St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 27TH JULY 2016
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

A G E N D A				Paper	Presenter
09:30	1.	Employee of the Month - July			
09:35	2.	Patient Story			Sue Redfern
10:00	3.	Public Health Annual Report – Knowsley CCG		Presentation	Matt Ashton
10:30	4.	Apologies for Absence			Richard Fraser
	5.	Declaration of Interests			
	6.	Minutes of the previous Meeting held on 29th June 2016		Attached	
		6.1	Correct record & Matters Arising		
		6.2	Action list	Attached	
Performance Reports					
10:40	7.	Integrated Performance Report		NHST(16) 078	Nik Khashu
		7.1	Quality Indicators		Sue Redfern/Kevin Hardy
		7.2	Operational indicators		Rob Cooper
		7.3	Financial indicators		Nik Khashu
		7.4	Workforce indicators		Anne-Marie Stretch

10:55	8.	Safer Staffing report		NHST(16) 079	Sue Redfern
		8.1	Shelford Acuity Tool	NHST(16) 079a	Sue Redfern
11:05	9.	HR indicators		NHST(16) 080	Anne-Marie Stretch
BREAK					
Committee Assurance Reports					
11:25	10.	Committee report - Executive		NHST(16) 081	Ann Marr
		10.1	Board Assurance Framework	NHST(16) 082	Sue Redfern
		10.2	Corporate Risk Register	NHST(16) 083	
11:40	11.	Committee Report – Quality		NHST(16) 084	David Graham
11:45	12.	Committee Report – Finance & Performance		NHST(16) 085	George Marcall
Other Board Reports					
11:50	13.	FT programme update report		NHST(16) 086	Nik Khashu
Closing Business					
12:00	14.	Effectiveness of meeting			Richard Fraser
	15.	Any other business			
	16.	Date of next Public Board meeting – Wednesday 28th September 2016			
LUNCH					

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

Minutes of the St Helens and Knowsley Hospitals NHS Trust Board meeting held on Wednesday 29th June 2016 in the Boardroom, Whiston Hospital

PUBLIC BOARD

Chair:	Mr R Fraser (RF)	Chairman
Members:	Ms A Marr (AM)	Chief Executive
	Mrs A-M Stretch (AMS)	Director of HR/Deputy Chief Executive
	Mrs A Risino (AR)	Director of Strategy
	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 P Williams (PW)	Director of Corporate Services
	Mr R Cooper (RC)	Acting Director of Operations and Performance
	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:	None noted	
In Attendance:	Mr T Foy (TF)	St Helens CCG
	Mrs K Pryde	Executive Assistant (Minutes)

RF welcomed AR, RC and TF to the Board meeting.

1. **Employee of the Month**

The award for Employee of the Month for June 2016 was presented to Elaine Porter, Occupational Therapist, Duffy Suite.

2. **Apologies for absence**

2.1. No apologies noted.

3. **Declaration of Interests**

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

4. **Minutes of the previous meeting held on 25th May 2016**

4.1. **Correct Record and Matters Arising**

4.1.1. Following inclusion of GM on the attendance list and amendment to paragraph 14.3, the minutes were approved as a correct record.

4.2. **Matters Arising**

4.2.1. AM requested an update from SR on the recent outbreak on Pseudomonas on Ward 4D.

4.2.2. SR reported that since November 2015, six patients admitted to the unit had been diagnosed as having a rare strain of pseudomonas. The index case was a patient from Romania, who was screened on admission. Specimens had been sent for typing and it was reported that they were all the same strain.

4.2.3. SR has liaised with Public Health England (PHE), and they will be at the Trust on 30th June for a peer review to support the Trust.

4.2.4. Full environmental screening has been carried out on Ward 4D and ICU and rooms have been fogged using hydrogen peroxide. Swabbing has taken place on patients and staff. Beds on Ward 4D have been decommissioned and replaced.

4.2.5. A question was raised if all patients identified with pseudomonas had been brought to the hospital via the same ambulance. SR will try to obtain this information.

4.3. **Action List**

4.3.1. Item 1 – Minute 8.12.3 (27.01.16): WRES action plan. Agenda item. AMS will report to the Board on a quarterly basis. Action closed.

4.3.2. Item 2 – Minute 6.4.2 (25.05.16): IT project to support e-learning across the Trust. HR and IT have met and AMS is the lead sponsor and Adam Rudduck is leading on the project. A paper will be presented to the Executive Committee at the end of July. Action closed.

4.3.3. Item 3 – Minute 8.5 (25.05.16): ANTT training. Agenda item. Action closed.

4.3.4. Item 4 – Minute 9.8 (25.05.16): PAS system funding. NK assured the Board that NHSI are aware. Action closed.

4.3.5. Item 5 – Minute 17.5 (25.05.16): Mortality Paper. KH provided an update to Board members. Action closed.

4.3.6. Item 6 – 19.5 (25.05.16): Governance structure. PW has met with SR and it has been agreed that the Claims Governance Group will now report to the Risk Management Council. Action closed.

5. **IPR – NHST(16)064**

5.1. Quality Indicators

5.1.1. SRe provided a brief update on Quality Indicators. There was one positive C.Difficile case in May, bringing the year to date total to two, one of which will be submitted for appeal. There were no hospital acquired grade 3/4 pressure ulcers. There were two falls in April, one resulting in severe harm which was discussed in detail at the Quality Committee. Performance for VTE for April was 89.96%; an action plan is in place.

5.2. Operational Indicators

5.2.1. RC provided an update to the Board. A&E performance was 79.7%, which is a deterioration from the previous month and continues to be a significant concern. Findings from the ED lean project are now being embedded, which include:

- Senior nurses will work on the night shift.
- Clear objectives for operational leads
- Changes in the process for medical intervention for patients.
- Senior decision making earlier in the patient pathway.

5.2.2. There was a lengthy and detailed discussion amongst Board members regarding A&E performance. Key topics debated included:

- The downward trend in performance figures.
- Ambulatory care
- How other Trusts are handling the A&E pressure.
- The relatively high percentage of complaints regarding A&E.
- The issues behind the performance; management, procedures, demand or a combination of all three

5.2.3. AR advised the Board that Warrington have seen a decrease in attendances and admissions primarily because of the initiatives in primary care and the community. There are six transformation programmes within the hospital.

5.2.4. GM enquired about the funding for a GP in A&E and if it was to be reinstated by St Helens CCG. TF replied that unfortunately, the money is no longer available to fund this.

5.3. Financial Indicators

5.3.1. NK reported against an Annual Plan of £3.328m surplus and confirmed for the month of May 2016 an overall Income & Expenditure surplus of £0.293m after technical adjustments, which is slightly behind the agreed plan.

5.3.2. To date, the Trust has delivered £1.706m of CIPs which is just behind the year to date plan. The CIP programme is formally

reviewed both at a Trust and Specialty level on a monthly basis and is also part of the Operational Transformation Group agenda.

5.3.3. Capital expenditure to date is low against plan at £0.041m, out of a total plan of £5.15m but further Capital schemes have already been approved and we anticipate that we will spend the full allocation.

5.3.4. Cash balance at the end of May 2016 is £16.545m, which equates to 19 operating days, mainly due to the Trust receiving the £13m PFI funding this month.

5.4. Workforce Indicators

5.4.1. AMS provided an update for the Board. The Q4 Staff Friends and Family Test survey results show the Trust is maintaining its excellent performance compared to the national position.

5.4.2. Mandatory training compliance has improved slightly in month and is 7.9% below target. Appraisal rates have fallen slightly in month to 2.6% below target. Recovery plans are in place for both Appraisal and Mandatory training which continue to be impacted by operational pressures.

5.4.3. Staff sickness for April was 4.6%; this is an improvement year on year but is 0.1% above the annual target and 0.35% above Q1 trajectory. There is a continued effort and a targeted approach between HR and managers to drive down sickness absence rates. AMS informed the Board that she would be speaking to Southport and Warrington regarding good practice.

6. Safer Staffing report – NHST(16)065

6.1. SRe provided an update for Board members.

6.2. The overall Trust fill rate for May was 100.47%. There were 91 ward areas with a fill rate below 90%; 12 wards for registered staff and 9 wards for care staff.

6.3. SOB queried the conclusions which should be drawn from the Care hours per Patient per Day (CHPPD) data. SRe advised that this was a new reporting measure which came into force in May, but it is quite subjective.

6.4. Retention and recruitment remains a priority for the Trust and an ongoing challenge nationally. Three recruitment days are planned throughout 2016, the latest one was held on 18th June and the following specialties were targeted; Respiratory Medicine, Gastroenterology, Endocrinology and General Medicine.

6.5. SRe has met with the Dean and Professor of Nursing from LJMU to agree a process whereby student nurses who have been offered a post, will work their last placement on that ward.

6.6. BH queried the figures in the filled and unfilled table, especially for Ward 2E. SRe informed the Board that this Maternity ward use their own staff and community and ward managers to provide cover and do not rely on bank or agency requests.

6.7. AM asked why the HCA demands still cannot be filled from the bank. AMS is meeting with the Resourcing Manager regarding the numbers around filled and unfilled rates and HCA requests, and will report back at the next Board meeting.

7. Workforce Race Equality Standard (WRES) update – NHST(16)066

7.1. AMS provided an update for the Board.

7.2. Of the 9 WRES indicators, only indicators 5, 6, 7 and 8 are able to be benchmarked as these are based on National Staff Survey results.

7.3. For staff reporting an experience of harassment, bullying or abuse, the spread of results is of concern with a disparity of 8% between White and BME results; the BME response is low compared to that of white colleagues. AMS advised that the incidents reported are not reflected in the cases raised via the Trust's internal policies, indicating under reporting and a missed opportunity to resolve concerns from this staff group.

7.4. AMS informed the Board of key initiatives and actions that are being undertaken:

7.4.1. Listening forums for BME staff (education and training).
7.4.2. Trust mentors identified.
7.4.3. Re-launch of ACE behavioural standards
7.4.4. 100 days of kindness scheme.

7.5. AMS will report to the Board on a regular basis.

8. Complaints, Claims and Incidents – NHST(16)067

8.1. SRe summarised the report for the Board.

8.2. There were a total of 60 formal 1st stage complaints and 607 PALS contacts/enquiries during Q4, compared to Q4 last year when there were a total 76 formal complaints and 354 PALS enquiries. The top three themes during Q4 were clinical treatment, values and behaviours and patient care/nursing care.

8.3. The Trust responded to 50% of the complaints received within agreed time frames during the quarter, with an annual average of 61.4%.

8.4. The number of incidents raised for this quarter was 3504 compared to 2884 in the same quarter last year and a reduction in harm of 40%. The number of StEIS incidents reported this quarter was 12 – this remains static, with 10 to 12 reported each quarter.

8.5. National Reporting and Learning System (NRLS) latest published data (April-September 2015), shows the organisation's practice in reporting to the NRLS remains excellent.

8.6. There are 406 active clinical negligence claims ongoing. 28 new claims were received in Q4 compared to 20 in the same period last year.

9. ANTT Training update – NHST(16)068

9.1. SRe provided an overview of the report.

9.2. The purpose of the report was to give an update on Trust compliance with ANTT training and to discuss the action plan to achieve sustained improvement in meeting the required trajectory of 85%.

9.3. Key actions include:

9.3.1. Revised ANTT chapter of the Infection Control manual.
9.3.2. Key infection control nurses to tackle the problem.
9.3.3. Junior doctors to have ANTT training as part of the ward induction.
9.3.4. Clinical staff who consider that they meet the exemption criteria, must notify the Director of Infection Prevention and Control, who will advise and were applicable, this will be recorded on ESR as exempt.

9.4. The Board discussed the frequency of the training and whether it was necessary for this to be done annually. KH asked that the policy is checked regarding the frequency of training. SRe will feedback to Board.

10. Update on Mandatory Training – NHST(16)069

10.1. AMS provided an update to the Board.

10.2. Current compliance is below the expected target of 85%, currently standing at 77%. A range of remedial actions have taken place to tackle the issue, including:

10.2.1. Recommendation to Executives that clinical mandatory training moves to every two years with three notable exceptions; life support, information governance and infection control.

10.2.2. Carry on working on the IT infrastructure to support e-learning.

11. Committee report – Audit – NHST(16)070

11.1. SR summarised the report for the Board.

11.2. Items discussed at the meeting held on 24th May included the Annual Governance Statement/Annual Report, presentation of the Annual Accounts, audit findings report, adoption of the accounts, Letter of representation and presentation and approval of the Quality Account.

11.3. Adoption of Annual Accounts – NHST(16)071

11.3.1. SR informed the Board that the Audit Committee had approved the annual financial accounts under delegated authority from the Trust Board.

12. **Committee report – Executive – NHST(16)072**

12.1. AM summarised the report for the Board.

12.2. Between 19th May and 16th June, four meetings of the Executive Committee have been held. Decisions taken by the Committee included differential sickness rates and overseas recruitment initiatives.

12.3. Assurance regarding safer staffing, STP and LDS planning, application of contractual penalties, management of bank and agency usage, CQC action plan, Ward 4D infections, and management of risks were obtained.

12.4. Investment decisions included on-call arrangements, midwifery staffing, Paediatric Consultant, pharmacy staffing, and supporting the Guardian role.

12.5. Whilst there were no specific items requiring escalation to the Board, AM discussed the accommodation review to maximise overnight bed capacity.

12.6. SR enquired as to when the CQC re-inspection would take place. AM replied that a date had not been set as yet. KH said that he was attending a meeting at the CQC on 30th June and it was felt that there will be a shift towards annual inspection and the re-introduction of intelligent monitoring.

12.7. SR also enquired as to how the collaborative working with Warrington was progressing. AM advised that this would be discussed within the STP report.

13. **Committee report – Quality – NHST(16)073**

13.1. DG provided a summary of the Quality Committee meeting held on 21st June.

13.2. Although a number of items in the report had already been discussed earlier in the meeting, DG wished to make a few observations to the Board:

13.2.1. Complaints: The ED may need increased support in responding to requests to assist with complaints received. An issue of the quality of the writing of report will be addressed by HR.

13.2.2. Intranet upgrade for Policies and Documents: This will provide users with a more accessible search engine when looking for policies and documents. The "go live" date will be in approximately four weeks.

13.3. Other items discussed included CQC action plan, ward dashboard, safer staffing, Pharmacy and weekend mortality.

13.4. SR asked if the Trust should revisit how quality ward rounds are conducted. NK said he would like them to be linked to problems and performance issues.

GM commented that more medics are needed to attend the quality ward rounds. SRe will look at the process with Anne Rosbotham-Williams and Neal Jones.

14. **Committee Report – Finance & Performance - NHST(16)074**

14.1. DM provided a summary of the Finance & Performance meeting held on 23rd June.

14.2. Key items were:

14.2.1. Maternity KPI dashboard.
14.2.2. Surgery SLR
14.2.3. A&E
14.2.4. CIPS

14.3. Actions agreed include A&E Six Sigma updated report to be presented at the July meeting, updated Estates return due in August and Maternity KPI's to be presented after review of the national dashboard and current targets.

15. **Committee Report – Charitable Funds**

15.1. DM brief the Board on the main issues discussed and decisions made at the meeting held on 23rd June.

15.2. The investment portfolio shows an unrealised gain of £73.3k against purchase price and an unrealised loss of £16.2k against the year-end valuation.

15.3. The Committee reviewed Income and Expenditure since the previous meeting and this showed income of £89,999 (includes a legacy of £40,000) and expenditure of £151,839.

15.4. The fundraising consultant has provided a number of fundraising activities to pursue. Going forward we will need to appoint into the fund raising post.

16. **FT programme update report – NHST(16)076**

16.1. NK provided an update for the Board.

16.2. This report provides the Board with assurance regarding the FT application programme, the development of the STP for Cheshire and Merseyside, and the continued development of the organisation's governance and leadership capacity for the future.

16.3. NK reported that there has not been an update on the £10.1 funding and how any penalties might be applied, but the financial template to complete the STP submission has now been received.

16.4. There are no red or overdue actions pertaining to the well-led framework.

17. **Clinical & Quality Strategy – NHST(16)077**

17.1. KH presented the refreshed Clinical & Quality Strategy for Board approval.

17.2. This will focus on a smaller number of key objectives over a shorter period with more frequent refresh.

17.3. AMS will speak to Kim Hughes, Head of Media, to arrange for a communication to go out to all staff, asking for support in delivering the strategy.

17.4. The Board approved the strategy.

18. **Effectiveness of meeting**

18.1. AR commented that everyone participated and there was time for everyone to engage, although the meeting did run over.

18.2. RC echoed AR's comments and also said that adherence to the agenda was good.

19. **AOB**

19.1. N/a

20. **Date of next meeting**

20.1. The next meeting is scheduled for Wednesday, 27th July 2016 in the Boardroom, Whiston Hospital commencing at 9.30 am.

Chairman: .....

Date: 27/7/16

TRUST PUBLIC BOARD ACTION LOG – 27TH JULY 2016

No	Minute	Action	Lead	Date Due
1	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. Agenda item.~~ ~~27.04.16: Anne-Marie Stretch will bring a paper to June Board before submission on 1st July – *Agenda item*~~ 29.06.16 Anne-Marie Stretch will report to the Board on a quarterly basis. Action closed.		Action closed
2.	25.05.16 (6.4.2)	Christine Walters to list a new IT project and assign a project manager to look at IT support/platforms to support e-learning across the Trust. 29.06.16 – A meeting has taken place between HR and IT. Anne-Marie Stretch is the lead sponsor and Adam Rudduck is leading on the project. Paper to Execs at the end of July. Action closed.		Action closed
3.	25.05.16 (8.6)	Sue Redfern will provide a verbal update to the Board regarding ANTT training. Agenda Item. Action closed.		Action closed
4.	25.05.16 (9.8)	Nik Khashu to "flag" up to the NHSI that the Trust have to replace the PAS system – funding from STP. 29.06.16 – Nik Khashu advised the Board that the NHSI are aware. Action closed.		Action closed
5.	25.05.16 (17.5)	Kevin Hardy to prepare a briefing to answer all questions under Section 2 of the Mortality paper presented to Board. 29.06.16 – Kevin Hardy provided a briefing paper to all Board members. Action closed.		Action closed
6.	25.05.16 (19.5)	Executive Directors asked to check the Governance structure included in the Board Effectiveness report and feedback any anomalies to Peter Williams. 29.06.16 - PW has met with SR and it has been agreed that the Claims Governance Group will now report to the Risk Management Council. Action closed.		Action closed
7.	29.06.16 (9.4)	Sue Redfern will check the Infection Control policy regarding the frequency of ANTT training and compliance. Information sent to Board members following the meeting.	SRe	Action closed

No	Minute	Action	Lead	Date Due
8.	29.06.16 (13.4)	Sue Redfern with meet with Anne Rosbotham-Williams and Neal Jones to discuss Quality Ward Round processes. 06.07.16 – Meeting arranged for 9th August	SRe	28 Sep 16
9,	29.06.16 (17.3)	Anne-Marie Stretch with liaise with the Media Office, to prepare a communication to all staff regarding supporting the refreshed Clinical & Quality Strategy	AMS	27 Jul 16

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(16)078
Title of Paper: 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.** 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 first Outpatient and Diagnostic service in the country to EVER be awarded this rating.

