St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 29th JUNE 2016
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

A G E N D A				Paper	Presenter
09:30	1.	Employee of the Month - June			
09:35	2.	Apologies for Absence			Richard Fraser
	3.	Declaration of Interests			
	4.	Minutes of the previous Meeting held on 25th May 2016		Attached	
		4.1	Correct record & Matters Arising		
		4.2	Action list	Attached	
Performance Reports					
09:45	5.	Integrated Performance Report		NHST(16) 064	Nik Khashu
		5.1	Quality Indicators		Sue Redfern/Kevin Hardy
		5.2	Operational indicators		Rob Cooper
		5.3	Financial indicators		Nik Khashu
		5.4	Workforce indicators		Anne-Marie Stretch
10:00	6.	Safer Staffing report		NHST(16) 065	Sue Redfern
10:10	7.	WRES update		NHST(16) 066	Anne-Marie Stretch

10:20	8.	Complaints, Claims & Incidents		NHST(16) 067	Sue Redfern
10:30	9.	ANTT Training update		NHST(16) 068	Sue Redfern
10:35	10.	Changes to Induction and Mandatory Training		NHST(16) 069	Anne-Marie Stretch
BREAK					
Committee Assurance Reports					
10:55	11.	Committee report – Audit		NHST(16) 070	Su Rai
		11.1	Adoption of annual accounts	NHST(16) 071	
11:05	12.	Committee report - Executive		NHST(16) 072	Ann Marr
11:10	13.	Committee Report – Quality		NHST(16) 073	David Graham
11:15	14.	Committee Report – Finance & Performance		NHST(16) 074	Denis Mahony
11:20	15.	Committee Report – Charitable Funds		NHST(16) 075	Denis Mahony
Other Board Reports					
11:25	16.	FT programme update report		NHST(16) 076	Nik Khashu
11:35	17.	Clinical & Quality Strategy		NHST(16) 077	Kevin Hardy
Closing Business					
11:45	18.	Effectiveness of meeting			Richard Fraser
	19.	Any other business			
	20.	Date of next Public Board meeting – Wednesday 27th July 2016			

TRUST PUBLIC BOARD ACTION LOG – 29TH JUNE 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***	AMS	29 Jun 16
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.	CW	27 Jul 16
3.	25.05.16 (8.6)	Sue Redfern will provide an update to the Board regarding ANTT training.	SRe	29 Jun 16
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	NK	29 Jun 16
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.	KH	27 Jul 16
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.	ALL	29 Jun 16

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(16)064
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.

There have been no cases of MRSA bacteraemia during April. and May The Trust has a zero tolerance of MRSA.

There was 1 C.Difficile (CDI) positive cases in May. Year to date there have been 2 positive cases of which 1 will be submitted for appeal. The annual tolerance for 2016-17 is 41 cases. The Trust recently received a letter from NHSI to offer congratulations on achieving the CDI objectives for 15/16.

There were no hospital acquired grade 3 / 4 pressure ulcers in April or May.

There was 1 fall resulting in severe harm and 1 fall resulting in moderate harm in April.

Performance for VTE assessment for April was 89.96%

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

YTD HSMR (Apr-15 to Feb-16) is 96.3. The latest available 12 month HSMR (Mar-15 to Feb-16) is 96.6.

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: 29th June 2016

Operational Performance

A&E performance (Type 1) was 79.7% which is a deterioration from the previous month and continues to be a significant concern. The ED Lean project focusing on improving the triage process and the amount of time spent waiting for clinical intervention continues with the Emergency Ambulatory care Unit pathways commencing in June. The NHSI facilitated Rapid Improvement Event, to sustainably reduce delayed transfers of care, took place in May, resulting in several immediate improvements in current process with further ongoing development s in train to deliver the required reduction . All other key national access standards continue to be 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
For the month of May 2016 (Month 2) the Trust is reporting an overall Income & Expenditure surplus of £0.293m after technical adjustments which is slightly behind agreed plan (by £43k).

CIP
To date the Trust has delivered £1.706m of CIPs which is just behind the year to date plan by £0.167m. 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 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 £5.15m.

Cash
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 .

Human Resources

The quarter 4 Staff Friends and Family Test survey results show the Trust is maintaining its excellent performance compared to the national position, particularly in relation to staff likely to recommend the Trust to friends and family if they needed care.

Mandatory training compliance has improved slightly in month and is 7.9% below target . Appraisals has fallen slightly in month to 2.6% below 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 33% of capacity in month.

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. This is an improvement on March'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

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	May-16	2.3%	2.4%	No Target	2.5%		Overall SHMI and HSMR within control limits, but not 5*. 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 not optimal but 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	▲	Sep-15	1.03		1.00						
Mortality: HSMR (Dr Foster)	Q	▲	Feb-16	72.8		100.0	96.3					
Mortality: HSMR Weekend Admissions (emergency) (Dr Foster)	Q	T	Feb-16	68.3		100.0	108.7					
Readmissions: 28 day Relative Risk Score (Dr Foster)	Q	T	Nov-15	99.0		100.0	100.8		Much improved over last 12 months. Still not 5*.	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	Feb-16	97.1		100.0	89.8		Sustained reductions in NEL LOS are assurance that medical redesign practices continue to successfully embed. The elective performance is believed to be partially a result of the shifting casemix to daycase, leaving an increasing volume of the more complex patients as inpatients.	Patient experience and operational effectiveness	To verify the assumption that the elective LOS performance is as a result of shifting casemix to daycases.	RC
Length of stay: Elective - Relative Risk Score (Dr Foster)	F&P	T	Feb-16	98.9		100.0	105.8					
% Medical Outliers	F&P	T	May-16	0.2%	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	May-16	50.0%	48.1%	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	▲	Apr-16	79.4%	79.4%	90.0%	79.9%		eDischarge performance below target, albeit compares favourably with neighbours.		Drive to ensure realtime completion on ward rounds to improve compliance.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients)	Q	▲	Apr-16	94.1%	94.1%	95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E)	Q	▲	Apr-16	98.8%	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	▲ £	May-16	0	0	0	0		There have been no never events since May 2013. Theatre harm has now reduced by more than 50% overall since the implementation of the safer surgery project in October 2013.	Quality and patient safety	The implementation of NatSSIPS is on target for a July delivery against a September target to further reduce episodes of harm during interventional procedures	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	May-16	98.9%	99.2%	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	An annual validation study will commence in June to ensure that the methodology is being applied appropriately.	SR
Prescribing errors causing serious harm	Q	T	May-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	▲ £	May-16	0	0	0	0		There was 1 C.Difficile (CDI) case in May. 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	▲ £	May-16	1	2	41	26					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		May-16	1	3	No Target	28					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	May-16	0	0	No Contract target	1		Pressure ulcer performance continues to improve. There were no grade 3 or 4 ulcers reported in May.	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	▲	Apr-16	1	1	No Contract target	21		The 1 severe harm fall in April places STHK harm from falls under the national benchmark at 0.10 against 0.15 nationally	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	▲ £	Apr-16	89.96%	89.96%	95.0%	93.31%		New electronic system introduced to allow eVTE assessment even when patients not on ADT.	Quality and patient safety	Intensive drive to improve VTE assessment in SAU, AMU & EAU in particular.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	May-16	1	2		38					
To achieve and maintain CQC registration	Q		May-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	May-16	94.3%	93.9%		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	May-16	0	2		1					

May-16

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	▲ £	Apr-16	95.9%	95.9%	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	▲ £	Apr-16	98.7%	98.7%	96.0%	97.8%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Apr-16	91.7%	91.7%	85.0%	88.6%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	May-16	95.2%	95.2%	92.0%	95.5%		Trauma & Orthopaedics continue to fail at a speciality level.	There is a risk due to the current medical bed pressures 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	▲	May-16	99.96%	99.98%	99.0%	99.99%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	May-16	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	May-16	0.9%	0.8%	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	▲ £	Apr-16	100.0%	100.0%	100.0%	99.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	May-16	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	May-16	79.7%	80.5%	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 ED Lean project focusing on improving the triage process and the amount of time spent waiting for clinical intervention continues with the Emergency Ambulatory care Unit pathways commencing June 20th.	RC
A&E: Total time in A&E: % < 4 hours (All Types)	F&P	▲	May-16	87.2%	87.8%	95.0%	89.4%					
A&E: 12 hour trolley waits	F&P	▲	May-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	▲ £	May-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	May-16	34	60		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 within agreed timescales	Q	T	May-16	15	30		159					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	May-16	78.9%	69.8%		42.7%					
Friends and Family Test: % recommended - A&E	Q	▲	May-16	86.8%	87.5%	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	▲	May-16	95.0%	94.9%	90.0%	96.4%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		May-16	100.0%	100.0%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	May-16	96.8%	97.1%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		May-16	100.0%	100.0%	95.1%	95.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		May-16	87.1%	89.5%	98.6%	98.6%					
Friends and Family Test: % recommended - Outpatients	Q	▲	May-16	94.2%	94.4%	95.0%	94.7%					

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	▲	Apr-16	4.6%	4.6%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.9%		Absence has decreased in April because of continued focus on areas with high levels of absence however is above target by 0.35%. Nursing is also above target by 0.6%. The Absence Support team have given increased support to mainly clinical areas. The highest reason for absence remains stress.	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	Apr-16	5.9%	5.9%	5.3%	6.0%					
Staffing: % Staff received appraisals	Q F&P	T	May-16	82.4%	82.4%	85.0%	87.2%		Appraisal compliance has fallen by 2.6%. For With Mandatory Training, we have seen a slight improvement however it is still 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. This continues to be eroded by the significantly high number of 'no shows' equivalent to 33% of available places being wasted in the current reporting period.	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 Executi8ve 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	May-16	77.1%	77.1%	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	Apr-16	0.7%	0.7%		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	May-16	2.0	2.0	2.0	2.0		The Trust's year to date performance is slightly behind 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	May-16	1,706	1,706	15,248	13,043					
Reported surplus/(deficit) to plan (000's)	F&P	T	May-16	293	293	3,328	(9,551)					
Cash balances - Number of days to cover operating expenses	F&P	T	May-16	19	19	2	2					
Capital spend £ YTD (000's)	F&P	T	May-16	41	41	5,150	4,169					
Financial forecast outturn & performance against plan	F&P	T	May-16	3,328	3,328	3,328	(9,551)					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	May-16	93.0%	93.0%	95.0%	94.2%					

APPENDIX A

		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-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	▲ £	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%	95.8%	100.0%	100.0%	100.0%	100.0%	85.0%		99.2%		
Lower GI	▲ £	100.0%	100.0%	100.0%	100.0%	77.8%	100.0%	84.6%	100.0%	100.0%	89.5%	100.0%	100.0%	100.0%	100.0%	85.0%		94.5%		
Upper GI	▲ £	100.0%	71.4%	100.0%	100.0%	100.0%	85.7%	71.4%	83.3%	100.0%	100.0%	100.0%	81.8%	75.0%	75.0%	85.0%		88.9%		
Urological	▲ £	77.8%	75.8%	82.4%	62.5%	100.0%	83.3%	76.7%	84.0%	79.2%	83.3%	83.3%	84.0%	85.7%	85.7%	85.0%		80.8%		
Head & Neck	▲ £	80.0%	50.0%	100.0%	50.0%	100.0%		83.3%	100.0%	50.0%	57.1%	60.0%	50.0%	50.0%	50.0%	85.0%		71.1%		
Sarcoma	▲ £	100.0%		50.0%	100.0%			100.0%			100.0%		100.0%			85.0%		87.5%		
Gynaecological	▲ £	87.5%	100.0%	100.0%	100.0%	100.0%	40.0%	100.0%	54.5%	50.0%	60.0%	66.7%	71.4%	66.7%	66.7%	85.0%		76.4%		
Lung	▲ £	66.7%	76.9%	85.7%	90.5%	75.0%	100.0%	71.4%	80.0%	100.0%	90.5%	100.0%	88.2%	66.7%	66.7%	85.0%		86.5%		RC
Haematological	▲ £	66.7%	100.0%	46.2%	50.0%	66.7%		60.0%	80.0%	66.7%	83.3%	50.0%	86.7%	100.0%	100.0%	85.0%		70.5%		
Skin	▲ £	94.9%	96.6%	97.0%	100.0%	90.0%	94.7%	88.5%	95.9%	95.3%	94.4%	92.5%	96.7%	97.4%	97.4%	85.0%		94.5%		
Unknown	▲ £		100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	33.3%	100.0%		50.0%			85.0%		83.3%		
All Tumour Sites	▲ £	86.7%	86.3%	88.7%	91.0%	91.2%	91.4%	85.1%	89.3%	86.9%	87.9%	90.1%	89.5%	91.7%	91.7%	85.0%		88.6%		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																				
Testicular	▲ £			100.0%		100.0%	100.0%					100.0%	100.0%			85.0%		100.0%		
Acute Leukaemia	▲ £								100.0%	100.0%						85.0%		100.0%		
Children's	▲ £															85.0%				

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)065
Title of paper: Safer Staffing Report for May 2016
Purpose: The aim of the report is to provide the Board with an overview of nursing and midwifery staffing levels in the inpatient areas during the month of May 2016. This will highlight the wards where staffing has fallen below the 90% fill rate, review the impact of this on patient care and will provide a summary of actions implemented to address gaps.
Summary: The Trust is required to publish monthly nursing and midwifery staffing levels by shift as 'expected' versus 'actual' in hours via the template set up on UNIFY, to provide the URL to our own "safe staffing" web page. The URL will enable the NHS Choices team to establish this link from the NHS Choices website to the Trust website. The month of May **2016** data indicates: • Overall Trust fill rate =100.47 % (for registered and for care staff) • Overall registered staff fill rate for days was 92.91% and for nights 96.93% • Overall care staff fill rate for days was 99.70% and for nights was 112.34% There were 19 ward areas with a fill rate below 90%, 12 wards for registered staff, 9 wards for care staff and 2 wards for both registered and care staff. The new measure of care hours per patient per day (CHPPD) is included in this report as per national guidance from May 2016.
Corporate objectives met or risks addressed: Contributes towards the achievement of Patient Safety and Workforce planning objectives.
Financial implications: None directly from this report.
Stakeholders: Patients, the public, staff and commissioners.
Recommendation(s): It is recommended that the Committee note this report and the data to be submitted to Unify.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance
Date of meeting: 29th June 2016

SAFER NURSING & MIDWIFERY WORKFORCE STAFFING LEVELS REPORT

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

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

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

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

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

6. Commencing 1st May 2016 the monthly Safer Staffing return is required to include each in patient wards average bed occupancy at 23.59 hours.

7. This is recorded as Nursing care hours per patient per day (CHPPD).

8. From 1st April 2017 this will need to be reported daily.

9. This measure records the physical number of patients in a bed at 23:59 each day, and then divides this figure by the combined trained and untrained nursing hrs. to provide a figure representing the individual number of care hrs. per day each patient is afforded.

$$\text{CHPPD} = \frac{\text{Registered Nurse Hours} \quad \text{Healthcare Support Worker Hours}}{\text{Number of inpatients}}$$

10. At the daily matron / lead nurse midday staffing level review meeting, any continuing, unresolved staffing gaps are referred to the Staffing Solutions Department to request bank staff or agency staff, the latter are only requested when all other avenues have been exhausted.
11. This daily staffing review meeting is where patient dependency and staffing skill mix issues are reviewed and decisions made where best to deploy staff to best meet patient requirements across the wards for the next 24 hours.
12. The meeting also identifies where additional staff are required to special patients who require close observation. This explains why the average fill rate is often above 100% for care staff. Also, if there is a shortfall in registered staff after every effort has been made to fill the gap with a registered nurse has been exhausted, attempts are then made to cover the gap with care staff in order to increase the numbers of staff on the shift acknowledging the skill mix is not as required for the shift.

13. The recruitment and retention of nursing staff of nursing staff remains a priority for the Trust and remains an on-going challenge nationally. Stabilising and retaining the nursing and midwifery workforce in clinical areas has been an area of increased focus throughout 2015/16. A new preceptorship program commenced in March 2016 to improve the retention and development of newly qualified recruits who will hopefully take full advantage of the development opportunities available to them at this Trust. There are three recruitment days planned throughout 2016, the first one took place on Saturday 27th February 2016 and, as a result, we have made 31 offers across the following specialities: Care of the Elderly, Respiratory, Medical Escalation Unit, General Surgery, Burns & Plastics, Cardiology. On the 18th June, at the next recruitment day, the following specialities will be directly targeted: Respiratory Medicine (wards 2B and 2C), Gastroenterology (ward 3D), Endocrinology (ward 2D) and General Medicine (ward 3E) – 27.13 WTE gaps in total.

14. In order to promote the Respiratory Department, 3 of their nursing staff have joined Vlad Somesan and Ann Rimmer at the LJMU nurse career fair on 7th June, where 2nd and 3rd year student nurses have attended and expressed an interest in working at the Trust and attending the recruitment day on 18th June.

15. The Director of Nursing, Midwifery and Governance has meet with the Dean and Professor of Nursing from John Moore's University (JMU), to agree a process whereby student nurses who have been offered a post will work their last placement on that ward.

16. A recent recruitment trip was undertaken and 100 posts offered to registered nurses, the majority of whom will hopefully commence employment within the Trust during Q4 of 2016/17. This will address the registered nurse vacancy gap within the Trust which as of May 2016 was 52.43wte. Significant delays are due to the low pass rate of the IELTS and the financial effort the nurses have to make for training and sitting the exam.

17. Wards 1a, 2b, 2c, 3d, 5a, 5b and 5c are currently on the Trust Corporate Risk register scoring 15 for on-going staffing shortfalls. six of the seven wards scored below 90% for trained staff fill rate but where over 90% in untrained staff fill rate.

18. CHPPD had demonstrated an average (mean) care hrs. per day of 9.14 hrs. The median value is 8.03hrs.
This figure varies from the lowest value of 5.1hrs on ward 3E Gynaecology, up to 32.5hrs on ward 4E critical care.
It should be acknowledged that the use of metrics such as CHPPD only measures the hours of care provided to each 'bed' and does not recognise the acuity and dependency of patients receiving the care or the turnover of patients through the bed.

19. In May 2016 there were 19 ward areas with a fill rate below 90%, 12 wards for registered staff, 9 wards for care staff and 2 ward for both registered and care staff.

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

	RN days%	HCA days%	RN nights%	HCA nights%
1A	78.7	104.1	83.6	131.5
1D	84.9	137.5	93.6	151.9
2B	77.5	94.2	92.6	111.3
2C	77.4	123.6	95.2	132.7
2E	89.3	88.7	99.0	103.2
3B	87.9	115.6	101.1	173.1
3D	80.6	108.3	86.0	135.3
4C	76.7	91.0	94.6	108.7
5B	99.5	105.3	89.5	111.8
5C	88.4	99.8	81.9	122.5
Duffy	86.5	143.3	100.0	151.9
Delivery suite	89.9	78.1	90.2	92.3

19.2. Wards with a care staff fill rate below 90% are set out below.

	RN days%	HCA days%	RN nights%	HCA nights%
2E	89.3	88.7	99.0	103.2
3A	103.6	80.1	112.9	100.1
3E	97.4	87.9	105.1	100.0
3F	100.6	80.7	103.9	96.8
4D	129.9	57.5	101.6	80.0
4E	93.2	68.3	95.5	87.1
5D	103.3	89.9	100.0	109.0
SCUBU	116.3	41.9	113.5	93.6
Delivery Suite	89.9	78.1	90.2	92.3

19.3. There were 2 wards in May (2E & SCUBU) with both a registered nurse and care staff overall fill rate of less than 90% during the same shift period.

