St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 24TH FEBRUARY 2016
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

A G E N D A				Paper	Presenter
9:30	1.	Employee of the Month			Richard Fraser
		1.1	December		
		1.2	February		
09:40	2.	Apologies for Absence			Richard Fraser
	3.	Declaration of Interests			
	4.	Minutes of the previous Meeting held on 27th January 2016		Attached	
		4.1	Correct record & Matters Arising		
		4.2	Action list	Attached	
09:50	5.	Committee Report - Audit		NHST(16) 015	Su Rai
09:55	6.	Committee Report – Charitable Funds		NHST(16) 016	Denis Mahony
10:00	7.	Committee Report – Finance & Performance		NHST(16) 017	Denis Mahony
		7.1	Integrated Performance Report	NHST(16) 018	Nik Khashu

10:15	8.	Committee Report – Executive		NHST(16) 019	Ann Marr
10:25	9.	Committee Report – Quality		NHST(16) 020	David Graham
		9.1	Safer Staffing & Shelford Acuity	NHST(16) 021	Sue Redfern
10:40	10.	FT update		NHST(16) 022	Nik Khashu
10:45	11.	Effectiveness of meeting			Richard Fraser
10:50	12.	Any other business			
	13.	Date of next Public Board meeting – Wednesday 30th March 2016			
10:50	BREAK				

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

Minutes of the St Helens and Knowsley Hospitals NHS Trust Board meeting held on Wednesday 27th January 2016 in the Boardroom, Whiston Hospital

PUBLIC BOARD

Chair:	Mr R Fraser (RF)	Chairman
Members:	Ms A Marr (AM)	Chief Executive
	Mr B Hobden (BH)	Non-Executive Director
	Mrs C Walters (CW)	Director of Informatics
	Prof D Graham (DG)	Non-Executive Director
	Mr D Mahony (DM)	Non-Executive Director
	Mr G Marcall (GM)	Non-Executive Director
	Prof K Hardy (KH)	Medical Director
	Mr N Khashu (NK)	Director of Finance
	Mr PJ Williams (PJW)	Director of Operations and Performance
	Mr P Williams (PW)	Director of Corporate Services
	Ms S O'Brien (SOB)	Associate Non-Executive Director
	Ms S Rai (SR)	Non-Executive Director
	Mrs S Redfern (SRe)	Director of Nursing, Midwifery & Governance
Apologies:	Mrs A-M Stretch	Director of HR/Deputy Chief Executive
In Attendance:	Mr A Cheshire (AC)	HR Graduate (observer)
	Mrs C Scrafton (CS)	Deputy Director of HR
	Mr M Vacara (MV)	Interim Patient Experience Manager (item 2)
	Mr T Foy (TF)	St Helens CCG
	Mrs K Pryde	Executive Assistant (Minutes)

1. **Employee of the Month**

1.1. The award for Employee of the Month for January was presented to Janet Freeman-Davies, Staff Nurse, Ward 2E.

2. **Patient Story – presented by Michael Vacara, Interim Patient Experience Manager**

2.1. MV related to the Board the story of Mrs Mc who had suffered for a number of years with abdominal pain and also had other co-morbidities. Mrs Mc said that on every occasion when she had attended the Trust, all members of staff were compassionate, showed empathy and displayed very dignified care. She was very complimentary of all staff including the domestics, nurses, doctors and consultant, who took time to ensure that she was made to feel respected and treated as an individual. The one issue that Mrs Mc did identify was with one of her routine medications not being prescribed but when staff on the ward were informed of this oversight it was quickly rectified with an apology for the delay. Mrs Mc has written a letter of appreciation to AM.

3. **Apologies for Absence**

3.1. Apologies for absence were noted.

4. **Declaration of Interests**

4.1. No member declared any interest relating to the business to be discussed at the meeting.

5. **Minutes of the previous meeting held on 25th November 2015**

5.1. **Correct Record and Matters Arising**

5.1.1. The minutes were approved as a correct record.

5.2. **Action List**

5.2.1. Item 1 - Minute 6.6 (24.06.15): RF to look at fundraiser secondment opportunities. Action closed.

5.2.2. Item 2 - Minute 5.6 (28.10.15): Trust Standards of Business Conduct Policy: User guide for Directors to be devised and disseminated to Board members. New proforma has been devised, which will be presented to Audit Committee next week and the disseminated to Board.

5.2.3. Item 3 – Minute 5.6 (28.10.15): Declarations of Interest: Lower limit for declarations to be reviewed. Lower limited is now £25.00. Action closed.

5.2.4. Item 4 – Minute 6.5 (28.10.15): Charitable Funds Committee: RF asked members of the Committee to review access that the Trust allows to charitable organisations for fund raising within our hospitals. Update at next Board meeting on 24.02.16.

6. **Committee Report – Executive Team – NHST(16)001**

6.1. AM summarised the report of the Executive Committee meetings held between 13th November 2015 and 14th January 2016.

6.2. Decisions taken by the Committee including bidding for Southport Breast Services, implementation of the Hyper-Acute Stroke Unit, arrangements to comply with Planning Guidance, and the income distribution plan for commercial research income.

6.3. Assurances regarding the management of bank and agency usage, orthopaedic activity, Emergency Planning Risk and Resilience compliance, embracing the Lord Carter report, and actions to meet the recommendations of the CQC were obtained.

6.4. Investment decisions included three A&E middle grade doctors, a system for monitoring FFT, a third pain consultant post, and an energy sustainability initiative.

6.5. There were no specific items requiring escalation to the Board.

6.6. RF discussed his attendance at the NHS Providers meeting, where the Lord Carter review was discussed.

6.7. Regarding finances, NK is meeting with Paul Brickwood, Chief Finance Officer, Knowsley, St Helens and Halton CCG, and should have a clearer picture of the CCGs position financially to support the Trust.

6.8. TF stated that St Helens CCG's have received £3m risk share funding, £1.5m to be repaid next year. The deficit of £0.5m being declared by them currently will have to be resolved by the end of the financial year.

6.9. **FT Progress report including TDA Self-Certification – NHST(16)002**

6.9.1. NK advised the Board of proposed changes to Section 7 of the regular submission regarding the revised financial plan stretch target. Board approval was granted for submission.

7. **Committee Report – Finance & Performance – NHST(16)003**

7.1. GM provided a summary of the meeting held on 21st January. Key issues discussed were:

7.1.1. Quarterly HCA sickness
7.1.2. Cash flow planning and loan facility plans
7.1.3. NHS Contracts
7.1.4. Maternity benchmarking
7.1.5. Transformational programme
7.1.6. Agency rules update

7.2. RF said that the agency cap was discussed at the NHS Providers where the consensus was that the cap will be broken if there is a safety issue. CS said that indications are that Trusts are trying hard to hold the line, but it is influenced by the contractual arrangements with agencies.

7.3. SR asked if the Turnaround Director post was viewed as a success and what continuity plans were in place. AMS said it had been successful and in order to maintain impetus the work has been handed over to the PMO.

7.4. **IPR – NHST(16)004**

7.4.1. NK provided an overview of the IPR report.

7.4.2. C.Diff: 7 cases were appealed with St Helens CCG and 4 were upheld. The cases not upheld were due to the standard of risk assessments and the timely isolating of a patient.

7.4.3. Stroke, cancer and 18 weeks RTT all continue to perform well, despite the significant non-elective demands. An operational turnaround forum has commenced regarding emergency care performance, with executive led workstreams established to address issues such as complex discharges, internal diagnostics, weekend discharges and ward round processes.

7.4.4. NK advised that the Trust is reporting a Month 9 deficit of £8.6m which is behind plan by £0.2m. To date the Trust has delivered £9.5m of CIPs which is £0.2m better than plan. NK advised the Board that some outstanding debts had been settled but the Trust may still need the loan facility in March.

7.4.5. The annual staff satisfaction survey has been completed with a return rate of 55%, which is in the top 20% of all Trusts nationally. The results will be published in Q4. BH asked how the figures compare to last year and CS replied that it is too early to give a definitive answer but they appear similar.

8. **Committee Report - Quality - NHST(16)005**

8.1. GM presented the paper from the Quality Committee held on 19th January. There were no concerns to be escalated to the Board, but key items discussed included:

8.1.1. Complaints
8.1.2. CQC report
8.1.3. Medicines Management action plan update
8.1.4. Enoxaparin update
8.1.5. Mobility aids
8.1.6. Patient ID wristbands.

8.2. GM commented that the CQC result was excellent, and he also praised Simon Gelder for an excellent presentation on the Medicines Management action plan. Items 8.1.4, 8.1.5 and 8.1.6 had all shown marked improvement.

8.3. GM advised the Board that an external peer review of Maternity services will take place on 28th/29th January.

8.4. GM briefly discussed the Clinical & Quality Strategy, as it is an agenda item, and confirmed that the Quality Committee had supported the recommendations made by KH.

8.5. SR asked which quality risk was currently most concerning and GM responded that in his opinion it would be Maternity as he was less assured of progress with the action plan, and concerned regarding staff morale. In addition, falls were highlighted as a further area of concern. The Board discussed the issues in detail and of the potential timetable for a CQC re-inspection.

8.6. BH suggested that the Quality Committee report should better signpost the areas of concern and depth of discussion. The role of the different

Committees in reviewing performance was also raised, and it was confirmed that against each measure in the IPR, the Committee responsible for monitoring was identified, although this should not prevent any Committee of the Board reviewing any result.

8.7. **Safer Staffing Report – NHST(16)006**

8.7.1. SRe presented the safer staffing figures for November and December. Wards falling below the target fill rate were discussed.

8.7.2. SRe assured the Board that the Trust was adhering to the agency cap wherever possible and any requests to go off framework had to be agreed by one of the Executive team.

8.7.3. It was noted that further analysis of the data to provide more useable information is being carried out assisted by KH.

8.8. **Complaints, Claims & Incidents – NHST(16)007**

8.8.1. SRe provided an update on complaints, claims and incidents.

8.8.2. The number of incidents raised for this quarter was 3254 compared to 3082 in the same quarter last year, demonstrating an increase of 5.5%.

8.8.3. Regarding clinical negligence and insurance claims SRe assured the Board that an internal claims group meets once per month looking at each case and lessons learned.

8.8.4. SR pointed out that the Trust were quite high on the table for local non-specialist organisations regarding incidents. KH responded that by operating an open and honest culture, incident reporting is encouraged and numbers therefore rise.

8.8.5. DG commented on the response rates to complaints which seemed low. AM acknowledged that timeliness needs to improve as activity during the winter period appeared to have impacted on the staff working on the complaints.

8.9. **Quality Account – NHST(16)008**

8.9.1. SRe updated the Board on the proposed timetable for the production of the 2015/16 Quality Account, which has been produced in order to meet stipulated deadlines. Work has already commenced on an initial draft.

8.9.2. It was noted that the Trust needs to maintain ongoing engagement with all stakeholders, including patients and staff in agreeing next year's quality priorities.

8.10. **Safeguarding report – Adults and Children – NHST(16)009**

8.10.1. SRe presented the annual report to the Board.

8.10.2. The Trust continues to achieve contractual compliance in respect of Level 1 and Level 3 safeguarding adult and children training. Level 2 compliance levels are not currently being achieved due largely to the numbers of staff recently transferring into the Trust. The Trust is therefore seeking approval from the commissioners for a revised set of trajectories to achieve compliance.

8.10.3. SRe informed the Board that a new lead nurse for safeguarding has been appointed, but the Head of Safeguarding is retiring in September and succession planning is required.

8.10.4. SR commented that the training figures appear worrying and that she remained to be assured regarding Level 2 training. KH responded that Level 2 training is done through workbooks and all ward managers need to be trained to make sure these are completed appropriately.

8.10.5. It was agreed that SRe will bring a proposal to address this issue to the Executive Committee.

8.11. **HR Indicators – NHST(16)010**

8.11.1. CS presented the report to the Board.

8.11.2. CS highlighted sickness absence levels and the activities that are ongoing to improve performance. The HR Advisory team continues to work closely with managers to address sickness absence, with particular attention being paid to areas with the highest levels. DG asked how performance is monitored and CS replied that the Workforce Council are tasked with this and report through the Quality Committee.

8.11.3. E-rostering was discussed, and the table showing bank, agency and overtime usage was examined. CS explained that in due course this should assist SRe with the safer staffing returns.

8.11.4. The Board discussed the annual leave figures and the target for each ward. AM asked CS to re-examine the colour rating per ward as this might be misleading.

8.11.5. Payroll Services and recruitment were also discussed.

8.12. **Workforce Race Equality Standard – action plan – NHST(16)011**

8.12.1. CS discussed the WRES workforce indicators with the Board, and advised that HR staff are liaising with Bill Hobden, Equality and Diversity Lead.

8.12.2. AM had concerns regarding the indicators and asked that more work is undertaken to understanding the results and what the information is suggesting.

8.12.3. KH expressed concern regarding the indicated level of bullying which seems at odds with other reports. CS advised that she would raise this with the steering group and a turnaround action plan will be implemented. This will be presented at the Workforce Council in March and then the Quality Committee.

8.13. **Clinical and Quality Strategy update report NHST(16)012**

8.13.1. KH provided a summary for the Board.

8.13.2. KH explained that the strategy had been discussed at the Quality Committee and it had been agreed that it was in need of a refresh and that the focus should be on a smaller number of targets, including mortality and sepsis. This was agreed by the Board.

8.13.3. KH took members through each of the reported indicators and highlighted actions that are in place for improvements.

8.13.4. SR enquired about the correlation between complaints and EOL care. SRe advised that the nature of such complaints tend to be with regards communication and discharge. AM asked SRe to gather all EOL care complaints and find common themes on which to base an action plan.

9. **Informatics Report – NHST(16)013**

9.1. CW provided a report on progress of the Informatics portfolio including:

9.1.1. eMEWS has gone live and is being piloted on two wards. Feedback has been extremely positive, especially from junior doctors. Changes have been made to the software and it is now ready to roll-out to other areas.

9.1.2. E-prescribing is back on track following the decision to implement different software with implementation date in September.

9.1.3. EDMS has been signed off by the CLIC Board and the go live date is 14th March.

9.1.4. Clinical portal testing has been completed and is the system is ready to implement but reliant on Maxims V10 to go live.

9.1.5. Modifications to OPERA are ongoing and most recently positive feedback was received. Demonstrations have been carried out with clinicians and the one outstanding risk can be mitigated safely.