YTD there have been no cases of MRSA bacteraemia.

There were 2 C.Difficile (CDI) positive cases in June. Year to date there have been 4 positive cases of which 1 has been submitted for appeal and another awaiting RCA before deciding whether to appeal. The annual tolerance for 2016-17 is 41 cases.

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

There were no falls that resulted in severe harm or death in May.

Performance for VTE assessment for May was 89.08%

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

The provisional 2015-16 HSMR is 97.5. It should be noted that the HSMR is only rebased up to Dec-15, however full year rebasing is not expected to make a material difference to the HSMR.

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 Officer: N Khashu
Date of Meeting: 27th July 2016

Operational Performance

The organisation led on a system wide event in May to sustainably reduce DTOC (Delayed Transfer of Care) patients. This focus has demonstrated a significant reduction in this group of patients. Pre event, the number of delayed patients in the Hospital stood at 87, this now stands at 67.

The Trust have also undertaken a strategic accommodation review to identify additional bed capacity to support increased activity going into Q3 & Q4 2016/17 to assist improved sustainable patient flow and performance against the 4 hour Emergency Access Standard (EAS).

ED performance was 73% (type 1) and 83.2% (type 1 & 3) in month. Following an in depth review of the ED, undertaken by the Project Management Department (PMO), several must do actions have been identified. These actions include implementation of senior medical rapid assessment and treatment, ambulatory emergency care, realignment of staff to reduce waste and increase medical and nursing productivity to see more patients in less time. All actions have been enacted across 7 days to support improved patient flow which will result in improved performance in July. These actions are currently being rolled across the department over the 24 hour period.

All other key national access targets are being achieved

Financial Performance

The Trust is reporting against an Annual Plan of £3.328m surplus, as approved by the Trust Board and confirmed with the TDA.

Income & Expenditure

As at the month of June 2016 (Month 3) the Trust is reporting an overall Income & Expenditure surplus of £0.492m after technical adjustments which is in line with agreed plan. Trust income is ahead of plan by £1.4m but we are not delivering the additional activity at the planned efficiency levels and expenditure on Agency in June was £1.3m, £0.2m higher than in the previous month. The Trust Executive team continues to meet with Specialties on a weekly basis to review the action plans in place to reduce agency expenditure in 2016/17.

The Trust's forecast outturn is to achieve its Annual plan of £3.329m surplus.

CIP

To date the Trust has delivered £2.649m of CIPs which is just behind the year to date plan by £0.218m. The CIP Programme is formally reviewed both at a Trust and Specialty level on a monthly basis and is also part of the Operational Transformation Group agenda.

Capital

Capital expenditure to date is £0.197m out of a total plan of £5.15m and we anticipate that we will spend the full Annual budget of £5.15m.

Cash

Cash balance at the end of June 2016 is £8.887m which equates to 10 operating days.

Human Resources

Mandatory training compliance has improved slightly in month but is still 7.3% below the 85% target. Appraisal compliance has fallen in month to 10.6% below the 85% target. Recovery plans in place for both Appraisal and Mandatory Training continue to be impacted by operational pressures. High rates of 'no shows' at booked mandatory training have wasted 31% of capacity in month.

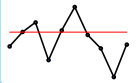
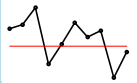
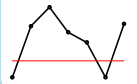
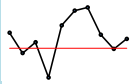
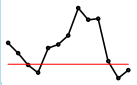
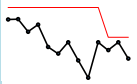
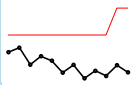
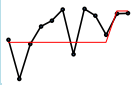
Staff sickness for May was 4.3%, this is an improvement year on year but is 0.05% above the Quarter 1 target. This is an improvement on March's and April's position with continued efforts and a targeted approach between HR and managers to drive down sickness absence rates. Absence , however, still remains higher than the Trust target.

The following key applies to the Integrated Performance Report:

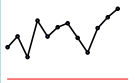
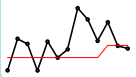
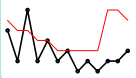
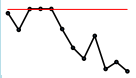
▲ = 2016-17 Contract Indicator
▲ £ = 2016-17 Contract Indicator with financial penalty
● = 2016-17 CQUIN indicator
T = Trust internal target

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

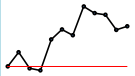
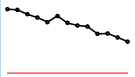
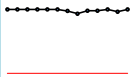
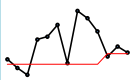
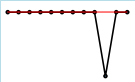
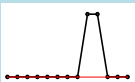
	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS												
Mortality: Non Elective Crude Mortality Rate	Q	T	Jun-16	2.2%	2.3%	No Target	2.5%		Overall SHMI and HSMR within control limits. Co-morbidity coding better, but not best in class. Palliative care coding suboptimal but being addressed by new consultant & his team & coding. Weekend admission mortality (Saturday admissions) is much improved.	Patient Safety and Clinical Effectiveness	The Trust is exploring an electronic solution to improve capture of comorbidities and their coding. Focus on missing notes (which is improving) as this impacts on R codes (and HSMR). A drive in ED and MAU to reduce excessive use of symptom-diagnoses, as this impacts on HSMR. Palliative care consultant now in post. Work to improve management of AKI and Sepsis is demonstrating early success and will reduce 'observed' mortality.	KH
Mortality: SHMI (Information Centre)	Q	▲	Dec-15	1.03		1.00						
Mortality: HSMR (Dr Foster)	Q	▲	Mar-16	93.3		100.0	97.5					
Mortality: HSMR Weekend Admissions (emergency) (Dr Foster)	Q	T	Mar-16	94.6		100.0	109.3					
Readmissions: 28 day Relative Risk Score (Dr Foster)	Q	T	Dec-15	102.8		100.0	101.0		Much improved over last 12 months.	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	Mar-16	93.7		100.0	90.3		Sustained reductions in NEL LOS are assurance that medical redesign practices continue to successfully embed. The elective performance is a result of the shifting casemix to daycase, leaving an increasing volume of the more complex patients as inpatients.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties	RC
Length of stay: Elective - Relative Risk Score (Dr Foster)	F&P	T	Mar-16	106.7		100.0	106.3					
% Medical Outliers	F&P	T	Jun-16	0.7%	0.7%	1.0%	2.2%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in LoS, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Jun-16	41.7%	45.8%	52.5%	50.9%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	The operational turnaround actions should assist in improving this metric as it is a function of the NEL demand and subsequent impact on patient flow.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients)	Q	▲	May-16	78.1%	78.8%	90.0%	79.9%		eDischarge performance below target, albeit compares favourably with neighbours.		Drive to ensure realtime completion on ward rounds to improve compliance. New report should tell wards virtually realtime who needs a summary.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients)	Q	▲	May-16	94.3%	94.2%	95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E)	Q	▲	May-16	98.7%	98.8%	95.0%	98.5%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

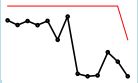
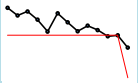
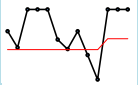
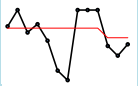
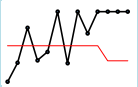
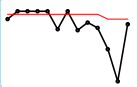
	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	May-16	98.1%	97.2%	83.0%	92.0%		Target is being achieved	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	This KPI is at risk from significant non-elective demand so the issue is reviewed at every Bed Meeting.	RC
PATIENT SAFETY												
Number of never events	Q	▲ £	Jun-16	0	0	0	0		There have been no never events since May 2013. Theatre harm has now reduced by 57% overall since the implementation of the safer surgery project.	Quality and patient safety	The implementation of NatSSIPS is on target for an August implementation against a September target to further reduce episodes of harm during interventional procedures	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Jun-16	98.8%	99.1%	98.9%	98.9%		Figures quoted relate to all harms excluding those documented on admission. StHK performs well against its neighbours.	Quality and patient safety	Reducing hospital acquired harm is a key priority and the in month 0.1% under target position will be monitored, and a recovery plan implemented should performance not return to above target in July.	SR
Prescribing errors causing serious harm	Q	T	Jun-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.	KH
Number of hospital acquired MRSA	Q F&P	▲ £	Jun-16	0	0	0	0		There were 2 C.Difficile (CDI) case in June. The annual tolerance for 2016-17 is 41 cases.	Quality and patient safety	The Infection Control Team continue to support staff to maintain high standards and practices. Monitor and undertake RCA for any hospital acquired BSI and CDI. CDI and Antibiotic wards rounds continue to be undertaken on appropriate wards.	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲ £	Jun-16	2	4	41	26					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Jun-16	1	4	No Target	28					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Jun-16	0	0	No Contract target	1		Pressure ulcer performance continues to improve. There were no grade 3 or 4 ulcers reported in June.	Quality and patient safety	Additional education sessions are being delivered to increase the tissue viability training compliance rates for 16/17 to further support the reduction in hospitals acquired PU.	SR
Number of falls resulting in severe harm or death	Q	▲	May-16	0	1	No Contract target	21		STHK harm from falls is now at 0.074 per thousand bed days(YTD) against a 0.19 national bench mark and a 0.15 internal target	Quality and patient safety	The Trust is undertaking a widespread audit into the use of bedrails in adult patients. This will be reported monthly at PSC from July onwards	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲ £	May-16	89.08%	89.52%	95.0%	93.31%		VTE solution has sorted A&E underperformance.	Quality and patient safety	Intensive training for new trainees starting in August planned.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Jun-16	2	4		38					
To achieve and maintain CQC registration	Q		Jun-16	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Jun-16	94.1%	94.0%		96.8%		Shelford Patient Acuity Audit is currently being undertaken across the Trust.	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.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Jun-16	0	2		1					

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

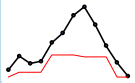
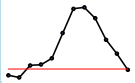
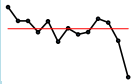
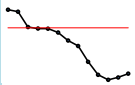
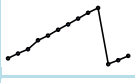
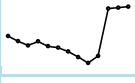
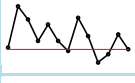
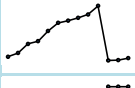
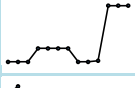
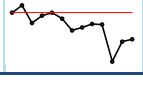
	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	May-16	96.2%	96.0%	93.0%	95.1%		Key access targets achieved	Quality and patient experience	A Programme approach is being utilised to monitor and improve the timeliness of the patients journey along the Cancer pathways.	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	May-16	97.4%	97.9%	96.0%	97.8%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	May-16	88.0%	89.4%	85.0%	88.6%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Jun-16	94.8%	94.8%	92.0%	95.5%		At specialty level Trauma & Orthopaedics and Plastic Surgery continue to fail the incomplete target.	There is a risk due to the current medical bed pressures and the increase in 2ww referrals and activity that the elective programme will be compromised	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. Alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand.	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Jun-16	100.0%	99.99%	99.0%	99.99%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Jun-16	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Jun-16	0.82%	0.83%	0.8%	0.9%		This metric continues to be directly impacted by increases in NEL demand (both surgical and medical patients). Increase in the number of cancelled operations due to significantly increased NEL demand in T&O	Patient experience and operational effectiveness Poor patient experience	The planned increase in elective surgical activity in St Helens has commenced. Potential to use external theatre and bed capacity continues to be progressed.	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	May-16	100.0%	100.0%	100.0%	99.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Jun-16	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Jun-16	73.0%	78.0%	95.0%	85.0%		Failure to ensure patients are managed within 4 hours in the Emergency Department All Type activity includes the Trusts contribution to the local urgent care centres.	Patient experience, quality and patient safety	The actions identified as part of the Lean project have been enacted within the department but require further embedding over the 24 hour period to achieve more sustainable improvement in performance.	RC
A&E: Total time in A&E: % < 4 hours (All Types)	F&P	▲	Jun-16	83.2%	86.3%	95.0%	89.4%					
A&E: 12 hour trolley waits	F&P	▲	Jun-16	0	0	0	2					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Jun-16	0	0	0	0		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.	RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Jun-16	33	93		291		A delay in responding to patient complaints leads to a poor patient experience.	Patient experience	A revised structure to support performance improvements in complaints response will be implemented imminently, however this will need a period of time to further embed and deliver a sustained improvement.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Jun-16	15	60		372					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Jun-16	60.0%	66.7%		42.7%					
Friends and Family Test: % recommended - A&E	Q	▲	Jun-16	84.6%	86.6%	90.0%	91.5%		Latest available benchmarking (Apr-15 to Feb-16) shows that nationally A&E performance is in the top half of Trusts, and Maternity has two elements in the top 25% of Trusts (Antenatal and Postnatal Community), and two others (Birth and Postnatal) in the top 50% of Trusts.	Patient experience & reputation	Scores have been fed back to the ED and Maternity departments.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Jun-16	93.5%	94.5%	90.0%	96.4%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Jun-16	100.0%	100.0%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Jun-16	97.6%	97.2%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Jun-16	100.0%	100.0%	95.1%	95.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Jun-16	97.6%	91.8%	98.6%	98.6%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Jun-16	93.9%	94.2%	95.0%	94.7%					

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE												
Sickness: All Staff Sickness Rate	Q F&P	▲	May-16	4.3%	4.4%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.9%		Absence has decreased again in May is now above Q1 target by only 0.05%. Absence Support team have given increased support to mainly clinical areas. The highest reason for absence remains stress. Nursing sickness has also decreased however the YTD remains 0.3% above target	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	Following approval by the Executives differential targets are being introduced across the Trust to give stretch targets to those department/staff groups that are not patient facing where they should be able to achieve well under the 4.5% overall Trust target. The HR Advisory Team and Absence Support Team continue to work closely with managers with top areas being targeted and action plans invoked.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P	T	May-16	5.3%	5.6%	5.3%	6.0%					
Staffing: % Staff received appraisals	Q F&P	T	Jun-16	74.4%	74.4%	85.0%	87.2%		Appraisal compliance has fallen to 10.6% behind target. Mandatory Training, there is a slight improvement however it is still 7.3% below target. During the reporting period, additional capacity of 15% was added to all existing training sessions, offering 35% more overall capacity in order to recover the position.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	A review of the content, delivery method and frequency of mandatory training is taking place with proposals being discussed at the Executive Committee in May 2016. An update will be provided at F&P on the 23/6/16. All managers are being asked to review those of their staff booked to attend future events to ensure attendance. The L&OD team is reviewing current programme in order to minimise the time commitment of staff.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Jun-16	77.7%	77.7%	85.0%	77.6%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q4	91.6%					The Trusts Staff Friends and Family Test results in Q4 continue to exceed the 2014/15 results and the 2015/16 national average for each question. Again the question relating to recommending the Trust as a place to receive care has returned an exceptionally high score.		Staff in Medical Care Group are currently undertaking the Q1 SFFT, with results expected in August 2016.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q4	80.2%								
Staffing: Turnover rate	Q F&P	T	May-16	0.8%			8.9%		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	Jun-16	2.0	2.0	2.0	2.0		The Trust's year to date performance is slightly ahead of plan. The Trust has significant contractual agreements with other NHS organisations which may impact on our ability to achieve Better Payment compliance.	Financial	Adherence against the submitted plan and delivery of CIP. Maintaining control on Trust expenditure. Agreeing with Commissioners and NHSE a more advantageous profile for receipt of planned income.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Jun-16	2,649	2,649	15,248	13,043					
Reported surplus/(deficit) to plan (000's)	F&P	T	Jun-16	492	492	3,328	(9,551)					
Cash balances - Number of days to cover operating expenses	F&P	T	Jun-16	10	10	2	2					
Capital spend £ YTD (000's)	F&P	T	Jun-16	197	197	5,150	4,169					
Financial forecast outturn & performance against plan	F&P	T	Jun-16	3,328	3,328	3,328	(9,551)					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Jun-16	93.2%	93.2%	95.0%	94.2%					