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

May 2016

staff group	Unfilled requested shifts	Filled requested shifts
Bank HCA	497	1784
Agency HCA	59	148
Bank RN / RM	471	231
Agency RN	87	292
Wards with RN shortfall	**Unfilled requested bank and agency shifts**	**Filled bank and agency requested shifts**
1A	89	52
1D	43	9
2B	74	32
2C	65	33
2E	0	0
3B	24	8
3D	24	1
4C	56	10
5B	6	13
5C	7	13
Duffy	0	0
Delivery suite	0	0

Wards with HCA shortfall	Unfilled requested bank and agency shifts	Filled bank and agency requested shifts
2E	0	0
3A	4	24
3E	8	49
3F	9	0
4D	0	10
4E	0	1
5D	10	42
SCUBU	0	5
Delivery Suite	Data not available	Data not available

21. During May 2016, there were a total of 20 incident forms completed related to staffing. No episodes of harm where reported as a result of any staffing difficulties. This related to 15 wards/departments as indicated in the table below:

ID	Incident date	Time	Location Exact	Description	Adverse event	Severity of harm	Staffing Establishment at time of incident
Incident date: 02/05/2016							
	02/05/2016	20:45	Ward 1D	close observation of patients	Lack of suitably trained /skilled staff	None (No harm caused)	
Incident date: 03/05/2016							
	03/05/2016	00:00	Delivery Suite	Midwife pulled from part of Project day to work clinically.	Lack of suitably trained /skilled staff	None (No harm caused)	due to short term MW sickness the maternity escalation policy was implemented staff redeployed to assist .
Incident date: 07/05/2016							
	07/05/2016	00:35	Ward 5A	ward short staffed for night shift. Due to sickness	Lack of suitably trained /skilled staff	None (No harm caused)	2 band 5, 3 band 2
Incident date: 12/05/2016							
	12/05/2016	00:00	Theatre Recovery	Delay in transfer from recovery to ward	Lack of suitably trained /skilled staff	None (No harm caused)	ward 3C busy recovery staff transfered patient to ward .
Incident date: 13/05/2016	13/05/2016	12:20	Ward 1A - Frailty Unit	Availability and skill mix of registered nurses. staff member cancelled at short notice leaving ward with junior staff	Lack of suitably trained /skilled staff	None (No harm caused)	matron and bed managers notified . Staff movement to address skill mix
	13/05/2016	03:10	Duffy Suite Intermediate Care	HCA not available for close observation of patient at risk of falls	Lack of suitably trained /skilled staff	None (No harm caused)	unable to cover from nurse bank of own staff
Incident date: 14/05/2016	14/05/2016	12:00	Theatre Main (Orthopaedic)	Delay in transfer from recovery to ward	Lack of suitably trained /skilled staff	None (No harm caused)	5 recovery nurses and 7 patients. Delay in transfer back to ward
	14/05/2016	13:00	Theatre Main (Orthopaedic)	Delay in transfer from recovery to ward	Lack of suitably trained /skilled staff	None (No harm caused)	5 recovery nurses and 5 patients. Delay in transfer back to ward
Incident date: 15/05/2016	15/05/2016	14:00	Ward 3D	RN short for late shift due to last notice sickness	Lack of suitably trained /skilled staff	None (No harm caused)	increase HCA to support as RN not available
	15/05/2016	08:00	Theatre General Areas	Orthopaedic LLP list not staffed with any Dual Role practitioners, this list is usually staffed with a two Dual Role Practitioners.	Lack of suitably trained /skilled staff	None (No harm caused)	Co-ordinator worked clinically
Incident date: 19/05/2016	19/05/2016	00:00	Ward 1C AMU	MED SPR VACANT SHIFT 2PM-11PM	Lack of suitably trained /skilled staff		medical staffing unable to cover rota
	19/05/2016	00:00	Ward 1C AMU	sho called in sick from 5pm-9.30pm	Lack of suitably trained /skilled staff		medical staffing unable to cover rota
	19/05/2016	17:23	Theatre Main (ENT)	Incorrect skill mix for the listing	Lack of suitably trained /skilled staff	None (No harm caused)	Co-ordinator worked clinically
Incident date: 20/05/2016	20/05/2016	11:00	Community Midwifery	Clinics not covered in community setting .	Lack of suitably trained /skilled staff	None (No harm caused)	Lead nurse informed to review staffing and clinic cover
	20/05/2016	16:00	Ward 3C	No SHO cover for ward	Lack of suitably trained /skilled staff	None (No harm caused)	SHO rota not covered
Incident date: 27/05/2016							
	28/05/2016	14:35	Ward 3D	Availability and skill mix of registered nurses. staff member cancelled at short notice leaving ward with junior staff	Lack of suitably trained /skilled staff	None (No harm caused)	matron and bed managers notified . Staff movement to address skill mix
Incident date: 28/05/2016	28/05/2016	07:30	Ward 2B	Availability and skill mix of registered nurses. staff member cancelled at short notice leaving ward with junior staff	Lack of suitably trained /skilled staff	None (No harm caused)	3 rgn 4hcas
	28/05/2016	15:07	Ward 2B	due to short term sickness the ward was staffed with 2 RGNs on the late there was no cover on the bleep/or bank/agency.	Lack of suitably trained /skilled staff	None (No harm caused)	2 rgns 4hcas
				due to short term sickness the ward was staffed with 2 RGNs on the late			

22. There was 1 recorded fall during May 2016 that resulted in moderate harm or above. The episodes took place on ward 1A which fell below 90% for trained staff during May. However on the date of the incident the registered nurse actual was 90% of the planned level of care, and the untrained was 87.5% of the planned level of care.

    Appendix 2 relates to all falls that took place during the month of May 2016. The areas for trained staff with a fill rate below 90% are coloured Red, and the areas for untrained staff below 90% fill rate are coloured Orange.

    Summary

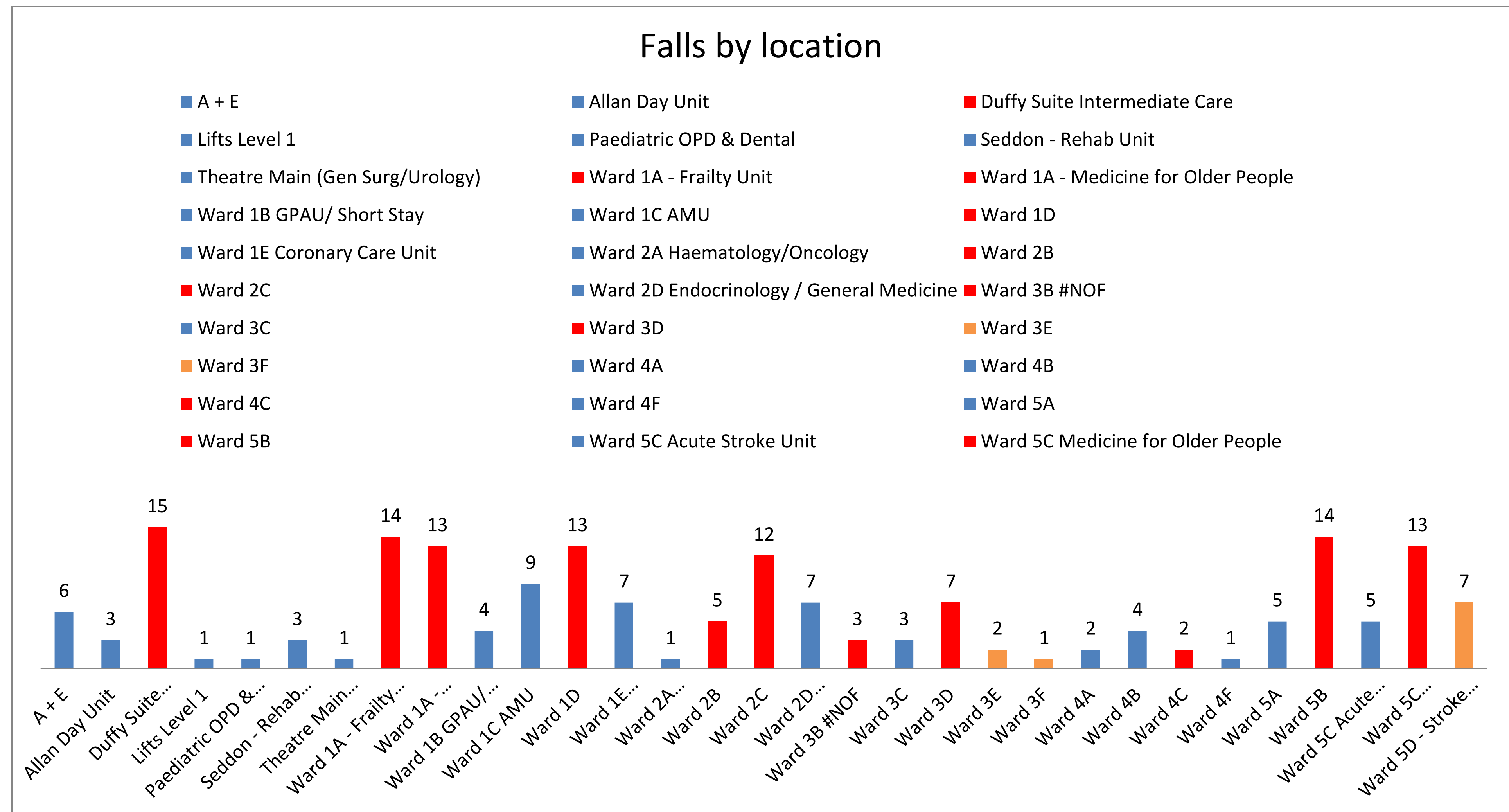
    The report provides assurance that every effort was made to ensure optimum staffing levels across all wards daily during May 2016 to reduce the incidence of harm to patients and long term to address vacancies. The number of wards falling below the 90% fill rate has decreased to 19 wards in May from 21 wards in April.

Appendix 1

Ward	Specialty	Monthly Hours - Days						Monthly Hours - Nights						Care Hours Per Patient Day (CHPPD)			
		Qualified staff			HCA's			Qualified staff			HCA's						
		Planned	Actual	Rate	Planned	Actual	Rate	Planned	Actual	Rate	Planned	Actual	Rate	Monthly cum.	Qual. staff	HCAs	Total
1A	Geriatric Medicine	2,089	1,645	79%	2,194	2,283	104%	910	761	84%	920	1,210	132%	918	2.6	3.8	6.4
1B	General Medicine	2,742	2,654	97%	1,094	1,213	111%	1,260	1,178	93%	643	603	94%	648	5.9	2.8	8.7
1C	General Medicine	3,255	3,161	97%	1,483	1,843	124%	1,753	1,868	107%	853	976	114%	864	5.8	3.3	9.1
1D	Cardiology	2,070	1,757	85%	1,384	1,903	138%	930	871	94%	620	942	152%	937	2.8	3.0	5.8
1E	Cardiology	2,489	2,135	86%	930	875	94%	1,240	1,150	93%	110	110	100%	431	7.6	2.3	9.9
2A	Gen. Medicine / Haematology	1,568	1,466	94%	886	919	104%	622	625	100%	310	310	100%	573	3.6	2.1	5.8
2B	Gen. Medicine / Respiratory	2,160	1,674	77%	1,624	1,529	94%	930	862	93%	620	690	111%	896	2.8	2.5	5.3
2C	Gen. Medicine / Respiratory	2,089	1,616	77%	1,391	1,720	124%	920	876	95%	620	823	133%	919	2.7	2.8	5.5
2D	General Medicine	1,386	1,279	92%	1,146	1,282	112%	620	620	100%	620	636	103%	666	2.9	2.9	5.7
2E	Obstetrics	3,022	2,699	89%	1,386	1,230	89%	1,240	1,227	99%	620	640	103%	803	4.9	2.3	7.2
3A	Plastic Surgery	1,723	1,785	104%	1,388	1,112	80%	620	700	113%	620	621	100%	490	5.1	3.5	8.6
3Alpha	Trauma & Orthopaedics	1,167	1,115	96%	921	863	94%	620	620	100%	310	310	100%	362	4.8	3.2	8.0
3B	Trauma & Orthopaedics	1,632	1,434	88%	1,771	2,046	116%	920	930	101%	620	1,073	173%	653	3.6	4.8	8.4
3C	Trauma & Orthopaedics	1,950	1,838	94%	1,622	1,799	111%	930	921	99%	930	920	99%	801	3.4	3.4	6.8
3D	Gen. Medicine / Gastro.	2,091	1,685	81%	1,393	1,509	108%	930	800	86%	620	839	135%	888	2.8	2.6	5.4
3E	Gynaecology	1,463	1,424	97%	863	758	88%	590	620	105%	310	310	100%	606	3.4	1.8	5.1
3F	Paediatrics	2,314	2,328	101%	463	374	81%	1,240	1,288	104%	310	300	97%	487	7.4	1.4	8.8
4A	101 - UROLOGY	2,153	1,963	91%	1,386	1,279	92%	930	996	107%	930	871	94%	910	3.3	2.4	5.6
4B	General Surgery / Urology	2,127	2,013	95%	1,735	1,717	99%	1,050	1,051	100%	430	431	100%	401	7.6	5.4	13.0
4C	General Surgery	2,312	1,773	77%	1,390	1,264	91%	930	880	95%	930	1,011	109%	825	3.2	2.8	6.0
4D	Plastic Surgery	1,388	1,803	130%	690	397	58%	620	630	102%	350	280	80%	193	12.6	3.5	16.1
4E	Critical Care	5,903	5,504	93%	1,521	1,039	68%	3,720	3,552	95%	620	540	87%	327	27.7	4.8	32.5
4F	Paediatrics	928	1,055	114%	456	433	95%	620	645	104%	310	300	97%	216	7.9	3.4	11.3
5A	Gen. Medicine / Geriatric	1,703	1,641	96%	2,320	2,246	97%	930	884	95%	930	1,050	113%	725	3.5	4.5	8.0
5B	Geriatric Medicine	1,475	1,467	99%	2,228	2,345	105%	920	823	89%	930	1,040	112%	881	2.6	3.8	6.4
5C	Geriatric Medicine	2,910	2,573	88%	1,911	1,908	100%	1,540	1,261	82%	930	1,139	123%	799	4.8	3.8	8.6
5D	Gen. Medicine / Geriatric	1,346	1,390	103%	1,571	1,412	90%	610	610	100%	570	621	109%	537	3.7	3.8	7.5
Duffy Ward	Gen. Medicine / Geriatric	1,417	1,226	87%	1,376	1,971	143%	620	620	100%	620	942	152%	676	2.7	4.3	7.0
SCBU	Paediatrics	1,395	1,623	116%	930	390	42%	930	1,056	114%	300	281	94%	359	7.5	1.9	9.3
Delivery Suite	Obstetrics	3,255	2,927	90%	915	715	78%	2,340	2,110	90%	620	572	92%	297	17.0	4.3	21.3
Seddon	Rehabilitation	1,373	1,641	120%	1,536	1,401	91%	620	620	100%	620	670	108%	437	5.2	4.7	9.9

APPENDIX 2

Trust wide falls by ward area in May 2016: Red = RN fill below 90% Orange = HCA fill below 90%



St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)066
Title of paper: Workforce Race Equality Standard 2016 & Action Plan
Purpose: To indicate the Trust's equality information, demonstrating the compliance with Public Sector Equality Duty. The report will demonstrate the Trust's commitment to providing equal access to career opportunities and receive fair treatment in the workplace and how the 2016 action plan will ensure areas requiring improvement are addressed.
Summary: Research within the NHS strongly suggests the less favourable treatment of Black and Ethnic Minority (BME) staff impacts negatively on the quality of care. The WRES was designed to prompt inquiry to better understand the difference in experience between ethnicities in the workplace. The report benchmarks the Trust against a national report and provides an action plan against the WRES standard.
Corporate objectives met or risks addressed: Developing organisational culture and supporting our workforce
Financial implications: N/A
Stakeholders: Staff, managers, staff side colleagues, patients, potential candidates and Healthwatch,
Recommendation(s): The Trust Board are requested to note the update, seek assurance via the Quality Committee of on-gong progress and receive the next annual update at the Trust Board in February 2016.
Presenting officer: Anne-Marie Stretch, Deputy CEO and Director of HR
Date of meeting: 29th June 2016

Trust Board Update

Workforce Race Equality Scheme (WRES) 2016 & Action Plan

1. Introduction

The Trust Board received the 2015 WRES results in January 2016 based on a 2015 data extract from Trust information. This was the first year of reporting since the WRES was introduced in 2015. At the January Board it was requested that a detailed action plan was developed reflecting the improvements required. Since then the Trust has received both the 2015 annual staff survey results and the NHS Equality and Diversity Council's document published in May 2016 which includes data analysis of the 2015 WRES for all NHS Trusts allowing benchmarking against Acute Trusts to be considered in the development of our local plan.

In May 2016, the NHS Equality and Diversity Council published the 2015 WRES data analysis for all NHS trusts. Research and evidence strongly suggests that less favourable treatment of Black and Ethnic Minority (BME) staff in the NHS, through poorer experiences or opportunities has significant impact on the efficient and effective running of the NHS and adversely impacts the quality of care received by all patients. The WRES is designed to prompt inquiry into better understanding why it is that BME staff often receive much poorer treatment than white staff in the workplace. While gathering data is only the first step, the document does provide the opportunity to compare all Trusts against the WRES and is split by the organisational type.

2. NHS Equality and Diversity Council Report

Below is a brief summary of how St Helens and Knowsley Teaching Hospitals NHS Trust, (StHK) compared to others in the 2015 WRES results throughout the region by indicator. Please note that 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.

Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.	
Trust 2015	National Average
White 22%	28%
BME 32%	28%
Total 22%	28%

Indicator 5

Compared with all Trusts, StHK shows a lower than average percentage (22%) of staff **experiencing** harassment, bullying or abuse from patients, relatives or the public compared to the national average (28%). Of concern however, is the higher percentage of BME staff who experienced bullying or abuse.

Indicator 6

Percentage of staff experiencing harassment, bullying or abuse form staff in last 12 months.	
Trust 2015	National Average
White 20%	25%
BME 28%	28%
Total 21%	26%

The StHK average figure (21%) of staff **reporting** experience of harassment, bullying or abuse from staff is lower than that of the national acute average (26%). However, the spread of results is of concern with a disparity of 8% between White and BME results with white staff reporting 20% and BME staff of 28%. While the BME response is low (40 participants) compared to that of white colleagues (375), the results do show 12 reported incidents of BME staff experiencing harassment, bullying or abuse from colleagues through the annual staff satisfaction survey. These incidents are not reflected in the cases raised via the Trusts internal policies indicating under reporting and a missed opportunity to resolve concerns from this staff group.