10. **Capability Statement – NHST(16)014**

10.1. KH sought Board approval for the annual Research & Development Operational Capability Statement.

10.2. GM asked about commercial viability of the research. KH reported on the scale of research which is growing in the areas of cancer, diabetes, stroke and cardiology.

10.3. DM asked for a report on all research, and KH agreed to forward the RDI annual report to Board members.

11. **Effectiveness of meeting**

11.1. AC said the Board was very well run and members were respectful – everyone has a chance to speak and listen to others views.

11.2. RF added that the NEDS routinely challenge the Executive decisions but it must be done professionally; the Executives are receptive to challenge. In addition, all Committees reporting to the Board are chaired by a NED.

11.3. CS commented that there was appropriate dialogue with good-mannered challenge and there were a number of actions to be taken away.

11.4. PW informed the Board that the paperwork for this meeting will be used for the meeting effectiveness review to be reported to the March Board meeting.

12. **AOB**

12.1. None noted.

13. **Date of next meeting**

13.1. The next meeting is scheduled for Wednesday, 24th February 2016 in the Boardroom, Whiston Hospital commencing at 9.30 am.

Chairman: .....

Date: 24 FEB 2016

TRUST PUBLIC BOARD ACTION LOG – 27th January 2016

No	Minute	Action	Lead	Date Due
1	24.06.15 (6.6)	Richard Fraser will look at fundraiser secondment opportunities for the Trust. **29.07.15 – Richard Fraser has spoken to his contact and will arrange a meeting. 30.09.15 – Richard Fraser will meet with United Utilities. 28.10.15 Meeting arranged for 29th October. 25.11.15 Action ongoing. To be discussed with Charitable Funds Committee leads.** **ACTION CLOSED**		
2	28.10.15 (5.6)	Trust Standards of Business Conduct Policy. User guide to be devised and disseminated to Board members. **27.01.16 New proforma devised. Will be presented to Audit Committee and then disseminated to the Board.**	KH/NK /PW	24 Feb 16
3	28.10.15 (5.6)	Lower limit for declarations to be reviewed. **27.01.16 Lower limit is now £25.** **ACTION CLOSED**		
4	28.10.15 (6.5)	Leads of the Charitable Funds Committee to review access that we allow to charitable organisations for fund-raising within our hospitals. **27.01.16 Update at next Board**	NK /DM	24 Feb 16
5	27.01.16 (8.10.5)	Sue Redfern will take a paper to the Executive Committee meeting regarding safeguarding training.	SRe	30 Mar 16
6	27.01.16 (10.3)	Following a request from George Marcall and Denis Mahony, Kevin Hardy will distribute the RDI annual report. **ACTION COMPLETED 27.01.16.**		
8	27.01.16 (8.11.4)	Ann Marr asked Claire Scrafton to review the table for the annual leave rates	CS	30 Mar 16
8	27.01.16 (8.12.3)	Claire Scrafton will discuss WRES at the steering group on 28.01.16 and a turnaround action plan will be implemented. Update at April Board	CS	27 Apr 16
9	27.01.16 (8.13.4)	Ann Marr asked Sue Redfern to gather all EOL care complaints and find a common theme; this work is to be carried out forensically and action plan must be put in place. **28.01.16 Information received from Complaints Team. Update to be given at March Board.**	SRe	30 Mar 16

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)015

Title of paper: Audit Committee Assurance Report.

Purpose: To feedback to members key issues arising from the Audit Committee.

Summary: The Audit Committee met on 3rd February 2016. The following matters were discussed and reviewed:

External Audit (Grant Thornton)**:**

- An update on progress with the annual external audit plan (including reference to current and emerging issues in the NHS) – currently going to plan.

Internal Audit (Mersey Internal Audit Agency – MIAA)**:**

- An update on progress with the annual internal audit plan, currently going to plan, including an update on recent follow-up audits (generally positive).
- MIAA Insight report on current events and issues of interest to the Audit Committee.

Anti-Fraud Service (MIAA):

- An update on progress with the annual counter fraud plan – currently going to plan.

Trust Governance and Assurance:

- The Director of Nursing update including Quality Committee update (DoN).
- Board Assurance Framework (DoN)

Standing Items:

- The audit log (report on current status of audit recommendations) (ADoF)
- The losses, compensation and write-offs report to the end of December 2015 (ADoF).
- Aged debt analysis (ADoF).
- Tender and quotation waivers (ADoF).
- External reviews (DoF).

Under “any other business” the following items were discussed:

- Annual report on use of the Trust’s seal (DoCS).
- Update of Anti-Fraud, Bribery and Corruption Policy (ADoF) – Routine revision accepted by the Audit Committee and recommended for approval to Trust Board.
- Paper re Prior Period Adjustment relating to the revaluation of the Trust’s Estate (ADoF) – accepted by the Audit Committee and recommended for approval to the Trust Board.
- Standards of Business Conduct Policy – Amendments suggested by the Trust Board re declaration forms and declaration levels for reporting were accepted by

the Audit Committee. (New forms and policy to be circulated in March) (ADoF).

- 2014/15 National Reference Cost Index Score (SLRA).

Key: DDoF = Deputy Director of Finance
DoN = Director of Nursing, Midwifery & Governance
DoCS = Director of Corporate Services
ADoF = Assistant Director of Finance (Financial Services)
SLRA = SLR Accountant

Corporate objectives met or risks addressed: Contributes to the Trust's Governance arrangements

Financial implications: None directly from this report

Stakeholders: The Trust, its staff and all stakeholders

Recommendation(s): Members are asked to approve the following items:

1. The updated Anti-Fraud, Bribery and Corruption Policy
2. The paper re the Prior Period Adjustment

Presenting officer: Su Rai, NED and Chair of Audit Committee

Date of meeting: 24th February 2016

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)016

Title of paper: Committee Report – Charitable Funds Committee

Purpose: To brief the Board on the main issues discussed and decisions made at the Committee meeting on 16th February 2016.

Summary:

1. Investment portfolio

The portfolio position shows an unrealised gain of £40.4k against purchase price, and an unrealised loss of £81.8k against year-end valuation

2. Financial position

The Committee reviewed Income and Expenditure since the previous meeting. This showed Income of £65,987 and Expenditure of £68,068

3. Approval of Expenditure over limits

Consultant Cardiologist Dr Wong submitted a proposal to purchase a portable GE Venue Vascular Ultrasound machine for the Cardiac Catheter Lab at Whiston Hospital, at a cost of £11,325, which includes 5 years warranty and training support. Based on the information provided by Dr Wong, the committee approved the funding from charitable funds.

4. Fundraising

The new Whiston and St Helens Hospitals' Charity launched on the 28th January with an extremely successful abseil. Over 105 people abseiled, with staff teams, members of the local community, local companies and colleges – raising in excess of £12,000. A second launch event is planned for 26th February, this is a 12hour static cycle challenge between the two hospitals.

Corporate objective met or risk addressed: Contributes to the Trust's objectives regarding Finance, Performance, Efficiency and Productivity.

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff and all stakeholders.

Recommendation(s): The Board are asked to note the contents of the report.

Presenting officer: Denis Mahony, Non-Executive Director, and Committee Chair.

Date of meeting: 24th February 2016

TRUST BOARD PAPER

Paper No: NHST(16)017

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the activities of the Finance and Performance Committee held in February 2016

Summary: Agenda Items

- **For Information**
  - IT Progress and Priorities
  - NWAS contract update
  - Operational Turnaround - January update
  - Annual Plan Update
  - Governance Committee Briefing Papers:
    - CIP Council
    - MITC

For Assurance

- IPR Report Month 10
- Finance Report Month 10
- CIP scheme – governance compliance
- Surgical SLR performance Q2 15/16

For Decision

- Forecast Outturn 2015/16
  - including an updated financial risk table with specific mitigations
- Budget Setting 2016/17 v2
- Productivity and Efficiency KPIs 2016/17
- Maternity KPIs 2016/17

Actions Agreed

- RTT growth in backlog and A & E performance to be noted as operational risks to the Board
- Efficiency dashboard
  - Proposed change to be implemented and reviewed in April
- Maternity dashboard:
  - Performance to be reviewed on a quarterly basis
  - KPI dashboard to be completed and reviewed
- FOT 2015/16 to revert to £9.79m deficit, in line with original plan
  - in recognition of contractual penalties being imposed by Commissioners
- The Committee reviewed the financial improvement list of options, circulated by the TDA and agreed to progress the technical option around single site asset valuation with DTZ. If needed this would have to be approved by Audit Committee and our auditors
- It was noted that incomplete spells were part of Contract negotiations with Commissioners.

Corporate objectives met or risks addressed: Finance and Performance duties
Financial implications: Risks to the Forecast outturn for 15/16 need to reflected
Stakeholders: Trust Board Members
Recommendation(s): Members are asked to note the contents of the report
Presenting officer: Nikhil Khashu Director of Finance and Information
Date of meeting: 24th February 2016

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(16)018
Subject: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

St Helens and Knowsley Hospitals Teaching Hospitals ("The Trust") has in place effective arrangements for the purpose of maintaining and continually improving the quality of healthcare provided to its patients.

The Trust has an unconditional CQC registration which means that overall its services are considered of a good standard and that its position against national targets and standards is relatively strong.

The Trust has in place a financial plan that will enable the key fundamentals of clinical quality, good patient experience and the delivery of national and local standards and targets to be achieved. The Trust continues to work with its main commissioners to ensure there is a robust whole systems winter plan and continued delivery of national and local performance standards whilst ensuring affordability across the whole health economy.

Patient Safety, Patient Experience and Clinical Effectiveness

England's Chief Inspector of Hospitals (CQC) has awarded the Trust an overall rating of **Outstanding** for the level of care it provides across ALL services. St Helens Hospital was rated as **Outstanding,** making it 1 of only 3 acute hospitals nationally to be rated at this level. Whiston Hospital has been rated as **Good with Outstanding Features** placing it amongst the best hospitals in the NHS. **Outpatient and Diagnostic Imaging Services** at **BOTH** hospitals have been given the highest possible rating **Outstanding** – The ONLY Outpatient and Diagnostic service in the country to EVER be awarded this rating.

There have been no cases of MRSA bacteraemia during 2015-16. The Trust has a zero tolerance of MRSA.

The tolerance for C.Difficile in 2015-16 is 41 cases. In total there have been 28 confirmed avoidable cases YTD. The Trust is appealing a further 2 cases (panel to be held in February 2016). RCAs are currently being undertaken.

There were no hospital acquired grade 3 / 4 pressure ulcers in January.

There has been one fall that have resulted in a harm level greater than moderate since October 2015. The management and prevention of falls is a key priority to ensure lessons learned are cascaded. The falls team are focusing delivering each aspect of the falls prevention action plan.

For the second month in succession the Trust VTE audit demonstrated 100% compliance for patients receiving enoxaparin.

There have been no "never events" since May 2013.

The latest available 12 month HSMR (Nov-14 to Oct-15) is 98.5.

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 15/16 financial outturn will have implications for the finances of the Trust
Stakeholders: Trust Board, Finance Committee , Commissioners, CQC, TDA, patients.
Recommendation: To note performance
Presenting Director: N Khashu
Committee Date: 24th February 2016

Operational Performance

Stroke, cancer and 18 weeks RTT all continued to perform well, despite the significant non-elective demands. The emergency access Operational Turnaround process has commenced. Internal diagnostic delays have been significantly reduced in the past month. Intensive interaction with the local authorities and CCG's continues, with the objective of optimising non-elective patient flow. Improved communication of medically optimised patients between the wards and social care has been introduced and is having an immediate benefit.

Financial Performance

The Trust is reporting against a revised Annual Plan of £6.647m deficit, as approved by the Trust Board and confirmed with the TDA. This equates to a £3.143m improvement, of which £2.8m relates to additional income from Commissioners.

For the month of January 2016 (Month 10) the Trust is reporting an overall Income & Expenditure deficit of £9.765m after technical adjustments which is adverse to agreed plans. This deterioration against plan relates to the imposition of contractual penalties by Commissioners , which were assumed would not be incurred in the Plan.

To date the Trust has delivered £12.645m of CIPs which is £0.221m ahead of plan. The Trust is forecasting to deliver its full CIP target of £13.043m and the PMO continue to support delivery of CIP.

Human Resources

Staff Friends and Family Test Q2 survey results again show the trust as performing exceptionally well compared to the national position and the Trust is continuing to improve from the same period in 2014/15 particularly in relation to the question relating to staff recommending the Trust as a place to receive patient care to their family and friends. Comparison of Q1&2 data places the Trust as best performing Acute Trust in the Cheshire and Mersey region for both.

The Trust has completed the annual staff satisfaction survey in Q3 with a return rate of 55% which is in the top 20% of all Trusts nationally. The results will be published in Q4.

The Trust is below the mandatory training target. Appraisals performance has fallen slightly and is now 1.2% below target. Recovery plans for both are in place to ensure compliance by year end.

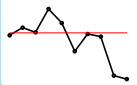
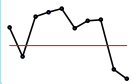
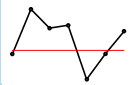
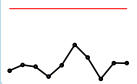
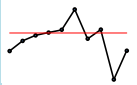
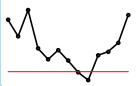
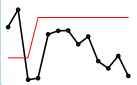
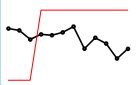
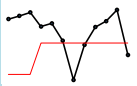
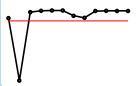
All staff sickness for December was 5.6% and year to date is 4.8% against a target of 4.72%. Qualified Nursing and HCA absence increased to 7.5% against the target of 5.3% (HCA % for December was 9.27% and Qualified was 6.10%) due to seasonal viruses which affected the health large number of staff prior to Christmas. YTD is 5.7% against a target of 5.3%.