APPENDIX A

			May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	2016-17 YTD	2016-17 Target	FOT	2015-16	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%	95.8%	100.0%	100.0%	100.0%	87.5%	92.1%	85.0%		99.2%		
	Total > 62 days		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.5	0.0	0.0	0.0	1.5	1.5			1.0		
Lower GI	% Within 62 days	▲ £	100.0%	100.0%	100.0%	77.8%	100.0%	84.6%	100.0%	100.0%	89.5%	100.0%	100.0%	100.0%	83.3%	89.2%	85.0%		94.5%		
	Total > 62 days		0.0	0.0	0.0	1.0	0.0	1.0	0.0	0.0	1.0	0.0	0.0	0.0	2.0	2.0			3.0		
Upper GI	% Within 62 days	▲ £	71.4%	100.0%	100.0%	100.0%	85.7%	71.4%	83.3%	100.0%	100.0%	100.0%	81.8%	75.0%	90.9%	86.7%	85.0%		88.9%		
	Total > 62 days		1.0	0.0	0.0	0.0	0.5	2.0	0.5	0.0	0.0	0.0	1.0	0.5	0.5	1.0			5.0		
Urological	% Within 62 days	▲ £	75.8%	82.4%	62.5%	100.0%	83.3%	76.7%	84.0%	79.2%	83.3%	83.3%	84.0%	85.7%	84.6%	85.1%	85.0%		80.8%		
	Total > 62 days		4.0	1.5	4.5	0.0	2.0	3.5	2.0	2.5	2.0	2.0	2.0	2.0	3.0	5.0			28.0		
Head & Neck	% Within 62 days	▲ £	50.0%	100.0%	50.0%	100.0%		83.3%	100.0%	50.0%	57.1%	60.0%	50.0%	50.0%	100.0%	75.0%	85.0%		71.1%		
	Total > 62 days		1.0	0.0	0.5	0.0		0.5	0.0	1.0	1.5	1.0	0.5	0.5	0.0	0.5			6.5		
Sarcoma	% Within 62 days	▲ £		50.0%	100.0%			100.0%			100.0%		100.0%		85.7%	85.7%	85.0%		87.5%		
	Total > 62 days			0.5	0.0			0.0			0.0		0.0		0.5	0.5			0.5		
Gynaecological	% Within 62 days	▲ £	100.0%	100.0%	100.0%	100.0%	40.0%	100.0%	54.5%	50.0%	60.0%	66.7%	71.4%	66.7%	81.8%	78.6%	85.0%		76.4%		
	Total > 62 days		0.0	0.0	0.0	0.0	1.5	0.0	2.5	1.5	1.0	0.5	1.0	0.5	1.0	1.5			8.5		
Lung	% Within 62 days	▲ £	76.9%	85.7%	90.5%	75.0%	100.0%	71.4%	80.0%	100.0%	90.5%	100.0%	88.2%	66.7%	81.5%	78.8%	85.0%		86.5%		
	Total > 62 days		1.5	0.5	1.0	1.0	0.0	1.0	1.0	0.0	1.0	0.0	1.0	1.0	2.5	3.5			10.5		RC
Haematological	% Within 62 days	▲ £	100.0%	46.2%	50.0%	66.7%		60.0%	80.0%	66.7%	83.3%	50.0%	86.7%	100.0%	100.0%	100.0%	85.0%		70.5%		
	Total > 62 days		0.0	3.5	1.0	0.5		1.0	1.0	1.0	1.0	2.0	1.0	0.0	0.0	0.0			13.0		
Skin	% Within 62 days	▲ £	96.6%	97.0%	100.0%	90.0%	94.7%	88.5%	95.9%	95.3%	94.4%	92.5%	96.7%	97.4%	96.0%	96.6%	85.0%		94.5%		
	Total > 62 days		0.5	0.5	0.0	2.0	1.0	3.5	1.0	1.0	0.5	1.5	0.5	0.5	1.0	1.5			13.0		
Unknown	% Within 62 days	▲ £	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	33.3%	100.0%		50.0%		100.0%	100.0%	85.0%		83.3%		
	Total > 62 days		0.0	0.0		0.0	0.0	0.0	0.0	1.0	0.0		0.5		0.0	0.0			1.5		
All Tumour Sites	% Within 62 days	▲ £	86.3%	88.7%	91.0%	91.2%	91.4%	85.1%	89.3%	86.9%	87.9%	90.1%	89.5%	91.7%	88.0%	89.4%	85.0%		88.6%		
	Total > 62 days		8.0	6.5	7.0	4.5	5.0	12.5	8.0	8.5	8.5	7.0	7.5	5.0	12.0	17.0			90.5		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £		100.0%		100.0%	100.0%					100.0%	100.0%				85.0%		100.0%		
	Total > 31 days			0.0		0.0	0.0					0.0	0.0						0.0		
Acute Leukaemia	% Within 31 days	▲ £							100.0%	100.0%					100.0%	100.0%	85.0%		100.0%		
	Total > 31 days								0.0	0.0					0.0	0.0			0.0		
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)079
Title of paper: Safer Staffing Report for June 2016
Purpose: To provide an overview of nursing and midwifery staffing levels in inpatient areas during June 2016 and the Trust's ability to provide safe, effective patient care.
Summary: • The Trust's mandated monthly submission of staffing levels to UNIFY for June 2016 indicates an overall fill rate of 101.47%. (RN days 92.89%, nights 96.52%; HCAs days 103.68%, nights 111.69%) • 20 wards had fill rates below 90%; 12 for RNs, 8 for care staff and 2 for both. • The overall fill rates for care staff is higher due to the numbers of 'specials' (i.e. 1 patient to 1 staff member) employed to protect vulnerable patients and to over ED to support RN if not at the agreed establishment levels • Workforce data shows 59.5wte RN and 23.6wte HCA vacancies and operational gaps (excluding maternity leave) in month. • 4147 bank and agency shifts were requested of which 2753 were successfully filled plus overtime and extra time employed whenever possible and required. • There was 1 incident of moderate harm resulting from a fall. • A Recruitment day was held on June 16th, 20 offers of jobs made to RNs.
Corporate objectives met or risks addressed: Care, Safety
Financial implications: None directly from report, indirectly the use of specials to provide one to one care is a cost pressure on current ward establishments
Stakeholders: Patients, public, staff, commissioners, Trust Board
Recommendation(s): Members are asked to approve the report
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 29th July 2016

Trust Safer Staffing Report June 2016

1. The purpose of this paper is to provide assurance to the Board 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 recruitment and retention of nursing and midwifery staff remains a priority for the Trust and remains an on-going challenge nationally. Workforce data shows 59.5wte RN and 23.6wte HCA vacancies and operational gaps (excluding maternity leave) in month. Staffing remains on the Corporate Risk Register which is reviewed monthly. Stabilising and retaining the nursing and midwifery workforce in clinical areas continues to be an area of increased focus throughout 2016/17:-

   2.1. A recruitment event on June 18th targeted Respiratory Medicine, Gastroenterology, General Medicine and General Surgery, where 20 job offers were made on the day and more could follow at subsequent interviews.

   2.2. The new preceptorship program commenced in April 2016 and has been well evaluated to date by new starters and ward staff in an effort to develop, support and retain new staff. Fifty new starters are commencing in September and October on the program.

   2.3. Progress is being made with the recent nurse recruits from India; delays are subject to matters outside the Trust's control as the nurses progress through all immigration and professional requirements.

   2.4. The Care Certificate for newly recruited care staff is to be re-launched and competencies for care staff are our next priority to ensure their development and retention.

3. Care Hours Per Patient Per Day (CHPPD) in month averaged 9.66 hours, median 7.1 hours, lowest was 5.2 hours on ward 2C and 30 hours on ward 4E (Intensive care). This mandated reporting is acknowledged nationally as difficult to interpret as to what 'good' looks like at present as it does not recognise acuity, dependency or turnover of patients plus other variables.

4. The Trust's mandated monthly submission of staffing levels to UNIFY (available on the Trust website) for June 2016 indicates an overall fill rate of 101.47% (RN days 92.89%, nights 96.52%; HCAs days 103.68%, nights 111.69%). The overall fill rates for both trained and care staff are very high because they are over-inflated by the high numbers of 'specials' (i.e. 1 patient to 1 staff member) employed to protect vulnerable patients who are staff employed in addition to the set staffing levels.

5. Twenty wards had fill rates below 90%; 12 wards for RNs, 8 for care staff and 2 for both. (Appendix 1). A review of the wards for the last 3 months with fill rates below 90% (Appendix 2) shows that 6 wards consistently had below 90% for RNs, 6 wards for HCAs and 3 wards for both RNs and HCAs. These wards are the ones targeted at the Recruitment day above and did request bank staff accordingly (Appendix 3).

6. The following wards have been consistently below RN 90% for 3 month period:
   - 1A
   - 1D
   - 2B
   - 2C

- 4C
- 5C

6.1 The reasons for the shortfall are combination of vacancies and sickness.

7 A total of 8 incidents were reported in month directly relating to staffing, (Appendix 4) of which none resulted in patient harm. There was one episode of moderate harm caused to a patient following a fall. This was on ward 2C which had a fill rate of less than 90% for trained staff on days in month. On further investigation at the time of the fall, the ward was fully staffed and the fall not considered to be as a result of staffing levels.

8 Future Developments**.** The Allocate E-Roster Company demonstrated an additional new facility at the beginning of July to the Corporate Nursing Team and E-Roster Trust team that can be purchased for use by frontline staff on the existing mini ipad ward systems as part of the e-rostering system. This system developed with Department of Health, would allow real time entry by shift leaders of staff moves to other wards and has the facility to allow the inputting of patient dependency and acuity at all times which would indicate Care Hours Per Patient per Ward continuously. This would allow efficient and effective use of staff across all wards at all times as a whole Trust view would potentially be available of current staffing levels and patient dependency. Further investigation into the effectiveness and benefits of this system currently being used at other Trusts is required prior to a possible business case proposal to the Trust Executive Committee.

Summary

This report provides assurance that every effort was made to ensure optimum staffing levels across all wards daily during June 2016 to provide high quality, safe, effective care and minimise the risk of harm to patients.

Appendix 1

Wards with fill rates below 90% for RNs

	RN days%	HCA days%	RN nights%	HCA nights%
1A	81.2	95.2	89.8	107.8
1B	97.0	119.8	68.8	98.9
1D	84.0	125.1	90.1	113.3
1E	87.7	86.6	90.8	100.0
2B	85.7	94.7	101.2	139.8
2C	82.2	111.8	93.3	108.3
2D	81.4	133.2	103.7	108.2
3C	86.7	109.4	95.5	102.3
3D	89.0	112.1	88.9	137.5
4C	80.1	92.8	100.0	99.2
5C	87.9	93.5	80.0	105.6
Delivery suite	87.0	79.0	95.8	92.7

Wards with fill rates below 90% for HCAs

	RN days%	HCA days%	RN nights%	HCA nights%
1E	87.7	86.6	90.8	100.0
3A	103.7	84.9	125.3	101.9
3F	95.4	89.9	101.9	96.7
4D	115.9	70.0	118.3	56.7
4E	91.1	73.0	91.5	90.0
SCUBU	108.8	79.0	103.8	90.3
Seddon	113.0	84.1	100.0	108.5
Delivery Suite	87.0	79.0	95.8	92.7

Appendix 2 – Wards with fill rates of less than 90% during the last 3 months

Ward	April 2016				May 2016				June 2016			
	RN Days	RN Nights	HCA Days	HCA Nights	RN Days	RN Nights	HCA Days	HCA Nights	RN Days	RN Nights	HCA Days	HCA Nights
1A	74.5%	100%	77.5%	111.1%	78.7	104.1	83.6	131.5	81.2	95.2	89.8	107.8
1B									97.0	119.8	68.8	98.9
1D	88.6%	125.5%	84.6%	119.7%	84.9	137.5	93.6	151.9	84.0	125.1	90.1	113.3
1E									87.7	86.6	90.8	100.0
2B	78.5%	109.7%	98.9%	126.7%	77.5	94.2	92.6	111.3	85.7	94.7	101.2	139.8
2C	87.1%	129.2%	88.9%	138.8%	77.4	123.6	95.2	132.7	82.2	111.8	93.3	108.3
2D	68.2%	115.2%	98.3%	91.8%					81.4	133.2	103.7	108.2
2E	86.0%	90.3%	97.9%	110.2%	89.3	88.7	99.0	103.2				
SCBU	114%	40.7%	106.3%	96.9%	116.3	41.9	113.5	93.6	108.8	79.0	103.8	90.3
D/S	91.4%	89.3%	95.6%	95.5%	89.9	78.1	90.2	92.3	87.0	79.0	95.8	92.7
3A	115%	82.6%	123.8%	108.1%	103.6	80.1	112.9	100.1	103.7	84.9	125.3	101.9
3Alpha	88.8%	93.4%	101.7%	100%								
3B					87.9	115.6	101.1	173.1				
3C									86.7	109.4	95.5	102.3
3D					80.6	108.3	86.0	135.3	89.0	112.1	88.9	137.5
3E	92.3%	89.3%	105.6%	100%	97.4	87.9	105.1	100.0				
3F	101.2%	86.9%	100.4%	95.1%	100.6	80.7	103.9	96.8	95.4	89.9	101.9	96.7
4A	92.7%	91.6%	107.8%	88.9%								
4C	79.1%	101.2%	93.3%	100%	76.7	91.0	94.6	108.7	80.1	92.8	100.0	99.2
4D	110.7%	66.1%	103.3%	45.0%	129.9	57.5	101.6	80.0	115.9	70.0	118.3	56.7
4E	92.0%	71.3%	97.8%	96.7%	93.2	68.3	95.5	87.1	91.1	73.0	91.5	90.0
4F	113.9%	82.5%	103.5%	93.4%								
5A	93.1%	116.4%	80.9%	121.7%								
5B	93.4%	103.2%	88.9%	91.1%	99.5	105.3	89.5	111.8				
5C	89.6%	100.8%	78.4%	108.9%	88.4	99.8	81.9	122.5	87.9	93.5	80.0	105.6
5D					103.3	89.9	100.0	109.0				
Seddon									113.0	84.1	100.0	108.5
Duffy	84.5%	139.9%	100%	145.0%	86.5	143.3	100.0	151.9				

Appendix 3 – Bank and agency unfilled and filled requests June 2016

staff group	**Unfilled requested shifts**	**Filled requested shifts**
Bank HCA	467	1,930
Agency HCA	94	157
Bank RN / RM	456	296
Agency RN	104	370
Wards with RN shortfall	**Unfilled requested bank and agency shifts**	**Filled bank and agency requested shifts**
1A	78	44
1B	19	18
1D	55	11
1E	17	1
2B	33	40

2C	50	33
2D	31	33
3C	18	12
3D	13	11
4C	54	5
5C	20	41

Wards with HCA shortfall	**Unfilled requested bank and agency shifts**	**Filled bank and agency requested shifts**
1E	5	4
3A	4	23
3F	2	8
4D	7	9
4E	0	14
SCUBU	0	2
Seddon	16	19

Appendix 4 – Staffing Related Incident Reports June 2016

Incident date	Time	Location Exact	Description	Adverse event	Severity of harm	Staffing Establishment at time of incident
03/06/2016	13:15	Ward 3D	RN moved from the late shift to cover ward.	Lack of suitably trained /skilled staff	None (No harm caused)	4 RN and 3 HCA
03/06/2016	14:00	Ward 3D	RN moved to another ward on am shift	Lack of suitably trained /skilled staff	None (No harm caused)	3x band 5 1x band 6 2x band 2 1x band 2(for specialing a patient)
07/06/2016	13:15	Ward 3D	Late with 4 RN (3 plus a preceptor) as per our minimum requirement. Plus HCA	Lack of suitably trained /skilled staff	None (No harm caused)	3 RN and 2 HCA
25/06/2016	07:00	Ward 1B GPAU/ Short Stay	Staff did not turn up for early shift leaving ward short of 1 RN	Lack of suitably trained /skilled staff	None (No harm caused)	4 EN and 3 HCA across the ward
27/06/2016	15:30	Ward 3A	RN rang in sick for late shift	Lack of suitably trained /skilled staff	None (No harm caused)	3 trained staff 3 trained health care.
29/06/2016	11:00	Critical Care Unit Accommodation & Offices	Patient needed a P.E.G insertion on itu this am. One trained nurse was required to assist with this procedure which resulted in the Endoscopy unit understaffed	Lack of suitably trained /skilled staff		
30/06/2016	00:00	Ward 3D	Late shift, as 4 trained staff and 2 hcas on shift. Trained member of staff had move to 1A.	Lack of suitably trained /skilled staff	None (No harm caused	3 RN and 3 HCA
30/06/2016	00:00	Ward 3D	on the late shift on the ward with 4 nurses and 2 HCAs where one band 5 got moved to another ward to cover,	Lack of suitably trained /skilled staff	None (No harm caused)	3RN and 2 HCA night shift

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)079a
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 May 2016.
Summary: 1. The report also summarises the results of the fourth Shelford patient dependency /acuity audit which was undertaken in May 2016 2. The previous Shelford audits were undertaken in October 2014 and June 2015 and October 2015. 3. The aim is to ensure nurse staffing levels and skill mix are 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. 4. The data compares the ward funded establishment against the Shelford recommendations 5. There is difference of 2.21 WTE RN under establishment in DMOP and additional 4.21 HCA 6. The results demonstrated the current nursing establishment is compliant with the Nurse Staffing guidance. 7. The Trust continue to report the monthly Nurse Safer staffing and upload to Unify. 8. The report highlights the work that is being progressed nationally in regard to guidance on safer staffing and other national mandates (such as agency price capping).
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: 29th July 2016

6 Monthly Nurse staffing Establishment Review

1. Purpose.

1.1 The purpose of this paper is to provide the Board with a 6 monthly report on Nursing and Midwifery staffing and to provide assurance that the Trust has a clear validated process for monitoring and ensuring safe staffing and that a formal 6 month review has been undertaken.

2. Background.

2.1 Following the Francis report, the National Quality Board (NQB) published guidance that set out the expectations of commissioners and providers for safe nursing and midwifery staffing, in order to deliver high quality care and the best possible outcomes for patients. This was followed by the NICE guidance *Safe staffing for nursing in adult inpatient wards in acute hospital* (July 2014) and *Safe midwifery staffing for maternity settings* (Feb 2015). NICE recommended that their guidance is read alongside that of the NQB guidance.

2.2 In June 2015 the Chief Nursing Officer for England confirmed changes to the safe staffing agenda for all care settings going forward. She emphasised the importance of the NQB expectations and NICE guidance but explained that safe staffing would now be led by NHS Improvement who would work closely with NICE, CQC and Sir Robert Francis, to ensure that there is no compromise on staffing and its impact on patient safety.

2.3 The Lord Carter Review (2016) highlights the importance of ensuring that workforce and financial plans are consistent in order to optimise delivery of clinical quality and use of resources. The review recommended use of a new metric , Care Hours per Patient Day (CHPPD) to be collected monthly (beginning in April 2016) and for this to be collected daily from April 2017, along with improved efficiency in the use of E-Rostering and implementation of the concepts of Enhanced Care. CHPPD is one part of the nursing workforce component of the model hospital which is being developed with the Carter Trusts and other volunteer trusts.

2.4 CHPPD is used to describe both the staff required and staff available in relation to the number of patients. It is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by every 24 hours of in-patient admissions (or approximating 24 patient hours by counts of patients at midnight). It can be broken down by grade – initially registered nurses and healthcare support staff, but ultimately bands/grades within these groups and all other staff groups contributing to ward-based care, including Allied Health Professionals. While total CHPPD will be reported, it will be split into registered nurses and healthcare support workers to ensure skill mix and care needs are met.

2.5 Demonstrating sufficient staffing is one of the essential standards that all health care providers must meet in order to be compliant with CQC requirements and we have been required to publish staffing data since April 2014.