Indicator 7

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	
Trust 2015	National Average
White 93%	89%
BME 75%	75%
Total 92%	87%

Almost all respondents (92%) agreed that the Trust provides equal opportunities for career progression and promotion, higher than the national average of 87%. However there is a 18% difference between white and BME staff who agree with the statement on equal opportunities.

Indicator 8

In the last 12 months have you personally experienced discrimination at work form manager/team leader or other colleagues?	
Trust 2015	National Average
White 6%	6%
BME 12%	13%
Total 9%	10%

In the final indicator StHK shows that 9% of staff have experienced discrimination at work from a manager, team leader or other colleague, which is lower than the

national acute average (10%). The comparison in diversity in this data shows that 12% of BME staff have felt discrimination compared to 6% of non BME staff. This percentage point difference (6%) remains high but is in line with the average difference nationally (7%).

Whilst the Trust scores favourably overall against the national average, across all 4 areas, our BME staff are reporting levels of concern higher than our non BME staff, although it is only in indicator 5 that our percentage for BME staff is higher than the national average. The small number of respondents from BME staff may impact on percentages but it is clear that a robust action plan is required to work with the small numbers of staff who have completed the questionnaire and shared their experiences.

3. The Development of the 2016 WRES & Action Plan

Attached to this paper is the refreshed WRES for 2016 which will be subject to changes from further NHS WRES Implementation Guidance expected from June 24th 2016. Accompanying this WRES is an action plan which will enable the Trust to achieve improvements in a number of key areas highlighted in the 2016 WRES results.

4. Recommendation & Governance

It is suggested that progress against the 2016 WRES action plan is monitored via the Equality, Diversity & Inclusion Steering Group, with quarterly assurance reporting to the Quality Committee via the Workforce Council and the next annual update in February 2017.

WRES Action Plan 2016/2017

This action plan will be updated as progress is made and/or the objectives are reviewed/amended as appropriate including adding in any further objectives to the action plan.

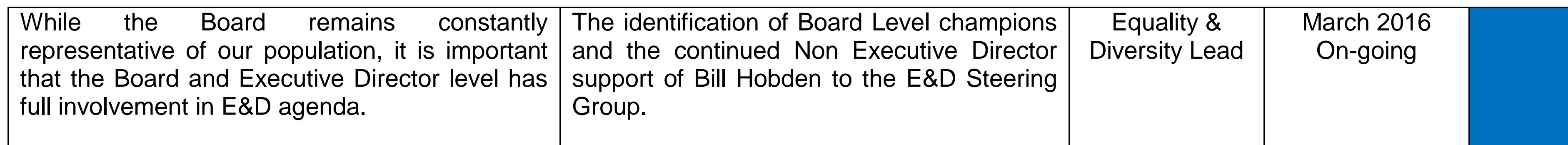
BRAG Rating	Missed Target	Behind Completion of Target	On Target for Completion	Completed

Objective	Action	Lead	Target/Review Date	RAG Rating
To ensure that the percentage of BME staff in bands 8-9 and VSM remains consistent and representative of the overall workforce	Review the Trust's percentage of staff at relevant bands to ensure that the Trust continues to achieves this standard	Head of HR	March 2016	
To ensure that the percentage of BME staff in bands 8-9 and VSM remains consistent and representative of the overall workforce	Review the recruitment & selection process to include the introduction of unconscious bias training for all levels of recruitment.	Equality & Diversity Lead/ Head of HR	July 2016	
	Commission unconscious bias training for all levels of recruitment to be delivered via e-learning	Assistant Director of OD	September 2016	
Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.				
To improve the relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts	Utilise the TRAC system with greater analysis into the success rate by ethnicity from application to appointment. Use a "dip-check" every 6 months to understand success rate using a sample size of 5% of recruited positions. This will allow the creation of an audit process to address any trends To explore e-learning and develop a business case for the on-going awareness of	Head of Strategic Resourcing Head of Strategic Resourcing	On-going July 2016 September 2016	

	E&D training for appointing managers.			
	Produce awareness leaflet for all leaders and managers across the Trust around unconscious bias, equal opportunity and details with statistics and available resources	Equality & Diversity Lead	August 2016	
	Review the E&D Policy for compliance with WRES statistics and Analysis while supporting improvements against current standards.	HR Business Partner	To Be Approved at Workforce Council in September 2016	
Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation				
To ensure that the formal disciplinary process is an equal and fair process.	Carry out a review of investigations and cases involving BME staff going to formal disciplinary process compared to that of overall workforce. Analysis to be separated for Medical & Dental and the Agenda For Change workforce.	HR Advisory Team	June 2016 & On-going	
	Following the introduction of the HR Case Tracker system, there will be a greater ease of reporting statistical analysis of cases by ward, staff group and ethnicity.	HR Business Partners & HR Advisors	On-going. Tracker to be implemented August 2016	
	Assistant Directors to write to staff through an "I'm here for you" letter. This will be done through a multitude of channels including at Team Brief for Assistant Directors to cascade as well as attachments to pay slips.	Head of HR	July 2016	

Relative likelihood of BME staff accessing non mandatory training and CPD as compared to White staff				
Ensure that there is an equal likelihood of BME staff accessing non-mandatory training and CPD compared with White staff.	Engagement with the BME Workforce, writing to all BME staff as identified via ESR, advising access to training and offering confidential development discussions with members of the L&D team to support how to access training and development opportunities.	Assistant Director of OD	August 2016	
	Identify all Band 8a staff both (clinical and non-clinical) and write to them to advertise the NHS Leadership Academy's Ready Now programme for BME Leaders.	Assistant Director of OD	Waiting on further information from the Academy - August 2016	
KF 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months				
To reduce the percentage difference between BME and White staff as well as overall percentage experiencing bullying, harassment or abuse from patients, relatives or the public	There will be targeted focus groups for clinical and non-clinical BME staff. This is to be facilitated to ensure an open and honest discussion around how best to address public attitudes towards staff.	Head of Equality and Diversity/Head of HR	September 2016	
	Design and publicize notices around public areas requesting zero tolerance around inappropriate treatment of staff in the hospital	Equality & Diversity Lead/Head of Media and PR	October 2016	
KF 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months				
To reduce the percentage difference in BME staff experiencing harassment bulling or abuse from staff while also reducing the overall figure	Annual campaign to reinforce the ACE Behavioural Standards throughout the Trust	Head of HR	August 2016	
	Send Communication around the Speaking out in Confidence Portal which is to be launched as a confidential service for all staff.	Head of HR/Assistant Director of Patient Safety	July 2016	
	Design and distribute communication from Director of HR regarding an update for all staff around protected characteristics and	Head of HR	August 2016	

	the support available			
To reduce the percentage difference in BME staff experiencing harassment bulling or abuse from staff while also reducing the overall figure	Create focus groups facilitated by E&D Lead and Head of HR. Patient Voice to be involved. To be run bi-annually to ensure consistent feedback around progression.	Head of HR/ Equality & Diversity Lead	November 2016	
To reduce the percentage difference in BME staff experiencing harassment bulling or abuse from staff while also reducing the overall figure	Noting that the Staff Survey report doesn't match the case load within HR. Focus Groups and Speaking out in Confidence report to be compiled and fed back to the Board in February 2017 with actions to address why staff have not reported their experiences	Head of HR	February 2017	
KF 27. Percentage believing that trust provides equal opportunities for career progression or promotion				
To ensure that the Trust provides equal opportunity for career progression or promotion	Include topics within focus groups to ensure that there is equal opportunity for progression and understanding any barriers which are perceived to be restricting progression	Head of HR	On-going In addition to Focus Groups	
To ensure that the Trust provides equal opportunity for career progression or promotion	Targeted work to carry out one to one meetings with a sample of our BME population across staff groups to understand why there is an imbalance amongst staff groups and inform future actions.	Head of HR	December 2016	
To ensure that the Trust provides equal opportunity for career progression or promotion	Identify and publicise Trust mentors of BME representation for advice and guidance of Career Progression	Assistant Director of OD	August 2016	
Q23b. In the last 12 months have you personally experienced discrimination at work from any of the following? **Manager/team leader or other colleagues**				
To ensure a reduction in the imbalance between the discrimination experienced between ethnicities.	The team will run focus groups and one to one interviews to understand in greater detail the challenges in which BME staff face.	Head of HR	December 2016	
Boards are expected to be broadly representative of the population they serve.				



While the Board remains constantly representative of our population, it is important that the Board and Executive Director level has full involvement in E&D agenda.	The identification of Board Level champions and the continued Non Executive Director support of Bill Hobden to the E&D Steering Group.	Equality & Diversity Lead	March 2016 On-going	

TRUST BOARD PAPER

Paper No: NHST(16)067

Title of paper:

Aggregated Incidents, Complaints and Claims Report Q4 2015-16

Purpose:

To highlight trends and learning obtained from the aggregation and analysis of complaints, claims, internal incident reporting and PALS enquiries received by the Trust in the period 1st January – 31st March 2016 (Quarter 4).

Summary:

Incidents

1. The number of incidents raised for this quarter was 3504 compared to 2884 in the same quarter last year (January to March 2015) demonstrating an increase of 620 (17.6%) and an associated reduction in harm of 40%. This is associated with the supportive culture of leaning and openness.
2. The number of Strategic Executive Information System (StEIS) incidents reported this quarter was 12. This remains static, with 10 to 12 reported each quarter.
3. National Reporting and Learning System (NRLS) reporting for the latest published data April – September 2015, shows the organisation's practice in reporting to the NRLS remains excellent with the mean number of days to report being 13 days against national average of 30 days.

Claims

4. There are 406 active clinical negligence claims on-going.
5. 1 new clinical negligence claim was received.
6. 28 new claims received in Q4 in 2015-16 compared to 20 in the same period last year, representing a 40% increase.

Complaints and Patient Advice Liaison Service (PALS)

7. There were a total of 60 formal 1st stage complaints and 607 PALS contacts/enquiries during Q4 2015-16, compared to Q4 2014-15 when there were a total of 76 formal complaints and 354 PALS enquiries.
8. The Trust responded to 50% of the complaints received within agreed time frames during the quarter, with an annual average of 61.4%.
9. The top 3 complaints themes during Q4 were: clinical treatment 48.3%; values and behaviors (Staff) 29.3%; patient care/nursing care 22.4%.
10. During the quarter, there were 15 complaints linked to 18 Incidents; there were 26 complaints linked to previous PALS contacts/enquiries and 21 complaints linked to 11 claims. There were 16 claims linked to 28 incidents.

Corporate objectives met or risks addressed:

Safety – We will embed a learning culture that reduces harm, achieves good outcomes and enhances the patient experience.
Financial implications: There are no direct financial implications arising from this report
Stakeholders: Patients, carers, commissioners, CQC and Trust staff.
Recommendation(s)/issues to escalate: Members are asked to consider and note the report.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance
Date of meeting: 29th June 2016

1. Introduction

The DATIX electronic reporting system allows incidents, complaints, claims and PALS information to be collated and cross-referenced. This report attempts to draw out the trends and learning derived from the aggregation and analysis of internal incident reporting and of the complaints, claims and PALS enquiries received by the organisation. The emphasis is on patient experience and safety. The information includes:

- All reported incidents
- Serious incidents (SIs) created on StEIS.
- Complaints
- PALS
- Litigation (claims and inquests)

The data included in this report covers 1st January to 31st March 2016 (Q4)

2. Quantitative analysis

1st Jan – 31st Mar 2016 (Q4)	Incidents	StEIS	Complaints	PALS	Claims
Total number reported	3504	12	60	607	28
Accident & Emergency	399	1	11	88	3
Anaesthetics	0		1	1	
Burns	12			5	3
Cancer Services	13				
Cardio Respiratory	17			2	
Cardiology	122	2	1	15	1
Critical Care	36				
Dermatology	17			4	
Diabetes	13			2	
Ear, Nose & Throat (ENT)	17			11	1
Facilities	128		1	7	
Finance	1				
Gastroenterology	110	1	4	8	1
General Medicine	477		6	33	2
General Surgery	179	2	9	82	4
Genito-urinary Medicine	0				
Gynaecology	43	1	1	27	
Haematology	62			2	
Human Resources	2			1	
Informatics	5		1		
Information Governance			1		
Medicine for Older People	368	3	1	29	1
Neurophysiology	0				
Obstetrics	196	1	4	14	5
Operational	11			1	
Ophthalmology	11			7	
Orthodontics & Oral Surgery	2			4	
Orthopaedic	150	1	6	74	5
Paediatrics	262		2	6	
Pain Services	2				
Palliative Care	1			4	

1st Jan – 31st Mar 2016 (Q4)	Incidents	StEIS	Complaints	PALS	Claims
Pathology	249		1	3	
Pharmacy	29			3	
Plastics	117		3	9	
Psychology	2				
Quality & Risk	10			16	
Radiology	85			6	
Rehabilitation	31				
Respiratory	126		6	17	
Resuscitation	0				
Rheumatology	7			1	
Sexual Health	18				
Theatres	125				
Therapy Services	12			4	
Unknown					1
Urology	37		1	4	1

NB. In relation to the unknown claim, this is a pre action protocol claim. This only included the patient details and made no reference to the reason for the claim.

Top 10 Themes

Incidents		Complaints		PALS		New clinical negligence claims	
Accident that may result in personal injury	877	Clinical Treatment	25	Admissions and Discharges (excl. delayed discharge re care package)	133	Failure to diagnose/ treat	12
Implementation of care or on-going monitoring/review	481	Patient Care/ Nursing Care	9	Communications	98	Performance of surgical procedure	7
Medication	401	Values and Behaviours (Staff)	7	Clinical Treatment	73	Delay	3
Access, Appointment, Admission, Transfer, Discharge	319	Admissions and Discharges (excl. delayed discharge re care package)	5	Patient Care/ Nursing Care	62	Consent	3
Infrastructure or resources	273	Communications	3	Access to Treatment or Drugs	55	Nursing care	1

Clinical assessment (investigations, images and lab tests)	247	Trust Admin/ Policies/ Procedures (Inc. Patient Record Management)	3	Appointments	41		
Abusive, violent, disruptive or self-harming behaviour	220	Waiting Times	3	Values and Behaviours (Staff)	20		
Treatment, procedure	189	Access to Treatment or Drugs	2	Other (e.g. abuse/ behaviour/Theft/ Benefits)	8		
Patient Information (records, documents, test results, scans)	154	Privacy and Dignity	1	End of Life Care	8		
Consent, Confidentiality or Communication	116	Consent	1	Trust Admin/ Policies/ Procedures (Inc. Patient Record Management)	2		

Note: The chart above should be used as guidance only as the claims received often fall into more than one category, for example there may have been negligent performance of a surgical procedure followed by a fall on the ward, or failure to diagnose a condition with general unhappiness regarding care received.

The top 5 themes have been consistent throughout the year are listed below:

Clinical care
Communication and records
Access/admission/discharge issues
Infrastructure
Attitude/behaviour/competence

2.1. Incident data

The latest data published by the NRLS in April 2016 relates to incident data from April 15 – September 15. Data for Setember 15 to March 16 will not be publshed until after September 2016.

The Trust has increased its reporting of patient incidents with a no or low harm over the last three years, which demonstrates an improved culture of reporting. The Trust reported 37.73 incidents per 1,000 bed days for the period April 2015 – September 2015, which is comparable to local Trusts and the national rate of 38.35 per 1,000 bed days. Our mean

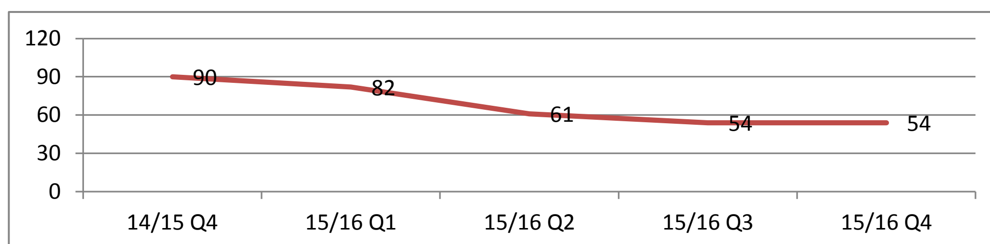
number of days for reporting incidents to the NRLS is 13, which is substantially under the expected which is 30 days.

The table below shows data published for local non-specialist organisations;

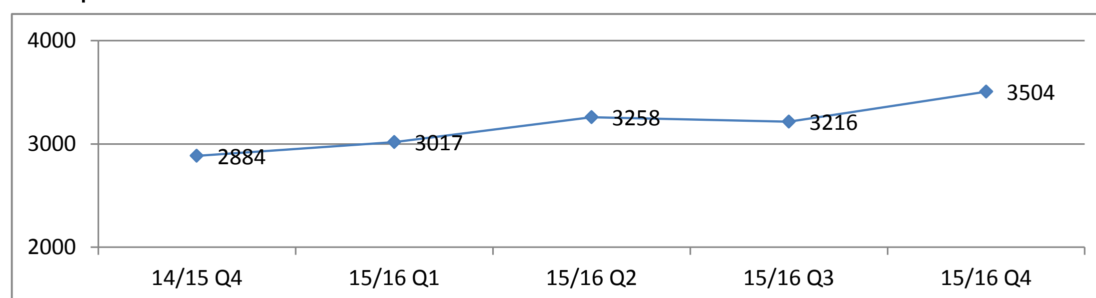
Organisation name	Median number of days between incidents occurring and being reported to the NRLS	Number of incidents occurring	Rate per 1,000 bed days
Countess Of Chester Hospital NHS Foundation Trust	8	4699	51.25
Royal Liverpool and Broadgreen University Hospitals NHS Trust	55	4434	33.2
St Helens and Knowsley Teaching Hospitals NHS Trust	13	4384	37.73
Southport and Ormskirk Hospital NHS Trust	6	3721	39.41
Warrington And Halton Hospitals NHS Foundation Trust	19	3482	29.47
Wirral University Teaching Hospital NHS Foundation Trust	41	3477	46.27
Wrightington, Wigan and Leigh NHS Foundation Trust	28	3159	33.46
Mid Cheshire Hospitals NHS Foundation Trust	46	3062	53.15
East Cheshire NHS Trust	13	2748	37.75
Aintree University Hospital NHS Foundation Trust	27	2575	22.58

The charts below shows the organisation's activity for reporting against harms (moderate, sever and death) for Q4 2014/15 and Q1, Q2, Q3 and Q4 2015/16.