The following key applies to the Integrated Performance Report:

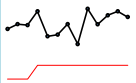
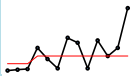
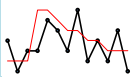
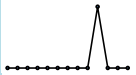
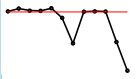
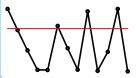
▲ = 2015-16 Contract Indicator
▲ £ = 2015-16 Contract Indicator with financial penalty
● = 2015-16 CQUIN Indicator
T = Trust internal target

St Helens and Knowsley Teaching Hospitals NHS Trust

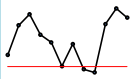
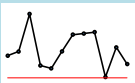
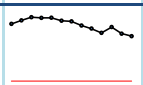
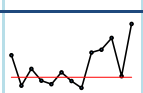
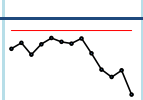
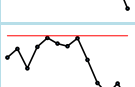
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2015-16 YTD	2015-16 Target	2014-15	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS												
Mortality: Non Elective Crude Mortality Rate	Q	T	Jan-16	2.9%	2.4%	No Target	2.6%		Palliative care consultant starts April - will improve palliative care provision, which should favourably affect HSMR. First phase of investigation to understand STHK weekend HSMR complete. Deaths in Saturday admissions are disproportionately increased. Further investigation ongoing.	Patient Safety and Clinical Effectiveness	Drive to reduce use of R codes in ED/EAU/AMU which negatively impact SHMI & HSMR is the next major drive to improve mortality estimates, together with work to improve management of AKI and Sepsis.	KH
Mortality: SHMI (Information Centre)	Q	▲	Jun-15	1.03		1.00	1.03					
Mortality: HSMR (Dr Foster)	Q	▲	Oct-15	77.3	95.0	100.0	102.3					
Mortality: HSMR Weekend Admissions (emergency) (Dr Foster)	Q	T	Oct-15	73.3	108.5	100.0	109.6					
Readmissions: 28 day Relative Risk Score (Dr Foster)	Q	T	Jul-15	103.6	100.7	100.0	107.9		Readmissions consistently higher than desired, mostly related to EAU usage.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	Work to improve listing of babies returning electively but documented as emergency admissions is underway.	KH
Length of stay: Non Elective - Relative Risk Score (Dr Foster)	F&P	T	Oct-15	86.8	86.6	100.0	87.7		This is a key efficiency, productivity and patient experience measure	Patient experience and operational effectiveness	Consistent reductions in NEL LOS are assurance that medical redesign practices continue to successfully embed. The elective improvement is welcomed with focus now on further improving and embedding the changes.	PJW
Length of stay: Elective - Relative Risk Score (Dr Foster)	F&P	T	Oct-15	90.6	97.4	100.0	102.0					
% Medical Outliers	F&P	T	Jan-16	4.0%	2.0%	1.0%	1.8%		Patients not in right speciality inpatient area to receive timely, high quality care	Increase in LoS, patient experience and impact on elective programme	The increase is a reflection of the growth in non-elective demand within medicine. Robust arrangements to ensure appropriate clinical management are in place.	PJW
Percentage Discharged from ICU within 4 hours	F&P	T	Jan-16	40.7%	52.5%	67.7%	54.1%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	This is a function of the NEL demand and subsequent impact on patient flow. The operational turnaround actions should assist in improving this metric.	PJW
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients)	Q	▲	Dec-15	79.5%	80.7%	85.0%	80.9%		The trust eDischarge performance remains strong compared with peers, with recent CCG-led audits showing 100% transmission of electronic discharge summaries (c.f. paper).		Further education and support for trainees to improve timely eDischarge delivery is on-going.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients)	Q	▲	Dec-15	81.2%	87.1%	85.0%	84.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E)	Q	▲	Dec-15	98.8%	98.4%	95.0%	89.5%					

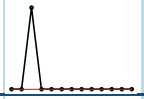
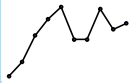
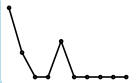
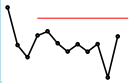
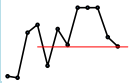
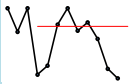
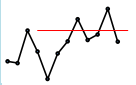
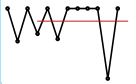
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2015-16 YTD	2015-16 Target	2014-15	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Jan-16	93.8%	92.3%	83.0%	84.4%		Target is being achieved	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	This KPI is at risk from significant non-elective demand. The issue is reviewed at every Bed Meeting.	PJW
PATIENT SAFETY												
Number of never events	Q	▲ £	Jan-16	0	0	0	0		There have been no never events since May 2013	Quality and patient safety	The safer surgery ward checklist has now been piloted and will be rolled out in March, to further protect against surgical never events	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Jan-16	99.9%	98.8%	98.6%	98.6%		Figures quoted relate to all harms excluding those documented on admission	Quality and patient safety	StHK reported best performance in January for hospital acquired harm: 0 harm from falls, 0 pressure ulcers and 0 UTI's reported in thermometer	SR
Prescribing errors causing serious harm	Q	T	Jan-16	0	0	0	0		The trust continues to have no prescribing errors which cause serious harm. Trust has moved from being a low reporter of prescribing errors to a higher reporter - which is good.	Quality and patient safety	Intensive work on-going to reduce medication errors and maintain no serious harm. Trust approved national insulin training programme to try to prevent insulin errors.	KH
Number of hospital acquired MRSA	Q F&P	▲ £	Jan-16	0	0	0	2		There have been 28 confirmed Cdiff cases YTD. The trust are appealing a further 2 cases from those RCAs completed.	Quality and patient safety	The Infection Control Team continue to support staff to maintain high standards and practices, Trust Board monitor infection rates. Monitor and undertake RCA for any hospital acquired BSI and CDT. CDT and Antibiotic wards rounds continue to be undertaken on appropriate wards.	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲ £	Jan-16	0	28	41	33		15-16 tolerance = 41 cases YTD tolerance = 37 cases			
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Jan-16	0	1	No Contract target	2		There was 0 grade 3 or 4 pressure ulcers in January.	Quality and patient safety	Pressure ulcer performance continues to improve with zero grade 3 or 4 reported in month and only 3 grade 2 and 1 grade 1 reported.	SR
Number of falls resulting in severe harm or death	Q	▲	Dec-15	0	16	No Contract target	19		There were 0 falls resulting in severe harm during December	Quality and patient safety	December falls performance against national benchmark was 6.42 falls against 6.63 benchmark and 0.0 significant harm against a 0.19 benchmark. New type falls alarms have been delivered and pilot completed on the 5th February.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲ £	Dec-15	91.32%	94.17%	95.0%	92.54%		VTE performance has dipped under intense pressure of increased number and complexity of emergency admissions. Still no implementation of the new eVTE system which means EAU & A&E patients cannot be electronically assessed.	Quality and patient safety	Consideration needs to be given to procurement of an alternative eVTE solution.	KH
Hospital acquired VTE events rate (National Safety Thermometer)	Q F&P	T	Jan-16	0.14%	0.29%	0.45%	0.45%					
To achieve and maintain CQC registration	Q	▲	Jan-16	Achieved	Achieved	Achieved	Achieved		This Trust continues to maintain CQC registration	Quality and patient safety	Through the Quality Committee and governance councils the Trust ensures it meets CQC standards. The Trust's Chief Inspection of Hospital (CQC) announced inspection took place between 19-21st August.	SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Dec-15	96.2%	97.4%		98.6%		Overall the Nurse/Midwife fill rate remains consistent	Quality and patient safety	Daily staffing huddles supported by escalation flow chart are in place. The Trust has an escalation protocol in place which includes Executive authorisation for requesting agency staff. Contact Care Time reviews undertaken on the Intermediate Care wards in November and the Shelford Patient Acuity Audit will be reported to Trust Board in February.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Dec-15	0	0		0					
Intelligent Monitoring Risk Banding	Q	T	May-15	5		6	4		The Trust has improved priority banding to band 5 (Band 1 = highest risk and Band 6 = lowest risk).	Quality and patient safety	Actions plans in place for areas identified as requiring improvement.	SR

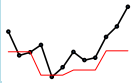
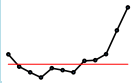
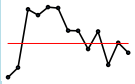
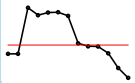
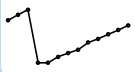
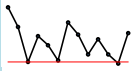
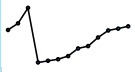
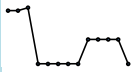
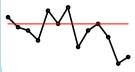
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2015-16 YTD	2015-16 Target	2014-15	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Dec-15	95.5%	94.3%	93.0%	94.0%		Access targets achieved in December although we continue to see individual specialty fails which remain under review to monitor referrals and patient pathways	Quality and patient experience	Dermatology missed the standard in month but actions are on going to improve capacity to cope with demand. All tumour pathways are under review as part of a cancer improvement programme and a revised Cancer PTL approach commenced in January 2016.	PJW
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Dec-15	96.4%	97.8%	96.0%	98.8%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ £	Dec-15	86.9%	88.4%	85.0%	89.9%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲ £	Jan-16	96.3%	96.3%	92.0%	98.1%			There is a risk due to the current surgical bed pressures that the elective programme will be compromised	18 weeks performance continues to be monitored daily and reported through the weekly PTL process.	PJW
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲ £	Jan-16	99.9%	99.99%	99.0%	100.0%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲ £	Jan-16	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Jan-16	1.6%	0.8%	0.6%	0.7%			Patient experience and operational effectiveness Poor patient experience	This metric continues to be directly impacted by increases in NEL demand (both surgical and medical patients). The planned increase in elective surgical activity in St Helens has begun. Potential to use theatre and bed capacity at Ormskirk is being investigated.	PJW
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Dec-15	100.0%	100.0%	100.0%	100.0%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Jan-16	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲ £	Jan-16	76.4%	87.3%	95.0%	92.8%		Failure to ensure patients are managed within 4 hours in the Emergency Department All Type activity includes the Trusts contribution to the Widnes WIC. From Jan-16 Huyton WIC data is included in All Type activity.	Patient experience, quality and patient safety	A Turnaround process has commenced with a view to increasing capacity and reducing inpatient demand, thus improving patient flow and the 4 hour standard.	PJW
A&E: Total time in A&E: % < 4 hours (All Types)	F&P	▲ £	Jan-16	85.5%	90.8%	95.0%	94.2%					
A&E: 12 hour trolley waits	F&P	▲	Jan-16	0	0	0	1					

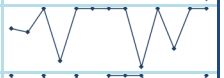
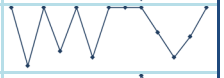
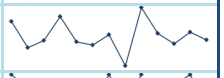
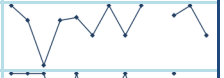
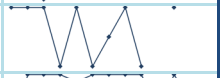
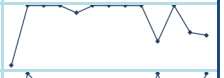
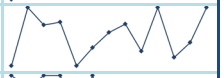
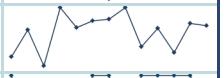
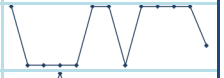
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2015-16 YTD	2015-16 Target	2014-15	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Jan-16	0	0	0	7		Increased demand for IP capacity has a direct bearing on the ability to maintain this quality indicator.	Patient Experience	Maintained focus and awareness of this issue across 24/7.	PJW
Complaints: Number of New (Stage 1) complaints received	Q	T	Jan-16	21	254		281			Patient experience		SR
Complaints: Number of New (Stage 1) complaints received in 2015-16 and resolved in 2015-16	Q	T	Jan-16	26	207							
Complaints: Number of New (Stage 1) complaints received in 2015-16 and resolved in 2015-16 within agreed timescales	Q	T	Jan-16	50.0%	63.3%							
Complaints: Number of New (Stage 1) complaints received in 2014-15 and resolved in 2015-16	Q	T	Jan-16	0	121							
Complaints: Number of New (Stage 1) complaints received in 2014-15 and resolved in 2015-16 within agreed timescales	Q	T	Jan-16	0.0%	5.0%							
Friends and Family Test: % recommended - A&E	Q	▲	Dec-15	93.5%	92.9%	95.0%	94.8%		The Trust ED and Maternity (birth and post natal ward) % that would recommend remains slightly below target. However, out of all Emergency Departments in the region we are the best performing Trust by a considerable margin. The pressures in the ED were heightened during December and achieving 93.5% is an achievement by all staff. The target required needs further discussion as it has been set at a high level, given how well we are performing within the region.	Patient experience & reputation	Scores have been fed back to the ED and Maternity departments. New company has taken over FFT surveys on behalf of the Trust since January 2016. Number of patients being surveyed will increase greatly from January. Roll out will be incremental during quarter 4 and will include all outpatients, day cases and all ages.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Dec-15	96.5%	97.1%	95.0%	97.2%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q	▲	Dec-15	97.4%	98.3%	97.3%	97.3%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Dec-15	95.1%	97.5%	98.7%	98.7%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q	▲	Dec-15	94.9%	94.6%	96.6%	96.6%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q	▲	Dec-15	100.0%	99.0%	99.4%	99.4%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Dec-15	96.6%	96.8%	>14/15 out turn						

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2015-16 YTD	2015-16 Target	2014-15	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE												
Sickness: All Staff Sickness Rate	Q F&P	▲	Dec-15	5.6%	4.8%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.8%		Trust sickness had showed a positive trend with significant reductions between January (5.4%) - June 2015 (4.3%) (-1.1%) Since October, sickness has been above 5% and December was the highest its ever been in the last 12 months, with a 0.88% increase against Q3 target. HCA % for December was 9.27% and Qualified was 6.10%. Stress remains the highest reason for absence.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	As part of the on-going 'Attendance Management Positive Action Programme' the policy has been further revised to address current workforce matters relating to absence i.e. triggers strengthened for moving staff to stages/levels and a robust process for managing trends. The HR Advisory Team and Absence Support Team continue to work closely with managers with top areas being targeted and action plans invoked. Stage/Level 3's were held during December to address unacceptable absence. In December there were 40 individuals absent for 3 months or more due to complex, LTS. The HWWB team continue to implement WellBeing initiatives in areas such as A&E, Pharmacy & Maternity o support staff during difficult periods of activity.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P	T	Dec-15	7.5%	5.7%	5.3%	5.8%					
Staffing: % Staff received appraisals	Q F&P	T	Jan-16	83.8%	83.8%	85.0%	89.6%		The Trust has slipped slightly on its position earlier in the year for Appraisal and Mandatory Training. This is due to activity levels resulting in staff being required to provide patient care and the need to postpone training due to operational pressures.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The Learning & Development team are developing a recovery plan for Q4 to ensure the Trust achieves end of year compliance. Where departments are about to/or have breached the target in month, turnaround plans are put in place to ensure the end of year target is achieved.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Jan-16	82.1%	82.1%	85.0%	88.3%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2	96.5%	95.4%	>14/15 out turn			In line with national requirements, there is no Trust Staff Friends and Family Test for the reporting period. this is replaced in Q3 by the National Staff Survey, the result of which will be published on 23rd February.		The Trust has issued the Q4 SFFT survey, Anticipated results are expected to remain positive.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2	90.1%	84.9%	>14/15 out turn						
Staffing: Turnover rate	Q F&P	T	Dec-15	0.7%			8.3%		Staff turnover remains stable and well below the national average of 14%.	Quality and patient experience, staff morale	Turnover is monitored across all departments as part of the Trusts Recruitment & Retention Strategy with action plans to address areas where turnover is higher than the trust average. Further action is required by Ward Managers to provide more support to newly qualified nurses.	AMS
FINANCE & EFFICIENCY												
FSRR - Overall Rating	F&P	T	Jan-16	2.0	2.0	2.0			The Trust's year to date performance is behind plan, due to the imposition of contractual penalties by Commissioners and the forecast outturn is therefore in line with the original plan of £9.790m deficit.	Financial	Adherence against the submitted plan and delivery of CIP. Future positive Cash flow will depend upon the Trust maintaining control on Trust expenditure and agreeing with Commissioners and NHSE a more advantageous profile for receipt of planned income. The Trust also has significant contractual agreements with other NHS organisations which may impact on our ability to achieve Better Payment compliance.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Jan-16	10,719	10,719	13,043	15,000					
Reported surplus/(deficit) to plan (000's)	F&P	T	Jan-16	(9,765)	(9,765)	(6,647)	(2,551)					
Cash balances - Number of days to cover operating expenses	F&P	T	Jan-16	29	29	>10	10					
Capital spend £ YTD (000's)	F&P	T	Jan-16	3,258	3,258	4,923	4,906					
Financial forecast outturn & performance against plan	F&P	T	Jan-16	(9,790)	(9,790)	(6,647)	(2,551)					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Jan-16	94.0%	94.0%	95.0%	94.8%					