2.6 The Trust remains compliant with the 10 expectations within the NQB guidance

2.7 The data which we have been providing has been:

- 6 monthly Trust Board report re: Safe staffing
- Board level report detailing planned and actual staffing for the previous month.
- Monthly report published on the Trust's website, and uploaded onto NHS Choices website. Nursing/Midwifery staffing levels each shift (planned and actual) displayed at ward level.

Boards must, at any point in time, be able to demonstrate to their commissioners that robust systems and processes are in place to assure themselves that the nursing, midwifery and care staffing capacity and capability in their organisation is sufficient to provide safe care. All NHS Trusts are accountable to NHS Improvement and will be expected to provide assurance that they are implementing the NQB staffing guidance and that, where there are risks to quality of care due to staffing, actions are taken to minimise the risk.

3. Methodology

3.1 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.

3.2 The Safer Nursing Care Tool (SNCT) is an evidence based tool which allows nurses to assess patient acuity and dependency.

3.3 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).

3.4 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.

3.5 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.

3.6 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.

3.7 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.

3.8 The Contact care time audit also has been undertaken in assessment and rehabilitation units. This tool is based on the Productive Series where nursing and Allied Health Professionals 'activity' is monitored and measured to determine what time is needed to provide direct patient care and what might be seen as not adding value .

4. NICE Guidance Compliance

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4.1 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.

4.2 Electronic Prescribing will support capturing and auditing this data.

4.3 Red flag events can be defined as events that prompt an immediate response by the Registered Nurse in charge of the ward.

4.4 A robust system and process is already in existence which captures adverse incidents through DATIX.

5. Benchmarking data

5.1 The ward nursing staffing levels and skill mix are reviewed at a minimum twice yearly.

5.2 The wards' skill mix is agreed for each early, late and night shift for both weekdays and weekends.

5.3 The ratios are identified as 'beds to Registered Nurse' to establish the RN to patient ratio and also Registered to un-registered ratio.

5.4 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.

5.5 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.

5.6 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.

5. Patient Acuity Summary

6.1 A full breakdown of patient acuity and dependency by ward is attached to this report. **(**

7. Recommended Establishments versus Actuals

7.1The 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.

7.2 The Shelford data is compared with the professional judgement model and the funded establishment to ensure a consistent approach to monitoring staffing level requirements.

7.3 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 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.

8. Supervisory Ward Managers and Structured Ward Rounds

8.1 Ward Managers are allocated 2 Supervisory shifts per week with the fundamental role of providing visibility to patients and leadership to the nursing team.

8.2 The move to allow Ward Managers to become completely supervisory has been partially realised, thus enhancing the delivery of safe, high quality care.

9. Agency Reduction

9.1 In October 2015 the Agency Rules5 were implemented and this was followed in November, February and April with the associated introduction of the pay cap.

9.2 The Trust are continuing to work towards meeting the national recommendations in reducing the use of non-framework agencies, through collaborative working with staff.

9.3 The implementation of these rules is within the context of providing safe patient care.

9.4 Approval for all non-framework agency use has been and continues to be made by the Director/ Deputy Director of Nursing to ensure a robust and safe risk assessment is undertaken.

9.5 A weekly attended by Director of Nursing, Director HR and Director of Finance has been instrumental in delivering this reduction.

9.6 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.

9.7. This is predominantly requested for specialist nursing skills required for Critical Care, Theatre and the Accident and Emergency Dept.

9.8. Agency spend data indicates that there has been a slight reduction in Non-framework agency use;

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 A review of Datix nurse staffing reports is monitored and reported monthly.

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

11.1 The nurse staffing related risks on the Trust's Corporate Risk Register relate to:

- :Increasing use of Bank and Agency
- Increased acuity of patients
- Failure to attract staff for specialist roles

12. Safe Midwifery staffing for maternity settings.

12.1. In August 2015, the Trust Executives approved the business case for the recruitment of an additional 5 WTE midwives (Band 5) and 5 WTE maternity support workers (Band 3).

12.2. 3 of the 5 midwives were already in post as the budget was over-establishment (2 public health midwives unfunded and 1 additional Midwife).

12.3. The additional staff have now been recruited and commenced in post.

12.4. It was agreed at the time by the Trust Executive team that a Birth-rate Plus (BR+) review would be undertaken.

12.5 The BR+ review was completed, the initial findings were considered to include duplication of community activity, and therefore further clarification was requested.

12.6 The BR + review indicated a need for 5 Band 5 development midwives over and above current establishment (of which 2 have already been approved and appointed) and 7 WTE Band 2 HCAs to develop into the Band 3 Maternity Support Workers.

12.7. A detailed review of maternity staffing which will be presented to the Executive Committee in September 2016 and will include recommendations on:

1.1. Pathway efficiencies
1.2. Role reconfiguration
1.3. E:Rostering

13. Staff Development

13.1**.** There is a formal development programme for Band 7 and matrons during the past 12 months.

13.2. There is also a band 6 development programme which launched in autumn 2016.

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 822.98 compared to Shelford WTE required 818.59WTE).

14.2 The difference in Shelford data suggested the trust were 2.21 RN under established with the DMOP care wards and over established by 4.37 HCA.

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

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.

Ward	Number of beds	Average daily levels of care					Nursing establishment WTE				Shelford Recommended WTE			ratio rn to patient
		level 0	level 1a	level 1b	level 2	level 3	ward funded WTE	RN WTE	HCA WTE		SNCT WTE required	SNCT RN	SCNT HCA	days
1A	31	14.5	4.6	11	0	0	37.36	20.63	16.73		38.5	22.7	7.7	1-8
1B	16	12.9	2.1	1	0	0	21.6	14.1	7.5		21.9	14.2	14.7	1-6.4
1C	32	17.2	11.9	1.2	0.4	0	45.6	29.7	15.9		44.9	29.2	15.7	1-6
1D	32	18	8	6	0	0	37.87	21.81	16.06		37.5	21.8	15.7	1-5.5
1E	17	2.5	0.1	13.2	0	0	25.1	15.1	10		25.2	15.1	10.1	1-5
2A	20	4.7	5.4	8.7	1.1	0	29.1	17.6	11.5		29.1	17.4	11.7	1-8
2B	32	1.1	14.8	16.1	0	0	38.28	22.3	15.98		39	22.4	16.6	1-8
2C	32	0.5	14.2	16.3	0.1	0	37.61	22.4	15.21		39	22.4	16.6	1-8
2D	23	7.9	7.3	6.3	0	0	29.9	18.2	11.7		29.7	17.8	11.9	1-8
2E	26	22	0	0	0	0	22.87	15.8	7.07		21.78	13.06	8.72	1-6.4
3 Alpha	18	11.6	3.1	0	0	0	15.5	9.5	6		15.7	9.4	6.3	1-8
3A	28	11	2.9	2.8	0	0	19.5	12	7.5		19.7	11.8	7.9	1-8
3B	27	1.9	0	21.1	0.1	0	38.8	23.4	15.4		38.3	23	15.3	1-6.4
3C	32	3.8	2.7	23.2	0	0	39.05	22.53	16.52		39	23	16	1-6.4
3D	32	14	13.6	3	0	0	38	22.8	15.2		37.8	22.6	15.2	1-8
3E Gynea	18	12.6	1.4	0.2	0	0	14.3	8.8	5.5		14.8	8.8	6	1-8
3E Med	12	7.4	1.7	2.6	0.1	0	13.8	8.5	5.3		14.1	8.5	5.6	1-6
4A	32	25.8	3.2	2.8	0.1	0	35.3	21.3	14		34.8	20.9	13.9	1-6.4
4B	16	13.9	0.2	0	0	0	13.8	8.5	5.3		14.1	8.5	5.6	1-8
SAU	16	14.3	0.7	0	0	0	19.1	12.7	6.4		19.3	12.6	6.7	1-8
4C	32	21	6.8	4.3	0	0	37.8	22.8	15		37.4	22.4	15	1-8
4D	12	0.4	0.1	7.4	0.5	0	17.7	10.9	6.8		14.2	8.52	5.68	1-4
5A	32	12.4	16.1	6.2	0	0	44.24	20.77	23.47		44.24	23.4	23.47	1-8
5B	32	4.6	26	1.3	0	0	44.24	21.08	23.16		42.67	23.6	19.07	1-8
5C stroke	16	0.9	4.7	0.2	5.7	0	22.67	13.8	8.87		21.8	12.9	8.9	1-8
5C dmop	16	1.3	5.3	8.6	0	0	22.67	13.8	8.87		23.2	13.9	9.3	1-8
5D	23	7	10.8	5	0	0	28.1	15.05	13.05		29.8	16.4	13.14	1-8
Duffy	28	12	14	4	0	0	33.12	15.6	17.52		31.1	17.4	12.44	1-8

TRUST BOARD PAPER

Paper No: NHST(16)080
Subject: HR/Workforce Strategy & Indicators Report
Purpose: To provide assurance to the Board of the Trust's achievement of workforce indicators that supports the achievement of the Trust's Corporate objectives specifically to developing organisation culture and supporting our workforce.
Summary: The Trust is committed to developing the organisational culture and supporting our workforce. This paper summarises achievements/progress to date.
Corporate Objective met or risk addressed: Developing organisation culture and supporting our workforce
Financial Implications: N/A
Stakeholders: Staff, Managers, Staff Side Colleagues and Patients
Recommendation(s): The Trust Board are requested to accept the report and to note the areas of achievement/progress against corporate objectives.
Presenting Officer: Anne-Marie Stretch, Director of Human Resources & Deputy CEO
Date of meeting: 27th July 2016

HR/Workforce Strategy & Indicators Report

July 2016

1. Developing our Workforce Culture

As part of our continuing development as an organisation, the Trust recognises that our staff are central to the provision of excellent services to our patients, their loved ones, commissioners and our local communities. The Trust HR & Workforce Strategy states that the Trust's vision is to develop a management culture and style that:

- ❖ Empowers, builds teams and recognises and nurtures talent through learning and development.
- ❖ Is open and honest with staff, provides support throughout organisational change and invests in Health and Wellbeing.
- ❖ Promotes standards of behaviour that encourages a culture of caring, kindness and mutual respect.

2. Purpose of the Paper

This paper is presented to provide assurance to the Board that the workforce strategies, objectives and indicators are being achieved to support the Trust's objectives, specifically to develop organisation culture and supporting our workforce.

3.0 Organisation Development and Education & Training

3.1 Appraisals & Personal Development Plans

In the reporting period 74% of staff completed an appraisal and created a personal development plan against a target of 85% (which is 100% of available staff). The Leadership and Organisational Development Team is working with managers and staff to support the Trust in achieving compliance by delivering a range of appraisal related training to ensure the year-end target of 85% is achieved by March 2017. During this reporting period (Q1), 51 members of staff with responsibilities for completing appraisals attended management training workshops and 9 members of staff attended workshops to help prepare them for an appraisal.

In July we commence piloting new appraisal documentation (non-medical staff) and are involving both Appraisee's and their Appraisers who will be actively undertaking appraisals during July – October 2016. This provides an opportunity for staff to be at the forefront of shaping appraisal conversations going forward.

3.2 Corporate Induction

During Q1, 62 new starters completed corporate and local induction on joining the Trust. As part of the local induction, new starters identify any initial training needs with their line manager or clinical lead to support them in performing their roles effectively.

We are currently undertaking a review of the Corporate Induction, utilising some of the new technology available, such as the staff app, to ensure that staff are inducted within the organisation effectively and efficiently.

3.3 Mandatory Training

During Q1, 912 members of Trust staff attended Mandatory Training, across 25 sessions. The mandatory training programme is currently under review. An audit of our partner organisations across the North West as well as a review of the guidelines around Mandatory training from the CQC and the Core Skills Framework highlighted an opportunity for us to change the compliance refresher period from 12 monthly to 24 monthly for clinical staff. This means that we are able to release more hours back into clinical practice to support our delivery of five star patient care.

We are also completing a re-design of the Mandatory Training programme, ensuring that the training is of high quality, engaging and caters for the needs of all learners. This includes looking at a blended approach to delivery including eLearning which will offer more choice and flexibility around accessing the training as well as catering for a broader range of learning styles. Pilots will commence over the coming months to ensure that statutory compliance is protected.

3.4 Apprenticeships

The Trust continues to lead the way in the North West in delivery of Apprenticeships. To date 161 Learners completed or are progressing through their Apprenticeship. In this quarter 17 new learners were enrolled onto an apprenticeship qualification in:

- Business Administration (4)
- IT Specialist (2)
- IT (1)
- Healthcare (1)
- Clinical healthcare support (4)
- Team leading (3)
- ITC functional skills (2)

3.5 Conflict Resolution Level 1 and Customer Service

Conflict Resolution training, (Level 1) is provided to staff to develop the communication skills required to deliver professional and effective customer care to patients, visitors and other members of staff, appreciate barriers to effective communication and to enable staff to manage the more challenging situations. 10 workshops, including 107 staff were delivered between April and June 2016.

3.6 Developing Personal Resilience

Developing Personal Resilience is a workshop designed to equip the workforce with the capability to cope with the challenges they might experience in their life, their jobs, their teams and departments. It introduces various skills, coping mechanisms and strategies to understand themselves and situations more effectively. It is also recommended for all staff returning from long-term absence where they have been suffering from stress/depression or anxiety. In Q1 workshops were delivered to 25 staff.

3.7 Healthwrap (Prevent)

The Trust has a statutory duty to provide training to staff relating to preventing radicalisation and terrorism. In order to achieve full compliance by March 2018, the Trust

will need to deliver the 'Healthwrap' course to 1240 selected staff. During the quarter, 80 staff attended a Healthwrap workshop across 12 sessions.

3.8 Mentorship Programme

The Trust Mentorship programme aligned to the NHS Leadership Academy remains a popular scheme. To date the Trust's scheme has 137 Mentors registered of which 70 are currently actively supporting Mentees.

3.9 Coaching Skills for Managers Workshop

This workshop has been developed for team leaders and managers at all levels across the Trust to develop their communication skills and support the use of coaching style conversations with individuals and their teams. During this period, approximately 4 workshops were delivered, this included 28 staff attending these workshops.

3.10 Enhancing our Leadership & Developing Teams

The Trust provides a range of Organisational Development (OD) interventions to support the effectiveness and performance of teams including;

3.10.1 Ward Manager and Matrons Leadership Development Programme:

The first cohorts of Ward Managers and Matrons have now completed the Leadership Development Programme. Objectives of the programme are closely aligned to those of the North West Leadership Academy Front-line Programme. Over the course of the Programme delegates have attended sessions to:

- Build their confidence and capability to have even greater influence on care.
- Learn to recognise what they do well and find out what they can do better.
- Develop new skills and put them into practice immediately back in the work-place.
- Develop enhanced people management skills.
- Take the opportunity to think about how their behaviour impacts on those around them.
- Learn skills to drive and sustain change, building a culture of patient-focused care at a departmental or functional level.
- Gain greater business acumen.

The Programme is designed to support staff in their roles as leaders of teams/departments; to reflect and build on their strengths, their role and abilities, learn new skills and how they can pro-actively take this learning back to the work-place. The programme has evaluated very well and, as a result of this successful pilot, we aim to open the programme up to all staff in Leadership roles across the organisation.

3.10.2 Bespoke Leadership and Organisational Development Team interventions

The Trust provides a range of Organisational Development interventions including; facilitated team meetings/activities to support objectives/expectations, team coaching, individual coaching, supporting action planning, leadership and team effectiveness. To date this has involved delivery of:

- MBTI (Myers Briggs Type Indicator) & Belbin Team Roles workshops.

- Collaborative Dialogue session is currently being facilitated with staff from the Special Care Baby Unit. These sessions provide a simple yet powerful method for groups and teams with mutual interests to focus on what matters, foster collaborative dialogue, actively engage, share & create new knowledge, listen together for insights & deeper questions, link & connect ideas and seek realistic possibilities. As a result of these conversations, teams have introduced new processes and procedures which are creating greater efficiencies and contributing to improved patient care.

3.11 Assessment/Development Centres

The Learning & Organisational Development Team in partnership with HR colleagues have designed and supported 10 management assessment centres and interviews involving the assessment of observed exercises and administration of psychometrics tests, with the team providing one to one feedback sessions to candidates on psychometrics/ability tests and leadership competencies to support their on-going personal development.

3.12 Senior Management Development

The Trust supports its senior clinical and non-clinical leaders through a comprehensive range of leadership development opportunities provided by the national NHS Leadership Academy and local interventions including development centres and coaching programmes. These ensure the Trust remains a well-led organisation and supports talent management and retention. To date 17 senior leaders are either enrolled or have successfully completed a range of NHS Leadership Academy programmes. Leaders at Divisional Manager level and above are now offered the support of an External Leadership Coach as part of their continuous professional development.

3.13 Staff Engagement

The Trust carried out the 2015 NHS Staff Satisfaction Survey during October and November. The feedback results were published in March 2016 with a report of findings and appropriate action plan presented to the April 2016 Trust Board meeting. Results were extremely positive again, building on the improvements made in last year's survey. In addition, the Trust continues to run a rolling programme of Team Talk lunches with the Chief Executive and a Non-Executive Director, listening events with a range of staff groups/departments across the Trust, bespoke leadership and cultural surveys, Board members shadowing on wards and Senior Management working in clinical areas either job shadowing or working as a HCA or Qualified Nurse, as part of the Staff Engagement Strategy and promoting the Trust Speaking out Safely Campaign.