Moderate, Severe and Death Harms reported



All reported incidents



2.2. Lessons learnt from incidents

The main lesson learnt from completed serious incidents in this quarter related to the administration of enoxaparin. The Trust became aware that not all enoxaparin prescriptions were being administered. This was highlighted in a case whereby a patient who developed a pulmonary embolism had not had this medication for 3 consecutive days. The Trust was concerned about this practice, despite there being no direct correlation that the missed medication caused the embolism. A number of actions were put into place including;

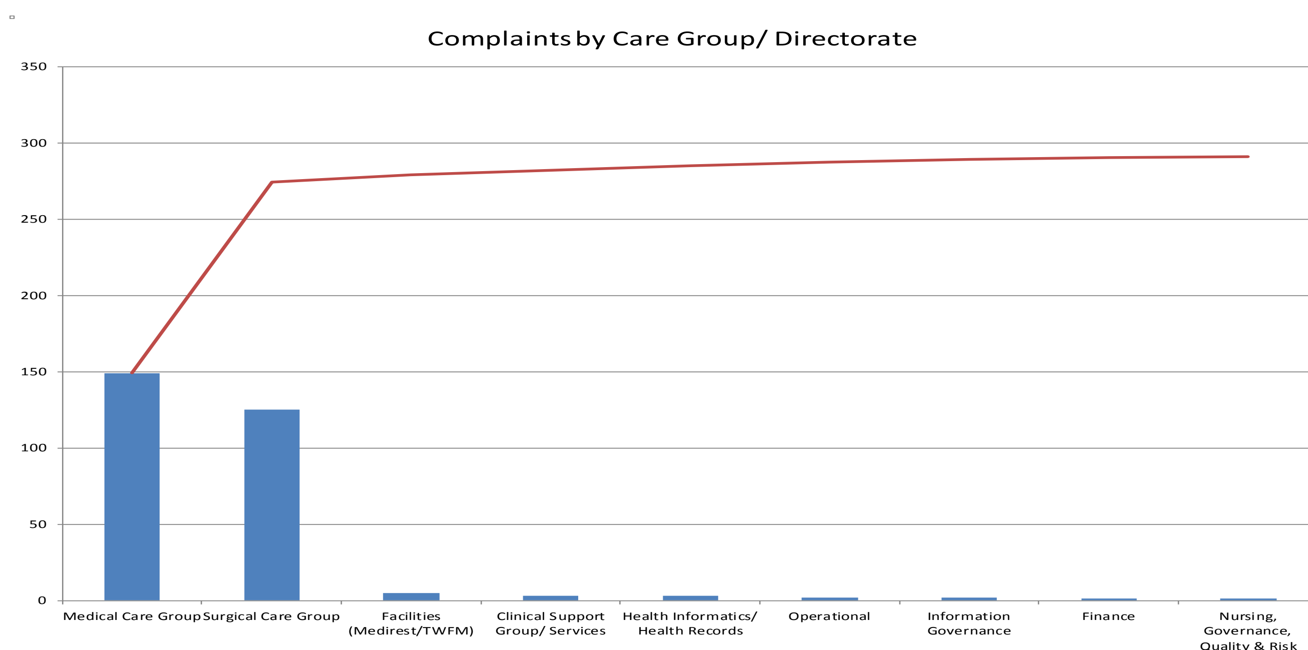
- A review of medication processes to eliminate unnecessary distractions for the staff member
- Ensuring the medicine prescriptions and administration were reviewed at every ward round
- A base line audit was performed in two ward areas to determine the extent of the problem, which highlighted that only 50% of patients received their medication as prescribed, leading to the following being implemented:
  - A daily review of kardex commenced and matrons were asked to feed back any poor practice to the Heads of Quality
  - Messages were placed in the Trust newsletter and via emails.
- Following the implementation of the actions the re-audit showed an increase to over 98% of medicine being administered and this continues to be monitored at Patient Safety Council via the VTE report on a monthly basis and remains over 96%.

3. Complaints and PALS

The following data is based on figures that are generated via DatixWeb. The table below shows the cumulative monthly totals of **1st Stage, approved** complaints received by the Central Complaints team during the financial year 1 April 2015 to 31 March 2016.

	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Total
Medical Care Group	20	16	10	15	10	12	9	16	11	13	6	11	149
Surgical Care Group	13	10	9	12	10	14	13	9	9	8	6	12	125
Clinical Support Group/ Services	1	1	0	0	0	0	0	0	0	1	0	0	3
Health Informatics/ Health Records	1	0	0	0	0	0	0	1	0	1	0	0	3
Facilities (Medirest/TWFM)	0	0	2	0	0	1	0	1	0	0	1	0	5
Nursing, Governance, Quality & Risk	0	0	0	0	1	0	0	0	0	0	0	0	1
Finance	0	0	0	0	0	1	0	0	0	0	0	0	1
Operational	0	0	1	0	0	1	0	0	0	0	0	0	2
Information Governance	0	0	0	0	0	0	0	1	0	0	1	0	2
Total	35	27	22	27	21	29	22	28	20	23	14	23	291

The chart below provides graphical illustration of the cumulative totals by Care Groups, of above 1st stage, approved complaints received during the financial year 1 April 2015 to 31 March 2016.



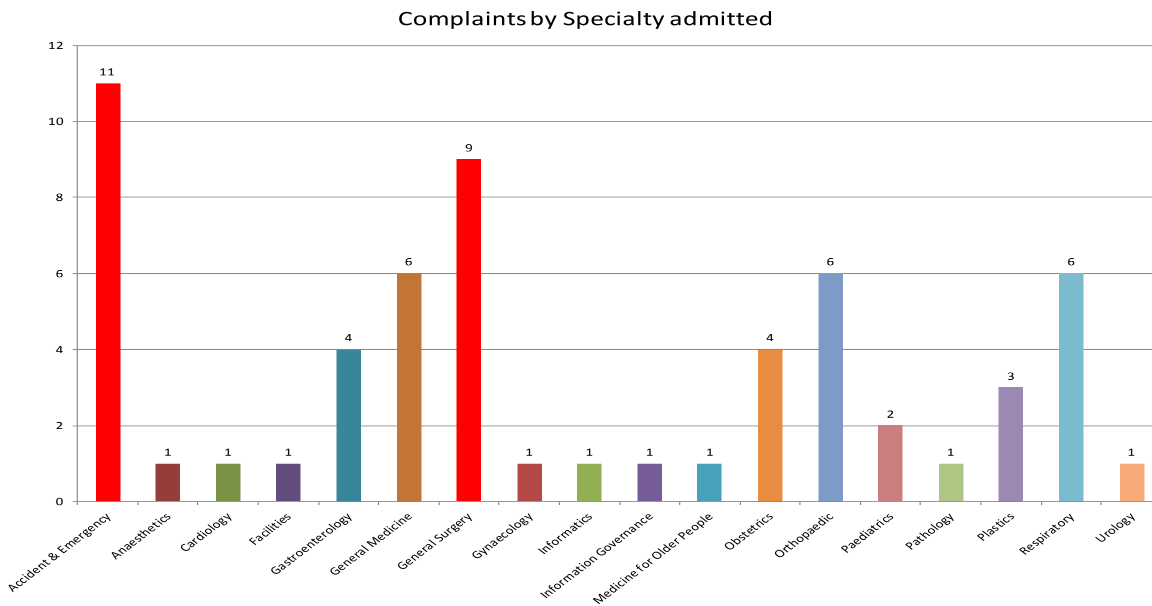
During the Q4 2015-16, there were 70 complaints cases that were responded to and closed. The table below shows the received date range of these complaints:

	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Total
Medical Care Group	1	0	1	6	15	9	5	2	39
Surgical Care Group	0	0	0	2	5	9	8	2	26
Clinical Support Group/ Services	0	0	0	0	0	0	1	0	1
Health Informatics/ Health Records	0	0	0	0	0	0	1	0	1
Facilities (Medirest/TWFM)	0	0	0	0	1	0	0	1	2
Information Governance	0	0	0	0	0	0	0	1	1
Total	1	0	1	8	21	18	15	6	70

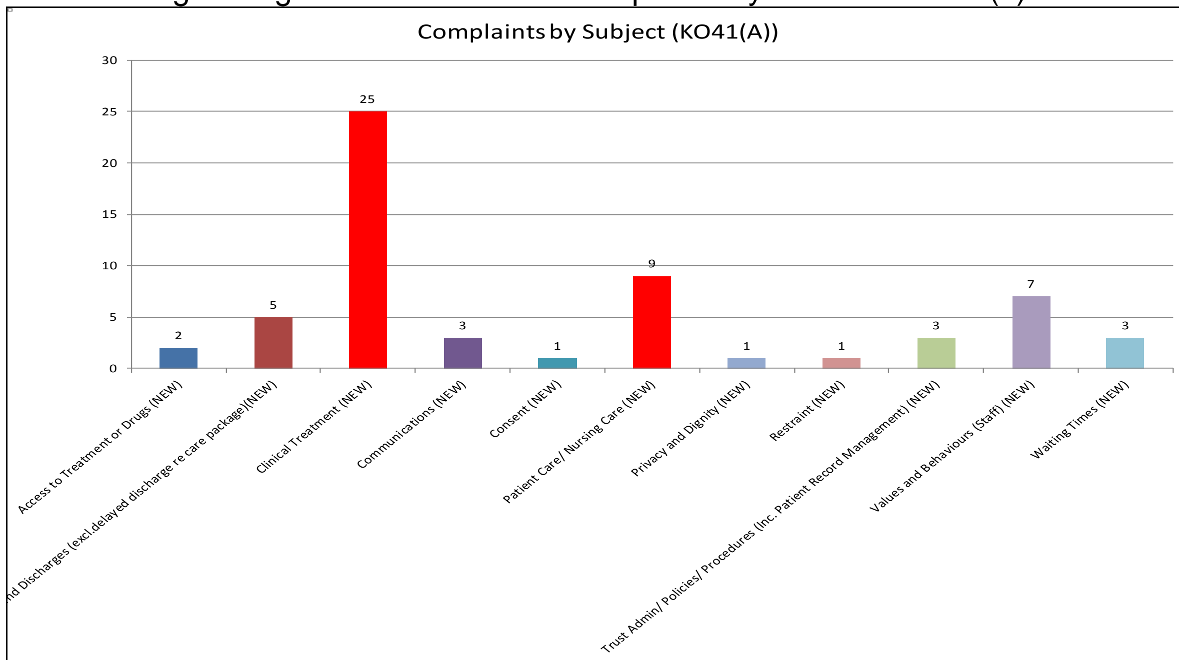
The table below, generated via Qlikview, shows the number of 1st Stage Complaints closed in Q4 with figures showing those complaints closed within agreed timescales, with an average of 50% for the period.

		Jan-16	Feb-16	Mar-16	Q4	2015-2016
Received 2015-16	Stage 1 Resolved	26	19	25		
	Stage 1 Resolved within agreed timescale	13	10	12		
	% Stage 1 Resolved within agreed timescale	**50.0%**	**52.6%**	**48.0%**	**50.2%**	**61.4%**

The following chart gives details of the specialty of these complaints:



The following table gives details of these complaints by the main KO41 (a):



4. Complaints escalated as serious incidents requiring investigation (SIRI)

There were two cases escalated and SIRI investigated in progress. They related to:

1. Potential missed diagnosis
2. Allegation against a health care professional.

5. PHSO Complaints

During Q4, there were four cases that were submitted to the PHSO by the complainants. All four cases have been accepted by the PHSO for full investigation which is currently pending.

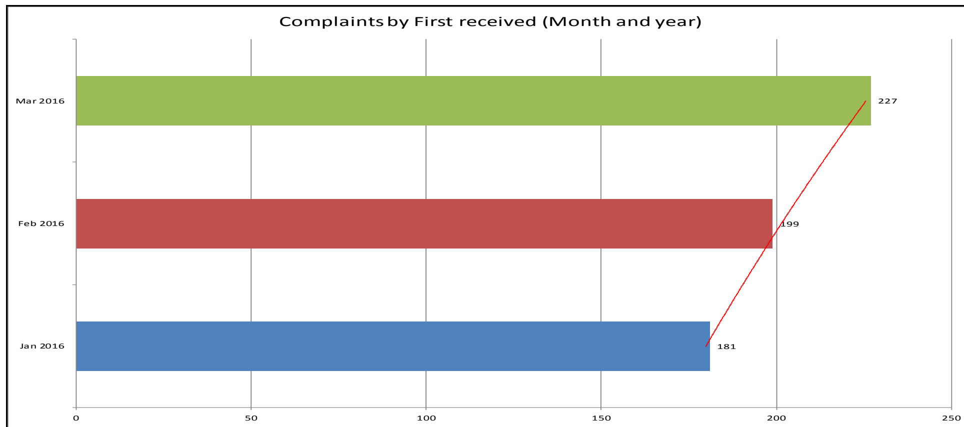
6. Lessons learnt from Complaints

The following table gives examples of five closed complaints with the actions/ lessons learnt.

Description	Sub-subject (primary)	Action taken	Lessons learned	Outcome
Complaint re attitude of the staff on the ward when breaking bad news and a potential delay in diagnosis	Staff attitude Delay in diagnosis	1. Reiteration of ACE 2. Discussion at MDT re Communication and review of patients care undertaken	1. compliance with ACE standards 2 importance of clear communication with patients and families	An action plan has been developed and this has been outlined in this response to ensure that lessons are learned for this complaint and that these are actioned and monitored. Unreserved apologies for failures identified in the outcome of this investigation.
Patient received an injury to his skin which resulted in pain when the nursing staff removed tape from his arm.	Injury sustained during treatment or operation	Retraining re removal of tape form skin to prevent tissue damage	1. IT error when communicating electronic lab results	Apologies on behalf of the team involved for any distress that has been inadvertently caused.
Concern re the care provided to daughter and the lack of compassion and empathy during a traumatic event.	Attitude of Nursing Staff/ midwives	Updated referrals completed and forward to the relevant personnel and copied to the family .	It was agreed that Matron would speak to all staff to ensure that these guidelines are adhered to. In addition the Trust	The Trust acknowledges the complainants experience and after an extensive investigation confirmed that the patient's best interests have always been a priority.
Baby suffered a burn to her right foot due to non-change of a probe.	Injury sustained during treatment or operation	Ward Manager completes regular spot checks. Nursing agency induction to include information regarding handover. RCA completed	Clear regarding who is providing delivery of care on SCBU. Communication with parents.	Root cause analysis investigation undertaken due to exceptional circumstances, and unreserved apologies given for failures identified, and following this investigation.

7. PALS Data

In October 2015 a new PALS contact/enquiry form was introduced to capture PALS data. Since the introduction of the PALS form, data collected is more robust and shows a steady increase in the number PALS contacts enquiries entered into DatixWeb. The following chart shows that during Q4 there were 607 PALS contacts/enquires:



Not all PALS contacts/enquiries are for specific Care groups or specialties or have specific subjects, some could be compliments or for directions/advice. The table below shows PALS contacts/enquiries by the Care Groups, where this is identified:

	Jan 2016	Feb 2016	Mar 2016	Total
Medical Care Group	66	85	83	234
Surgical Care Group	54	86	109	249
Clinical Support Group/ Services	5	4	5	14
Facilities (Medirest/TWFM)	2	0	3	5
Nursing, Governance, Quality & Risk	5	6	4	15
Operational	1	1	0	2
Human Resource	0	0	1	1
Total	133	182	205	520

There were 490 PALS contact/enquiries related to specific specialties, the table below gives details of these specialties.

PALS contacts by specialty

Specialty	
Accident & Emergency	88
Anaesthetics	1
Burns	5
Cardio Respiratory	2
Cardiology	15
Dermatology	4
Diabetes	2
Ear, Nose & Throat (ENT)	11
Facilities	7
Gastroenterology	8
General Medicine	33
General Surgery	82
Gynaecology	27
Haematology	2
Human Resources	1
Medicine for Older People	29
Obstetrics	14
Operational	1
Ophthalmology	7
Orthodontics & Oral Surgery	4
Orthopaedic	74
Paediatrics	6
Palliative Care	4
Pathology	3
Pharmacy	3
Plastics	9
Quality & Risk	16
Radiology	6
Respiratory	17
Rheumatology	1
Therapy Services	4
Urology	4
	490

The table below shows the main KO41 (a) subjects that were raised within these PALS enquiries.

Subject	
Access to Treatment or Drugs	55
Admissions and Discharges (excl.delayed discharge re care package)	133
Appointments	41
Clinical Treatment	73
Communications	98
End of Life Care	8
Facilities	2
Integrated Care (incl. delayed discharge re care package)	1
Patient Care/ Nursing Care	62
Prescribing	2
Privacy and Dignity	1
Trust Admin/ Policies/ Procedures (Inc. Patient Record Management)	2
Values and Behaviours (Staff)	20
Waiting Times	1
Other (e.g. abuse/behaviour/Theft/Benefits)	8
	507

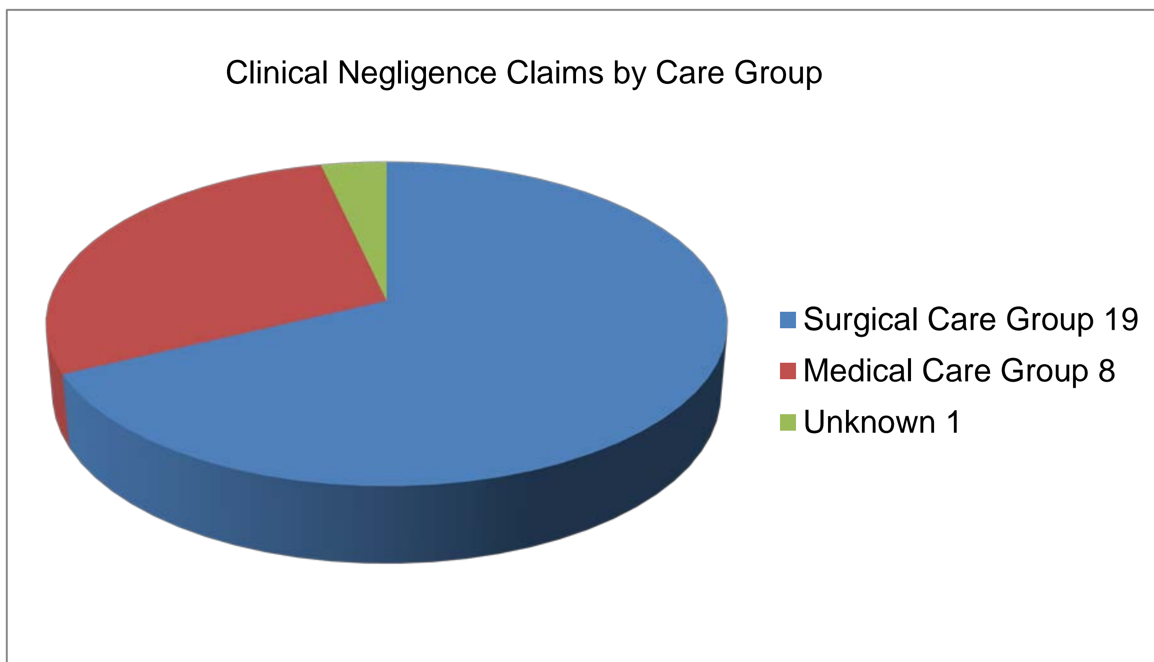
8. Claims

The Trust currently has 406 active clinical negligence claims on-going. This includes those in the pre-action stage through to those which are in the final stages of settlement. The Trust continues to deal with approximately 70% of claims “in house” in order to ensure continuity and cost reduction.