APPENDIX A

		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	2015-16 YTD	2015-16 Target	FOT	2014-15	Trend	Accountable Exec
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																				
Breast	£	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%	99.4%	85.0%		99.5%		Paul Williams
Lower GI	£	92.3%	90.9%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	77.8%	100.0%	84.6%	100.0%	100.0%	94.2%	85.0%		90.6%		
Upper GI	£	100.0%	66.7%	100.0%	75.0%	100.0%	71.4%	100.0%	100.0%	100.0%	85.7%	71.4%	83.3%	100.0%	87.1%	85.0%		86.3%		
Urological	£	90.9%	74.1%	78.6%	94.1%	77.8%	75.8%	82.4%	62.5%	100.0%	83.3%	76.7%	84.0%	79.2%	79.8%	85.0%		87.4%		
Head & Neck	£	100.0%	75.0%	0.0%	75.0%	80.0%	50.0%	100.0%	50.0%	100.0%		83.3%	100.0%	50.0%	77.4%	85.0%		59.4%		
Sarcoma	£	100.0%	100.0%	100.0%		100.0%		50.0%	100.0%			100.0%			80.0%	85.0%		100.0%		
Gynaecological	£	0.0%	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%	40.0%	100.0%	54.5%	50.0%	78.9%	85.0%		88.2%		
Lung	£	66.7%	100.0%	90.0%	91.7%	66.7%	76.9%	85.7%	90.5%	75.0%	100.0%	71.4%	80.0%	100.0%	84.3%	85.0%		80.9%		
Haematological	£	100.0%	88.9%	100.0%	100.0%	66.7%	100.0%	46.2%	50.0%	66.7%		60.0%	80.0%	66.7%	66.0%	85.0%		77.0%		
Skin	£	87.5%	94.3%	85.2%	100.0%	94.9%	96.6%	97.0%	100.0%	90.0%	94.7%	88.5%	95.9%	95.3%	94.5%	85.0%		94.6%		
Unknown	£	100.0%	0.0%				100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	33.3%	86.7%	85.0%		89.5%		
All Tumour Sites	£	89.8%	88.1%	88.7%	93.9%	86.7%	86.3%	88.7%	91.0%	91.2%	91.4%	85.1%	89.3%	86.9%	88.4%	85.0%		89.9%		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																				
Testicular	£			100.0%	100.0%			100.0%		100.0%	100.0%				100.0%	85.0%		91.7%		
Acute Leukaemia	£			100.0%									100.0%		100.0%	85.0%		100.0%		
Children's	£															85.0%				

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)019
Title of paper: Executive Committee Assurance Report.
Purpose: To feedback to members key issues arising from the Executive Committee meetings.
Summary: 1. Between the 115th January and 17th February, three meetings of the Executive Committee have been held; the meeting of 28th January being a Clinical Senate. The attached paper summarises the issues discussed at the meetings. 2. Decisions taken by the Committee included improvements for VTE performance and flash reporting. 3. Assurances regarding the Quality Account, management of bank and agency usage, junior doctor cover, CQC action plan, and Sustainability and Transformation Planning were obtained. 4. No significant investment decisions were made. 5. There are no specific items requiring escalation to the Board.
Corporate objective met or risk addressed: Contributes to the Trust's Governance arrangements, and its short and longer-term plans.
Financial implications: None directly from this report.
Stakeholders: The Trust, its staff and all stakeholders.
Recommendation(s): The Board are asked to note the contents of the report.
Presenting officer: Ann Marr, Chief Executive.
Date of meeting: 24th February 2016.

EXECUTIVE COMMITTEE REPORT (15th January to 17th February 2016)

The following report highlights the key issues considered by the Executive Committee.

21st January

1. Risk Report

   1.1. SR briefed on the Corporate Risk Register (CRR), including the new high scoring risks reported in December 2015.

   1.2. The risk regarding the Medway IT system for Community Midwives was discussed and it was agreed that PJW and CW would come back with a proposal, plus benefits realisation from the initial investment.

   1.3. The level of assurance provided by the current system was discussed and it was agreed that further improvement is required.

2. AQ Programme Funding

   2.1. Sue Hill (SH) briefed members on the value of AQ and AQuA membership, which are bundled together, and considered the merit of remaining with the programme at a cost of c£40k per year. It was concluded that AQ pathways to improve outcomes are not as evidence based as they have been in the past.

   2.2. It was agreed that KH will lead on this, and talk to Commissioners to ascertain their views on the way forward.

3. Finance progress report

   3.1. SH gave a presentation on the forecast outturn for 2015/16. Income and expenditure were discussed. SH reported that all management actions plans are being delivered now, reducing the risks.

   3.2. Noted that KH and NK are meeting with Steve Cox and Paul Brickwood to discuss year-end funding.

4. Safer staffing / vacancy dashboard

   4.1. Reports for the months of November and December were discussed. The wards where fill rates were below 90% for specific shifts were scrutinised in detail.

   4.2. It was acknowledged that it is difficult to definitively attribute patient incidents to unfilled shifts, and there is no clear pattern, although inevitably risk is increased. KH agreed to give extra support to look at this data in more depth.

   4.3. AMS presented the vacancy dashboard, which correlates with SR's data. Noted that the next recruitment day is scheduled for 27th February.

   4.4. Noted that 122 posts have been offered from international recruitment and are progressing through the appointment process.

5. VTE progress update

   5.1. KH and CW have jointly reviewed the current VTE process. IT, paper-based and retrospective systems are in place and it was agreed that a definitive Standard Operating Procedure would be developed.

   5.2. PJW agreed to review the appropriateness of the Committee and Council reporting arrangements for monitoring VTE performance.

6. Cheshire & Merseyside Women and Children's Services Partnership Vanguard Executive Leadership meeting

   6.1. AMS briefed members and agreed to circulate documents from the discussions held. A Memorandum of Understanding is being drafted for all Trust Boards.

7. Forward View event

   7.1. AM briefed members on the planned event at Aintree Racecourse on 29th January where the proposed footprint for future 5-year plans will be agreed.

8. LNC meeting agenda

   8.1. Agenda discussed along with the options being considered by Trusts regarding Clinical Excellence Awards in light of Consultant Contract negotiations.

28th January

9. Junior Doctor allocation changes

   9.1. Colette Hunt (CH) updated Senate on the FY2 changes effective from August 2016 following directives received last year from Health Education North West (HENW) and the UK Foundation Programme Office (UKFPO). Contingency plans implemented last year were acknowledged, and CH expressed confidence that the outstanding posts will be filled.

   9.2. Discussion followed on recruiting Prescribing Nurse Clinicians to the vacant posts in place of doctors, and additional overseas recruitment. Agreed AMS will bring a proposal on the way forward back to next Senate.

10. Quality Account priorities for 2016/17

    10.1. ARW provided an update and sought guidance on the quality priorities for inclusion. The main options were debated, with emphasis given to the three domains of patient safety, patient experience and clinical effectiveness. Sepsis, complaints and communication were highlighted but it was agreed that ARW would finalise the list through discussions outside the meeting.

11. Revised CQC Action Plan

    11.1. The five “must do” actions and 46 “should do” actions on the plan were reviewed. Noted that good progress is being made in delivering many of the actions, with 50% due to be completed by 31st January.

    11.2. The Trust is required to submit its final action plan to the CQC on 18th February following ratification by the System Resilience Group (SRG). Agreed that Executive leads need to forensically examine the accompanying narrative to each item, ensuring accuracy.

    11.3. The rag rating of the action plan was discussed and it was agreed to amend to a BRAG rated plan where BLUE will indicate action complete; GREEN will indicate action on track to be deliver by deadline; AMBER will indicate action at risk of missing the deadline; and RED will indicate action overdue.

12. CQPG

    12.1. SR gave a verbal update on the key issues from the CQPG meeting in January which included:

    - Community nurse access to ICNET
    - VTE RCAs
    - Timeliness of CCG reporting from SUI investigations

- National guidance screening for infection control
- GPs receipt of electronic discharge summaries.

4th February

13. Medway Maternity system

13.1. CW advised that the benefits realisation report of the system had not been finalised, and the action had been given to the PMO to take forward. NK will now pick up the action and report back as soon as possible.

13.2. PJW reported that a business case regarding the community element of the system will be brought to Committee on 3rd March.

14. TDA/ Monitor submission on Bank and Agency spend

14.1. Malise Szpakowska (MS) provided an update on the instances where the Trust has breached the agency rules. Noted that there has been a 20% reduction in breaches between December and January, and the spend for December was 2.88% of the qualified nursing workforce spend, against a limit of 3.0%.

14.2. Issues discussed included:

- NK challenged the high usage of agency HCAs, however the additional bank recruitment should address this
- Difficulties in Registered Nurse recruitment
- The work of the Absence Support Team (AST) in actively assisting managers to bring down sickness absence rates
- AMS queried the usage of agency staff in St Helens Theatres; it was noted that recent additional recruitment will assist
- Medical workforce agency usage and the high expenditure. The use of a devolved booking service in A&E was noted which will be investigated further
- Sharing data from other Trusts.

15. Cancer Strategy

15.1. Rani Thind (RT), Mark Hogg (MH) and Pat Gillis (PG) briefed members on the ideas emerging from Clatterbridge Cancer Centre (CCC) to develop an East Mersey Oncology Hub.

15.2. How this initiative links to strategic proposals from the Liverpool City Region and Cheshire for the rationalising of cancer centres was discussed.

15.3. It was agreed that the Trust should actively consider each opportunity and that PJW and KH will link in with their opposite numbers at CCC.

16. First draft 2016/17 Operational Plan

16.1. Sue Hill (SH) and Nicola Bunce (NB) presented the outline draft annual plan for submission to the TDA on 8th February (final submission in April). It was confirmed that the plan has been consolidated to reflect proposed Sustainability and Transformation funding to the Trust and is subject to final refinements.

16.2. Noted that the Trust Board has agreed to accept the funding offer with the successful review of the risks by representatives of the Finance & Performance Committee. Discussions held on CIP opportunities and agreed that NK and AM would discuss the details later.

17. Flash Reporting

17.1. PW presented a proposal for a system to report key issues to Board members between formal meetings of the Trust Board. It was noted that this is for urgent information only, and by exception, and was approved for implementation.

18. Trust Board Agenda

18.1. The proposed agenda was considered and, following minor amends, agreed.

19. eVTE

19.1. CW took members through the update paper. It was noted that the majority of assessment and recording issues pertain to A&E, plus a small number of wards predominantly used for assessment of non-elective admissions. The following actions were agreed:

- Further scrutiny to ensure that there is absolute clarity on the systems used
- SR will speak to the clinical lead regarding compliance on the Stroke Unit
- A paper solution should be introduced into A&E
- A policy for using ADT will be developed by SR and CW
- Improvements in VTE performance should be monitored through the Quality Committee.

19.2. SR will speak to representatives at Southport NHS Trust to see if we can learn from their successes with regards to both VTE and falls management.

20. Bridgewater IT Contract

20.1. NK and CW gave an update on the situation regarding payment by Bridgewater for IT services. The realignment of contracts and payments has been agreed, by the HIS Board with the timescale for change generally felt to be circa 3 years. Whilst it is acknowledged that this is an issue for all joint members to address, STHK is currently taking all the financial risk which must be resolved, and the HIS chair should be asked to confirm in writing to members the expectations of the HIS Board.

20.2. Bridgewater had promised an element of the payment but this has still to be received.

21. Sustainability and Transformation Planning

21.1. AM briefed members on the discussions held to agree the STP footprint which ultimately approved a Liverpool City, Region and Cheshire area, which is an excellent outcome for the Trust.

ENDS

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)020
Title of paper: Quality Committee Assurance Report.
Purpose: The purpose of this paper is to summarise the Quality Committee meeting held on 16th February 2016 and escalate issues of concern.
Summary: Key items discussed were: 1. Complaints 2. CQC action plan update 3. Safer Staffing 4. Weekend mortality 5. Ward Dashboard 6. Accessible Information Sharing 7. Dementia Training
Corporate objectives met or risks addressed: Five star patient care and operational performance.
Financial implications: None directly from this report.
Stakeholders: Patients, the public, staff and commissioners.
Recommendation(s): It is recommended that the Board note this report.
Presenting officer: David Graham, Non-Executive Director
Date of meeting: 24th February 2016

QUALITY COMMITTEE ASSURANCE REPORT

Summary of the discussions and outcomes from the Quality Committee meeting held on 16th February 2016.

Action Log

1. All actions on the log were reviewed.

Complaints Report

2. A Rosbotham-Williams updated the Committee on complaints and trends.

   2.1. There have been 39 during January 2016; of these 22 are 'Approved" 1st stage complaints, an increase of one compared to the December figure of 21.

   2.2. The top three themes are communication, clinical treatment and patient care/nursing care.

   2.3. There were 182 PALS contacts/enquiries during January; the top three PALS themes were Accident and Emergency, Orthopaedics and General Surgery.

   2.4. A Rosbotham-Williams and S Redfern are meeting with A Marr at the end of February to discuss the Complaints structure and it's development.