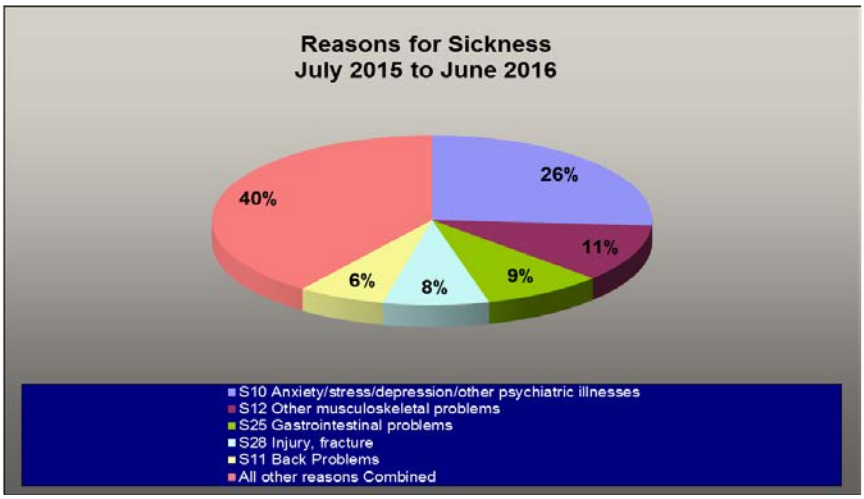
4.0 Health, Work & Wellbeing (HWWB) - Supporting our Workforce

The Trust has submitted evidence to Safe, Effective Quality Occupational Health Service (SEQOHS) to enable maintenance of accreditation of the nationally required standard for Health, Work & Wellbeing Services. The Trust continues to provide HWWB support to external organisations e.g. local CCGs and as the Lead Employer c.2,200 junior doctors in training on behalf of Health Education North West. This service will be extended to a further c. 1200 Junior Doctors in Training from HEE West Midlands with effect from August 2016.

The Trust's Lead Employer Service has been invited to host the new Physicians Associate trainee role on behalf of Health Education England North to be deployed in Trusts across the North West. The HWWB Department have carried out employment checks and vaccinations for 160 Physicians' Associates who have commenced employment on the two year training scheme on the 1st February 2016.

4.1 Health, Work & Wellbeing – Key Performance Indicators

The Trust's HWWB services are aligned to needs identified via analysis of the main reasons for absence whilst also offering services to keep staff healthy and in work.



4.2 Fast Track Physiotherapy Service

The Trust offers a fast track telephone triage, assessment and treatment service to staff who report they have a muscular skeletal condition while in work or on a period of sickness absence. The table below shows the number of referrals April – June 2016. Staff who are assessed as requiring "hands on" treatment are referred to the Trust's in-house Physiotherapist.

Month	Apr	May	Jun	Total
No. of Referrals	19	21	18	58

Of the 58 referrals the analysis is as follows:

- 55% at work with pain
- 41% off sick due to injury
- 1 inappropriate referral

4.3 Counselling Support

The Trust offers a comprehensive counselling support service to staff via self or management referral. Ideally staff will access early support to proactively manage personal situations.

Number of Staff Accessing Counselling Support - April to June 2016				
Month	**April**	**May**	**June**	**Total**
Number of Staff	21	17	20	58

4.4 Employee Assistance Programme (EAP)

The Trust continues to offer a 24 hour staff support programme via an external provider in Q4 and Q1 a total of 21 staff accessed a range of services as detailed in the table below.

	% of staff by reasons
Breakdown of Support Provided	
Ad-hoc Counselling Support from Helpline	24
Legal / Financial Advice	10
Support Call Referral	10
In-House Services	5
Telephone Counsellor Referral	33
Email Enquiry	19
Primary Presenting Issues	
Personal Presenting Issues	52
Work Related Presenting Issues	14
Legal and Financial Issues	10
Information about the Service	24

4.5 HWWB Health Referral Service

The Trust provides an ill health referral service to Trust Staff, Medirest/Compass Employees and the Lead Employer Junior Doctors in training. This can either be self or management referral. Staff are triaged and referred to see either an Occupational Health Physician, Occupational Health Nurse or the Occupational Therapist. The table below highlights that 480 staff have visited the HWWB service for a health assessment or support during Q1.

Number of Referrals to HWWB April to June 2016	
Type of Referral	Number
Ill Health Appointments with a Doctor	183
Ill Health Appointments with a Nurse	209
Appointments with Occupational Psychologist	88
Total	480

4.5.1 Mental Health Nurse Support - April to June 2016

In addition to the ill health referral service as outlined in 4.5 above, the Trust also provides contact with staff by the Trust's Mental Health Nurse via telephone contact within 48 hours of reporting absence with a reason of stress/depression or anxiety to offer support. The mental health nurse also has follow up clinics with staff to provide face to face on-site support.

Reporting Period	Mental Health Nurse Support
April	8
May	14
June	43
Total Contacts	**65**

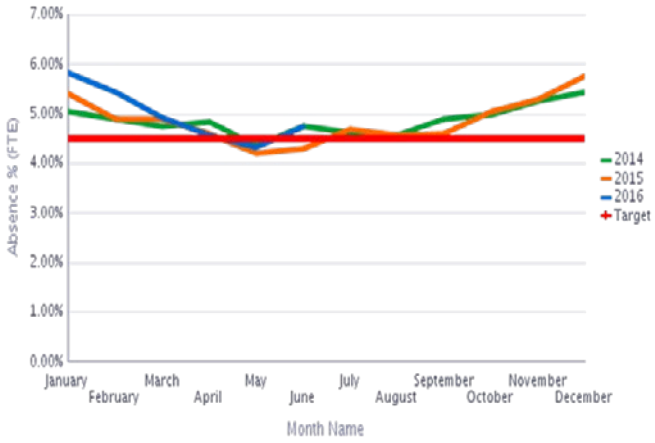
5.0 Human Resources Advisory Team – Attendance Management

In addition to the support provided to staff and Trust management to improve the health and wellbeing of staff by the HWWB service, the Human Resources Advisory Team assist managers in the consistent application of the Trust's Attendance Management policy. The most recent benchmarking data available covers the period from April 2016 to June 2016 and shows that the Trust sickness absence for this period (4.58%) compares favourably to Alder Hey Children's Hospital (4.96%), Royal Liverpool and Broadgreen (5.06%) but slightly worse than Warrington & Halton NHS at 4.40%.

Benchmarking of Cumulative Absence April 2016 to June 2016				
	St Helens & Knowsley	Royal Liverpool	Alder Hey	Warrington & Halton
Trust Overall Absence Rate	4.58%	5.06%	4.96%	4.40%
Add Prof Scientific and Technical	5.59%	4.78%	2.95%	4.41%
Additional Clinical Services	6.99%	8.36%	6.48%	5.95%
Administrative and Clerical	3.63%	4.85%	4.14%	3.56%
Allied Health Professionals	2.81%	3.19%	2.89%	4.39%
Estates and Ancillary	6.02%	9.16%	9.76%	4.83%
Healthcare Scientists	2.93%	2.33%	2.61%	2.99%
Medical and Dental	1.08%	0.76%	1.45%	1.29%
Qualfied Nursing Staff	4.62%	5.46%	5.74%	4.92%

Analysis of sickness over the last 3 years indicates that sickness is very similar to during 2014.

3 Year Absence Trend Analysis



Month	2014	2015	2016
January	5.06%	5.40%	5.83%
February	4.91%	4.90%	5.44%
March	4.75%	4.89%	4.93%
April	4.85%	4.59%	4.56%
May	4.37%	4.21%	4.33%
June	4.75%	4.30%	4.74%
July	4.62%	4.67%	
August	4.57%	4.55%	
September	4.90%	4.58%	
October	4.98%	5.05%	
November	5.25%	5.28%	
December	5.45%	5.77%	

5.1 Human Resources Advisory Team - Attendance Management Positive Action

The HR Advisory Team continues to work closely with Ward Managers, Matrons and Directorate Managers to address sickness absence, with particular attention being paid to areas with the highest levels of sickness absence. They also continue to work in partnership with the HWWB team to tackle long term sickness absence and support staff back to work. There are currently 67 members of staff who have been absent for 3 months or more. Action plans are in place for all long term sickness absence cases and are updated regularly by ward managers, the HR Advisory Team and HWWB. Across the Trust, there are 543 employees on stages of the attendance management policy and 182 employees on levels of the policy, (i.e. with underlying conditions).

Stages and Levels	MCG	SCG	St H	CSSG	Pharmacy	Corp	Non Clinical
Stage 1	**174**	**96**	**26**	**45**	**9**	**23**	**94**
Stage 2	**17**	**19**	**6**	**8**	**4**	**2**	**14**
Stage 3	**1**	**1**	**0**	**1**	**1**	**0**	**1**
Stage 4	**0**	**1**	**0**	**0**	**0**	**0**	**0**
Level 1	**32**	**31**	**21**	**21**	**1**	**4**	**24**
Level 2	**12**	**10**	**4**	**10**	**1**	**0**	**3**
Level 3	**1**	**1**	**0**	**1**	**0**	**0**	**5**
Level 4	**0**	**0**	**0**	**0**	**0**	**0**	**0**

6.0 Enhancing Workforce Systems & Processes

6.1 eRostering

Key to the efficient rostering practice is the monitoring and analysis of available metrics from within the Roster Perform reporting element of the e-Rostering system. Following the roll-out of the system to all 47 ward areas, including the Emergency Department and Theatres, a management reporting tool has now been enabled.

A report and action plan of these key metrics will be presented to the September 2016 Trust Board Meeting. This will further demonstrate the Trust's progress towards the achievement of the Workforce Carter action plan as received by the Quality Committee on the 19th July 2016.

6.2 Medical & Dental Workforce e-Job & Jnr Drs eRostering

Following the announcement of the details of the new 2016 junior doctor contract the Trust will be commencing the phased implementation of Junior Doctors eRostering in line with the national timeline and will be appointing a 'Guardian of Safe Working Hours' who will be a member of the Trust's workforce. Consultant job plans are currently being refreshed for 2016/17.

7.0 Payroll Services

The Trust's Payroll Department currently provides a service to c.25,000 NHS staff across Cheshire and Merseyside, this will be extended to include HE West Midlands GP Doctors in Training with effect from August 2016.

Achievements in Q1 include:

- Expanded product portfolio that we offer to clients to include weekly payroll and an E-Expenses locally developed system
- Increased number of clients, now 21 clients
- Project plan for implementation of E-Expenses by April 2017
- Reduction of staffing costs to recognise efficiencies from service improvement processes and 'e' functionality
- Significant assurance received from Internal Audit by MIAA
- Extension of all client contracts that expired in 2015/2016
- Supported the Trust through the pensions Auto Enrolment and Re Enrolment process

8.0 Workforce Planning – Staff in Post

Staff Group	WTE		
	Apr-16	Jun-16	Difference
Add Prof Scientific and Technic	146.77	147.57	0.80
Additional Clinical Services	869.93	886.06	16.13
Administrative and Clerical	934.64	943.32	8.68
Allied Health Professionals	228.72	222.26	-6.46
Estates and Ancillary	290.74	290.39	-0.35
Healthcare Scientists	177.98	183.38	5.40
Medical and Dental	402.28	399.33	-2.95
Nursing and Midwifery Registered	1,346.62	1,348.36	1.75
Grand Total	**4,397.68**	**4,420.68**	**23.00**

Since April 2016, the figure for staff in post increased overall by 23 wte. Increases in Additional Clinical Services staff accounted for most of this increase (HCAs, AHP Assistants etc.) Administration and Clerical staff increases in June includes the workforce required to provide services for the additional Lead Employer arrangements. i.e. HE West Midlands. There are currently 91 wte staff on maternity leave, with 46 wte of staff on secondment from their substantive posts, 5 wte on Career Break and 4 wte

are suspended/action short of suspension.

8.1 Workforce Planning - Staff Turnover Rates

Turnover rate is currently 9.2% for the YTD (June 2015 to July 2016) The Trust benchmarks the lowest against all local Acute Trusts and against the national average of c.14%.

Staff Group	St Helens & Knowsley			Royal Liverpool			Alder Hey			Warrington & Halton		
	Headcount	Leavers Headcount	Staff Turnover	Headcount	Leavers Headcount	Staff Turnover	Headcount	Leavers Headcount	Staff Turnover	Headcount	Leavers Headcount	Staff Turnover
Add Prof Scientific and Tech	151	14	9.27%	375	46	12.20%	211	34	16.10%	176	17	9.69%
Additional Clinical Services	1013	85	8.39%	1062	104	9.79%	412	49	11.89%	767	110	14.34%
Administrative and Clerical	1106	83	7.50%	1638	174	10.62%	624	86	13.78%	837	118	14.11%
Allied Health Professionals	230	33	14.35%	418	48	11.48%	154	11	7.20%	315	48	15.24%
Estates and Ancillary	435	32	7.35%	137	10	7.33%	217	16	7.37%	415	42	10.12%
Healthcare Scientists	209	36	17.27%	282	36	12.79%	112	12	10.71%	99	11	11.11%
Medical and Dental	472	33	6.99%	680	178	23.18%	275	53	19.24%	299	77	25.75%
Qualfied Nursing Staff	1485	154	10.37%	1963	191	9.73%	1046	112	10.75%	1085	163	15.02%
Total	**5101**	**470**	**9.20%**	**6555**	**787**	**12.00%**	**3053**	**373**	**12.21%**	**3993**	**586**	**14.67%**

Retirement Profile Next 12 Months – both Men and Women Aged 65

Staff Group	Retirements Due	3 Months	6 Months	9 Months	12 Months
Add Prof Scientific and Technic	1	1	2	2	2
Additional Clinical Services	28	37	38	43	48
Administrative and Clerical	20	23	28	30	34
Allied Health Professionals	3	3	3	3	3
Estates and Ancillary	34	35	36	39	42
Healthcare Scientists	3	3	4	5	5
Medical and Dental	5	5	5	7	11
Nursing and Midwifery Registered	17	18	24	26	26
Grand Total	**111**	**125**	**140**	**155**	**171**
Nurses Aged 55+	**249**	**262**	**273**	**289**	**303**
Nurses Aged 60+	**85**	**88**	**92**	**95**	**103**

The above table above indicates that in the next 12 months there will be a high number of Sister/Charge nurses and staff grade nurses who will be of retirement age should they choose to retire. The Trust is taking steps to include analysis about level of potential retirement into workforce plans. Planning assumptions are now factoring in different retirement ages for a variety of staff groups dependent on their roles and also their age based on recent changes to both the state retirement age and changes to NHS pensions schemes. The Trust is also promoting flexible retirement options to encourage staff who wish to retire to consider return on a part time basis so the Trust retains the knowledge and skills of highly experienced staff.

9.0 Recruitment & Retention

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9.1 Registered General Nursing (RGN)

As at 30th June 2016, there were 43.7 wte Registered General Nursing (RGN) vacancies within the Trust. The recruitment of 63.6 wte external applicants are the final stages of the recruitment process for these positions. Proactive recruitment is on-going to ensure a proactive recruitment planning cycle.

In order to address expected nursing gaps due to e.g. retirement and career progression, recruitment days were held in February & June. The Trust made the following offers to fill trained nursing gaps in the Department of Medicine and Older People (DMOP), General Surgery, Burns and Plastics, Respiratory, Gastroenterology and General Medicine.

Offered	Total
June	17
February	39
Total	56

There is a further nurse recruitment day scheduled on the 3rd September 2016. In order to maximise attraction, the Trust has been working with the Media Department to enhance advertisement of these events and will be placing extended adverts in media outside of the Merseyside Area, i.e. Manchester Evening News, Manchester Metro as well as targeting the radio, the RCN Bulletin and all Job Centres and their partners across Knowsley, St Helens and Liverpool areas. In addition, all 3rd year student nurses from the 3 universities will receive regular advance email notifications regarding the recruitment events.

1 to 1 meetings with matrons have taken place to assist in establishing and agreeing on-boarding activities for applicants, i.e. successful candidates to receive a 'welcome pack' containing information on the Trust and the details of a dedicated contact from the team they will be joining, who will involve them in various activities: coffee mornings, shadowing and attending team meetings to help familiarise with the new work environment.

Use of the recruitment Facebook page has been increased to both support the recruitment days and to boost attraction to on-going recruitment.

The Trust launched a mobile 'app' on the 23rd June which is being used to support on-boarding activities to aid retention of applicants.

Work is currently being scoped out to develop and deliver a series of key performance indicators for all recruitment activities within the Trust. These KPI's are expected to centre on reducing time to hire and will include both quantity and qualitative recruitment data, to support and engender an ethos of continuous improvement within the recruitment function. To facilitate this, it is expected that a series of SLA's will be developed with key service providers within the Trust i.e. HW&WB etc. to ensure the optimum provision of all recruitment services.

9.2 Healthcare Assistant Recruitment (HCA)

The Trust recruits the majority of substantive Healthcare Assistants from the Trust's Bank after a period of bank working when they will have gained the required knowledge, skills and experience required and are already familiar with Trust policies and procedures. The Trust continues to hold regular recruitment drives to increase the number of Bank HCA's. A recruitment campaign held during March resulted in 63 HCA Bank worker offers, of which 45 have started in post. A further campaign has been held during June/ July and interviews are currently being scheduled.

9.3 Employee Online

The Trust Bank system is part of the e-rostering system so that managers can request shifts on-line when planning their rosters and ensure they have appropriate levels of staff. Following the enhancement of the bank system in June workers with the right skill match can now self-book onto shifts 24 hours per day in order to increase bank fill rate and avoid the need to agency workers.

10.0 HR Advisory Team Achievements

10.1 Mediation Service

Continued successful implementation of the Trust Mediation service, supporting colleagues at the Trust to resolve relationship issues or disputes at an early stage before relationship issues escalate further or recourse to formal processes. An additional two members of the team have also been trained in mediation – increasing our numbers of trained mediators readily available.

10.2 Organisational Development (O D) Plans

HR Business Partners and OD Lead supporting each Specialty to devise targeted Organisational Development plans to help drive improvements in organisational effectiveness. Plans are focussing on positive changes to people management, culture, competence, communications, systems, structures and leadership. These plans follow the Mckinsey 7s model which focuses on a holistic approach for transformational OD. Excellent feedback and progress has already been seen in areas such as Pharmacy and Maternity Services as a result of these interventions. The Workforce Council monitors and provides assurance to Quality Committee on the development and delivery of these plans which now also includes the OD Plans for the Emergency Department, Sexual Health and Pathology. Deep Dive cultural surveys have also been completed in targeted areas across the Trust to improve staff engagement and to inform future actions plans and the on-going development of our workforce.

10.3 Bespoke Training on HR Policy

As part of the Ward Manager and Matron Leadership Development Programme the HR Advisory Team delivered a bespoke targeted training session on key people management policies – attendance management, managing capability and disciplinary investigations. These sessions were designed by the HR Advisory Team to be interactive and engaging and the team received excellent feedback from all delegates who attended.