Activity during Q4 includes:

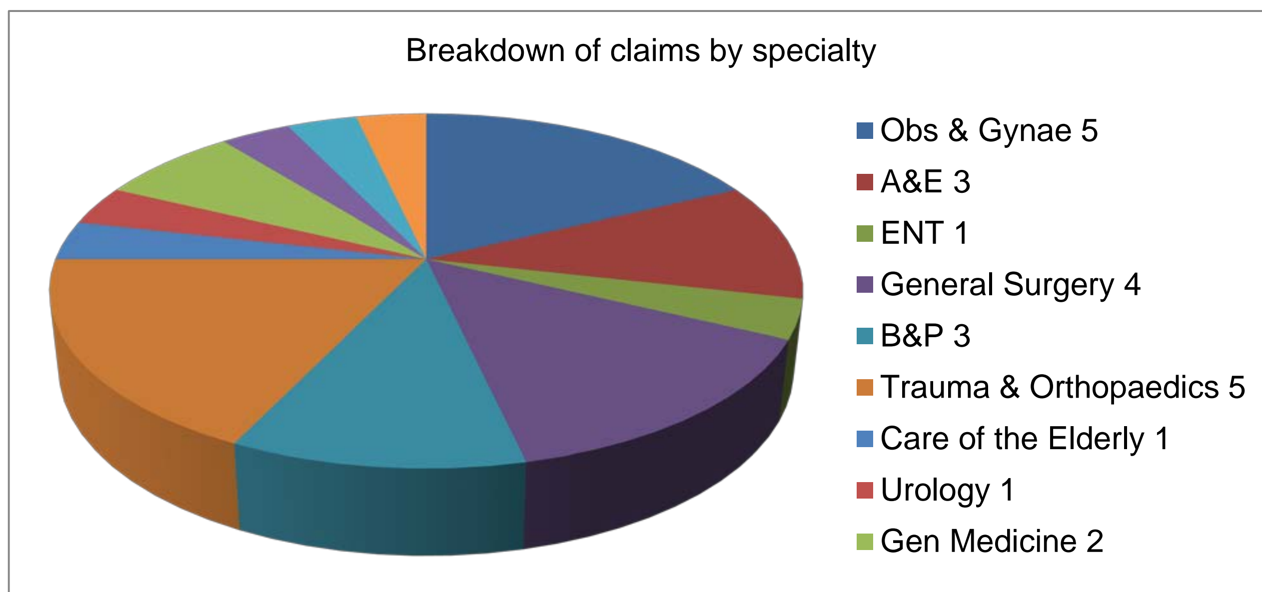
- 1 new clinical negligence claim
- 28 new claims compared to 20 new claims in the same period last year, representing a 40% increase

The chart below shows the breakdown of the 28 new clinical negligence claims received by Care Group

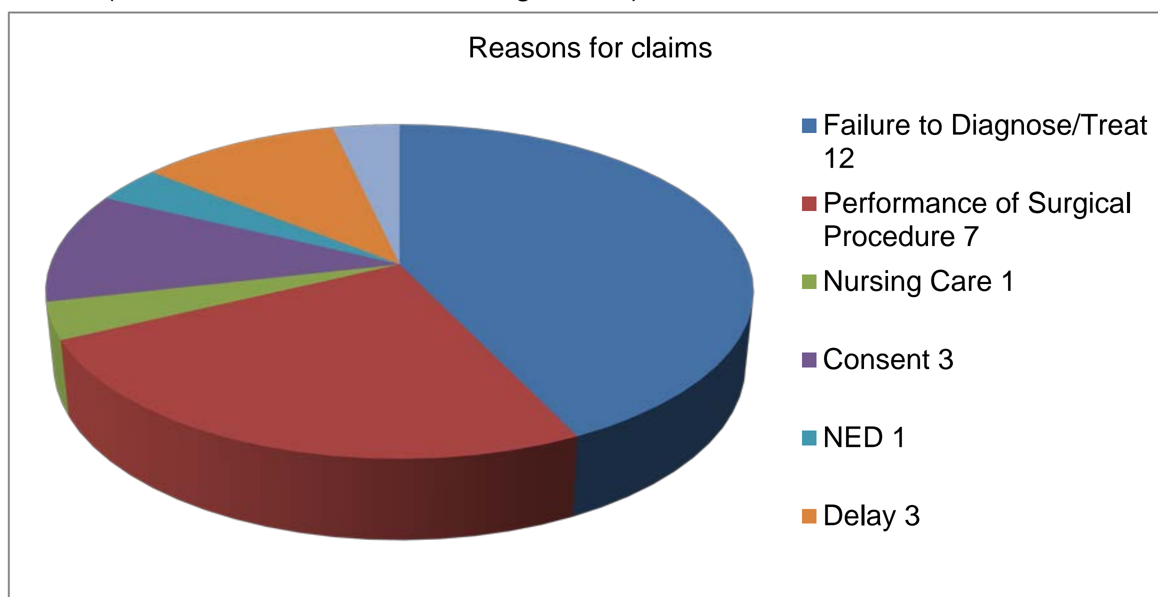


In this quarter Medical Care Group received 8 claims whereas last quarter they received 13 claims which represent a decrease of 38%. This quarter Surgical Care Group received 19 claims whereas last quarter they received 14 claims which represent an increase of 36%. The chart below shows the breakdown of the 28 new clinical negligence claim

specialty.



The chart below highlights the breakdown in the reasons for the 28 new clinical negligence claims. (Please note NED is not enough detail)



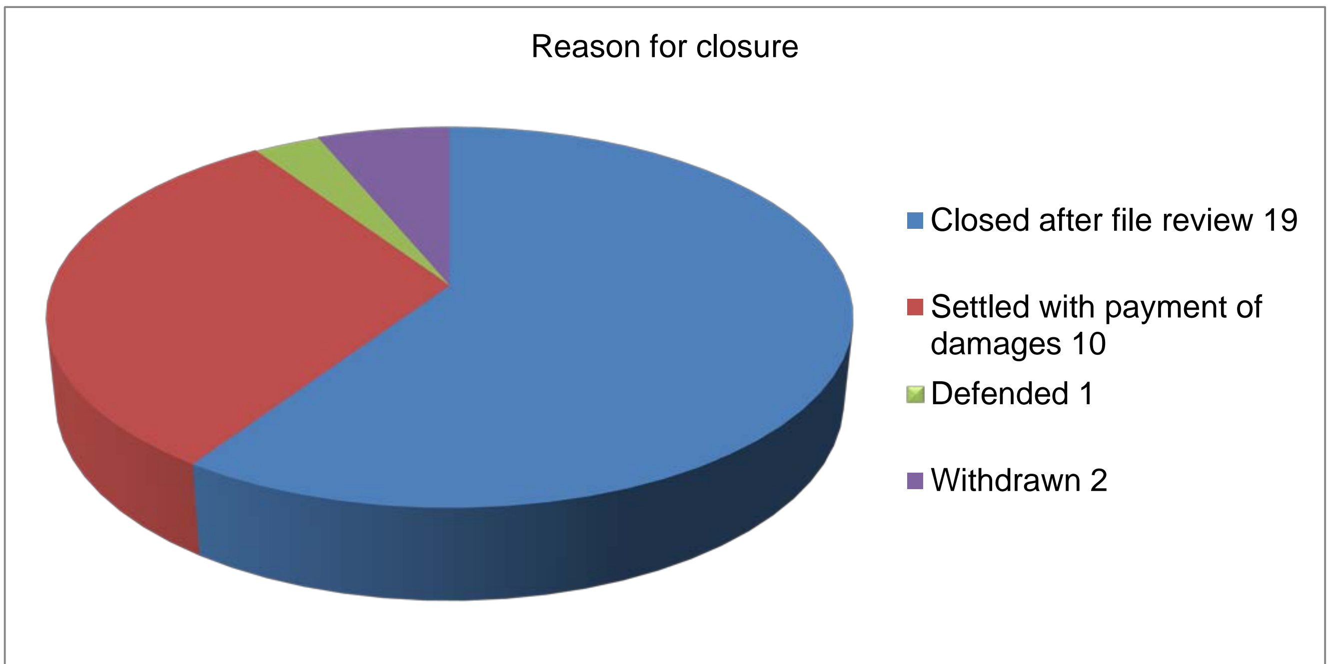
As in the previous quarter, failure to diagnose/treat and performance of surgery remain high litigation areas. However, it must be noted that these figures relate to the time when the claim was received rather that the index event which could have been some time earlier.

9. Clinical negligence claims closed in the period

A total of 32 claims were closed in Q4 2016.

- 10 claims were closed with payment of damages. The total amount paid in damages on behalf of the Trust was £191,715.00. In the same period last year £1,346,228.69 was paid out on the Trust's behalf. This represents an 86% decrease.
- 22 claims were closed without payment of damages. These claims were either withdrawn, successfully defended or closed after file review.

The chart below shows the breakdown in the reason for closure of the 22 claims closed in Q4.



10. Lessons learned from claims

Claims outcome reports and service improvement forms for successful claims are sent to clinicians involved in the care of claimants. This is part of the Trust's requirement to demonstrate lesson learning as part of its membership of the NHSLA. In general the claims outcome reports are continuing to be reviewed to ensure the most effective use of the information provided. Any risk management issues identified by the NHSLA or Trust panel Solicitors are included in these reports.

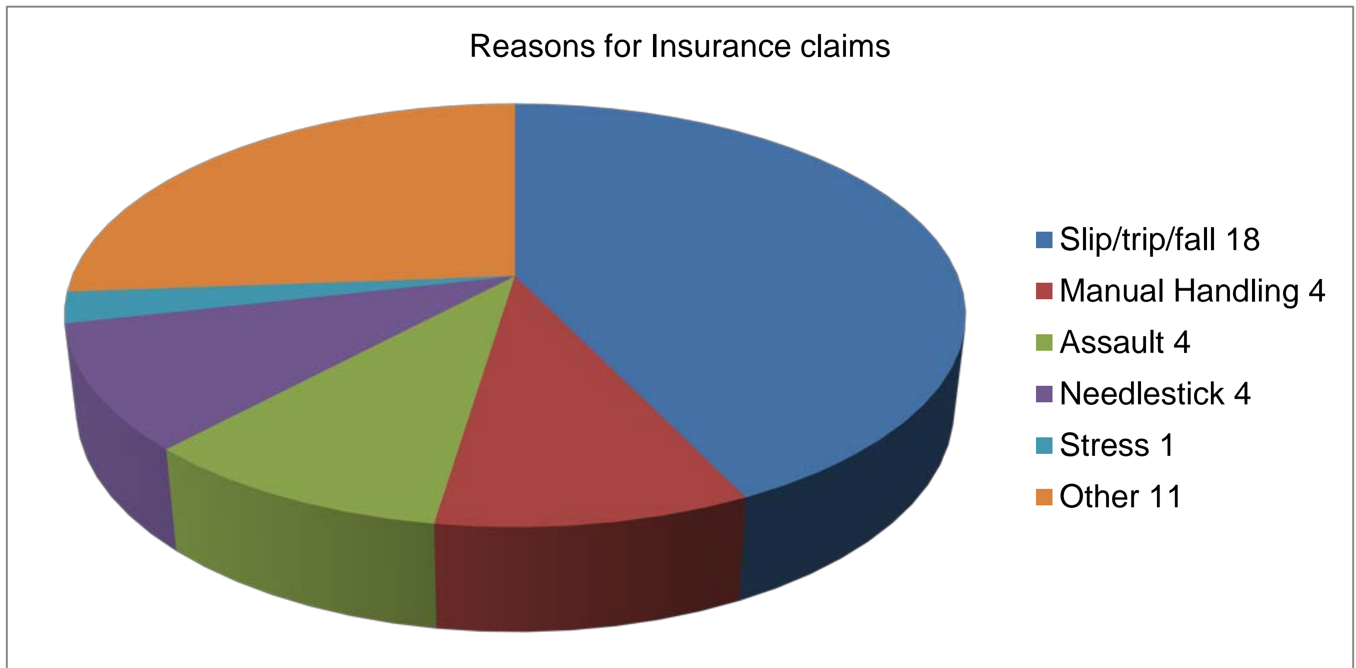
Training sessions have been provided for clinicians recently to facilitate statement writing and development of understanding of the claims process. It is noted that consent continues to be a developing issue and the Montgomery Judgement tested through the Courts. It is intended that further training sessions will be provided in the future according to demands and developments.

The Claims Governance Group consisting of senior managers and clinicians, review all new claims received in the preceding month and advise on claim defendability. It is intended that the NHSLA attend a future meeting to discuss risk management and claims.

11. Insurance Claims

The Trust currently has 42 open insurance claims, with 36 employer's liability claims and 6 public liabilities.

The chart below shows the breakdown by the reason for the 42 insurance claims



12. Insurance claims closed in the period

11 insurance claims were closed in Q4, all with payment of damages, which totalled £49,695.00. The total paid in damages in the previous quarter was £0.00.

13. Inquests

The Trust, via the Legal Department, proactively manages non-routine inquests. These inquests are where members of our staff are being called to give evidence and/or there are novel or contentious issues. In many cases there are lessons to be learned and require a corporate witness to inform the Coroner of these lessons and what action has been subsequently taken to prevent recurrence. The Press and Public Relations Office are also kept informed if there is any potential for media interest and therefore a risk to the organisation's reputation. Currently there are 7 open Inquests that fall within the above criteria.

There were 5 new inquests received during Quarter 4

- Patient involved in chip pan fire – escalation process to ICU
- Patient admitted to ED with Fits potential drug related – Police investigation. No implications for the Trust
- CHAMS patient admission due to overdose x 5 times in January
- Patient Collapse – found on floor in care home
- Head injury in community, full police investigation ,currently being assessed by CPS

3 cases were closed in Q4

- Maternity case which was related to a SIRI August 2015.Outcome: Narrative verdict – number of missed opportunities to review and respond to the CTG's particularly at 7.45am and 8.30am who lead to subsequent intervention.

- Un-witnessed fall in care home. Trust not required to attend: Outcome : accidental death
- Patient found by police at foot of stairs, Trust not required to attend: Outcome, Natural causes

Police
New requests in this period = 90
Re-opened in this period = 23
Outstanding in this period = 30
Closed in this period = 106

14. Access to Health Records

New request within this period = 115
Closed out in this period = 75
Targets breached in this period = 6

15. Third Party

New requests within this period = 515
Closed out in this period = 560
Targets breached in this period = 34

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)068
Title of paper: ANTT update and action plan Report
Purpose: For the Trust Board to receive an update on the Trust compliance with ANTT and to discuss the Improvement action plan implemented to ensure sustained improvement in meeting the required trajectory of 85%.
Summary: The aim of the report is to provide an over view of the Trust compliance rate with the infection control mandatory Antiseptic Non touch Technique (ANTT) procedure and to provide assurance that actions are in place to improve compliance. The Code of Practice specifies that where aseptic procedures are performed the technique should be standardised across the Organisation and all persons undertaking such clinical procedures should receive education and training in such techniques ANTT aims to prevent the contamination of wounds and other susceptible sites, by ensuring that only uncontaminated equipment or sterile fluids come into contact with susceptible or sterile body sites during clinical procedures**.** The Trust has identified ANTT as a key skill to be achieved by staff that carries out aseptic procedures as part of their role. A cascade approach is used to train ANTT assessors in the workplace The Trust has set a trajectory of 85% compliance for all relevant staff who undertake ANTT procedures. An annual update and assessment of practice are undertaken to monitor compliance in accordance with DH guidance. The Trust is not achieving this target in all wards / depts with an overall compliance of 55 %. The improvement action plan to address compliance is embedded as Appendix 1.
Corporate objectives met or risks addressed: We will deliver care that is consistently high quality, well-organised, reflects best practice and provides the best possible experience of healthcare for our patients and their families
Financial implications: None arising directly from the approval of this paper. .
Stakeholders: CQC, commissioners, NHS Improvement, patients, carers, public, staff
Recommendation(s): The Trust Board is asked to note the progress to date in relation to ANTT compliance and to discuss and agree the improvement plan to ensure sustained improvements
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 29th June 2016

Antiseptic Non touch Technique (ANTT) update

1. Introduction

1.1. The aim of the report is to provide an over view of the Trust compliance rate with the infection control mandatory Antiseptic Non touch Technique (ANTT) procedure and to provide assurance that actions are in place to improve compliance.

2. Background

2.1. The Trust is committed to reducing Healthcare Associated Infections (HCAI) therefore demonstrating compliance with The Health and Social Care Act 2008 *Code of Practice on the prevention and control of infections and related guidance* (Department of Health, 2010).

2.2. The Code of Practice specifies that where aseptic procedures are performed the technique should be standardised across the Organisation and all persons undertaking such clinical procedures should receive education and training in such techniques.

2.3. Due to the invasive nature of clinical procedures, health care workers are inherently the main route of infection if compliance with best practice is not adhered to.

2.4. Aseptic Non Touch technique (ANTT) provides health care workers with a practice framework which promotes safe and efficient aseptic technique.

2.5. The Association for Safe aseptic Practice, 2013. Pratt et al (2007) recognise that standardised aseptic technique plays a significant part in care provision as it has been shown to significantly reduce HCAI and provide safe care.

2.6. Asepsis is the method by which healthcare workers can prevent microbial contamination during invasive procedures or breaches in the skins integrity.

2.7. ANTT is the method used to reduce the risk of microbial contamination to a vulnerable site. ANTT is supported by the use of infection control standard precautions for all patients, all of the time.

2.8. ANTT was developed in University College Hospital London; it is a unique and contemporary practice framework for aseptic technique.

2.9. It has become the accepted practice standard for aseptic technique in the National Health Service and it is now used widely internationally (ANTT 2014).

2.10. ANTT aims to prevent the contamination of wounds and other susceptible sites, by ensuring that only uncontaminated equipment or sterile fluids come into contact with susceptible or sterile body sites during clinical procedures.

2.11. The Trust has identified ANTT as a key skill to be achieved by staff that carry out aseptic procedures as part of their role.

2.12. A cascade approach is used to train ANTT assessors is used to train ANTT assessors in the workplace.

2.13. The Trust has 12 ANTT key trainers, 22 Consultant IPC Champions and 82 link nurses.

2.14. The ANTT technique is standard practice across the Trust.

2.15. All staff undertaking procedures involving asepsis are provided with education, training and assessment.

2.16. Annual update and assessment of practice are undertaken to monitor compliance in accordance with DH guidance.

2.17. The main focus of ANTT is to minimise the introduction of micro-organisms, which may occur during any invasive procedure. To reduce the potential for contamination, the technique follows some fundamental rules such as carrying out risk assessment, effective hand hygiene and the appropriate wearing of personal protective equipment and maintaining an aseptic environment.

2.18. The ANTT approach can be considered as surgical or standard.

2.19. The need for Surgical or Standard ANTT is determined by risk assessment based on the technical difficulty of achieving asepsis (the procedure environment, procedure invasiveness, the number & size of Key-Parts & Key-sites and length of procedure).