   2.5. K Hardy was not assured that the responses dealt with in a "timely manner" are being counted correctly and asked would the figure be worse if the Trust did not request "extensions"?

   2.6. D Graham asked why the figure had gone down again following the successful recovery last year. A Rosbotham-Williams replied that last year a lot of staff worked overtime and put in additional hours, but with operational pressures at the Trust at the moment, the input has tailed off. The efficiency of agency staff is a further issue, as is the standard of report writing and letter writing. A Rosbotham-Williams also said that training will be available for investigation and response writing. M Manning said that this training has not been well received, but he will take this up with the Surgical Care Group.

   2.7. A M Stretch would like a different format of the complaints report to be presented at Quality Committee, to include the structure and what the Trust is doing about issues raised. A Rosbotham-Williams agreed, saying the report needs less numbers and more about learning from complaints and what action is taken.

CQC action plan update

3. A Rosbotham-Williams briefed the Committee on the CQC action plan.

   3.1. The Trust has developed an action plan detailing how it will respond to the "must do" and "should do" actions set out in the CQC report. The plan will be brought to the Quality Committee for monitoring and will also be discussed at the engagement meetings that S Redfern attends with the CQC.

   3.2. D Graham asked what were seen as the biggest risks. A Rosbotham-Williams stated that access targets and ambulance turnaround times were high on the agenda. We also need to be vigilant about medicines security such as locking cupboards and resuscitation trolleys. The Trust is looking at the idea of replacing the locks with swipe cards, which will enable cupboards to lock and closure and will also provide an audit trail of who has accessed the cupboard, but this will involve capital expenditure.

3.3. K Hardy asked how will we give the CQC assurance and was informed that the Resuscitation Team have been conducting audits. K Hardy said that the ultimate test is how is practise changing/improving?

3.4. The action plan will be signed off at the Executive Team meeting on Thursday, prior to submission on Friday.

Safer Staffing Report

4. A Rosbotham-Williams provided an update:

4.1. The overall Trust fill rate for January 2016 was 98.88% for registered and for care staff. There were 13 ward areas with a fill rate below 90%, 6 wards for registered staff, 4 wards for care staff and 3 wards for both registered and care staff.

4.2. The paper indicates the efforts that are undertaken to improve staffing and also includes incidents and harm that has occurred.

4.3. D Graham asked if there was any correlation between falls and staffing on the Care of the Elderly wards. K Hardy is undertaking a piece of work to analyse the data. K Hardy informed the Committee that the BMJ has published an article giving compelling evidence that there is a relationship with staffing and safety and this is based on UK data and the RN fill rates are particularly important.

IPR

5. N Khashu presented the IPR to the Committee:

5.1. There have been no MRSA cases during 2015-16.

5.2. There have been 28 confirmed avoidable cases of C.Diff year to date. The Trust is appealing a further 2 cases (panel to be held in February 2016).

5.3. There were no hospital acquired grade 3/4 pressure ulcers in January.

5.4. There has been one fall that resulted in a harm level greater than moderate since October 2015. The falls team are focusing on delivering each aspect of the falls prevention action plan

5.5. For the second month in succession, the Trust VTE audit demonstrated 100% compliance for patient receiving enoxaparin.

5.6. The Trust is reporting a Month 10 overall income and expenditure deficit of £9.765m after technical adjustments which is adverse to agreed plans. This deterioration against plan relates to the imposition of contractual penalties by commissioners, which were assumed would not be incurred in the plan.

5.7. To date the Trust has delivered £12.645m of CIPs (green) which is £0.221m ahead of plan.

5.8. All staff sickness for December was 5.6% and year to date is 4.8% against a target of 4.72%.

5.9. K Hardy discussed weekend mortality with Committee members. Weekend mortality is high across the UK, but the Trust is disproportionally high compared

to others. K Hardy has written to Dr Foster to ask about methodology and for the figures to be put through their model. The figures for all adults and all specialties have increased and the figures sit just under the control limits. The high mortality figures are mostly Saturday admissions. Analysis is to try and understand what it is we need to address. M Manning said it could be the variation of the number of tests ordered at the weekend and how fast the results return. R Thind will collate the number of inpatient investigations at the weekend. K Hardy will present a Weekend Mortality paper at the next Quality Committee meeting.

5.10. K Hardy also queried the cancer 62 day wait figures. P J Williams said that there are pathways for each cancer group. D Graham asked N Khashu to put the cancer figures in the headline section on page 1 of the IPR.

Ward Dashboard – presentation

6. G Pickett presented the ward dashboard.

6.1. A Rosbotham-Williams asked if any feedback had been received from the Ward Managers/Matrons regarding the training. G Pickett said that he was awaiting feedback but was aiming to simplify the dashboard, also allowing wards to drill down if required. A Rosbotham-Williams commented that it is good that wards can benchmark against each other.

6.2. D Graham asked about the timescale for development, training and roll out. G Pickett said it should be completed in four weeks. A report is to be brought back to the April meeting.

Accessible Information Standard update

7. P Dearden presented the update to the Committee:

7.1. The standard provides 5 steps with MUST, MAY and SHOULD actions:

7.1.1. Identification of need.
7.1.2. Recording of need.
7.1.3. Flagging of need.
7.1.4. Sharing of need.
7.1.5. Meeting of need.

7.2. This is based on: ask, record, alert/flag/highlight, share, act.

7.3. P Dearden said that most areas in the Trust are doing this moderately well, but we must be compliant by 1st April and co-operation is required from the Care Groups. M Manning said he would email all concerned within Surgery and copy in Julie Hendry.

7.4. K Hardy asked if a new field could be put onto PAS, identifying that a patient had a communication need. P Dearden said this option has been explored by Informatics, but was not feasible with the current system.

Dementia training

8. J Sumner provided an update to the Committee:

8.1. The training was launched in October 2015 and there are three tiers of training:
8.1.1. Level 1 – all staff. E-learning and classroom.
8.1.2. Level 2 – Clinicians and nursing staff dealing with dementia patients – e-learning and classroom.
8.1.3. Level 3 – those staff in leadership roles.

8.2. The training will be recorded on ESR and is part of the CQUIN. Training will take approximately two hours.

8.3. K Hardy asked how staff will know when they need the training. J Sumner said that a notification would be sent through ESR to the member of staff's line manager.

8.4. A M Stretch asked to meet J Sumner outside of the meeting to discuss operational issues around the length of time to complete the training.

8.5. J Sumner will discuss the length of time needed for the training with Marie Honey.

Feedback from Patient Safety Council

9. S Beckett reported:

9.1. There is nothing to report by exception, but S Beckett would like to bring to the Committee's attention the highest recorded safety thermometer score has been noted which included 0 harm from falls, 0 pressure ulcers and 0 urinary tract infections from catheters.

9.2. VTE target of 95% failed = 91.32%. K hardy commented that this is the second successive month that the target has been missed and there are two reasons around this; on a weekend, junior doctors are inundated with patients and in A&E, patients are entered onto the IMS Maxims system, but they need to be entered on ADT before a VTE assessment can be carried out, so either a paper system is required or an electronic add on.

Feedback from Patient Experience Council

10. A Rosbotham-Williams reported:

10.1. The Council asked for a "you said, we did" section to be included in the reports.

10.2. The Quality Care Assessment Tool (QCAT) has a number of action plans missing. The Heads of Quality are to oversee the production of action plans. 25 wards have had the assessment completed with 1 ward receiving a gold award. 5 wards were awarded bronze awards, one of which has remained at bronze on reassessment, for which there is an action plan in place and one has gone from silver to bronze, for which there are a number of actions taking place to improve standards.

Feedback from Clinical Effectiveness Council

11. K Hardy reported:

    11.1. Weekend mortality has been discussed earlier in the meeting.

    11.2. AQ – there has been deterioration in AQ measures due to activity and volume of patients. An action plan will be presented to the next CEC. K Hardy informed the Committee that the Trust will not be carrying on with AQ next year.

CQPG Meeting – January

12. K Hardy reported on key issues:

    12.1. MSSA suppression is an ongoing discuss with the CQPG. We had asked for information regarding neighbouring trusts regarding their screening, but the CQPG have confirmed that contrary to previous information available, other trusts do not undertake this screening.

    12.2. Timeliness for SUI investigations has improved, but it is still taking a long time to respond to queries. K Hardy will raise this with S Redfern.

    12.3. The timing of the presentation of this year's Quality Account will align with the FT timetable.

Executive Team

13. P Williams reported:

    13.1. For the month of January there were 3 meetings of the Executive Committee.

    13.2. Areas identified for further discussion and action were related to:

    13.2.1. Delivery of CQC action plan
    13.2.2. Draft outline of the Quality Account
    13.2.3. VTE risk assessment compliance
    13.2.4. Operational turnaround
    13.2.5. Junior doctor industrial action.

    13.3. Assurances regarding the management of safer staffing and bank and agency usage were discussed, in particular the use of agency staff and compliance with the Off Framework cap.

    13.4. D Graham requested an update regarding the junior doctors strike action. As yet, there has been no confirmation of another strike date.

    13.5. There are no further items requiring escalation to the Quality Committee.

Workforce Council

14. A M Stretch reported:

    14.1. There were no items requiring escalation to the Quality Committee.

Policies/documents approved by Councils

15. Verification of expected deaths
    IPC Chapter 44 Blood Culture
    IPC Chapter 17 viral haemorrhagic fever
    SOP for admissions to Duffy Suite
    Off Payroll Engagement
    Private Patient/Overseas Visitors
    Drug & Alcohol
    Non Employment Routes
    Recruitment, Booking Deployment & Utilisation of Temporary Bank and Agency Staff
    Special Leave
    Access to Personal Files

Effectiveness of meeting

16. P Williams said the meeting was conducted in a timely fashion at the same time allowing appropriate discussion of important items. He felt the papers were generally concise and he emphasised the need they should say something meaningful.

    P Williams asked committee members to complete the questionnaire that was given out before the start of the meeting, as this will form part of the annual effectiveness review.

AOB

None noted.

Date of Next Meeting

Tuesday, 22nd March 2016.

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)021
Title of paper: Safer Staffing Report for January 2016
Purpose: The aim of the report is to provide the Trust Board with an overview of nursing and midwifery staffing levels in the inpatient areas during the month of January 2016. This will highlight the wards where staffing has fallen below the 90% fill rate, review the impact of this on patient care and will provide a summary of actions implemented to address gaps.
Summary: The Trust is required to publish monthly nursing and midwifery staffing levels by shift as 'expected' versus 'actual' in hours via the template set up on UNIFY, to provide the URL to our own “safe staffing” web page. The URL will enable the NHS Choices team to establish this link from the NHS Choices website to the Trust website. The month of **January 2016** data indicates: • Overall Trust fill rate = 98.88% (for registered and for care staff) • Overall registered staff fill rate for days was 96.03% and for nights 94.83% • Overall care staff fill rate for days was 100.27% and for nights was 104.12%% There were 13 ward areas with a fill rate below 90%, 6 wards for registered staff, 4 wards for care staff and 3 wards for both registered and care staff.
Corporate objectives met or risks addressed: Contributes towards the achievement of Patient Safety and Workforce planning objectives.
Financial implications: None directly from this report.
Stakeholders: Patients, the public, staff and commissioners.
Recommendation(s): It is recommended that the Board note this report and the data to be submitted to Unify.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance
Date of meeting: 24th February 2016

SAFER NURSING & MIDWIFERY WORKFORCE STAFFING LEVELS REPORT
January 2016

1. The purpose of this paper is to provide assurance regarding nursing and midwifery ward staffing levels which is an indication of the Trust's capacity to provide safe, high quality care across all wards at St Helens and Knowsley Teaching Hospitals NHS Trust.

2. The Trust is committed to ensuring that its nursing workforce is sufficiently robust to deliver high quality, safe and effective care in order to meet the acuity and dependency requirements of patients within our care. This report forms part of the organisation's commitment in providing open and honest care, through the publication of its 'safer staffing' data for each ward on the Trust's Website and formal data submission via UNIFY which is published on the NHS Choices website. The safer staffing data for January 2016 for all wards is attached for information as Appendix 1.

3. The Safer Staffing data calculates the 'expected' staffing levels agreed by the Trust Board in hours for each ward for days and nights for both registered and care staff against the 'actual' staffing levels on shift for the previous month. A fill rate of the 'actual' staffing levels against the 'expected' staffing levels is then calculated as a percentage fill rate for each ward and overall for the Trust for the month. This report focuses on wards where there is a fill rate of less than 90% on days or nights and triangulates that information against patient safety information for that ward to see if staffing levels have had an adverse effect on patient care during the month.

4. Guidance from NHSE and NICE on which staff are included in the 'actual' staffing numbers is followed when calculating the monthly safer staffing figures for each ward. The 'actual' numbers include both registered and care staff who works extra time, over time or flexible time and bank and agency staff usage. The supernumerary ward manager management days are also included in the 'actual' registered staff numbers.

5. The inpatient wards and assessment units completed in October 2015 the third 6th monthly Shelford patient dependency and acuity report. The results will be presented to the public Trust Board by the Director of Nursing, Midwifery and Governance in February 2016. The 'Time to Care' audit was undertaken on Duffy and Seddon wards in November 2015 and the findings will be reported together with the Shelford audit findings.

6. Nursing and midwifery workforce daily staffing shortfalls (due to sickness, absence, vacancies and maternity leave not successfully backfilled) which are not addressed at ward level by the shift leaders / ward managers each shift by staff working extras or swapping shifts, are escalated to, monitored by and managed by the matrons/lead nurses daily. The matrons input daily staffing levels for each shift for their ward into a central database which shows the daily expected staffing levels for each shift for each ward and the actual staffing levels for both registered and care staff.

7. At the daily matron / lead nurse midday staffing level review meeting, any continuing, unresolved staffing gaps are referred to the Staffing Solutions Department to request bank staff or agency staff, the latter are only requested when all other avenues have

been exhausted. This daily staffing review meeting is where patient dependency and staffing skill mix issues are reviewed and decisions made where best to deploy staff to best meet patient requirements across the wards for the next 24 hours. The meeting also identifies where additional staff are required to special patients who require close observation. This explains why the average fill rate is often above 100% for care staff. Also, if there is a shortfall in registered staff after every effort has been made to fill the gap with a registered nurse has been exhausted, attempts are then made to cover the gap with care staff in order to increase the numbers of staff on the shift acknowledging the skill mix is not as required for the shift.