10.4 Employee Relations Case Tracker System

The HR Advisory Team is currently in the final stages of implementing a new electronic system which will allow the team to track all employee relations casework in a central system. The 'ER Tracker', is a flexible solution for tracking, recording and monitoring all employee relations cases such as investigations, grievances and also sickness. Managers involved in formal casework will receive reminders, documents such as letters, case evidence, referrals; PDP's can be uploaded and saved for current and future reference. A clear timeline is kept meaning reports can be generated and timescales for meetings such as Professional Standards can be provided. Information will be regularly uploaded from ESR, meaning that the system will also aid the Trust's obligation to report on FOIs, WRES, WRDS and Board suspension reports for example with much more reliability.

10.5 Organisational Change Programmes

As demonstrated in previous Workforce Council reports, it has been a busy year for Organisational Change across all Care Groups, particularly around the implementation of 7 day working in some areas. These changes have been effectively supported by the HR Advisory Team working in partnership with Staff Side colleagues. Early intervention and planning has helped us to achieve these changes with minimal disruption to staff morale, aided a smooth transition for staff affected and ultimately helped to bring about significant improvements to frontline patient services and patient experience.

11 Governance

The Workforce Council provides on-going assurance to the Quality Committee that policies and procedures ratified are legally compliant and in line with national guidance.

12 Recommendations

The Trust Board are requested to accept the Report, noting the areas of achievement/progress against corporate objectives and governance standards.

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)081
Title of paper: Executive Committee Assurance Report.
Purpose: To feedback to members key issues arising from the Executive Committee meetings.
Summary: 1. Between the 17th June and 14th July three meetings of the Executive Committee have been held. The attached paper summarises the issues discussed at the meetings. 2. Decisions taken by the Committee included measures to improve safeguarding training, the PAS replacement options for Board consideration and changes to mandatory training. 3. Assurances regarding safer staffing, application of contractual penalties, management of bank and agency usage, overseas doctor recruitment, IPR, progress on accommodation review, Corporate Risk Register, CQC action plan, BAF, Maternity Services Development STF allocation guidance, Pharmacy Growth in OP and Cancer 62 day performance were obtained. 4. There were no investment decisions taken. 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: 27th July 2016.

EXECUTIVE COMMITTEE REPORT (17th June to 14th July 2016)

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

23rd June

1. CCG eReferral

    1.1. Progress with implementation of the CCG plans for referral controls were discussed.

2. Bridgewater IT services

    2.1. Confirmed that constructive meeting have been held with Bridgewater representatives and outstanding invoices for 2016/17 resolved.

3. Safeguarding Report

    3.1. Phil Dearden updated on compliance against the training trajectories agreed with commissioners. All staff receive Level 1 through Mandatory Training; staff require Level 2 if they have direct patient contact, and Level 3 in specialist areas.

    3.2. Compliance at Levels 1 and 2 remains problematic and guidance has been sent to managers. To reinforce the message it was agreed that compliance would be linked to appraisals and revalidation. For consultant medical staff non-compliance would be referred to Terry Hankin for follow-up.

    3.3. In the case of the A&E Department it was agreed that a solution needs to be found which adequately accommodates the pressures within the department.

4. VTE

    4.1. SR reported on the continuing challenge with VTE assessments. New systems are in place along with training and education; however the targets are still not being met. SR and KH are meeting with doctors to discuss further. CW will produce flow diagram to demonstrate the process to Committee.

5. PHE review

    5.1. SR updated the Committee on the recent pseudomonas cases in the Burns Unit. SR confirmed that all appropriate and necessary actions had been undertaken, and this had been confirmed by PHE who will visit on 30th June.

6. Electronic Patient Record

    6.1. CW, Rowan Pritchard-Jones (RPJ) and Mark Hogg went through the paper planned for the June Board meeting. Long discussion held, and RPJ confirmed the preferred clinical solution. CW gave assurance on the processes followed and rigour applied.

    6.2. The phased implementation and the total costs over a 10 year period was scrutinised in detail. It was acknowledged that a new system will also provide opportunities to work more efficiently and effectively, which should improve patient safety and reduced operational and administration costs.

7. Accommodation Review

    7.1. Initial options to increase bed spaces were discussed. It was agreed that timescales were required and grading of the modifications proposed (e.g. must have and desirable). Noted that none of the proposals are currently funded in the Capital Programme.

7.2. It was agreed that a scheme for forward wait for theatre, and a mock-up 4-bed bay would be progressed. Update back to Committee on 14 July.

8. HSJ National Patient Safety Awards

8.1. SR advised that she and Neal Jones are attending the awards in London, at which the Trust has two nominations.

7th July

9. Agency usage return

9.1. Malise Szpakowska provided an update on bank and agency staff usage. This indicated that further work is still required to address agency expenditure which is above the target limit set, and the use of agency HCAs.

9.2. Ongoing difficulties in recruiting to medical staffing posts were discussed, along with the need to consider alternative staffing solutions.

10. FY2 changes

10.1. Colette Hunt briefed members on the success of the junior doctor overseas recruitment campaign with Brno, and of the planned expansion to the scheme.

11. Review of penalties

11.1. Nicola Broderick provided information on the final outcome on 2015/16 contract sanctions and of the 2016/17 proposals (excluding CQUINS which were previously covered).

11.2. There are 44 contractual sanctions with varying financial penalties with a value of circa £5m. The level of risk for each was discussed and the lead officer confirmed.

12. Community service tender

12.1. AR updated the Committee on the potential options being considered by St Helens CCG for the future provision of community services.

13. Mandatory training proposals

13.1. AMS briefed members on the revised plans for delivering mandatory training to clinical staff and the aspiration to expand the use of eLearning with the upgrade of the IT platform.

14. C&M Women and Children's Services Partnership Programme Board

14.1. AMS briefed members on progress with the current vanguard initiative, and the parallel work within the Alliance LDS for delivering improved services for women and children.

15. Outlier policy

15.1. RC confirmed that the revised proposals for outlying medical patients in surgical beds are currently being considered by the care groups and will be presented to the Committee on 21st July.

16. Trust Board agendas

16.1. The agendas for the Trust Board meeting on 27th July were agreed.

14th July

17. Integrated Performance Report (IPR)
    17.1. Chris Yates presented the draft IPR highlighting any relevant performance issues and management responses.
18. Accommodation Review
    18.1. Nicola Bunce and the accommodation review team updated their progress on options for better utilising the Whiston site for clinical demands. Executives received assurance on key stakeholder engagement and requested further work on options discussed with expected costs adjustments for next update.
19. Corporate Risk Register
    19.1. Nicola Bunce presented paper and it was accepted with minor adjustments.
20. BAF
    20.1. Nicola Bunce presented paper and it was accepted with minor adjustments.
21. CQC Action Plan
    21.1. Nicola Bunce presented paper and it was accepted with minor adjustments.
22. Pharmacy Business Plan - Growth
    22.1. Kevin Hardy presented on a paper which provided assurance to the OP growth being at 25% for prescribing directorates. Further analysis highlighted variation in dispensing activity and costs within directorates over time. This was to be investigated to see if opportunities were available to reduce variations.
23. Cancer 62 day wait with RCA summary
    23.1. Rob Cooper presented a paper which assured the committee on 62 day cancer performance and actions planned to achieve expected targets by March 2017 or sooner.
24. Maternity OD Plan
    24.1. Sue Mundy and Claire Scrafton updated the committee identifying the methodology employed for the OD plan and current RAG status of the action plan. It was requested that they consider the KPIs which would measure improvements recognising this might be both hard and soft intelligence.
25. STF Funding Guidance
    25.1. Sue Hill presented on the recently published national guidance describing how the national STF funding will be allocated to providers.

ENDS

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD MEETING

Paper No: NHST(16)082
Subject: Review of the Board Assurance Framework (BAF) – July 2016
Purpose: For the Board to review the BAF and agree proposed changes.
Summary: The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its strategic plans and key long term objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in March 2016. As this is the first review during 2016/17 the Trusts annual objectives have been aligned to the long term strategic objectives to ensure that all areas of importance to the Board are covered by the BAF. The Board is asked to review the proposed changes to the BAF recommended by the Executive Committee and determine if the proposed actions and additional controls are sufficient to mitigate the strategic risks being managed by the Trust, in accordance with the level of risk appetite acceptable to the Board. **Key to Changes:** ~~Score through~~ = proposed deletions Blue Text = proposed additions Red = overdue actions There are no proposed changes to the scoring of any of the risks (either to increase or to decrease the scores), since the last review.
Corporate Objective met or risk addressed: To ensure that the Board has put in place sufficient controls to assure itself that risk to the delivery of its strategic objectives can be effectively managed.
Financial Implications: None arising directly from this report
Stakeholders: NHSI, CQC, Commissioners
Recommendation(s): To approve the proposed changes to the BAF
Presenting Director: Sue Redfern, Director of Nursing, Midwifery and Governance
Committee date: 27th July 2016

St Helens and Knowsley Teaching Hospitals NHS Trust – Board Assurance Framework 2016/17

Review – July 2016

Strategic Risks - Summary Matrix

Vision: 5 Star Patient Care

Mission: To provide high quality health services and an excellent patient experience

BAF Ref	Long term Strategic Risks	Strategic Objectives					
		We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes	We will be the hospital of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will be a sustainable and efficient organisation
1	Systemic failures in the quality of care	✓		✓	✓	✓	✓
2	Failure to agree a sustainable financial plan with commissioners	✓		✓		✓	✓
3	Sustained failure to maintain operational performance/deliver contracts	✓	✓		✓	✓	✓
4	Failure to protect the reputation of the Trust			✓			✓
5	Failure to work in partnership with stakeholders	✓	✓	✓	✓		✓
6	Failure to attract and retain staff with the skills required to deliver high quality services	✓				✓	✓
7	Major and sustained failure of essential assets, infrastructure	✓	✓	✓			✓
8	Major and sustained failure of essential IT systems	✓	✓	✓			✓

The BAF will be reviewed quarterly by the Executive Committee and the Trust Board.

Alignment of Trust 2016/17 Objectives and Long Term Strategic Aims

2016/17 Trust Objectives	Strategic Aims					
	We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes	We will be the hospital of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will be a sustainable and efficient organisation
Five star patient care - Care						
Five star patient care - Safety						
Five star patient care - Pathways						
Five star patient care - Communication						
Five star patient care - Systems						
Organisational culture and supporting our workforce						
Operational performance						
Financial performance, efficiency and productivity						
Sustainability and Transformation Plans						

Risk Scoring Matrix

Impact Score	Likelihood /probability				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible (very low)	1	2	3	4	5

Likelihood – Descriptor and definition
Almost certain - More likely to occur than not, possibly daily (>50%)
Likely - Likely to occur (21-50%)
Possible - Reasonable chance of occurring, perhaps monthly (6-20%)
Unlikely - Unlikely to occur, may occur annually (1-5%)
Rare - Will only occur in exceptional circumstances, perhaps not for years (<1%)
Impact - Descriptor and definition
Catastrophic – Serious trust wide failure possibly resulting in patient deaths / Loss of registration status/ External enquiry/ Reputation of the organisation seriously damaged- National media / Actual disruption to service delivery/ Removal of Board
Major – Significant negative change in Trust performance / Significant deterioration in financial position/ Serious reputation concerns / Potential disruption to service delivery/Conditional changes to registration status/ may be trust wide or restricted to one service
Moderate – Moderate change in Trust performance/ financial standing affected/ reputational damage likely to cause on-going concern/potential change in registration status
Minor – Small or short term performance issue/ no effect of registration status/ no persistent media interest/ transient and or slight reputational concern/little financial impact.
Negligible (very low) – No impact on Trust performance/ No financial impact/ No patient harm/ little or no media interest/ No lasting reputational damage.

BAF Ref	Risk Description	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
1	Systemic failures in the quality of care									
	Cause: • Failure to deliver the Clinical and Quality Strategy • Failure to deliver CQUIN element of contracts • Patient experience indicators decline • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting Effects: • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage Impact: • Harm to patients • Loss of reputation • Loss of contracts/market share	5x4= 20	• Quality metrics and clinical outcomes data • Safety thermometer • Quality Board Rounds • Complaints and claims • ~~Friends and Family scores & response rates~~ • Incident reporting • IPR monitoring • Quality Governance structure • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with lead CCG • NHSI Accountability Framework • Appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC Action Plan • Medicines Optimisation Strategy	To Board; • IPR • Patient Stories • Quality Board Round reports • Quality Committee and its Councils • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Staff Survey • Friends and Family scores • Nursing Strategy • Mortality Review Reports • Quality Account • Internal audit • Clinical and Quality Strategy • National Inpatient Survey • Sign up to safety Indicators Other; • National clinical audit programme • External inspections and reviews • PLACE Inspections • Reports • CQC CIH Inspection Report • Learning Lessons League • IG Toolkit results	5 x2 = 10		~~Maternity Service Independent Peer Review report~~ Consistent achievement of the VTE screening target Achievement of the national targets for AKI and Sepsis Introduction of the midwifery led care pathway for women having low risk births	Development of a new Complaints Management system and performance monitoring - October 2015 Achievement of complaints response times targets for 2016/17 – March 2017 Delivery of the CQC Action Plan (December 2016) ~~Preparation for the CQC re-inspection of areas rated as requires improvement (June 2016)~~ ~~Assessment of weekend mortality (May 2016)~~ Revised Clinical and Quality Strategy to support the delivery of the STP – July 2016 Plans for implementing the four key 7-day service standards - March 2017 Stroke Service integration with WHH - March 2017 Weekend mortality improvement plan - September 2016	5 x 1 = 5	KH/ SR

BAF Ref	Risk Description	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
2	Failure to agree a sustainable financial plan with commissioners									
	Cause; • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to delivery LTFM, including growth and CIP • Failure to control costs • Failure to implement transformational change at sufficient pace • Failure to meet the TDA 4 tests and secure national PFI support • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions Effects; • Failure to meet statutory duties • TDA Escalation status increases • Failure to progress FT application Impact; • Unable to deliver viable services • Loss of market share • External intervention	5 x 5 = 25	• IBP/LTFM • Business Planning • Budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 5 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review) • Contract monitoring and reporting • Contract review Board and CQPG • Activity planning and profiling • IPR • NHSI monthly monitoring submissions • Creation of a PMO to support delivery of CIP and service transformation • Signed Contracts with all Commissioners • Application of agency caps • Internal audit programme	To Board; • Finance and Performance Committee • Annual financial plan • Finance report • IPR • Statement of Internal Control • Annual Accounts • Audit Committee • Grant Thornton CIP Review and Report • SLM Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports • Annual audit programme • ~~Medicine Redesign Impact and progress Report.~~ Other; • NHSI monthly reporting • Contract Monitoring Board	5 x 4 =20	Agree a shared health economy financial and sustainability strategy Develop 2016 - 19 detailed CIP plans ~~Agreement of a financial recovery plan as part of 2016/17 Sustainability and Transformation fund acceptance~~	Commissioner engagement in joint long term financial modelling and planning Resolution of all financial disputes with Bridgewater NHSFT ~~Establishment of Merseyside and Cheshire structure and governance for agreeing the 5 year Sustainability and Transformation Plan (STP) 2016 - 2021~~	~~Agree a STP for the Trust and with the STP footprint (June 2016)~~ ~~Negotiation of contracts for 2016/17 that support sustainability and financial recovery and make clear the activity assumptions and caveats to delivering the performance and access target improvement trajectories (April 2016)~~ Develop skills models for capacity and demand modelling - September 2016 PMO impact assessment and ROI - March 2017 Develop a detailed STP implementation plan with Alliance LDS partners - October 2016	4 x3 = 12	NK

BAF Ref	Risk Description	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
3	Sustained failure to maintain operational performance/deliver contracts									
	Cause; • Failure to deliver against national performance targets (ED, RTT, Cancer etc) • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting Effects; • Reduced patient experience • Poor quality and timeliness of care leading to poorer outcomes • Failure of KPIs and self-certification returns • Increases in staff workload/stress Impact; • Potential patient harm • Loss of reputation • Loss of market share/contracts • External intervention	4 x 4 = 16	• NHS Constitutional Standards • Care group activity profiles and work plans • Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIST review of A&E performance • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • Membership of CCG System Resilience Groups • Internal Urgent Care Action Group (UCAG) • Data Quality Policy	To Board; • Finance and Performance Committee • IPR • System Resilience Plan • Annual Operational Plan • ~~TDA Annual Operational Plan~~ • Data Quality audits Other; • Contract review meetings/CQPG • NHSI monitoring and escalation returns/sitreps • CCG CEO Meetings	4x4 = 16	Mid-Mersey SRG Emergency Access Target action plan to reduce NEL hospital admission rate Speciality level capacity and demand delivery plans for 2016/17	Long term health economy emergency access resilience and urgent care services plans	~~Benefits realisation from the A&E Turnaround programme (April 2016)~~ ~~Agreement of A&E improvement trajectory for 2016/17 with Commissioners (April 2016)~~ ~~Agreement of capacity plans for 2016/17 planned activity programme May 2016~~ Agreement of a Whiston Hospital medium term Accommodation Development plan - September 2016 Implementation of the DTOC Rapid Improvement Event Action Plan - September 2016	4 x 3 = 12	PJW

BAF Ref	Risk Description	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
4	Failure to protect the reputation of the Trust									
	Cause; • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff engagement and involvement • Failure to maintain CQC registration/Good Rating • Failure to report correct or timely information Effect; • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff • Increased external scrutiny/review • Delay in FT application timetable Impact; • Reduced financial viability and sustainability • Reduced service safety and sustainability • Reduced operational performance • Increased intervention	4 x 4 = 16	• Communication and Engagement Strategy • Communications and Engagement Action Plan • ~~Membership Strategy~~ • Workforce Strategy • Publicity and marketing activity • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement programme • Trust internet and social media monitoring and usage reports	To Board; • Quality Committee • Audit Committee • Communications and Engagement Strategy • IPR • Staff Survey • Complaints reports • Friends and Family • Staff F&F Test • PLACE Survey • National Cancer Survey • Francis action plan • Referral Analysis Reports • Market Share Reports • CQC national patient surveys • CQC Inspection ratings • Annual assessment of compliance against the CQC fundamental standards Other; • Health Watch • CQC • TDA Escalation Rating	4 x 3 = 12	Regular media activity reports , including social media, to the Board Develop a new Communications and Engagement Strategy for 2016 – 2019 (July 2016)		Review of corporate reporting and scheme of delegation for approval for external reports – October 2015 New Trust intranet to be developed and launched - July 2016 Plans to improve patient communications and information - November 2016	4 x 2 = 8	AMS