2.20. While these two approaches differ to accommodate different levels of procedure complexity they both adhere to the same principles of ANTT.

2.21. The ANTT policy has a mandatory training requirement which is detailed in the Trust's mandatory training matrix and is reviewed on a yearly basis.

2.22. The training is provided to all staff who undertake aseptic procedures as part of their role through a cascade approach using ANTT trainers and ANTT e-learning package (DVD).

2.23. Staff is required to undertake theory and competency assessment following training.

3. ANTT Position Statement – May 2016

3.1. A review of the compliance data has been undertaken to ensure all completed assessment has been recorded on ESR.

3.2. A report of staff that have not completed or updated competency assessment in the last 12 months was circulated to the department leads, Heads of quality and clinical Leads to address non-compliance with policy and practice.

3.3. A number of senior clinical staff do not perform ANTT procedures in the course of their clinical work but are responsible for the care of patients who require them, and the supervision of staff that perform them.

3.4. Chapter 45 (ANTT) is to be revised, with a clearer statement for exemptions, for those who do not perform ANTT procedures but remain indirectly involved in ANTT as above.

3.5. 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 form annual update of competency.

3.6. All clinical staff are required to complete ANTT Theory; those performing procedures will also be required to complete ANTT Practice (assessments).

3.7. From July 2016 ESR will reflect ANTT theory and ANTT practice as separate domains.

3.8. A nationally accredited ANTT e-learning package is available, feasibility and time –scales for introduction are to be established by the IPCT.

3.9. Successful completion of e-learning (Theory) would be automatically fed to ESR.

3.10. The nationally accredited ANTT assessment framework (DOPS) is to be rolled out from September 2016.

3.11. ANTT stickers to be displayed on name badges for all staff who have undertaken both theory and practical competency assessments from September 2016.

3.12. ANTT Key Trainers training sessions to be continued on a quarterly basis.

3.13. Ward and department key trainers will assess all staff, both Nursing, Medical and Allied Health Professionals, were applicable.

3.14. A monthly report will be provided to the Patient Safety Council to monitor compliance.

4. **Current compliance rate as per ESR data (21st June 2016)**:

4.1. Overall compliance 55%. A review of compliance data indicates that 32 areas are achieving the required trajectory for nursing staff compliance. However, there are a number that still need further assessments to be undertaken.

4.2. In relation medical staff compliance a different approach is required to ensure the Medical teams receive appropriate assessment of compliance.

4.3. Suggestions have included Nursing staff to train medical staff to become trainers and assessors for ANTT and provide sessions on audit days to increase compliance.

4.4. The recent data cleanse process has highlighted that a numbers of staff have undertaken training and competency assessment in venepuncture and peripheral cannulation which involves the ANTT process. However, this had not been recorded on the ESR system.

4.5. The Infection control and training and development teams are meeting to agree the process for coordinating this data to ensure ESR reflects the compliance rate accurately.

4.6. Matrons and ward managers for each area are ensuring that there is an increased focus to ensure compliance is improved and sustained.

4.7. A number of areas have indicated that they will be above 90% compliant within 2 weeks for nursing staff. EG ENP's in ED, delivery suite, 5D stroke, Gynaecology and Cardiology.

4.8. In addition, the key trainer is undertaking the assessments of Doctors within their ward or department.

5. **Action plan to monitor and improve compliance**

5.1. The Trust Board is asked to note that a clear action plan is in place to achieve the required standard and this will be regularly reported through the Quality Committee.

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)069
Title of paper: Update on Mandatory Training
Purpose: To advise the committee of actions taken and planned to address the shortfall in compliance in Mandatory Training
Summary: Current mandatory compliance is below expected target of 85%. Currently stands at 77, a slight improvement on last months' position. A range of remedial actions have been taken to tackle the issue including increasing capacity on pre exiting programmes and systems to address high levels of non-attendees, currently at 30% per month. Medium and longer term actions include revising the retraining period from 12 to 24 months for clinical staff to bring the trust in line with the core skills framework recommendations and a range of similar acute trusts nationally.
Corporate objectives met or risks addressed: Safety, Developing organisational culture, Financial performance
Financial implications: Potential costs associated with implementation of effective e-learning. Details to be advised in July following a thorough options appraisal.
Stakeholders: All Staff, CQC, CCGs, Patients
Recommendation(s): To accept the shift in retraining period to 24 months. To support the move of recommended subjects to distance/ e-learning.
Presenting officer: Anne-Marie Stretch, Director of HR
Date of meeting: 29th June 2016

MANDATORY TRAINING UPDATE FOR FINANCE & PERFORMANCE COUNCIL

OVERVIEW

Mandatory training (and Corporate Induction) are currently delivered face to face and comprise a number of statutory subjects, including H&S, fire safety, moving and handling, life support and subjects which are mandated by a range of external bodies including the CQC or by the Trust itself.
Over time there has been an increase in the number of subjects that areas of the Trust have requested.
Delivery is targeted at all staff which are subdivided into 2 broad groups of clinical (patient facing) and non-clinical staff, with clinical staff attending for a full day and non-clinical for a half day due to the relevance of subjects.
Retraining periods for each group are currently set at 12 months for clinical staff and 24 months for non-clinical, these are based on each subject having a specified retraining period defined by the relevant external body which ranges from 12 to 36 months. The current programmes structure is based on the complexity of delivery and assurance that the Trust would achieve compliance.

The following table details the current programme.

Subject	***Delivered by***	***Staff Targeted***
Safeguarding, Disability & Mental Capacity Awareness	Diane Gould/Anne Monteith/Tina Cavendish (Safeguarding Team)	All
Information Governance	Craig Walker (IG)	All
MET	L&OD	All
Health & Safety and Fire Awareness	L&OD	All
Load Handling	Heidi McMahon (L&OD)	All
Infection Control	Julie Grimes /Tracey Kelly (IPC Nurses)	All
MEWS	Outreach Team	Clinical
Life Support	Paul Craven /Jane Carnall (Resus Team)	Clinical
Medicines Management	Sophie Helsby (Pharmacist)	Clinical
Patient Falls	Chris Stanley (Falls Team)	Clinical
Medical Devices	Rose Parker (L&OD)	Clinical
Blood Transfusion	Malcolm Roberts/Helen Buchanan (Pathology)	Clinical

Delivery of each subject on the programme is by the Subject Matter Expert (SME), i.e. the organizational lead for that subject, to ensure both audience buy in and an ability to respond to the complex questions often raised. SMEs are predominantly specialist nurses e.g. falls and infection control.

CURRENT POSITION

In the year 01/04/2015 to 31/03/2016, 4,125 places were offered for clinical staff and 1,940 places for non-clinical staff, with a similar capacity planned for delivery between 01/04/2016 and 31/03/2017. With a clinical workforce of 3,100 and non-clinical workforce of 1,200 this provides a minimum of 33% more places than should be required assuming all courses are fully booked and all staff attend. The programme is delivered a minimum of 2 times each week with capacity on each date for 20 non clinical staff and 35 clinical.

Up to 31/03/2016 this model had achieved the necessary target, based on an historical 20% wasted or unused spaces. However, a significant increase in the number of no shows and the

requirement to cancel sessions to maintain service delivery due to industrial action and operational pressure, impacted the ability of all non -compliant staff to attend by 31/03/2016 and continues to be an issue.

A number of remedial actions have been taken in an effort to recover the position including;

- Increasing the capacity of all existing mandatory training sessions by over booking by 10% adding approx. 350 additional places per month.
- Targeting the managers of areas with low compliance to access the additional capacity. L&OD are communicating directly with managers of these areas to facilitate access to training supported by the HRBPs and Directorate Managers.
- Contacting managers of staff that failed to attend to reinforce the message about wasting valuable capacity. Requesting they rebooked those staff and review all future bookings to ensure staff attend. In May, 30% of booked spaces were lost due to no shows. When challenged, the predominant reason given for non-attendance was an inability of the manager to release staff due to operational pressures.
- Managers of non-compliant areas continue to be contacted in line with policy on restriction of incremental pay. The excessively high level of wasted spaces in the form of 'no shows' is cancelling out the additional capacity added above and restricting the ability to provide spaces in the short term.
- Adding additional sessions to the existing schedule. This has proven difficult due to availability of SMEs, linked to their existing clinical commitments and access to suitable rooms.

FURTHER ACTIONS

The L&OD team are undertaking a radical review of mandatory training focusing on the following 3 key elements relating in particular to clinical staff.

1. Retraining periods.

L&OD have reviewed the recommended retraining periods for all the Trust current mandatory training subjects against the requirements of the various lead bodies and the Core Skills Framework, which sets out for each of 10 identified mandatory subject areas:

- Learning outcomes.
- Standards for delivery.
- Refresher training periods.
- Mapping to Professional Regulatory Bodies Standards for Competence.

L&OD also compared the current requirement of 12 months for clinical staff with that adopted by a significant number of similar acute organisations both locally and nationally.

On the basis of the findings it is clear that the refresher period for clinical staff could be safely extended to 24 months and still remain within the recommendations. Non-clinical staff would remain at 24 months.

There are 3 notable exceptions to this:

- Life support
- Information Governance
- Infection control

These could be addressed by access to e- learning to cover the theoretical elements and for Life Support a shorter annual face to face session involving assessment of competence.

A recommendation is being made to the Executive Committee for the immediate adoption of the change in retraining period which, whilst not placing patients, staff and the Trust at risk, would;

- Raise compliance, based on Mays' data, to over 95%.
- Release sufficient capacity for all non-compliant staff to access mandatory training.
- Provide the headroom necessary to make the suggested changes to delivery.
- Reduce demands on service to release staff and ability to train non-compliant staff.
- Reduce the need for backfill in clinical areas to release staff, thereby reducing reliance on bank and agency usage.

2. Content

Many of the subjects are in a presentation 'Chalk and Talk' format and present difficulties in engaging effectively with all those present. Due to the diverse nature of the audience and the complexity of different professional groups requiring different content in each specific subject area, subjects are delivered in a 'one size fits all' approach, the impact of this being that certain groups are compelled to listen to presentations which may not be either wholly appropriate to them or not fully meet their specific needs.

Content is being reviewed in line with statute, mandate and guidance from the relevant bodies as indicated in 1 above, to develop content specific to the needs to the staff groups moving away from a one size fits all approach and to reduce the time commitment of staff.
In line with this, content has been reviewed in relation to its currency, identifying a number of subjects previously added to the programme to meet a short term need, which are now being removed or replaced as the purpose for which they were added has been achieved.

In order to manage new content, governance processes require all new requests for additions or changes to mandatory training to be reviewed and signed off by the Medical Director and Director of Nursing to ensure they are of a sufficiently critical nature to be included, have appropriate, not excessive content and are targeted at the correct staff groups. In addition, going forward all mandatory training subjects will be reviewed by L&OD against the Core Skills Framework recommendations to ensure that they meet the minimum standards and retraining periods.

3. Delivery methods.

All content has been reviewed against its ability to be delivered in a more time efficient and flexible way. A large proportion of material could be delivered as distance learning in the form of e-learning which would allow us to readily monitor both progress and compliance without increasing administrative burden.

Adoption of e-learning would allow tailored programmes for each professional group, as indicated in 2 above, removing the requirement to receive training or information irrelevant to the role and reducing the time commitment of the individual. On logging into the system, staff would be presented with only the e-learning relevant to their role in the form of a 'learning path'.

The Trust has 1023 PCs at St Helens, 2205 at Whiston, 500 laptops across both sites and ready access to an e-learning platform in ESR/OLM on which resides a range of readily usable packages that could substitute for some face to face provision.
These packages have and are, being effectively used in other Trusts nationally and locally and would, subject to the IT infrastructure supporting it, allow a rapid transfer to an e-learning solution.

To date, previous attempts to effectively deploy e- learning across the organisation have been hampered by the Trusts' current IT infrastructure and the clash between software requirements for Trust clinical and other systems and those required for e-learning. A joint project is underway with L&OD and IT to look at resolving these issues with an options appraisal to be compiled with all costs and presented to Executive Committee at the end of July. Initial work indicates that the use of ESR/OLM to deliver e-learning may prove the most time and cost efficient option.

Other work being completed as part of this project includes a review of the number of PCs that could support e-learning and their distribution, the number of staff with email accounts and how these are issued to new employees and how those staff that don't have immediate access to a PC in their work area or those with vision, hearing or other disabilities are supported. To address this it is suggested a number of sessions within a suitably specified room would be bookable, during which a facilitator would be present to support them in case of any access issue.

Although distance learning offers increased flexibility, there are some important points to note:

- Staff will need time protected to complete their mandatory training, although this may be in a series of shorter blocks rather than commitment to 1 full day out of the workplace for clinical staff and ½ day for non-clinical staff. – As part of the project, work is being undertaken to understand the average amount of time an individual might need to complete the training.
- Some e-learning may take longer than its face to face alternative - Longer term plans include the development of e- learning knowledge assessments as a less time onerous alternative to repeated training in the same subject. For any individual that has previously completed the full course, an automated test would allow them to answer a series of questions on the mandatory subjects appropriate to their role. Those passing would be credited with compliance, those failing being compelled to complete the programme.

In the shorter term, to ensure compliance can be maintained it is recommended the Trust maintains some face to face delivery of the Core Skills Subjects with a longer term plan to phase this out.

In all cases it is imperative that managers take responsibility to ensure their staff are accessing and completing the training. To ensure this, recording, reporting and monitoring processes will be amended to provide feedback on compliance for all modes of training delivery.

4. Access.

In line with the change to 24 months retraining period, staff are being pre booked onto relevant sessions in an effort to limit the number of no shows and to ensure all staff have a pre-assigned date for training. The L&OD team are working with e-rostering to identify how this information can be entered into the system to ensure managers do not place on shift any staff already booked for training on that day.
This is subject to the longer term development of the e-learning solution which would negate the need for face to face contact in the case of most subjects.
Where the Trust adopts an e-learning option, all staff would be issued with usernames and passwords by the ESR/OLM team which would act as the administrative support team for the system users.

NEXT STEPS

The following action plan details the steps and timescales currently being led by the L&OD team.

Action	*By Whom*	*Target Date*
Review of current content of mandatory training against national and local standards	L&OD	May 2016
Discuss with SME the current relevance and potential removal of mandatory training subjects from programme or alternative delivery.	L&OD	May 2016
Review of current retraining periods for each mandatory subject against national and local standards	L&OD	May 2016

Benchmark current retraining periods for each mandatory subject against other acute trusts nationally and locally	L&OD	May 2016
Identification of all available relevant e-learning packages on ESR/OLM	ESR/ OLM Team	May 2016
Review of available e-learning packages on ESR/OLM by SMEs	ESR/ OLM Team	July 2016
Liaise with other organisations delivering e-mandatory training using ESR/ OLM	L&OD	June 2016
Set up learning paths for each role on ESR/ OLM	ESR/ OLM Team	July 2016
Establish required time commitment for an individual completing mandatory training as e-learning	ESR/ OLM Team	July 2016
Set up usernames and passwords for all staff.	ESR/ OLM Team	August 2016
Establish understanding of distribution and access to PCs by workforce	IT	July 2016
Understand issues relating to software and hardware requirements of PCs to run e-learning on ESR/OLM	IT	July 2016
Identify number of staff without email addresses	IT	July 2016
Establish processes to ensure all new employees are issued email addresses on entry to the organisation	IT	July 2016
Options Appraisal Paper to Executive Committee	L&OD	July 2016
Pilot use of e-mandatory training with medical workforce	L&OD/ ESR Team/IT	August 2016
Review pilot of e-mandatory training with medical workforce	L&OD/ ESR Team/IT	September 2016
Trust wide roll out of e-mandatory training.	L&OD/ ESR Team/IT	November 2016

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)070
Title of paper: Committee Report - Audit.
Purpose: To feedback to members a summary of the activities of the Audit Committee.
Summary: The Audit Committee met on 24th May 2016 to discuss and review the Trust's annual accounts, annual report and quality account. This involved the following: • **Annual Governance Statement/Annual Report** – Mr P Williams gave a presentation of the Annual Governance Statement on behalf of the Chief Executive and of the Trust's annual report and, subject to a minor amendment to the Annual Report, these were approved by the Audit Committee. • **Presentation of the Annual Accounts** – Mr D Brimage provided a brief overview of the Trust Annual Accounts concentrating on the Trust's performance on its key statutory financial duties. • **Audit Findings Report** – Mrs J Bellard of Grant Thornton presented the Audit Findings Report and gave an unqualified opinion on the financial accounts with nothing to bring to the Committee's attention except for some minor re-categorisation instances. With regard to value for money, the auditors were also satisfied that, in all significant respects, the Trust had proper arrangements in place to secure economy, efficiency and effectiveness in its use of resources. • **Adoption of the Accounts** – See separate paper NHS(16) 071. • **Letter of Representation** – Mr Khashu presented the draft Letter of Representation which declares in writing that the financial statements and other presentations to the auditor are sufficient, appropriate and without omission of material facts to the financial statements. This was approved by the Committee and a copy can be provided on request from the Director of Finance. • **Presentation of the Quality Account** – Mrs S Redfern gave a detailed presentation of the Quality Account. • **Quality Account Report** – Mr G Winstanley presented the auditor's report on the Quality Account for which an unqualified conclusion was given. • **Approval of the Quality Account** – This was approved by the Audit Committee.
Corporate objectives met or risks addressed: Contributes to the Trust's Governance arrangements
Financial implications: None directly from this report
Stakeholders: The Trust, its staff and all stakeholders
Recommendation(s): The Board are asked to note the contents of the report.
Presenting officer: Su Rai, NED and Chair of Audit Committee
Date of meeting: 29th June 2016

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)071
Title of paper: Adoption of the Annual Accounts.
Purpose: To inform Board members of the Audit Committee approval of the accounts
Summary: The Audit Committee which met on 24th May 2016 approved the annual financial accounts under delegated authority from the Trust Board following a review of the accounts, considering the external auditor's Audit Findings Report (and the unqualified opinion on those accounts contained therein) and after reviewing and accepting the Management Letter of Representation. A copy of the statutory accounts (with signed certificates/opinion appended) can be provided by the Director of Finance on request.
Corporate objectives met or risks addressed: Contributes to the Trust's Governance arrangements
Financial implications: None directly from this report
Stakeholders: The Trust, its staff and all stakeholders
Recommendation(s): The Board are asked to note the contents of the report.
Presenting officer: Su Rai, NED and Chair of Audit Committee
Date of meeting: 29th June 2016

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)072
Title of paper: Executive Committee Assurance Report.
Purpose: To feedback to members key issues arising from the Executive Committee meetings.
Summary: 1. Between the 19th May and 16th June four 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 differential sickness rates and overseas recruitment initiatives. 3. Assurances 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. 4. Investment decisions included on-call arrangements, midwifery staffing, Paediatric Consultant, pharmacy staffing, and supporting the Guardian role. 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: 29th June 2016.