8. During December 2015 (January 2016 unavailable at the time of writing the report) a total of 48.18wte additional registered nurses and 67.91wte care staff were employed as either bank staff, agency staff, over time or extra hours to fill gaps on shifts or to special patients requiring close observation in addition to the regular nursing and midwifery workforce. December 2015 e-rostering off duties have been scrutinised retrospectively to monitor annual leave taken over the festive holiday period and every ward allocated correctly no higher than 17% of staff annual leave.

9. The recruitment and retention of nursing staff remains a priority for the Trust and remains an on-going challenge nationally. Stabilising and retaining the nursing and midwifery workforce in clinical areas has been an area of increased focus throughout 2015/16. A new preceptorship program commences in March 2016 to improve the retention and development of newly qualified recruits who will hopefully take full advantage of the development opportunities available to them at this Trust. There are 6 recruitment days planned throughout 2016, the first one is arranged for Saturday 27th February 2016. In March 2016, 6.8wte registered nurses are commencing in post in the Emergency Department, Gastro, Critical Care, Paediatrics and Respiratory.

10. International recruitment to India was undertaken and 100 posts offered to registered nurses, the majority of whom will hopefully commence employment within the Trust during the summer and autumn of 2016. This will address the registered nurse vacancy gap within the Trust which as of December 2015 was 42.86wte in spite of extensive, proactive efforts to recruit during 2015 and will also absorb any additional leavers during 2016 who we may be unable to replace due to a national shortage of nurses.

11. GPAU and ward 3D are the two wards presently on the Trust Corporate Risk register scoring above 15 for on-going staffing shortfalls. GPAU achieved above 90% fill rate using additional staff to fill gaps, whilst ward 3D achieved 82.8% RN fill rate on nights, but overstaffed with care staff on nights, achieving a fill rate of 107.6% to compensate.

12. In **January 2016** there were a total of 13 ward areas with a fill rate below 90%; 6 for registered staff, 4 for care staff and 3 for both care and registered staff.

12.1. **The wards below the 90% fill rate for registered staff** are set out in the table below. The table shows that each of the wards were over-established with care staff to increase overall numbers.

	RN days	HCA days	RN nights	HCA nights
1A	89.1%	105.4%	76.3%	104.3%
1D	94.1%	106.5%	87.1%	130.6%
2B	89.5%	103.2%	78.3%	122.6%
2C	92.2%	100.1%	77.4%	127.4%
3D	96.3%	93.7%	82.8%	107.6%
Duffy Ward	88.4%	127.5%	100.0%	108.6%

12.2. **Wards with a care staff fill rate below 90%** are set out below. Wards 5C and 4F were over-established for registered nurses to compensate for the short fall in care staff.

	RN days	HCA days	RN nights	HCA nights
3E	97.1%	87.4%	100.0%	103.2%
3F	97.8%	89.2%	100.8%	100.0%
4F	109.2%	89.8%	100.0%	100.0%
5C	95.3%	101.5%	100.8%	89.2%

12.3. Wards with both a registered nurse and care staff fill rate of less than 90%

	RN days	HCA days	RN nights	HCA nights
5A	88.1%	86.5%	75.3%	98.9%
5B	93.9%	84.2%	75.3%	88.2%
Delivery Suite	89.1%	88.6%	95.4%	83.6%

13. The table below shows the amount of bank and agency shifts for trained and care staff that were filled and remained unfilled during **January 2016**, including the requests for the wards where the fill rate was less than 90%. This is evidence of efforts made to address staffing shortfalls to maintain patient safety.

January 2016

staff group	**Unfilled requested shifts**	**Filled requested shifts**
Bank HCA	680	1504
Agency HCA	50	273
Bank RN / RM	479	254
Agency RN	79	373
Wards with RN shortfall	**Unfilled requested bank and agency shifts**	**Filled bank and agency requested shifts**
Ward 1D RN	41	5
Ward 1A RN	64	39
Ward 2B RN	68	19
Ward 2C RN	50	16
Ward 3D RN	23	6
Duffy RN	2	4
Ward 5A RN	22	27
Ward 5B RN	19	16
Del Suite RM	2	2
Wards with Care staff shortfall	**Unfilled bank and agency requested shifts**	**Filled bank and agency requested shifts**
Ward 5A HCA	55	63
Ward 5B HCA	29	62
Del Suite HCA	19	109
Ward 3E HCA	6	58
Ward 3F HCA	4	8
Ward 4F HCA	3	0
Ward 5C HCA	41	67

14. During **January 2016**, there were a total of 21 incident forms completed related to staffing. This related to 15 wards/departments as indicated in the table below:

Ward	Reports	Datix details	Actions
ED	2	Department on black, required additional nursing support X 2	Nurse specialists assisted with ward transfers
Ward 1A	1	RN shift remained unfilled on night duty	Staff on ward provided cross cover no harms occurred

Ward 4B	1	RN shortfall due to additional inpatients overnight to manage ED pressures	Staff on ward provided care. No harm occurred to patients
Ward 2E	3	Last minute staff sickness of RM X 2 occasions 1 midwife shift unfilled because midwife transferred to DS due to high patient acuity	Ward staff covered, no harm occurred
Ward DS	1	Requested an additional midwife to usual numbers due to high patient acuity	Supervisor arranged additional cover from 2E
Ward 5C stroke	1	RN late shift unfilled	Extra HCA employed on shift to increase numbers
Ward 3A	2	Only 1 RN on duty able to administer IVs on night duty RN levels correct but skill mix unsafe, two agency nurses on duty	Cross cover to check IVs provided by ward 3Alpha
Ward 5C DMOP	1	1 RN short on early shift	Staff on ward provided cross cover no harms occurred
Ward 1D	2	2 RN shifts unfilled on early shift 1 RN shift unfilled on night duty	Staff on ward provided care. No harm occurred to patients
Ward 1E	1	1 RN short as moved to cover other ward shortfall	Staff on ward provided cross cover no harms occurred
Sanderson	2	1 HCA shift short as staff member moved to Whiston site 1 agency nurse did not attend for duty leaving 1 RN short	Staff on ward provided cross cover no harms occurred
Ward 2C	1	1 RN short as moved to cover shortfall on other ward	Staff on ward provided cross cover no harms occurred
Ward 1C	1	1RN night shift moved to cover other ward	Staff on ward provided cross cover no harms occurred
Ward 1B	1	Additional beds remained open over night to support ED, 1 RN short	Staff on ward provided cross cover no harms occurred
Ward 4E	1	1 RN short due to last minute sickness	Staff on unit provided cross cover no harms occurred

15. For the first time in this report the correlation of safer staffing fill rates with patient incidents has been undertaken. This has to be presented one month retrospectively because the patient incident data for January 2016 has not been validated at the time of writing the report. December 2015 findings are presented in the table below. During December 2015, fortunately only low or no harm was experienced following patient falls. There were 3 X grade 2 and 1 X grade 1 pressure sores and four cases of c-difficile hospital acquired infections. This can now be monitored month on month going forward to look for links between staffing levels and incidents.

December 2015 safer staffing and patient incidents

Ward Name	Number of beds	Pressure Sores	Total validated Falls	Total Med Incidents	Infect-ions - CDT	RN fill rate days	HCA fill rate days	RN fill rate nights	HCA fill rate days
1A Care of the Elderly	32	0	15	2	0	94.3%	101.5%	89.7%	115.7%
1B AMU	27	1	4	6	0	98.9%	95.4%	97.7%	94.6%
1C AMU	32	1	9	6	0	97.9%	99.5%	100.6%	98.4%
1D Cardiology	32	0	4	1	1	94.0%	93.5%	86.0%	96.8%
1E Coronary Care	17	0	4	1	0	96.6%	89.9%	95.2%	-
2A Oncology	24	0	3	6	0	98.4%	97.7%	100.0%	100.0%
2B Respiratory	32	0	11	0	0	89.4%	108.2%	81.7%	112.9%
2C Respiratory	32	0	11	1	0	95.8%	94.0%	77.4%	114.5%
2D General Medicine	23	1	3	4	0	94.2%	106.7%	100.0%	88.7%
2E Obstetrics	37	0	0	0	0	93.7%	88.3%	96.8%	72.6%
3 Alpha Orthopaedics	18	0	7	2	0	86.4%	125.0%	101.6%	111.3%
3A Plastics	28	1	1	3	0	97.8%	98.6%	119.4%	97.4%
3B Orthopaedics	26	0	4	0	0	91.3%	104.0%	98.3%	90.3%
3C Orthopaedics	32	0	9	0	0	95.5%	113.7%	100.0%	97.8%
3D Gastro	32	0	10	2	1	97.7%	100.4%	91.4%	121.0%
3E Gynaecology	17	0	2	0	0	96.6%	97.5%	100.0%	100.0%
3F Paediatrics	19	0	1	3	0	100.0%	95.2%	100.0%	100.0%
4A General Surgery	32	0	5	1	0	89.9%	96.6%	96.8%	95.7%
4B General Surgery	31	0	1	1	0	99.0%	103.1%	100.0%	136.6%
4C General Surgery	32	0	2	3	0	95.3%	99.5%	98.9%	98.9%
4D Burns	12	0	0	0	0	120.1%	93.5%	103.2%	96.8%
4E ITU	12	0	1	0	0	100.4%	116.1%	96.5%	114.5%
4F Paediatrics	10	0	0	1	0	98.3%	95.9%	100.0%	100.0%
5A Care of the Elderly	32	0	9	3	0	97.1%	86.7%	78.5%	106.5%
5B Care of the Elderly	32	0	9	1	1	96.3%	91.7%	79.1%	97.8%
5CStroke& DMOP	32	0	8	5	1	98.1%	102.2%	100.8%	88.2%
5D General Medicine	27	0	8	0	0	89.3%	106.6%	100.0%	96.8%
Delivery Suite	17	0	0	0	0	96.8%	81.4%	95.9%	71.0%
Special Care Baby Unit	15	0	0	0	0	95.8%	100.0%	100.0%	96.8%
Duffy	27	0	5	1	0	85.5%	109.3%	100.0%	100.0%
Seddon	20	0	2	0	0	91.9%	104.2%	100.0%	100.0%

Summary

The report has provided assurance that every effort was made to have optimum staffing levels across all wards daily during January 2016 to reduce the incidence of harm to patients and long term to address vacancies. It is difficult to definitively attribute patient incidents to unfilled shifts, although the first month's data (January 2015) suggests there may be an increased association between patient incidents and staffing levels. Future monitoring will provide more robust information. Fortunately no moderate or serious harm was experienced by patients during December 2015 on the indicators monitored.

Appendix 1

10 - January 2016 Upload Form.xls

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

Org: RBN St Helens And Knowsley Hospitals NHS Trust

Period: January_2015-16

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

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

http://www.sthk.nhs.uk/about/publication-of-information

Comments

Validation alerts (see control panel)	Only complete sites your organisation is accountable for					Day				Night				Day	
	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours		
	RBN01	WHISTON HOSPITAL - RBN01	1A	430 - GERIATRIC MEDICINE		1880.9	1675	2051.5	2161.5	930	710	930	970	89.1%	105.4%
	RBN01	WHISTON HOSPITAL - RBN01	1B	300 - GENERAL MEDICINE		2567.5	2401.5	1113.5	1102.5	1140	1040	570	580	93.5%	99.0%
	RBN01	WHISTON HOSPITAL - RBN01	1C	300 - GENERAL MEDICINE		3192.5	3107.5	1701	1880.5	1550	1720	620	660	97.3%	110.6%
	RBN01	WHISTON HOSPITAL - RBN01	1D	320 - CARDIOLOGY		1963.5	1848.5	1611	1716.5	930	810	620	810	94.1%	106.5%
	RBN01	WHISTON HOSPITAL - RBN01	1E	320 - CARDIOLOGY		2202.5	2091.5	905	837	1240	1150	0	0	95.0%	92.5%
	RBN01	WHISTON HOSPITAL - RBN01	2A	303 - CLINICAL HAEMATOLOGY	300 - GENERAL MEDICINE	1570.5	1495	849.5	810.5	620	620	310	310	95.2%	95.4%
	RBN01	WHISTON HOSPITAL - RBN01	2B	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	1961.5	1755	1554	1603.5	920	720	620	760	89.5%	103.2%
	RBN01	WHISTON HOSPITAL - RBN01	2C	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	1995.5	1839.5	1594.5	1596	930	720	620	790	92.2%	100.1%
	RBN01	WHISTON HOSPITAL - RBN01	2D	300 - GENERAL MEDICINE		1436	1515.5	1134	1136.5	620	620	610	750	105.5%	100.2%
	RBN01	WHISTON HOSPITAL - RBN01	2E	501 - OBSTETRICS		3008	2939.5	1332	1231	1240	1240	620	590	97.7%	92.4%
	RBN01	WHISTON HOSPITAL - RBN01	3A	160 - PLASTIC SURGERY		1892.5	1881.5	1281.5	1256.5	930	930	740	740	99.4%	98.0%
	RBN01	WHISTON HOSPITAL - RBN01	3Alpha	110 - TRAUMA & ORTHOPAEDICS		1217	1161	1454	1469	620	630	670	740	95.4%	101.0%
	RBN01	WHISTON HOSPITAL - RBN01	3B	110 - TRAUMA & ORTHOPAEDICS		1586.5	1550	1569	1552.5	620	620	620	620	97.7%	98.9%
	RBN01	WHISTON HOSPITAL - RBN01	3C	110 - TRAUMA & ORTHOPAEDICS	430 - GERIATRIC MEDICINE	1652.5	1625.5	1610	1915	930	880	990	1080	98.4%	118.9%
	RBN01	WHISTON HOSPITAL - RBN01	3D	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	2001.5	1926.5	1504.5	1409	930	770	660	710	96.3%	93.7%
	RBN01	WHISTON HOSPITAL - RBN01	3E	502 - GYNAECOLOGY	300 - GENERAL MEDICINE	1437.5	1396	808.5	707	620	620	310	320	97.1%	87.4%
	RBN01	WHISTON HOSPITAL - RBN01	3F	420 - PAEDIATRICS		2375.5	2323	467	416.5	1240	1250	310	310	97.8%	89.2%
	RBN01	WHISTON HOSPITAL - RBN01	4A	101 - UROLOGY	100 - GENERAL SURGERY	2060.5	1977.5	1370.5	1341.13	930	890	930	950	96.0%	97.9%
	RBN01	WHISTON HOSPITAL - RBN01	4B	100 - GENERAL SURGERY	101 - UROLOGY	2585	2574.5	1801	1740.04	1170	1160	470	460	99.6%	96.6%
	RBN01	WHISTON HOSPITAL - RBN01	4C	100 - GENERAL SURGERY		1946	1833	1358	1302.5	930	925	930	920	94.2%	95.9%
	RBN01	WHISTON HOSPITAL - RBN01	4D	160 - PLASTIC SURGERY		1692.5	1713.5	410.5	410.5	660	660	280	280	101.2%	100.0%
	RBN01	WHISTON HOSPITAL - RBN01	4E	192 - CRITICAL CARE MEDICINE		5638	5556	1195	1240.5	3720	3620	620	610	98.5%	103.8%
	RBN01	WHISTON HOSPITAL - RBN01	4F	420 - PAEDIATRICS		1920	2097.5	519.5	466.5	680	680	310	310	109.2%	89.8%
	RBN01	WHISTON HOSPITAL - RBN01	5A	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1633	1438	2223.5	1923	930	700	930	920	88.1%	86.5%
	RBN01	WHISTON HOSPITAL - RBN01	5B	430 - GERIATRIC MEDICINE		1660.5	1559	2160.5	1819.5	930	700	930	820	93.9%	84.2%
	RBN01	WHISTON HOSPITAL - RBN01	5C	430 - GERIATRIC MEDICINE		2509.5	2392	1762.5	1789.5	1240	1250	930	830	95.3%	101.5%
	RBN01	WHISTON HOSPITAL - RBN01	5D	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1603	1453	1296.5	1462	620	620	620	580	90.6%	112.8%
	RBN02	ST HELENS HOSPITAL - RBN02	Duffy Ward	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1379.5	1219.5	1789.48	2281.94	620	620	930	1010	88.4%	127.5%
	RBN01	WHISTON HOSPITAL - RBN01	SCBU	420 - PAEDIATRICS		1564	1494.5	428	412.5	980	980	260	260	95.6%	96.4%
	RBN01	WHISTON HOSPITAL - RBN01	Delivery Suite	501 - OBSTETRICS		3191.5	2843.5	843.5	747	2170	2070	610	510	89.1%	88.6%
	RBN02	ST HELENS HOSPITAL - RBN02	Seddon	314 - REHABILITATION		1438	1508.5	1626	1699	620	620	620	780	104.9%	104.5%