BAF Ref	Risk Description	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
5	Failure to work effectively with stakeholders									
	Cause; • Different priorities and strategic agendas of multiple commissioners • Unable to create or sustain partnerships • Competition amongst providers • Complex health economy • Poor staff engagement • Poor community engagement • Poor patient and public involvement Effect; • Lack of whole system strategic planning • Inability to secure support for IBP/LTFM • Potential loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff Impact; • Unable to reach agreement on collaborations to secure clinically and financially sustainable services • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff • Failure to win new contracts • Increase in complaints and claims	4 x 4 = 16	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCC/ Workforce Council • Patient and Public Engagement and Involvement Strategy • CCG CEO Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • CCG Board to Board Meetings • CCG Representative attending StHK Board meetings • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Merseyside and Cheshire Sustainability and Transformation Planning governance structure • Acute Alliance LDS Exec to Exec working • StHK Hospitals Charity annual objectives	To Board; • Quality Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports • Francis Action Plan • TDA IDM's • Review of digital media trends and trust mentions • Monitoring of and responses to NHS Choices comments and ratings • Charitable funds committee	4x3 = 12	Annual programme of engagement events with key stakeholders to obtain feedback and inform strategic planning Agreement of the process and governance arrangements to support the STP footprint planning for the June 2016 five year plan submission and subsequent implementation	STP performance and accountability framework reports to Board	~~Quality Account to record how patients have been involved in service improvement and re-design – May 2016~~ Re-fresh stakeholder mapping and engagement plans as part of the renewal of the Communications and Engagement Strategy – July 2016 ~~Alliance LDS STP Plans (June 2016)~~ STP and Alliance shared implementation plans and accountability structures - October 2016	4 x2 = 8	AMS

BAF Ref	Risk Description	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
6	Failure to attract and retain staff with the skills required to deliver high quality services									
	Cause; • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment Effect; • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff Impact; • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	5x4 = 20	• Team Brief • Staff Newsletter • Mandatory training • Staff benefits package • Health and Wellbeing Provision • Staff Survey action plan • JNCC/Workforce Council • Francis Report Action Plan • Education and Development Plan • HR Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Workforce Strategy Implementation Plan • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews • Workforce KPIs • Recruitment and Retention Strategy action plan • Nurse development programmes • Agency caps and usage reporting • LWEG/LETB membership • Speak out safely policy • ACE Behavioural standards	To Board; • Quality Committee • Finance and Performance Committee • IPR - HR Indicators • Staff Survey • Monthly Nurse safer staffing reports • Workforce plans aligned to strategic plan • Monitoring of bank, agency and locum spending • Monthly monitoring of vacancy rates and staff turnover • Staff F&FT snapshots Other • Annual workforce plans • HR benchmarking • Nurse staffing benchmarking	5x4= 20	Successful induction and orientation of overseas nurses (December 2016)	Junior Medical Cover following reduction in Deanery allocations Specific strategies to overcome recruitment hotspots RMO cover for St Helens in line with strategic site development plans and changing nature of patients Impact assessment of the new apprenticeship levy for 2017	Specialist nurse staffing review – Phase II to review the deployment, roles and responsibilities and how supporting the longer term workforce requirements - October 2015 Complete E-Rostering roll out to all Medical Staff - September 2016. ~~Plans for Physicians Assistants and recruitment of newly qualified Doctors – March 2016~~ Specialist nurses to dedicate time to research and training - January 2017 Systems for capturing and reporting staff innovation and suggestions - December 2016 Departmental Development and Succession Plans - March 2017	4 x 2 = 8	AMS

BAF Ref	Risk Description	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
7	Major and sustained failure of essential assets or infrastructure									
	Cause; • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire Effect; • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective or • Increase in complaints Impact; • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 4 = 16	• New Hospitals / Vinci Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • Capital programme • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy	To Board; • Finance and Performance Committee • Finance Report • Capital Programme • Audit Committee • I.P.R. Other; • Major Incident Plan • Business Continuity Plans • ERIC Returns • PLACE Audits • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee, to capture: ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance	4 x 2 = 8	3 – 5 Year Estates, Accommodation and Equipment Strategy to support the long term strategic sustainability and transformation plan being developed by the Trust and Merseyside and Cheshire STP footprint (September 2016)		~~St Helens site strategy and accommodation development plan - December 2015~~	4 x 2 = 8	PW

BAF Ref	Risk Description	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
8	Major and sustained failure of essential IT systems									
	Cause; • Poor replacement or maintenance planning • Poor contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage • Lack of effective risk sharing with HIS shared service partners Effect; • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Inability to record activity and duplication due to reliance on back up paper or manual systems. • Loss of data or patient related information Impact; • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4x4=16	• HIS Management Board and Accountability Framework • IM&T Strategy monitoring • Procurement Policy • Information Strategy • HIS performance framework and KPIs • HIS customer satisfaction ratings	To Board; • HIS Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • MITc Other; • Major Incident Plan • Business Continuity Plans	4x2=8	Secure on-going HIS funding from CCGs and other partners	~~Review IT Strategy and system development /replacement plans in light of reduced national funding for IT projects and incorporate in to the new strategy~~	~~Current HIS IM&T Strategy expires in 2016, a new 3-5 year separate Trust and HIS strategies to be developed – June 2016.~~ New HIS shared service business agreement to be finalised with all partners –June 2016 Develop a final business case for the next generation of clinical IT systems - December 2016	4x2=8	CW

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)083
Title of paper: Corporate Risk Register Report – July 2016.
Purpose: To provide assurance to the Board that the Trust has effective systems and processes in place for identifying and managing risk and in particular those risks escalated to the corporate risk register (CRR).
Summary: The Trust has a Risk Management Council (RMC) which meets monthly to provide routine oversight of the risk management processes. The RMC reports to the Executive Committee and once a quarter the CRR is routinely reported to the Trust Board. This report is based on information taken from DATIX on 1st July. • The total number of risks recorded on the Trusts risk register is 596. • There are 17 high/extreme risks that have been escalated to the CRR, including; • o 3 new risks that have been escalated during June o The number of risks relating to specific staffing concerns has risen to 8
Corporate objectives met or risks addressed: The Trust has in place effective systems and processes to identify manage and escalate risks to the delivery of high quality patient care.
Financial implications: None directly from this report.
Stakeholders: Staff, Patients, Executive Committee, Trust Board, Commissioners.
Recommendation(s): It is recommended that the Trust Board note the report and the actions being taken to mitigate the CRR risks.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance.
Date of meeting: 27th July 2016.

CORPORATE RISK REGISTER REPORT – JULY 2016

1. Purpose

The purpose of this report is to provide an overview of the changes to the Trust's risks, and to focus on those risks which score 15 or above which are included on the Corporate Risk Register (CRR). This report is based on DATIX data extracted on 1st July 2016, and covers the changes to the risk register reported in June.

2. Risk Register Summary for the Reporting Period

This table provides a high level overview of the "turnover" in the risk profile of the Trust compared to previous months.

RISK REGISTER	Current Reporting Period 01.07.16	Previous Reporting Period 01.06.16	Previous Reporting Period 03.05.16
Number of new risks reported	36	34	22
Number of risks closed or removed	35	25	22
Number of increased risk scores	8	0	8
Number of decreased risk scores	11	10	12
Number of risks overdue for review	55	101	225
Total Number of Datix risks	**596***	**593***	**584**

**Includes 5 risks recorded but not scored at the time of reporting and 2 unapproved 2 high risks*

3. Trust Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
51	**26**	**27**	**66**	**9**	**135**	**49**	**90**	**37**	**82**	**11**	**6**	**0**	**0**
104 = 17.66%			**210 = 35.65%**			**258 = 43.80%**				**17 = 2.89%**			

**based on 589 risks (2 risks are unapproved high risks and 5 have been reported but do not yet have a current score)*

The risk profile for each of the Trusts Care Groups and for the collective Corporate Services are;

Care Group	Very Low Risk	Low Risk	Moderate Risk	High/ Extreme Risk	Total Number
Surgical	26	81	90	1	198
Medical	16	30	69	7	122
Clinical Support	6	8	18	1	33
Corporate	56	91	81	8	236
Total	**104**	**210**	**258**	**17**	**596**

4. The Trusts Highest Scoring Risks

Risks of 15 or above are added to the CRR. New risks reported in the month are formally reviewed and consistency checked by the Risk Management Committee.

Summary of the Corporate Risk Register – July 2016

KEY	Medicine		Surgical		Clinical Support		Corporate	

Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Review dates	Target Risk Score I x L	Action plan in place with target completion date
Achievement of Targets or Performance	1048	Failure of VTE Risk Assessment Targets	3 x 5 = 15	3 x 5 = 15	22/06/2016 - KH	Last 22/06/2016 Next 01/08/2016	3 x 2 = 6	Action plan developed and in place on Datix
	1152	Potential impact on quality of care, contract delivery and finance due to increased use of bank and agency	4 x 4 = 16	4 x 4 = 16	08/07/2015 - AMS	Last 05/05/2016 Next 15/07/2016	4 x 2 = 8	Escalation procedures in place
Clinical Care	1647	Risk to patients of Multi resistant pseudomonas on wards 4D and 4E	4 x 5 = 20	4 x 4 = 16	01/06/2016 - SR	Last 27/06/2016Next 14/07/2016	3 x 2 = 6	Action plan developed and reported via QC
Continuity of Service Delivery	351	Inability to provide a consistent service to GP referrals when GPAU used in times of escalation	3 x 4 = 12	3 x 5 = 15	11/01/2016 - SR	Last 10/06/2016Next 08/07/2016	3 x 2 = 6	Escalation process in place
	962	Risk to poor patient experience due to the physical layout on 1B not being conducive to the current service model	3 x 5 = 15	3 x 5 = 15	14/12/2015 - RC	Last 10/06/2016 Next 08/07/2016	3 x 2 = 6	Accommodation review and ambulatory care strategy being developed
	1653	Vascular demand and capacity	3 x 5 = 15	3 x 5 = 15	22/06/2016 - RC	Last 03/06/2016 Next 04/07/2016	3 x 2 = 6	SLA discussions on-going with RLBUHT
Finance, including achievement of CIP	1555	Failure to achieve financial plan in 2017/18 due to cost pressure from the introduction of an apprenticeship levy	3 x 5 = 15	3 x 5 = 15	01/04/2016 - AMS	Last 03/04/2016 Next 01/12/2016	3 x 4 = 12	Cost pressure for 2017/18 and will form part of financial plan
	209	Risk of failure to deliver the annual financial plan 2016/17	5 x 4 = 20	4 x 4 = 16	08/07/2015 - NK	Last 30/06/2016 Next 21/10/2016	4 x 3 = 12	Action plan in place
IT Systems or Equipment Failure	1237	IG risk due to the use of unencrypted USB drives	4 x 3 = 12	4 x 4 = 16	15/01/2016 - CW	Last 16/06/2016 Next 15/07/2016	Not provided	Action plan in place due to be completed in July
	609	IG risk due to lost or stolen mobile devices	4 x 2 = 8	4 x 4 = 16	15/01/2016 - CW	Last 16/06/2016 Next 15/07/2016	Not provided	Action plan in place due to be completed in July
Workforce capacity or capability	1285	Insufficient staffing levels on the frailty unit (1A) affecting patient safety and operational effectiveness	4 x 4 = 16	3 x 5 = 15	12/04/2016 - SR	Last 21/06/2016 Next 05/07/2016	3 x 3 = 6	Action plan in place
	1080	Risk to patient safety, quality and experience due to insufficient staffing levels on ward 2B/2C	4 x 5 = 15	3 x 5 =15	19/04/2016 - SR	Last 30/06/2016 Next 03/08/2016	2 x 2 = 4	Escalation process, safer staffing reporting and recruitment and retention strategy
	913	Patient safety risk due to staffing levels below establishment on DMOP	3 x 5 = 15	3 x 5 = 15	12/04/2016 - SR	Last 21/06/2016 Next 05/07/2016	2 x 2 = 4	Action plan in place
Workforce	762	Potential risk of the	4 x 4 =	4 x 4 =	08/07/2015 -	Last	4 x 2 = 8	Recruitment and

capability or capacity		Trust not being able to provide safe levels of staffing	16	16	AMS	05/05/2016Next 24/06/2016		retention strategy and staffing escalation process.
	1523	Risk to patient outcomes due to the inability to consistently fill all 3 blood science rotas	3 x 4 = 12	3 x 5 = 15	04/01/2016 - AMS	Last 30/06/2016 Next 31/08/2016	3 x 3 = 9	Action plan in place
	1337	Risk to patient quality, safety and experience due to the increased acuity on 3D	4 x 4 = 16	3 x 5 = 15	18/07/2015 - SR	Last 27/06/2016 Next 08/07/2016	2 x 2 = 4	Action plan in place
	1621	Risk to patient safety, quality and experience on Ward 3E due to established registered nurse numbers and band 2 are depleted	4 x 4 = 16	3 x 5 = 15	09/06/2016 - SR	Last 27/06/2016 Next 08/07/2016	2 x 3 = 6	Action plan in place

***blue text denotes new risks that have been escalated in June

ENDs

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)084
Title of paper: Quality Committee Assurance Report.
Purpose: The purpose of this paper is to summarise the Quality Committee meeting held on 19th July 2016 and escalate issues of concern.
Summary: Key items discussed were: 1. Medical Revalidation 2. CQC action plan 3. Ward dashboard 4. Safer staffing 5. IPR 6. Lord Carter review update 7. Francis action plan update 8. Complaints 9. Draft Maternity strategy 10. National End of Life Care audit
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: 27th July 2016

QUALITY COMMITTEE ASSURANCE REPORT

Summary of the discussions and outcomes from the Quality Committee meeting held on 19th July 2016.

Action Log

1. All actions on the log were reviewed.

Revalidation Report

2. Kevin Hardy (KH) summarised the report.

   2.1. In 2015/16 there were 315 doctors with a prescribed connection to St Helens & Knowsley Hospitals NHS Trust's Responsible Officer. Of these, 268 were fully appraised by 31st March 2016 (91.42%).

   2.2. Within the appraisal year 2015/16, he Trust had 77 trained appraisers. During June 2016, 25 trained appraisers attended an appraiser refresher training course. The Trust has funding to provide further refresher training sessions during 2016 and 2017.

   2.3. Between April 2015 – March 2016 98 recommendations were completed on time. Deferral requests were received for 12 people, due to maternity leave or investigation.

   2.4. KH informed the Committee that a great deal of effort is afforded to the process and CS commented that there is a revalidation steering group chaired by Dr Terry Hankin.

   2.5. The Quality Committee accepted the report and approved the statement of compliance.

CQC action plan update

3. Nicola Bunce (NB) provided an update for the Committee:

   3.1. 49 out of 57 actions have been completed. 7 actions are still in progress and remain on course. 1 action is overdue, which is the Maternity Strategy, an item on the Quality Committee agenda.

   3.2. The Trust commissioned MIAA to look at a cross section of 10 actions completed. The results have shown that all actions are fully implemented and embedded, although 2 needed a little more work; K2 training and bed rail assessment forms being used consistently across the Trust. This has been actioned and will be audited further.,

   3.3. NK commented that lessons should be learnt given the Trust felt actions were complete, but MIAA felt two were not yet embedded.

IPR

4. Nik Khashu (NK) summarised the IPR.

   4.1. There were 2 C.Diff positive cases in June. Year to date there have been 4 positive cases of which 1 has been submitted for appeal and another awaiting RCA before deciding whether to appeal.

   4.2. Sue Redfern (SR) updated the committee on the outbreak of Pseudomonas on the Burns Unit and Critical Care. Index case was a burns patient from Romania. Public Health England visited the Trust last month for a one day review – focus was on the bathroom and swabs have been sent out for typing.

4.3. Beds in the Burns Unit have been decommissioned and hospital beds and dynamic mattresses have been installed. SR has been in discussion with suppliers regarding dirty mattresses (45 have been sent back). Weekly meetings are now taking place, but internal processes must be in place. No new cases identified.

4.4. The Committee were informed that a case of MRSA was reported on 4th July. The RCA meeting was held on 18th July. The patient had four admissions since the end of May with a long history of Diabetes and was known to Urology. An action plan should be complete by the end of the week, but it was felt that this matter should be brought to the attention of the Board.

4.5. There were no falls that resulted in severe harm or death. There were no grade 3/4 pressure ulcers.

4.6. Performance for VTE assessment for May was 89.08%.

4.7. The Committee discussed the VTE figures and if the new software system will assist in assessments. KH said it would not solve the problem but the system would allow the eVTE form to be accessed in A&E before a patient is admitted. The ongoing problem is that there are not enough junior doctors on the ward to carry out the assessments and not enough capacity.

4.8. The organisation led on a system wide event in May to sustainably reduce DTOC (delayed transfer of care) patients. This focus has demonstrated a significant reduction in this group of patients. Pre event, the number of delayed patients in the Hospital stood at 87, this now stands at 67.

4.9. ED performance was 73%. Following an in depth review of the ED, undertaken by the Project Management Department, several “must do” actions have been identified.

4.10. The Trust is reporting against an annual plan of £3.328m surplus, as approved by the Trust Board and confirmed with the TDA.

4.11. As at the month of June, the Trust is reporting an overall Income & Expenditure surplus of £0.492m after technical adjustments, which is in line with agreed plan. Trust income is ahead of plan by £1.4m, but the Trust is not delivering the additional activity at the planned efficiency levels and expenditure on agency in June was £1.3m.

4.12. To date, the Trust has delivered £2.649m of CIPs, which is just behind the year to date plan by £0.218m. Capital expenditure to date is £0.197m out of a total plan of £5.15m and it is anticipated that we will spend the full annual budget of £5.15m.

4.13. Mandatory training compliance has improved slightly in month but is still 7.3% below the 85% target. Appraisal compliance has fallen in month to 10.6% below the 85% target. Recovery plans are in place in place for both appraisal and mandatory training continue to be impacted by operational pressures. Claire Scrafton (CS) informed the Committee that it had been agreed at the Executive Committee to extend the period of mandatory training from 12 to 24 months, which will alter the reporting figures.

