WRES task & finish Group/Senior managers	Nov 2016