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

Org: RBN St Helens And Knowsley Hospitals NHS Trust

Period: January_2015-16

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

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

http://www.sthk.nhs.uk/about/publication-of-information

Comments

Validation alerts (see control panel)	Only complete sites your organisation is accountable for				Day				Night				Day	
	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	RBN01	WHISTON HOSPITAL - RBN01	1A	430 - GERIATRIC MEDICINE		1880.9	1675	2051.5	2161.5	930	710	930	970	89.1%	105.4%

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

Org: RBN St Helens And Knowsley Hospitals NHS Trust

Period: January_2015-16

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	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours		
	RBN01	WHISTON HOSPITAL - RBN01	1A	430 - GERIATRIC MEDICINE		1880.9	1675	2051.5	2161.5	930	710	930	970	89.1%	105.4%
			Total			64762.4	62192	41324.98	41436.61	32210	30545	19190	19980		

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)021

Title of paper: 6 monthly nurse staffing report

Purpose:

The aim of the report is to provide the Trust Board with an overview of the 6 monthly review of nurse, midwifery staffing levels in inpatient wards and to provide an overview of the findings of the Shelford acuity tool conducted in October 2015.

Summary:

1. Following the National Quality Board recommendations the Trust Board are required to review nurse staffing establishment on a 6 monthly basis
2. The report should indicated finding of the patient dependency audit and recognise the use of validated audit tools .
3. The report also summarises the results of the third Shelford patient dependency /acuity audit which was undertaken in October 2015.
4. The previous Shelford audits were undertaken in October 2014 and June 2015.
5. The aim was to ensure nurse staffing levels and skill mix were at the agreed establishment within the Trust and that the Trust are achieving a registered nurse to patient ratio for 1:8 on day shifts and 1:11 on night shifts.
6. The results demonstrated the current nursing establishment is compliant with the Nurse Staffing guidance.
7. The Shelford audit tool methodology calculates nurse staffing requirements based on multipliers, which are allied to acuity and dependency measurement. The Shelford multipliers agreed for each level of patients on in-patient wards are:

   Level 0 0.99* WTE nurse per bed
   Level 1a 1.39* WTE nurse per bed
   Level 1b 1.72* WTE nurse per bed
   Level 2 1.97* WTE nurse per bed
   Level 3 5.96* WTE nurse per bed

* This includes a 22% uplift for annual leave, study leave etc.

8. For example, if a 28-bedded ward has 12 patients at Level 0, 7 patients at Level 1a, 8 patients at Level 1b, and 1 patient at Level 2, a total of 37.34 WTE nursing staff would be required.
9. The report indicates that during the October 2015 audit, there has been a decrease in levels 1b, 2 and 3 care dependency descriptors however there was an increase in levels 0 and 1.
10. This suggests that during the period of the audit in October the level of patient dependency was marginally less than the previous audit undertaken in June 2015.
11. Appendix 2 provides individual ward level data and outlines changes in the dependency of patients since the last report.
12. It also compares the current ward WTE funded establishment against the Shelford audit WTE required calculations

13. The Trust continue to report the monthly Nurse safer staffing and upload to Unify.
Corporate objectives met or risks addressed: Contributes towards the achievement of Patient Safety and Workforce planning objectives.
Financial implications: None directly from this report.
Stakeholders: Patients, the public, staff and commissioners.
Recommendation(s):
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance.
Date of meeting: 24th February 2016

6 Monthly Nurse staffing Establishment Review

1. Introduction

1.1 The publication of the second Francis Report in 2013 highlighted potential issues around safe staffing levels at Mid-Staffordshire NHS Foundation Trust and lack of transparency was among the contributing factors.
1.2 The response from the National Quality Board (NQB) -*How to ensure the right people, with the right skills, are in the right place at the right time: a guide to nursing, midwifery and care staffing capacity and capability, (2013*)1. (Hard Truths) requires hospitals to review staffing levels at least six monthly, using validated methods.
1.3 In light of national guidance Trust Boards should be:

- Managing nurse staffing capacity and capability by agreeing staffing establishments
- Considering the impact of wider initiatives (such as cost improvement plans) on staffing
- Monitoring staffing capacity and capability through regular and frequent reports on the actual staff on duty on a shift by shift basis versus planned staffing levels
- Examining trends in the context of key quality and outcome measures
- Asking about the recruitment, training, skills and experience, and management of nurses
- The Director of Nursing is required to provide twice yearly review of nurse and midwife staffing to assure that they are confident that the nurse staffing levels and skill mix are at sufficient to provide safe care to patients.

1.4 This report outlines the national context in relation to safer staffing recommendations as well as recognising the significant work that has been undertaken in St Helens and Knowsley Hospitals in relation to monitoring nurse staffing establishment and dependency of patients.
1.5 The report also summarises the results of the third Shelford patient dependency /acuity audit which was undertaken in October 2015.
1.6 The previous Shelford audits were undertaken in October 2014 and June 2015.
1.7 the aim was to ensure nurse staffing levels and skill mix were at the agreed establishment within the Trust and that the Trust are achieving a registered nurse to patient ratio for 1:8 on day shifts and 1:11 on night shifts.
1.8 The results demonstrated the current nursing establishment is compliant with the Nurse Staffing guidance.

2 Aim

2.1 The aim of the report is to share the results of the third patient acuity and dependency study which took place during October 2015 in all adult inpatient areas.
2.2 The format of the report has been changed since the previous report to ensure consistency in reporting for the acute hospital trusts.
2.3 The Trust have continued to use recommended audit tools in relation to safe staffing, these include Safer Nursing Care Tool (Shelford, RCN adult safe staffing tool and the professional judgement model.
2.4 The results of this review will be used as part of ward budget setting to determine the safe staffing levels required to support patient acuity and dependency levels
2.5 Recognising that ensuring wards have the appropriate funded establishment to provide safe staffing is only one element of ensuring safe staffing, the paper describes the Trust approach to maximise recruitment and retention opportunities to maximise the number of posts being filled.

2.6 It is important to recognise the current national challenges in relation to Nurse Recruitment.
2.7 To address this, the Trust has recruited from overseas (India) in November 2015, however, it is anticipated that the staff will not be in post until autumn 2016.
2.8 6 weekly recruited events focusing on key areas are continued to be held.

3. National Quality Board Recommendations

3.1 The Trust remains compliant with the 10 expectations within the NQB guidance
3.2 The wards display of information in relation to actual and expected nurses, midwives and care staff present on the ward on each shift.
3.3 The completion of a detailed skill mix review which is presented to Board twice yearly.
3.4 .Every ward has a ward staffing board which displays shift by shift level staffing numbers 'planned versus actual'.

4. Methodology

4.1 The Safer Nursing Care Tool (Shelford Group, 2013) is currently the most commonly used method and in October 2014 was endorsed by NICE as the toolkit to be used alongside the NICE guidelines on safe staffing.
4.2 The Safer Nursing Care Tool (SNCT) is an evidence based tool which allows nurses to assess patient acuity and dependency.
4.3 The data is collected and matched with present staffing multipliers to ensure that nursing establishments reflect patient needs in acuity/dependency terms. The recommended number of staff following analysis is in whole time equivalent only (i.e. registered and unregistered)
4.4 The tool includes 22% uplift for holiday, sickness, study leave etc.). There is no reference to skill mix, allocation for a supervisory ward co-coordinator (if appropriate) or supervisory ward leader. The staffing numbers recommended are to provide patient care only.
4.5 It should be noted that recommended staffing levels are based on an analysis of the actual patients on the ward at the time of data collection. Therefore the ward may be a 32 bedded ward but if the average number of patients on the ward at the time was 31 then the proposed staffing levels reflect this actual number. This is one of the reasons why a number of cycles are recommended before firm conclusions are reached.
4.6 The tool is appropriate for use in any acute hospital. Multipliers which have been validated for areas and have been applied to all adult inpatient wards on both sites.
4.7 All adult acute inpatient wards were selected for review using the SNCT. Data was collected at 15.00 hours daily using the SNCT monitoring form and referring to the SNCT Levels of Care Criteria. The Ward Sister or nominated deputy entered data onto the data entry tool
4.8 A quality assurance process was established, as this is crucial to ensure accurate scoring, this was conducted by the Deputy Director of Nursing, and Heads of Quality.
4.9 During October 2015, the third trust wide acuity and dependency review was undertaken, applying the SNCT. The adult inpatient wards captured daily patient acuity data using the Safer Nursing Care Tool.
4.10 Following the publication of the DH Care Contact Time and the CNO letter dated 3rd June 2015 clearly reinforced that Safe staffing for nursing in adult inpatient wards in acute hospitals' (July 2014) and 'Safe Midwife Staffing in Maternity Settings' (January 2015) are important approach to ensuring safe and high quality care .
4.11 The Contact care time audit also has been undertaken in areas. This tool is based on the Productive Series where nursing and other 'activity' is monitored and measured to

determine what time is needed and what might be seen as not adding value. (Lean methodology).

5. NICE Guidance Compliance

5.1 A Gap Analysis has been completed in relation to Trust compliance with the key recommendations of NICE guidance for safe staffing.
5.2 The Trust has declared partial compliance with the guidance with the only recommendation outstanding relating to the identification of nursing 'red flag' events; particularly in relation to late administration of medicines
5.3 Electronic Prescribing will support capturing and auditing this data.
5.4 Red flag events can be defined as events that prompt an immediate response by the Registered Nurse in charge of the ward
5.5 A robust system and process is already in existence which captures adverse incidents through DATIX.

6. Benchmarking data

6.1 The ward nursing staffing levels and skill mix are reviewed at a minimum twice yearly
6.2 The wards' skill mix is agreed for each early, late and night shifts for both weekdays and weekends.
6.3 The ratios are identified as 'beds to Registered Nurse' to establish the RN to patient ratio and also Registered to un-registered ratio.
6.4 NICE has recommended that the RN to patient ratio should not be more than 8 patients per RN during the day shift as previous research suggests that the number of RNs to patients will affect patient outcomes. However, this research would not necessarily have taken into account changes in skill mix e.g. Band 4 Support Worker roles, or Discharge Coordinator and level of therapy resource available.
6.5 The is the same in relation to RN:HCA ratios, whereby the recommended ratio from the Royal College of Nursing guidance Safe Staffing Levels (2010) for RNs in general adult wards is 60%. However, changes in skill mix need to be considered e.g. Support worker roles, numbers of staff on duty and acuity and dependency levels for each ward which differ.
6.6 The benchmark that Trusts allocate for a percentage of backfill costs in ward budgets is 22% (annual leave, sickness, study leave) and 20 % for Health care assistants.

7. Patient Acuity Summary

7.1 Appendix1 attached provides Shelford level of care descriptors and key data source.
7.2 Please note additional wards have been included in the October 2015 audit it includes the assessment areas which we not in the previous report.
7.3 A full breakdown of patient acuity and dependency by ward is attached to this report. Appendix 2. However an overarching Trust wide comparison of patient acuity/dependency is outlined below in Table below.
7.3 Comparison of Patient Acuity Study Results for June 2015 and October 2015.

Parameter	June 2015		October 2015		Increase/Decrease in patient acuity
Total number of wards included	22		25		
Total Number of Assessments Completed	9350		11790		
Number of Level 0 Assessments	3316	35.5 %	5678	48.1%	
Number of Level 1a Assessments	1514	16.13 %	2992	25.4%	
Number of Level 1b Assessments	4082	43.7 %	3092	26.27 %	
Number of Level 2 Assessments	404	4.3%	28	0.23%	
Number of Level 3 Assessments	34	0.37 %	0	0%	

7.4 There has continued to be a high number of Levels 0 and 1a patients within the Trust throughout the audit period and a decrease in level 1b and 2 patients. The October 2015 audit increase in level 1a is due to the number of elderly, frail and 'nursing dependent' patients admitted to our wards and on-going need for 1-1 nursing care. .
7.5 Further comparison between the February 2015 and July 2015 studies has revealed that 6 wards showed an increase in patient acuity, 4 wards showed a decrease patient acuity and 13 wards showed minimal change.