4.14. Staff sickness for May was 4.3%; this is an improvement year on year but is 0.05% above the Q1 target. This is an improvement on March’s and April’s position with continued efforts and a targeted approach between HR and managers to drive down sickness absence rates.

4.15. SR reported on the Nutrition screening figures. She has met with Dr Theis to take this forward. A number of complaints have been received regarding fasting patients and then operations being cancelled. SR has asked for an audit to be undertaken.

Ward Dashboard report

5. SR summarised the report for the Committee.

5.1. The ward dashboard has been in development for some time and is used to highlight performance across a range of quality and performance measures. Training has been provided to ward managers in how to use the dashboard including its drill down facility to monitor their own areas performance.

5.2. SR reported on specific wards and the Committee discussed VTE, falls and medication errors.

5.3. Neal Jones (NJ) will review the scoring on the safety matrix as this requires further development.

5.4. Ali Kennah (AK) informed the Committee that there has been a degree of challenge regarding the figures in the report.

Safer Staffing report

6. NJ provided an update for the month of June.

6.1. Overall Trust fill rate was 101.47%. There were 20 ward areas with a fill rate below 90%, 12 wards for registered staff, 8 wards for care staff and 2 wards for both registered and care staff.

6.2. There was 1 moderate harm fall in June 2016. The episode took place on Ward 2C which fell below 90% for trained staff during June. However, on the date of the incident, the registered nurse fill rate actual was 102.6% of the planned level of care, and the untrained was 96.6% of the planned level of care.

6.3. The Committee discussed the new Care Hours per Patient Day (CHPPD), which remains a work in progress. David Graham (DG) asked if enough work is being done to deliver what is required as the system is developed. NK responded that the Trust had not really done Workforce Planning, but Workforce Reporting. SR said that we need to focus on medical and allied health professionals as well as nursing. This is on the CQPG and Directors of Nursing agenda.

6.4. CS provided an update on the overseas recruitment. To date, 9 nurses have passed the test required. The Trust is in the process of talking to a number of universities regarding running our own school of nursing, across the alliance. A paper will be presented to the Executive Committee.

Lord Carter review update

7. CS provided an update.

7.1. This is the quarterly update and the Trust is progressing as expected against the measures. We are well ahead of timeframes but work is needed to embed the actions; we remain on target.

Francis action plan update

8. CS provided an update.

8.1. CS discussed the role of the Guardian at the Trust and we must make an appointment by 1st October. We should leave the current structure of senior guardians in place, however, there is no funding for the new role. The national job template suggests Band 8A or 8B level, but it is up to the individual trusts as to how how they progress this as long as the role is established.

8.2. NK asked what the role encompassed. CS said it would be to help staff facilitate how they take concerns forward. A paper will be presented to the Executive Committee.

Complaints update

9. Sally Duce (SD) provided an update.

9.1. There were 93 1st stage approved complaints received during Q1, an increase of 11% in comparison to Q1 2015-16 when there were 84 and 55% compared to Q4 2015-16, when there were 60. This rise in 1st stage complaints is having an impact on the Trust's complaints management capacity and is being closely monitored.

9.2. The Trust responded to 67% of 1st stage complaints within the agreed time frames in Q1 compared to 61.4% in 2015-16. The top three complaint themes were:

9.2.1. Clinical treatment
9.2.2. Value and behaviours
9.2.3. Admissions and discharges.

9.3. DG commented that 33% of complaints were still outside the time frame and we need to develop a more efficient service or more resources. DG would report this back to the Board.

Draft Maternity Strategy

10. Sue Mundy (SM) summarised the report.

10.1. The purpose of the paper is to provide the Committee with an update of progress made towards developing and agreeing a Maternity Strategy for the Trust.

10.2. The priorities for Maternity are that women want to receive care from the same midwife, be involved in decision making and services should provide more opportunities for water to be used for pain relief and delivery.

10.3. The strategy has been out for consultation for a month, the closing date was 18th July. SM informed the Committee that she has received enough feedback to populate the strategy; the final draft will be finished by 15th August, then circulated for ten days and the final strategy prepared for 31st August.

10.4. DG suggested that perhaps Maternity could hold an event to launch the strategy.

National End of Life Care audit – presentation

11. Dr Anthony Thompson presented the National End of Life care audit, which provided benchmarking against national figures.

    11.1. DG said he would speak to the Chairman regarding a NED having specific responsibility for EOLC.

    11.2. SM commented that Maternity had a really good bereavement service which may well be worth sharing.

Feedback from Patient Safety Council

12. NJ reported:

    12.1. Key items discussed:

    12.1.1. There was 1 moderate fall harm in May.
    12.1.2. Patient safety thermometer performance was 98.66%
    12.1.3. No grade 3/4 pressure ulcers in May
    12.1.4. eVTE continues to fall before the 95% target at 89.08% in May.
    12.1.5. New acute care handover document approved.

    12.2. GM queried the 1 severe harm incident in the body of the report. NJ will email the details to GM.

Feedback from Patient Experience Council

13. SD reported:

    13.1. Key items discussed:

    13.1.1. Patient story – gentleman who had his surgical procedure cancelled at 6pm on the day of surgery, when he was scheduled for the afternoon list and PALS involvement to address his concerns.
    13.1.2. Patient care within Breast Cancer Services.
    13.1.3. KPI's
    13.1.4. Healthwatch
    13.1.5. Dignity Champions report
    13.1.6. Interpreter and Translation Services annual report – it was noted that interpreter activity is increasing dramatically year on year and no budget is available for this service.

Feedback from CQPG Meeting

14. NJ said that there was nothing that needed escalating to the Committee.

Feedback from Executive Committee

15. SR reported on meetings of the Executive Committee between 2nd June – 23rd June:

15.1. Decisions taken by the Committee included review of penalties risks, Therapy Services review, Apprenticeships briefing, Vascular Service and Safeguarding.

15.2. Assurances regarding the CQC action plan, management of bank and agency usage, Corporate Risk Register and CQUINS were obtained.

15.3. There were specific investment decisions regarding the Paediatric Consultant business case, Pharmacy business plan and Maternity staffing.

15.4. Items requiring escalation to the Quality Committee were:

15.4.1. VTE performance being below the required 95% for the past five months.

15.4.2. Burns peer review.

16. **Effectiveness of meeting**

GM said that the timing of the meeting was excellent, discussion full and appropriate and the presentation by Dr Thompson was very clear and succinct.

17. **AOB**

None noted.

18. **Date of Next Meeting**

Tuesday, 20th September 2016.

TRUST BOARD PAPER

Paper No: NHST(16)085

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 July 2016

Summary:

Agenda Items

- **For Information**
  - Q4 SLR – Medicine
  - Bank & Agency Usage
  - NHSI – financial Planning Update
  - Carter Report update
  - STF funding

- **For Assurance**
  - HCA Sickness Update
  - PMO Review
  - A&E RIW Update
  - IT Priority 1 calls
  - CIP scheme – governance compliance
  - Integrated Performance Report Month 3 2016/17
  - Month 3 2016/17 Finance Report
  - Governance Committee Briefing Papers:
    - CIP Council

Actions Agreed

- Operational review of Duffy Suite to be discussed at Executive Committee
- A&E updated report to be presented each month
- HCA Sickness improvement plan to be presented in September
- Agency expenditure review to be presented in September
- PMO review to be updated in October
- Progress on Carter recommendations to be presented in December

Corporate objectives met or risks addressed: Finance and Performance duties

Financial implications: 2016/17 Annual Plan forecasting a £3.3m surplus, based on receipt of £10.1m Sustainability and Transformation Funding

Stakeholders: Trust Board Members

Recommendation(s): Members are asked to note the contents of the report

Presenting officer: George Marcall Non-Executive Director

Date of meeting: 27th July 2016

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

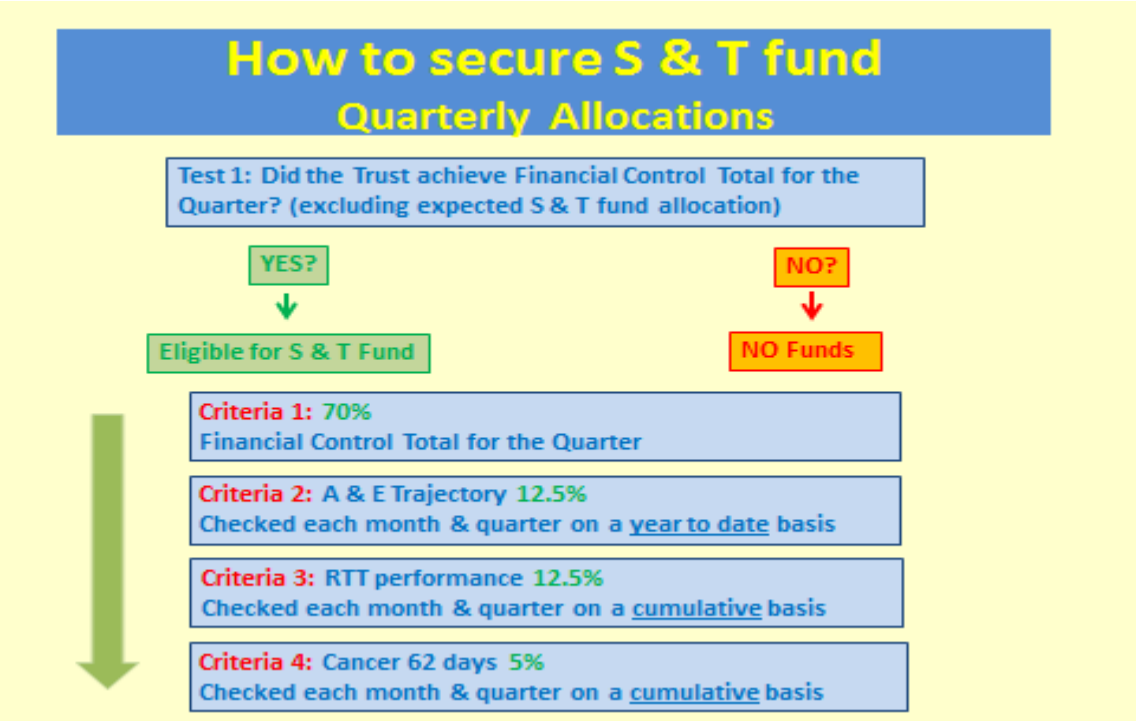
Paper No: NHST(16)086
Title of paper: Foundation Trust Application Programme – Update Report
Purpose: To provide the Board with a progress report on the Foundation Trust (FT) application programme, the development of the Sustainability and Transformation Plan (STP) for Cheshire and Merseyside, and the continued development of the organisations governance and leadership capability for the future.
Summary: This paper reports on the progress in responding to the national planning guidance, the requirement to develop place based 5 year sustainability and transformation plans and the on-going elements of the FT development programme. NHS Improvement (NHSI) have now published a draft Single Oversight Framework(SOF) for consultation, which set out proposals for how they will both support and performance manage all NHS provider organisations (both NHS Trusts and Foundation Trusts). NHSI plan to start using the final SOF from Q3 and until this time the Board Compliance and Provider Licence monthly declarations remain suspended. The draft SOF has not addressed the issue of the FT development pipeline, but NHSI anticipate that policy guidance on this issue will also be announced in the near future. This report provides an update on; 1. 2016/17 Planning and STP Development 2. NHS Improvement - Single Oversight Framework 3. Well Led Framework Action Plan
Corporate objectives met or risks addressed: Provide high quality sustainable services
Financial implications: This paper does not include a request for additional funding
Stakeholders: Patients, Staff, Alliance LDS Partners, Commissioners, NHSI
Recommendation(s): Members are asked to note the report
Presenting officer: Nik Khashu, Director of Finance and Information
Date of meeting: 27th July 2016

Foundation Trust Application Programme – Update June 2016

1. 2016/17 Planning and STP Development

- NHSI have now issued guidance on the allocation of the Sustainability and Transformation Fund (STF). A full briefing has been given to the Finance and Performance Committee on the implications and potential risks for StHK in securing the full £10.1m STF available.

  The diagram below illustrates how the allocations will be calculated



- The Cheshire and Mersey STP Footprint submitted its outline STP on 30th June, with input from each of the 3 Local Delivery Systems (LDS) areas. This has been reviewed by the national bodies and representatives from the STP met with Simon Stevens (NHSE) and Jim Mackey (NHSI) and their teams on 20th July.
- Following this review the 44 STPs and recognising that different areas were starting from different positions; STPs will either be given the approval to move ahead with their plans or will be required to do more work to develop their proposals.
- NHSI have reviewed all the Trust annual operational and financial plans and the provider sector is currently forecasting a £550m deficit for 2016/17. NHS providers have therefore been asked to review by the end of July, three areas to see if any further financial savings can be delivered;
  - Pay cost growth (planned for 2016/17 and actual in 2015/16)
  - Plans for back office and Pathology Services consolidation
  - Unsustainable service consolidation

2. NHS Improvement – Single Oversight Framework (SOF)Consultation

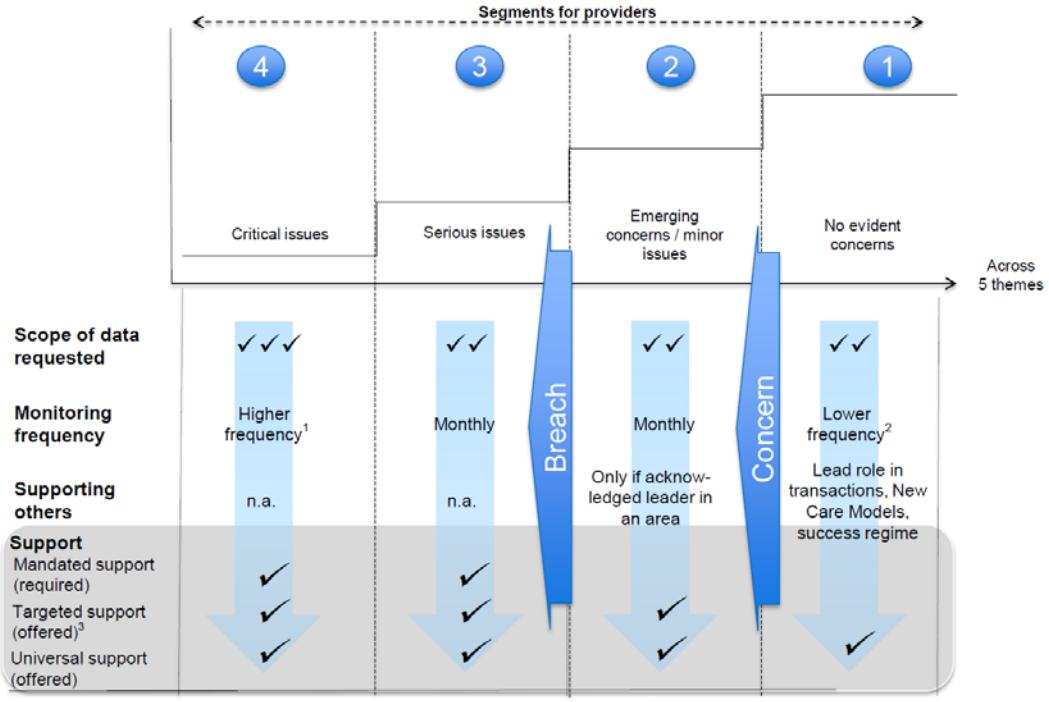
- NHSI has published its draft Single oversight proposals for consultation. The document sets out the performance framework that NHSI will use to assess NHS provider organisations and makes no distinction between NHS Trusts and Foundation Trusts in the way that performance and intervention will be managed.
- The draft SOF recognises that the current focus is on individual organisations and it asks for comment on how STP wide or other shared control totals to facilitate transformation and the delivery of the STPs could be incorporated.
- NHSI have proposed a performance framework based on 5 criteria; Quality of care (where it will work with the Care Quality Commission (CQC)), Finance and use of resources, Operational performance, Strategic change and leadership and improvement capability
- A new financial rating metric is proposed, which introduces several new measures;

Proposed financial rating metrics

Area	Metric	Definition	Score			
			1	2	3	4[1]
Financial sustainability	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	EBITDA margin	EBITDA/total revenue	≥5%	3-5%	0-3%	≤0%
	Change in Cost per Weighted Activity Unit[2]	Assessing provider efficiency by measuring its average cost increase for an average episode of care (smaller is better)	≤1.1%	1.1%-2.1%	2.1%-3.1%	>3.1%
Financial controls	Capital controls[2]	Distance above capital control total	<5%	0-5%	5-15%	≥15%
	Distance from Control Total or financial plan	**Providers with control totals:** Ytd actual surplus/deficit vs. Ytd trajectory **Providers without control totals :** Ytd actual I&E surplus in comparison to the Ytd plan I&E surplus[2]	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	Agency spend[2]	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

- The draft SoF also proposes a new performance assessment structure for Trusts, which allocates each organisation to one of 4 "segments" which will determine the level of monitoring, support and direct intervention that NHSI will provide;

Proposals for segmenting the provider sector



- The assessment of the organisations leadership capability will in part be based on the Well Led Framework, which NHSI are adopting.
- The SOF sets out the expectation that every provider organisation will adopt and develop internal capability in one of the recognised improvement methodologies.
- The closing date for responses to the consultation is 4th August, and NHS Providers are collating a joint response on behalf of provider organisations
- If this segmentation is adopted it is anticipated that at the current time the majority of NHS provider organisations would be allocated to segments 3 and 4.

3. Well Led Framework Action Plan

There are 47 identified actions on the Trust well led framework action plan, of which 45 of which were due for completion by the end of June 2016. 41 of these actions have been completed, 3 are in progress and 1 is behind schedule. The 2 remaining actions are due to be completed in July 2016, and then a further self-assessment will be undertaken.

Well Led Leadership Framework Action Plan – Following 2nd Self-Assessment

June 2016 – Summary Progress Report

Domain	Total No of Actions	Actions Due to be Completed	Actions Completed (Green)	Actions due and in progress (Amber)	Actions not completed and overdue (Red)
Planning and Strategy	18	16	13	3	0
Capability and Culture	15*	15	14	0	1
Process and Structure	12	12	12	0	0
Measurement	2	2	2	0	0
Total	**47**	**45**	**41**	**3**	**1**

***1** action re FT membership and governors on hold

ENDS