EXECUTIVE COMMITTEE REPORT (19th May to 16th June 2016)

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

19th May

1. MAXIMS
   1.1. Business continuity issues arising during the MAXIMS upgrade were discussed and actions agreed to address these through the Risk Management Council.
2. Safer staffing / Vacancy dashboard
   2.1. April data was discussed. Inconsistencies with eRostering data were noted and confirmed that further investigation is ongoing.
   2.2. The process and timeliness of data collection was discussed and it was agreed that improvements are required along with the quality and appropriateness of descriptions within the report. Noted that MIAA are looking to undertake a random sample check to test controls, compliance and procedures.
   2.3. Staffing Dashboard data discussed and improvements noted.
3. Strategic accommodation review
   3.1. Nicola Bunce (NB) provided the monthly progress report. Early work indicates that theoretically there is sufficient non-clinical space in the main hospital building to create additional wards (but not necessarily in the optimum locations or with appropriate clinical adjacencies). However this would require re-provision of accommodation elsewhere and additional staffing.
   3.2. 'Quick win' options were discussed along with possible temporary solutions to help with winter flows.
4. Sickness targets
   4.1. AMS proposed the introduction of differential sickness targets for specific staff groups which was approved for implementation from 1st June.
5. Feedback on FY2 changes and Brno recruitment
   5.1. AMS reported that the 6 FY1s recruited from Brno were being retained and further recruitment is required in readiness for next year. It is agreed that a further 8 can be recruited and a visit will take place at the end of the month.
6. 3-way Executive to Executive meeting on 26th May
   6.1. Feedback from the work-streams was discussed, along with ToR for the Clinical Reference Group. Agreed that greater consistency in reporting is required.
   6.2. Noted that Steve Cox has requested an extension to the date for STP submission until September but this is not thought to have been successful.
7. HEE report on education and training for safety
   7.1. Neal Jones provided an overview of published plans for enhancing the safety of healthcare in the NHS. A gap analysis was provided showing that the Trust is compliant in most areas. Proposals for Human Factors Training, and gaps on the Guardian role specification were debated with further work agreed.
8. On-call arrangements
   8.1. PJW presented a paper recommending that senior managers should be entitled to A4C on-call payments. CW indicated that this would need to be replicated for Informatics.

8.2. This was approved but it was confirmed that funding would need to be identified from within current Care Group and HIS resources.

9. VTE update

9.1. KH confirmed that a monthly report will be brought to Clinical Senate; the next being 30th June, and that intense support is being given to address this issue.

10. On-call neurosurgical advice

10.1. KH briefed members on the proposals from the Walton Centre and agreed to seek views from A&E and AMU for responding to the plans.

11. Cover to Warrington Hospital for Lung Clinical Network Group

11.1. KH briefed members on this request and it was agreed that further discussion with Dr Simon Twite would be required prior to dialogue with Warrington reps.

12. Local Clinical Excellence Awards

12.1. The Trust stance with respect to this issue was reviewed and reconfirmed.

12.2. Locum Payment Policy is due for discussion at the LNC meeting and it was agreed that a fresh-start on drafting this agreement is probably required.

13. Cover for Director of Operations

13.1. The arrangements following PJW departure in early June were discussed and noted that Rob Cooper will be acting-up until a formal appointment is made. The importance of appropriate backfill of the ADO role was reiterated.

14. PA Consulting

14.1. Noted that NK is meeting with PA Consulting on 23rd May with the intention of bringing a report and recommendations back to Committee at the end of June.

15. Clinical Digital Maturity Roadmap

15.1. CW expressed her disappointment with the Trust ranking being reported by the HSJ. This was based on self-assessment, has not undergone an external consistency or validation process, and was meant to be internal to the NHS.

15.2. CW confirmed that future technology funds are to be allocated by the STPs.

16. Car parking

16.1. Brief discussions were held on the current pressures and the problems with either increasing supply or reducing demand.

2nd June

17. Trust Board agenda

17.1. The agendas for the meeting on 29th June were agreed with the inclusion of a Sustainability and Transformation Plan update.

18. Review of penalties

18.1. NK gave an overview of the financial impact of penalties applied for 2015/16 and the mapping of the same for 2016/17.

18.2. The realignment of penalties following acceptance of the Sustainability and Transformation Fund was discussed.

18.3. It was noted that 88% of the mitigated financial risks related to CQUINs and A&E/Ambulance performance. A further paper was requested.

19. Analysis of Birth-rate Plus data

19.1. Sue Hill (SH) and Sue Mundy (SM) provided a summary of the findings from applying the Birth-rate Plus methodology to the maternity unit. HCA roles, case mix comparison, midwife led births and the birth forecast were discussed.

19.2. SM advised that some pathway efficiencies had been identified, and a more detailed review with greater clarity on the births: midwives ratio will be presented in September including role reconfiguration and eRostering.

19.3. Following detailed discussion it was agreed that as an interim measure, 5 additional midwives could be recruited over the current establishment, with minimal financial risk due to turnover.

20. CQC action plan – Maternity Services

20.1. Tennyson Idama (TI) and SM reported on actions in response to the CQC inspection.

20.2. It was noted that the Maternity Strategy will be ready by 30th June with inclusive input from all maternity staff, and links to the local Vanguard.

20.3. TI reported on progress in general and the implementation of the Maternity Led Unit by October/November 2016. He went on to report that the electronic medicine handover was a massive improvement with up to date information.

20.4. Improvement in staff participation and engagement was noted, and CTG training has surpassed the target.

21. Paediatric Consultant business case

21.1. Laweh Amegavie (LA), Maysara Aziz, Susan Thong and Natalie Gilmore presented the case for additional staffing.

21.2. The commencement of initiatives to address DNAs and first to follow-up ratio was discussed.

21.3. LA is producing a report on the requirement for more comprehensive training for Deanery junior doctors.

21.4. Following discussion the business case was approved.

22. Vanguard Memorandum of Understanding

22.1. Following discussion on the aims and objectives of the Vanguard, it was agreed that the Trust would confirm full membership of the wider system.

23. Therapy services review

23.1. Dave Anwyl (DA) and Anne Molton (AMo) provided a summary of progress with therapy services and the priorities for service improvement. The importance of training and rotation was noted, in particular with regards to retention of staff.

23.2. NK agreed to liaise further with DA and AMo and undertake a benefits analysis in two months, when there will be more clarity on the financial position.

24. Agency usage

24.1. Malise Szpakowska provided the update for May. The work being undertaken with the wards to assist with eRostering annual leave booking was noted.

25. Ward 4D infections

25.1. SR fed back from the PHE discussions on Pseudomonas where it was confirmed that the Trust could not have done anything to prevent the outbreak.

9th June

26. Apprenticeship levy

    26.1. Adam Rudduck (AR) provided an outline of the new levy to be applied to all employers in April 2017. The Trust will be required to deliver 2.5% of its workforce as apprenticeships (116 in total) and a charge of 0.5% of the pay bill will be applied (c£1m).

    26.2. AR reported that negotiations were ongoing with local colleges and universities, and noted that HENW is also looking at the best way to maximise the use of the funding.

27. Pharmacy business plan

    27.1. Simon Gelder, Neil Schroeder, Tracey Thornton and Mark Hogg described the plans for the development of the Pharmacy and Medicines Management services.

    27.2. Further resource is now required to meet increased activity and to improve support to timely discharges. This initial proposal will be revenue neutral from removal of current agency budget, use of patients own drugs, and 2016/17 growth allocation, and was approved.

28. Vascular service

    28.1. Phil Nee, Gwen Pantak and SH updated on progress with the SLA for Vascular Services. The rapid growth was acknowledged, along with consequent capacity issues, all indicating that an improved model is required for the Trust, with more available sessions. Next steps with regards to discussions with Joint Venture partners were agreed.

29. eReferral system

    29.1. CW reported on the IT system being rolled-out by St Helens CCG and confirmed that it will be delayed until full testing has been undertaken.

16th June

30. CQUINs

    30.1. Nicola Broderick briefed members on the 2015/16 CQUIN targets and the resulting penalties applied, and the targets for 2016/17. Progress against targets will be regularly reported through Clinical Senate.

31. Corporate Risk Register (CRR)

    31.1. NB briefed members on the latest CRR which includes 14 high-level risks. The report also provided a comparison of risks from the surgical and medical care groups to confirm that the procedures are being uniformly applied.

32. CQC action plan

    32.1. Anne Rosbottom-Williams updated on progress against the plan. The key areas considered were the End-of-Life Strategy, supernumerary senior midwife cover, medicines management, and mandatory training for staff in A&E. Further actions were agreed.

33. Integrated Performance Report (IPR)

    33.1. Chris Yates took members through the draft IPR and amendments to the commentary were agreed. Revisions to the data on complaints were proposed to better describe the performance in timeliness of responses.

34. Cypriot Medical School

34.1. The request from to send a number of their students for clinical postings was discussed. It was agreed that in principle such international links should be encouraged provided that they are adequately resourced and can be carried out with no adverse impact on services, and may be beneficial with recruitment.

34.2. As a follow-up action it was agreed that a more joined-up strategy on international collaboration and recruitment is required.

35. Guardian role

35.1. The new role required for monitoring Junior Doctors was discussed. It was confirmed that data gathering and reporting would require additional resources, both in support of doctors working in the Trust, and for Lead Employer obligations. Funding of 1.5 SPA's and full-time administrative support was approved.

36. Recruitment pressures

36.1. AMS advised of the increase in workload within the recruitment department and the strain this was putting on staff. It was agreed that the drivers for the increase in workload need to be better understood.

37. Alliance LDS / STP

37.1. AMS fed back from the 3-way Executive to Executive meeting on 13th June. It was agreed that a further meeting should be arranged for 30th June to review the final submission.

37.2. AM fed back from the STP meetings held over 13th and 14th, and in particular the role that PWC have been appointed to, of ensuring uniformity of financial information provided within plans.

38. HIS IT contract

38.1. CW advised that the 2016/17 contract has still to be signed by Bridgewater Trust and a meeting is arranged for 28th June to try and resolve any outstanding issues preventing their approval.

ENDS

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)073
Title of paper: Quality Committee Assurance Report.
Purpose: The purpose of this paper is to summarise the Quality Committee meeting held on 21st June 2016 and escalate issues of concern.
Summary: Key items discussed were: 1. Complaints 2. New intranet development: policies 3. CQC action plan 4. Ward dashboard 5. Safer staffing 6. IPR 7. Quarterly weekend mortality update 8. Pharmacy checklist audit update
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: 29th June 2016

QUALITY COMMITTEE ASSURANCE REPORT

Summary of the discussions and outcomes from the Quality Committee meeting held on 21st June 2016.

Action Log

1. All actions on the log were reviewed.

New Intranet Policies

2. Linda Jump (LJ) presented the new intranet initiative for Polices and Documents, which provides users with a more accessible search engine when looking for policies or documents. The "go live" date will be in approximately four weeks. David Graham (DG) passed on his thanks on behalf of the Quality Committee for the excellent work that has been achieved so far.

Complaints update

3. Anne Rosbotham-Williams (ARW) updated the Committee on complaints.
   - 3.1. There were 34 1st stage 'approved' complaints in May 2016. This is a increase of seven in comparison to May 2015.
   - 3.2. There were 134 PALS contacts/enquiries during May 2016.
   - 3.3. The Trust responded to 79% of 1st stage complaints within agreed time frames during May, leading to a year to date response rate of 70%.
   - 3.4. The top complaint themes during May were:
     - 3.4.1. Clinical treatment
     - 3.4.2. Admissions and discharges
     - 3.4.3. Values and behaviours
   - 3.5. 17 satisfaction survey responses have been received, noting some positive findings and reiterating the areas for improvement.
   - 3.6. Julie Hendry (JH) outlined two observations:
     - 3.6.1. There has been improvement within ED but this still needs micro managing. There is a backlog of statements due, both from medical and nursing staff and we are constantly hearing that the staff do not have sufficient time to write the reports. Ann Marr (AM) asked if medical staff could not use their SPA time to complete reports.
     - 3.6.2. JH's second observation concerned the quality of some of the written responses. It was decided that this would be dealt with outside of the meeting.
     - 3.6.3. AM asked ARW to include in future reports the number of 1st stage complaints then become 2nd stage and also how many are then referred to the Ombudsman – it was pointed out that these have become quality indicators.

CQC action plan update

4. Nicola Bunce (NB) briefed the Committee on the CQC action plan.
   - 4.1. 46 out of the 57 actions are now complete. 8 are still in progress and on course to be completed.
   - 4.2. 1 action is in progress but there is a risk to its completion by the agreed deadline. The action is achieve compliance with the Trust's mandatory training and appraisal targets in the ED and has a revised deadline of 30th June, but this

is currently at risk due to continuing staffing pressures within the ED and the need to stagger the release of staff for training. This has been discussed by the Executive Team.

4.3. Two actions are overdue; these are:

4.3.1. Band 7 shift co-ordinators on the Delivery Suite working in a supernumerary capacity to meet best practice guidance. This action has been re-opened as it has not been possible to allocate supernumerary shift co-ordinators to all shifts, due to vacancies and sickness absence. A business case has been approved by the Executive Team.

4.3.2. An End of Life Strategy has been drafted by the Consultant in Palliative Care, who took up post in April and is currently out for consultation. The Executive Team have requested that the consultation period be reviewed, so that it is meaningful but allows the new Strategy to be formally approved no later than 31st July.

4.4. AM commented that one of the CQC inspectors had been "mystery shopping" at the Trust and had praised A&E and one of the surgical wards.

Ward Dashboard

5. ARW asked the Committee for approval to bring a monthly report to Quality Committee, outlining a small number of poorly performing wards, together with the action plan/lessons learned.

Safer Staffing Report

Safer Staffing report

6. Neal Jones (NJ) provided an update.

6.1. The overall Trust fill rate for April was 100.47%. There were 19 wards with a fill rate below 90%;12 wards for registered staff, 9 wards for care staff and 2 of those wards were for both registered and care staff.

6.2. NJ commented that the report for May was slightly different in that a new measure of care hours per patient per day (CHPPD) is included in the report as per national guidance from May 2016.

6.3. Recruitment and retention remains a priority of the Trust and remains an ongoing challenge nationally. A new preceptorship programme commenced in March 2016 to improve the retention and development of newly qualified nursing staff.

6.4. Nurses from the Respiratory Department joined HR colleagues at the LJMU nurse career fair on 7th June. Student nurses have expressed an interest in working at the Trust and attending the recruitment date on 18th June.

6.5. NJ commented on the recruitment of nurses from India, where it has been reported that 25% have failed the English test. AMS said that NHS Employers were carrying out some work with the RCN as this is a national problem.

6.6. Kevin Hardy (KH) queried the unfilled and filled requested shift numbers. AMS replied that she would be looking at the figures following the meeting.

6.7. The Committee discussed a particular fall which resulted in severe harm and whether a more formal process is required to "step down" a patient who is having one to one care?

6.8. NJ said that there has been a 53% reduction in harm from falls. AM asked NJ to include falls per 1000 patients in future reports.

IPR

7. Rob Cooper (RC) summarised the IPR.

7.1. There have been no cases of MRSA during April and May. There was 1 C.Difficile case in May. The annual tolerance for 2016/17 is 41 cases. There were no hospital acquired grade 3/4 pressure ulcers in May. Performance for VTE for April was 89.96% and there have been no never events since May 2013.

7.2. David Graham (DG) asked if a refresher/reminder process was required to keep "never events" on everyone's radar. KH replied that the systems are very robust and near misses are fully investigated. The last three near misses were related to the ward operation check list. A new checklist is now in place and is going through a 2nd pilot.

7.3. A&E performance (Type 1) was 79.7%, which is a deterioration from the previous month and continues to be a significant concern.

7.4. The NHSI facilitated Rapid Improvement Event, to sustainably reduce delayed transfers of care, took place in May, resulting in several immediate improvements in current process with further ongoing developments to deliver the required reduction.

7.5. For the month of May 2016 (month 2), the Trust is reporting an overall Income & Expenditure surplus of £0.293m after technical adjustments, which is slightly behind agreed plan (by £43k).

7.6. To date, the Trust has delivered £1.706m of CIPS, which is just behind the year to date plan by £0.167m.

7.7. 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 £5.15m.

7.8. Mandatory training compliance has improved slightly in month but is 7.9% below target. Appraisals have fallen slightly in month to 2.6% below target.

7.9. 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.

Quarterly Weekend Mortality update

8. KH provided an update.

8.1. Crude mortality and SHMI are largely stable. HSMR has continued to fall and the weekend admission HSMR has fallen substantially.

8.2. The Trust data is better than the Northwest average.

Medicine storage and security audit update

9. Simon Gelder (SG) provided an update.

   9.1. The results of the audit carried out in June indicated that St Helens Hospital had improved whilst Whiston had not. The Chief Technical Officer who leads the audit feels that everyone is improving but it is not seen in the results. SG said that although a significant number of areas are attaining 100% there is still work to be done and the team will support areas that are struggling.

   9.2. AM asked for more information to be included in the audit results before a decision is made on remedial action for wards that are failing; a richer analysis is required. SG will present another paper to Quality Committee in July after the next audit.

   9.3. AM asked that the staff are thanked for all their hard work regarding the medicines audit – this will be done at Team Brief.

National End of Life Care audit

10. This item was deferred until the meeting on 19th July.

Feedback from Patient Safety Council

11. ARW reported:

   11.1. Management review of incidents within 5 days shows deterioration to 52% and this has been escalated to senior level.

   11.2. Poor compliance with ANTT training (currently 57%) was raised as an issue, with plans in place to target new medical staff in August and for ward managers and matrons to ensure all staff are fully compliant. AM advised that this figure was unacceptable and an action plan/recovery plan needs to be presented to the Board (a paper is due at Board on 29th June).

   11.3. Level 2 safeguarding training is behind trajectory and therefore, a recovery plan has been submitted to the Executive Committee.

   11.4. There are low compliance rates regarding transfusion training and this has been highlighted on the ward dashboard.

Feedback from Patient Experience Council

12. ARW reported:

   12.1. The Ophthalmic outpatient survey report highlighted significant improvements from the previous survey two years earlier. Areas for ongoing improvement related to waiting times and the waiting area.

   12.2. Other items discussed included living with and beyond cancer event, CQC patient survey consultation and the carers support team.

Feedback from Clinical Effectiveness Council

13. KH reported:

    13.1. Key items discussed at the Clinical Effectiveness Council included:

    13.2. Diabetes and Endocrinology report – a business case will be taken to the Executive Committee in due course in relation to the under resourcing within the team.

    13.3. ICNARC – benchmarked risk adjusted mortality is within control limited, but persistently higher than peer and English average.

    13.4. Mortality – Biliary Tract disease mortality persistently high and alerting. Previous review of all cases found no causes for concern.

    13.5. Maternity indicators – Maternity will send a representative to future meetings to address issues and report on action plans to resolve them.

    13.6. Histopathology lab times – Improved but still below target.

Feedback from CQPG Meeting – May

14. DG selected key items from the CQPG meeting.

    14.1. 62 day Cancer breach report and any RCA's. RC to send the paper through to AM.