8. Recommended Establishments versus Actuals

8.1The Shelford dependency tool allows for measurement and comparison between funded Whole Time Equivalent (WTE) and the average/estimated WTE on duty for each ward during the study period. This needs to be compared with the professional judgement model
8.2 During the October 2015 study, there was a slight deficit between the total funded nursing establishment and the average WTE actually on duty.
8.3 Following investigation the reasons for this include staff absence due to sickness, nursing staff on study leave, allocated annual leave and vacant nursing posts.
8.4 Whilst it is acknowledged that the challenge of recruiting suitable numbers of nurses is a national issue, the Trust are proactively managing recruitment in order to close the gap by holding monthly recruitment events, engaging with universities, utilising overseas recruitment campaigns and publicising the wide range of nursing job opportunities in a number of different ways, including the use of social media.

9. Supervisory Ward Managers and Structured Ward Rounds

9.1In 2014 the Trust Board approved an investment to allow Ward Managers to become Supervisory 2 shifts per week with the fundamental role of providing visibility to patients and leadership to the nursing team.
9.2 The move to allow Ward Managers to become completely supervisory has been partially realised, thus enhancing the delivery of safe, high quality care.
9.3 The full benefits of supervisory status has yet to be achieved due to Registered Nurse vacancies, sickness, extra capacity in the existing ward bed base and an increase in

patient acuity and dependency which has led to Ward Managers being rostered to deliver direct patient care on some shifts.

10. Datix reports on ward nurse staffing levels

10.1 The number of Datix nurse staffing reports at ward level is captured within the monthly safer staffing report.
10.2 The staffing levels and Datix reports are being critically analysed against the patient quality and safety matrices and any wards of noted within the exception report.
10.3 The Deputy Director of Nursing has also undertaken a 'deep dive' review of Datix relating to nurse staffing
10.4 The main findings of the deep dive review were:

- The majority of Datix reports reported no harm to patients
- The majority of Datix reports were graded as insignificant
- There were no Datix reports reported as being major harm or high risk
- The highest number of Datix reports was over the peak holiday periods and days when there was escalation with bed capacity.
- The top reasons for Datix reports being submitted were for lack of suitably trained/skilled staff,HCA Bank availability and the need for close observations
- The implications that may have a detrimental effect on patients and staff were: delays in treatment and/or care, poor documentation, increased stress on staff and inability to take breaks.

10.5 It is planned that a similar review of Datix nurse staffing reports will be repeated every six months.

11. Nursing workforce risks on the Trust's Risk Register.

11.1 There are currently 3 nursing related risks on the Trust's Corporate Risk Register:
Risk 1152: Increasing use of Bank and Agency
Risk 1137 Increased acuity of patients and high demand for intravenous – ward 3D
Risk 762 Failure to attract staff for specialist roles
11.2 The Trust has an agreed process in place in relation to the request to book nursing staff via framework to off Framework Agencies. This is being strictly monitored and requires an Executive Director authorisation.
11.3 This is predominantly requested for specialist nursing skills required for Critical Care, Theatre and the Accident and Emergency Dept.

12 Nursing Quality Assessment Tool (NQAT

12.1The Nursing Quality Assessment Tool (NQAT) has been in place since April 2015 and provides assurance that the quality and safety of care is being monitored and that action is being taken where any fundamental standards of care are not met.
12.2 Following each assessment Wards/Departments are given a 'Bronze' 'Silver' and 'Gold' rating. The NQAT certificates are displayed at ward level and supported by each are action plans for areas of improvement.

12.3 25 wards have had a QCAT performed and the following have been achieved:

- 1 Gold ward
- 20 Silver wards

- 4 Bronze wards

13. Safe Midwifery staffing for maternity settings.

13.1 Following a review of the Maternity establishment in July 2015, the Trust agreed a business case in relation to maternity staffing.
13.2 Further investment was made for 5 Midwives and 5 maternity support workers (MSW)
13.3 In addition the Trust has commissioned a Birth rate plus review which is currently being analysed.
13.4 The results will be reported in the next report to board

14. Conclusions of workforce review

14.1 The data indicates that the Trust has safe staffing levels in place as compared with the Shelford group benchmark. As the trust slightly exceed the recommended levels for WTE required in the areas included in the audit (WTE in establishment 808.25 compared to Shelford WTE required 794.36)

14.2 If 1:8 ratio is required as a minimum the current establishment of WTE meets the requirements.

14.3 However if investment was to become available the areas that would be prioritised are would be:
:

- RN 2.5 WTE Ward 1A frailty due to high turnover of patients and assessments required.
- HCA 1.2 and RN WTE wards 2B and 2C on the night shifts due to dependency of patients (4.8 WTE)
- RN 2 WTE ward 3D due to high volume of IV treatments and dependency of patients
- Review of skill mix in DMOP wards as RN to HCA ratio
- Total WTE : 9.2

Recommendations

The Trust Board are requested to note the findings of the Shelford acuity audit in relation to patient dependency and nurse staffing levels, and to consider that if financial investment was to become available if the additional resources for the 4 ward areas could be identified.

The Board will continue to receive a six monthly workforce reviews.

Appendix1	
Acuity Study October 2015 - Key and Data Sources	
PARAMETER	**DEFINITION**
Levels of Care	**Number audited patients assessed as requiring Level 0, Level 1a, Level 1b and Level 2 care**
Level 0	Needs are met through normal ward care
Level 1a	May be acutely ill requiring intervention, or may be unstable
Level 1b	In a stable condition but have an increased dependence on nursing support
Level 2	May be managed within clearly identified Level 2 beds resourced with the required staffing level OR may require transfer to a High Dependency Unit
Nursing Establishment Whole Time Equivalent (WTE)	**A comparison of the funded, estimated and recommended nursing establishment WTE during the duration of the Acuity Study**
Funded WTE	The actual number of WTE staff funded for the ward during the period of the study
Average WTE	The WTE establishment required based on the average patient acuity during the period of the study
Estimated WTE	The effective WTE staff establishment based on the staff recorded as present on each shift during the period of the study
Recommended WTE	The WTE staff establishment required for the ward based on the patient acuity scores over the period of the study taking into account the daily variation in scores. Setting staffing at this level takes into consideration the daily variation in patient acuity levels.
Complaints	**The number of complaints registered for each ward during the period of the Acuity Study**
Patient Harms	**Patient Harms registered and reported through Datix for each ward during the period of the Acuity Study**
MRSA Bacteraemia	All harms from hospital acquired MRSA bacteraemia
CDT	All harms from hospital acquired Clostridium difficile toxin
All Falls	All inpatient falls
PU	All harms from grade 2-4 hospital acquired pressure ulcers
Drug Errors	All drug and medication errors

Activity	**The bed occupancy level on each ward during the period of the Acuity Study**
Bed Occupancy	The bed occupancy percentage based on the funded beds for each ward

Appendix 2

Ward	NO Of Bed	Levels of Care					Nursing Establishment WTE						Formal Complaint received						Activity			Changes in acuity since June 2015
		L0	L1a	L1b	L2	L3	WARD Funded WTE	RN WTE	HCA WTE	SNCT WTE Required	SNCT RN	SNCT HCA		MRSA Bact.	CDT	Falls	PU Grade 2	Medication Error	Adm	Disch	Bed Occ	
1A	31	172	290	154	0	0	37.36	20.63	16.93	41.46	25.4	16.6	1	0	0	1	1	1	52	55	99.03%	Level 1a and 1b increased
1B	16 and GP AU	182	20	112	0	0	48.09	34.1	13.99	46	33.2	12.8	0	0	0	0	0	0	156	38	96.25%	level unchanged activity increased
1C	32	364	242	26	2	0	58.09	39.28	18.81	46	32.2	13.8	0	0	0	0	0	1	329	118	98.75%	Level 1b and activity increased
1D	32	412	132	94	0	0	37.87	21.81	16.06	37.4	22.4	15	0	0	0	0	0	0	53	53	99.38%	Slight Reduction in level 1b and increase in level1a
1E	17	0	8	322	0	0	34.85	27.45	7.4	28.3	17.0	11.3	0	0	0	0	0	0	99	54	97.65%	Reduction from level 2 increase level 1B
2A	20	128	112	144	16	0	27.10	18.43	8.67	27.7	16.6	11.1	0	0	0	0	0	0	42	35	99%	Increased level 1a
2B	32	356	34	248	0	0	38.28	22.6	15.68	41.2	24.7	16.5	0	0	0	0	0	0	65	65	99.69%	No change
2C	32	248	184	208	0	0	38.93	22.39	15.22	42.6	25.6	17.1	1	0	1	0	0	2	81	86	99.69%	No change
2D	23	316	78	68	0	0	29.30	16.4	12.9	26.7	16.0	10.7	0	0	0	0	0	1	36	34	99%	Increase in level 1a and 1b
Alpha	18	162	68	120	0	0	30.03	15.47	14.56	22.9	13.8	9.2	1	0	0	0	0	0	14	12	97.22%	No change
3A	28	202	130	112	0	0	34.78	20.2	14.58	28.4	17.0	11.4	0	0	1	1	0	1	140	87	78.93%	Slight Reduction in level 1a and 1 b
3B	27	352	126	2	0	0	33.28	18.03	15.25	32.6	18.6	14.0	1	0	0	2	0	0	142	109	88.89%	No change
3C	32	62	540	20	0	0	39.06	22.53	16.53	41.9	25.2	16.8	1	0	0	8	0	0	31	41	96.88%	Increase in level 1b from 1a
3D	32	246	98	288	8	0	38	22.8	15.2	41.7	25.6	16.1	0	0	0	5	0	0	79	78	99.69%	Increase in level 1a from level 0
3E	21	278	32	0	0	0	22.87	15.8	6.27	17.9	11.5	6.4	0	0	0	1	0	0	76	82	73.81%	No change
4A	32	532	106	2	0	0	37.37	22.34	15.03	34.8	21.3	13.5	0	0	0	1	0	1	25	96	100%	No change

4B	16	292	2	0	0	0		15.08	9.7	5.38	14.5	10.3	4.2	0	0	0	3	0	1	271	187	91.88%	No change
B SAU	13	226	16	2	0	0		13	9.5	3.5	15.6	10.9	4.7	0	0	0	0	0	0	233	53	93.08%	No change Increase in activity
4C	32	354	196	84	2	0		36.68	22.56	14.09	38.3	23	15.3	0	0	1	3	1	0	7	60	99.06%	No change
4D	13	14	70	102	0	0		27.36	21.03	7.33	14.2	8.5	5.7	0	0	0	1	0	1	24	13	71.54%	Increase in level 1b
5A	32	324	58	250	0	0		44.2	20.77	23.43	41.4	24.8	16.5	1	0	0	10	1	2	24	27	98.44%	Increase in level 1b
5B	32	252	276	124	0	0		44.24	20.03	23.66	42	25.2	16.8	0	0	0	6	0	1	12	14	101.56%	No change
5C CEO	16	60	98	162	0	0		22.67	13.81	8.86	23.31	13.91	9.4	0	0	0	1	0	1	19	19	100%	No change
5C Stroke	16	68	24	136	8	0		28.74	17.28	11.46	17.3	16.4	6.9	1	0	0	9	0	1	45	26	73.13%	No change
5D	23	74	56	314	0	0		28.10	15.05	13.45	32.6	18.8	13.8	1	0	0	7	0	1	0	17	96.96%	No change
Total								845	509.99	334.24	796.77	497.91	305.6										

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)022
Title of paper: Foundation Trust application programme progress report
Purpose: To provide assurance to the Board on the progress being made against the key Foundation Trust application programme workstreams.
Summary: The Foundation Trust (FT) application programme reports to the Strategic Development Delivery Council (SDGC) which is accountable to the Executive Committee. The issues reported this month are; • Suspension of the NHSTDA Accountability Framework monthly reporting requirement • Development of a Board development programme for 2016 • Progress against the Well Led Framework self-assessment action plan • 2016/17 Operational and Sustainability and Transformation Planning update
Corporate objectives met or risks addressed: Be a sustainable and efficient Foundation Trust
Financial implications: None arising directly from the approval of this paper.
Stakeholders: NHSTDA, Patients, Staff
Recommendation(s): The Board is recommended to note the progress being made against the FT application workstreams.
Presenting officer: Nik Khashu, Director of Finance and Information
Date of meeting: 24th February 2016

FOUNDATION TRUST APPLICATION PROGRAMME

1. Introduction

The Trust continues to progress the FT application programme workstreams to;

- Ensure it remains in the best position to progress a rapid application at the point when a timetable can be agreed.
- Continue to develop the governance systems and capability of the Trust to respond to the changing NHS strategic and policy environment

2. Accountability Framework

The NHS Trust Development Authority (NHSTDA) has "suspended" the requirement for Boards to submit monthly self-certifications and Board statements against the Provider Licence and NHSTDA Accountability Framework.

The reporting and accountability regime is being reviewed as part of the establishment of NHS Improvement the new body that will come into effect in April 2016 and will become the single regulator for both Foundation Trusts and NHS Trusts.

3. Board Development

A full Board development programme for 2016 is being finalised based on 2.5 days of time out time (1/2 day in February and two full days in June and November), plus the designated strategy board meetings.

4. Well Led Framework self-assessment action plan

Progress against the action plan to the end of January 2016 is summarised in the table below;

Domain	Total No of Actions	Actions Due to be Completed	Actions Completed (Green)	Actions In Progress (Amber)	Actions Overdue (Red)
Planning and Strategy	18	8	7	1	0
Capability and Culture	15*	8	4	2	2
Process and Structure	12	9	8	1	0
Measurement	2	2	0	2	0
Total	**47**	**27**	**19**	**6**	**2**

It should be noted that for some actions the target completion dates have been extended so that they align to the 2016/17 Operational Planning guidance timetable.

The overdue actions both relate to Non-Executive Director terms of office. This action can be progressed now that the Chairman has been appointed for a second term by the NHSTDA.

5. 2016/17 Operational and Sustainability and Transformation Plan

The draft 2016/17 one year operational plan submissions were made to the NHSTDA by the 8th February deadline. These submissions covered finance, workforce, activity and performance and were accompanied by a narrative commentary. This submission included the Trusts acceptance of the conditions attached to the additional sustainability and transformation funding offer.

The NHSTDA will assess the plan and triangulate with the submissions of the other organisations within the local Sustainability and Transformation Planning (STP) footprint. The Trust will receive formal feedback in March.

The final one year plan submission deadline is 11th April 2016.

The 5 year STP for the Trust and the Merseyside and Cheshire STP footprint submission deadline is 30th June 2016.

ENDS