    14.2. CIP – The Trust provided a summary of the key CIP schemes for this year. It was highlighted that this was a very comprehensive report which provided assurance that quality would not be impacted by the CIP programme.

Feedback from Executive Committee

15. Peter Williams (PW) reported:

    15.1. Decisions taken by the Committee included Medway Maternity Off Line IT system, Paediatric business case, capital spend and on call arrangements.

    15.2. Assurances regarding the CQC action plan update and management of bank and agency usage were obtained.

    15.3. There were no specific investment decisions or items requiring escalation to the Quality Committee, with the exception of VTE performance being below the required 95% for the past four months.

Feedback from Workforce Council

16. PW reported:

16.1. There was nothing in the report that required escalation and a number of issues had already been discussed earlier in the meeting.

17. Policies/documents approved by Councils

None noted

18. Effectiveness of meeting

RC commented that the meeting was chaired well and the timing was good. The relevant people were at the meeting and the discussion of the papers was appropriate and of good quality.

19. AOB

None noted.

20. Date of Next Meeting

Tuesday, 19th July 2016.

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)074
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 June 2016

Summary:
Agenda Items
o **For Information**
    o Estates Return Collection
    o Mandatory Training Update
    o Maternity KPI Dashboard
    o Q4 SLR – Surgery
    o IT Progress Report
    o Capital Programme 2016/17
    o Reference Cost Submission
o **For Assurance**
    o A&E RIW Update
    o Integrated Performance Report Month 2 2016/17
    o Month 2 2016/17 Finance Report
    o CIP scheme – governance compliance
    o Efficiency dashboard
    o Governance Committee Briefing Papers:
        ▪ CIP Council
        ▪ MITC
        ▪ Procurement Council
 	
Actions Agreed
• A&E Six Sigma updated report to be presented in July
• Updated Estates Return in August
• Maternity KPI's to presented after review of national dashboard and current targets.

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: Denis Mahony Non-Executive Director
Date of meeting: 29th June 2016

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)075
Title of paper: Committee Report – Charitable Funds Committee
Purpose: To brief the Board on the main issues discussed and decisions made at the Committee meeting on 23rd June 2016.

Summary:

1. JT, Charitable Funds Officer, presented the latest positions on the following items:
   - Investment portfolio – This shows an unrealised gain of £73.3k against purchase price, and an unrealised loss of £16.2k against the year-end valuation.
   - Financial position - The Committee reviewed Income and Expenditure since the previous meeting. This showed income of £89,999 (includes a legacy of £40,000) and expenditure of £151,839.
   - Approval of expenditure - No items were submitted for approval by the Committee.
2. SK, Fundraising Consultant, and KH, Head of Media, PR and Communications, provided an update on fundraising activity since the re-launch of the Trust's charity in January 2016 which include:
   - A 5-aside football tournament.
   - A Mount Snowdon climb.
   - Running in the Liverpool Rock n' Roll Marathon.
   - A sponsored swim.
   - Collection tins and donation envelopes have been rolled out across the wards and department on both hospital sites (with a second stage to be rolled out across the local community in shops, sports centres, etc.)
   - Two staff members have been recruited as lead charity champions for each hospital, with the intention of having a charity champion for each ward/department.

(Overall, income has increased by 22% during 2015/16 in comparison to previous year.)

SK talked about the aim going forward is to possibly have a charity graphics wall at both hospitals, a volunteer-manned charity office at Whiston, the launch of a charity newslettter and September being chosen as the charity month with the aim to raise £20,000.

3. The Committee reviewed and accepted the annual meeting effectiveness review and terms of reference.

4. JT presented the draft Annual Accounts and Report 2015-16 for the Committee to review prior to submission to External Audit for an independent examiners review. JT informed the Committee of some minor changes to the format and disclosure as a result of recent changes in accounting standards.
5. KH presented a funding request by Maternity Services and SCBU to help enhance the environment in the Delivery Suite, Ward 2E and SCBU following feedback from patients, staff , visitors and CQC. The Committee agreed to fund the cost of £2,000 from the General Fund.

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

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff and all stakeholders.

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

Presenting officer: Denis Mahony, Non-Executive Director

Date of meeting: 29th June 2016

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)076
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) are due to publish a new accountability and performance framework for NHS provider organisations (both NHS Trusts and Foundation Trusts), over the summer months. Until this time the Board Compliance and Provider Licence monthly declarations remain suspended. The accountability and performance framework will also clarify the future national expectations and requirements for the FT development pipeline. It is hoped that a full impact assessment of the implications of the framework can be made to the Board in September (subject to publication by NHSI) This report provides an update on; 1. 2016/17 Operational Plan 2. STP Development 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: 29th June 2016

St Helens and Knowsley Teaching Hospitals NHS Trust

Foundation Trust Application Programme – Update June 2016

1. 2016/17 Operational Plan

- The Trust has now agreed a revised improvement trajectory for the four hour emergency access target with NHSI. This trajectory brings forward part of the expected improvement to the first two months of Quarter 4 2016/17.
- Conditions in achieving the STF fund include the achievement of our submitted trajectories for performance in areas such as A&E, RTT and cancer waiting times.
- The national guidance setting out how the STF will be allocated at the end of each quarter against all of the conditions has not yet been published.

2. STP Development

- The Trust continues to work alongside partner organisations in the Alliance Local Delivery System (LDS) and the Cheshire and Merseyside STP footprint to develop the STP submission for 30th June.
- A standardised financial template has been issued to each STP which allows the baseline financial information for each partner organisation to be collated to give an overall STP financial gap by 2020/21, based on national planning assumptions.
- The template also captures the financial impact of the proposed high level solutions to “bridge” this gap currently being developed.
- The Cheshire and Merseyside STP have appointed PWC to produce one overall financial template for the STP based on the inputs from the three Local Delivery Systems (North Mersey, The Alliance and Cheshire), and to support the production of the final STP submission.
- The national leadership bodies will be reviewing all the 44 STP submissions during July
- Those STPs judged to be sufficiently ambitious and deliverable will be supported to begin implementation of their proposed solutions. Other STPs may be required to undertake further work, before their plans are approved.
- NHSE have published indicative financial allocations, including the proportion of the sustainability and transformation funding beyond 2016/17 that each STP footprint can expect to receive by 20120/21. For the Cheshire and Merseyside STP, these allocations are;

Sustainability and Transformation Footprint	2016/17 STP placed based allocations	2020/21 STP place based allocations	2020/21 STP place based allocations including STF funds
	£m	£m	£m
Cheshire and Merseyside STP	4,628	5,136	5,326

- These indicative allocations show that the Cheshire and Merseyside STP footprint can plan to receive an £508m extra baseline funding based on inflation and population changes, and an additional £190m to support service transformation to deliver the STP plans, by 2020/21.

- NHSE have advised that there will be no other new funding for the NHS during this period and also that there will not be large capital allocations.

3. Well Led Framework Action Plan

NHSI have confirmed that one of their main objectives will continue to be to improve the effective governance and leadership of provider organisations using the Well Led Framework model.

There are 47 identified actions on the Trust well led framework action plan, of which 35 of which were due for completion by the end of May 2016. All of these have been completed. There are currently no red rated/ overdue actions. Of the remaining actions 9 are due to be completed in June and 2 in July 2016.

A further self-assessment against the well led framework criteria will then be undertaken.

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

May 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)	Mitigation Plan
Planning and Strategy	18	10	10	0	0	
Capability and Culture	15*	12	12	0	0	
Process and Structure	12	11	11	0	0	
Measurement	2	2	2	0	0	
Total	**47**	**35**	**35**	**0**	**0**	

*1 action re FT membership and governors on hold

ENDS

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)077
Title of paper: STHK Clinical and Quality Strategy
Purpose: Refreshed CQS for Board Approval
Summary: The aim of this Clinical & Quality Strategy is to take us from 'good' to 'great' so that the LDS/STP deliver and patients realise the benefits of our 5* aspiration.
Corporate objective met or risk addressed: Care, safety, systems, pathways
Financial implications: N/A
Stakeholders: All
Recommendation(s): Progress on the previous CQS was largely positive, but the NHS has moved on and the Board has decided that a refreshed strategy is appropriate. This will focus on a smaller number of key objectives over a shorter period with more frequent refresh.
Presenting officer: Kevin Hardy, Medical Director
Meeting date: 29th June 2016

St Helens and Knowsley Teaching Hospitals NHS Trust

STHK Clinical & Quality Strategy

April 2016-2020

Executive Summary

In 2012-13, following extensive consultation with a wide range of stakeholders, St Helens & Knowsley Teaching Hospitals NHS Trust (STHK) Board developed and subsequently approved its Clinical & Quality Strategy.

The Strategy has served STHK well. Against a backdrop of 2-3 years of unprecedented growth in elective and non-elective referrals by GPs and similar increases in patients self-presenting for emergency care at the hospital, STHK has enjoyed extraordinary success improving quality, safety and patient experience. The Trust has won numerous awards, many where it was the top-performaing acute hospital in England and has received an outstanding CQC inspection report (2016).

Yet much remains to be done to achieve and sustain our aspiration for 5 star care and the Board is determined to build on its success and has resolved that STHK should have a new, more focussed Clinical & Quality Strategy aimed at addressing some specific areas for further improvement over a relatively shorter timeframe.

Locally, deprivation and unemployment remain high; smoking, drug and alcohol misuse common, health inequalities wide, health outcomes poor, and emergency attendances and admissions to hospital excessive. Primary care is stressed, community care lags much of the rest of England and local CCGs are challenged.

To the wider public, 5-star has become synonymous with best quality, so we describe our aspiration as 5-star care. Clinically and financially sustainable services can only be realised through collaboration, with vertical and horizontal integration delivering seemless care. Within the Cheshire & Merseyside 'Sustainability & Transformation Plan' (STP), the 'Alliance' 'Local Delivery System' (LDS) will deliver a new service configuration with STHK the likely 'hot' site at its heart. ? do you want to be this explicit at this stage in a public document The aim of this Clinical & Quality Strategy is simple: to take us from 'good' to 'great' so that the LDS/STP deliver and patients realise the benefits of our 5* aspiration.

Our Aim 5-Star Care

Our Values Caring, Listening, Learning, Competent and Respectful

Our Priorities Safety, Kindness, Effectiveness, Experience, Timeliness,

Our Metrics 10 Key Performance Indicators

The National and Local Context

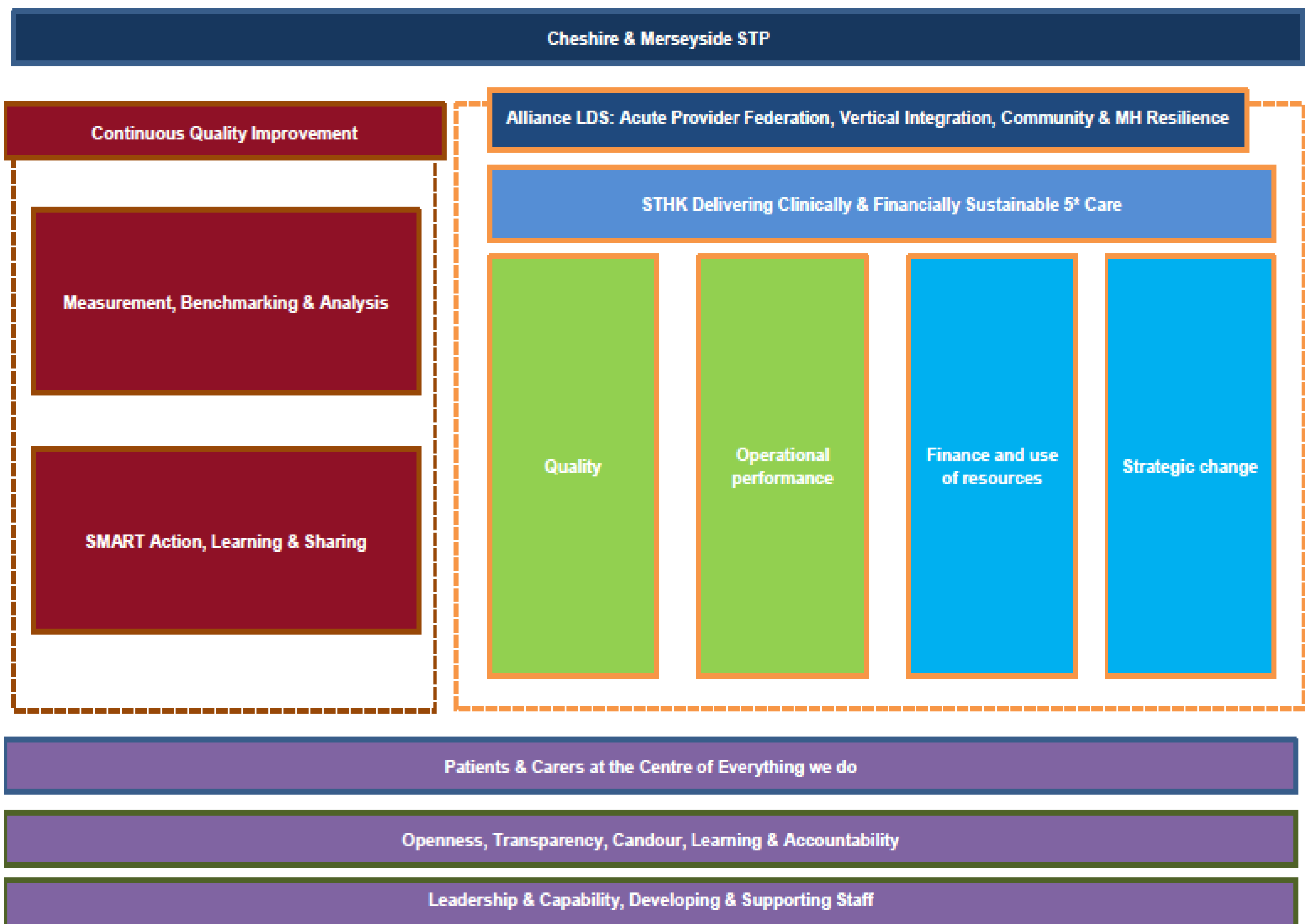
The national and local context were described at length in the 2012-13 document (Appendix A) and continue to provide a rationale for driving improvements in health outcomes through our 5-star aspiration. They are not duplicated here.

STHK Hospitals 2016-20 Strategic Priorities

The STHK Board has set a range of priorities in its Trust Objectives 2016-17 to realise its aspiration of 5-star care and these are known to Trust staff and visible throughout the Trust for easy reference.

Our Board is focussed on 5 key themes:

- Quality
- Financial sustainability
- Operational Performance
- Strategic change
- Leadership and improvement capability



‘Finance & Use of Resources’ and ‘Strategic Change’ are dealt with in the STP Financial Sustainability Model. This Clinical & Quality Strategy deals with ‘Quality’ & ‘Operational Performance’ priorities for 2016-20.

There are many regional and national performance and quality targets, which evolve over time; the purpose of this strategy is to focus specific performance improvement work on a small number of clinical and quality priorities that have proved challenging to achieve and have been judged by the Trust and its commissioners to be local health economy priorities. The the overarching strategy embraces 2016-20, but the NHS is evolving at pace so the Board wishes to see in-year achievement and an annual refresh of its clinical and quality priorities.

Clinical & Performance Priorities for 2016/17

- 4hr A&E trajectory and standard to be achieved in 2016/17
- Mortality: achieve English average SMR of weekend vs weekday mortality
- 62-day cancer target to be achieved in all tumour groups
- VTE Assessment: consistently achieve national target
- eDischarge: improve number of eDischarges sent within 24 hr of discharge
- Falls: reduce moderate and severe harm as a result of inpatient falls
- Complaints: improve timeliness of complaint response
- Improve timeliness of first dose antibiotics in Sepsis
- Improve timeliness of surgery for Fractured Neck of Femur
- Critical Care Mortality

5-STAR CARE: KPIs

1. “A&E” Performance

Metrics: 4-hour Target

Source: Integrated Performance Report

1 yr Target: Type 1 & 3 performance ≥95% by March 2017

Executive Lead: Director of Operations

2. Weekend Emergency Admission Mortality

Metric: Weekend emergency admission HSMR (c.f. England)

Source: Integrated Performance Report

1 yr Target: <100

Executive Lead: Medical Director

3. 62-day Cancer Performance (all groups)

Metric: 62-day Cancer Pathway completion

Source: Integrated Performance Report

1 yr Target: ≥85%

Executive Lead: Director of Operations

4. VTE

Metric: VTE assessment within 24 hr

Source: Integrated Performance Report

1 yr Target: ≥95%

Executive Lead: Medical Director

5. eDischarge Performance

Metric: Percentage inpatient discharges summaries sent ≤ 24 hr

Source: Integrated Performance Report

1 yr Target: Inpatients (excluding A&E) ≥85%

Executive Lead: Medical Director

6. Falls

Metric: Reduction in falls causing moderate or severe harm

Source: Integrated Performance Report

1 yr Target: 50% reduction 2016/17 vs 2015/16

Executive Lead: Director of Nursing, Midwifery & Governance

7. Complaints

Metric: % Complaints response within agreed timeframe

Source: Integrated Performance Report

1 yr Target: ≥80%

Executive Lead: Director of Nursing, Midwifery & Governance

8. Antibiotic in Sepsis

Metric: Timeliness of first dose antibiotic in ≥ Severe Sepsis

Source: Integrated Performance Report

1 yr Target: >90%

Executive Lead: Medical Director

9. Surgery for Fractured Neck of Femur

Metric: % Eligible patients getting surgery in ≤ 48 hr

Source: Integrated Performance Report

1 yr Target: ≥95%

Executive Lead: Medical Director

10. Critical Care Mortality

Metric: ICNARC model mortality c.f. England

Source: Integrated Performance Report

1 yr Targets: Standardised ratio of 100

Executive Lead: Medical Director

Action Plan & Monitoring

Action	KPI from	Monitoring Committee	Leads	Exec
4hr Performance	IPR	F&P	DD/ADO Med	Dir Ops
Weekend Mortality	IPR	Quality	DD/ADO Med	MD
62-day Cancer	IPR	Quality	Cancer Leads	Dir Ops
VTE	IPR	Quality	DD/ADO Med	MD
eDischarge	IPR	F&P	DD/ADO Med & Surg	MD
Falls	IPR	Quality	DDoN Safety	DoN
Complaints	IPR	Quality	Gov Leads Med & Surg	DoN
Sepsis	IPR	Quality	Sepsis Lead	MD
#NOF Surgery	IPR	Quality	CD T&O/ADO Surg	MD
ICU Mortality	IPR	Quality	DD/ADO Med	MD

- Section of IPR will collate CQS Monitoring KPIs

- CQS KPIs will be discussed (and minuted) at Med & Surg Governance Meetings, relevant Ward & Departmental meetings, T2T meetings & CD Forum

- DD or ADO (or both), Cancer Lead (either Cons Lead or Nurse Lead), Sepsis Lead (Cons or Nurse) and Governance Leads, will be required to attend Committee monthly to update on current progress against KPIs and actions to achieve target

- Committee chair's report to Board will include progress against CQS

- Formal report to Board at 6 and 12 months by Medical Director.