St Helens and Knowsley Teaching Hospitals NHS Trust

Trust PublicBoard Meeting

TO BE HELD ON WEDNESDAY 30TH NOVEMBER 2016
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

A G E N D A				Paper	Presenter
09:30	1.	Employee of the Month - November			Richard Fraser
09:35	2.	Patient Story			Peter Williams
09:55	3.	Apologies for Absence			Richard Fraser
	4.	Declaration of Interests			
	5.	Minutes of the previous Meeting held on 26th October 2016		Attached	
		5.1	Correct record & Matters Arising		
		5.2	Action list	Attached	
Performance Reports					
10:05	6.	Integrated Performance Report		NHST(16) 109	Nik Khashu
		6.1	Quality Indicators		Kevin Hardy
		6.2	Operational indicators		Nik Khashu
		6.3	Financial indicators		Nik Khashu
		6.4	Workforce indicators		Anne-Marie Stretch
10:25	7.	Safer Staffing report		NHST(16) 110	Rob Cooper

10:30	8.	Agency staffing self-certification checklist		NHST(16) 111	Anne-Marie Stretch
BREAK					
Committee Assurance Reports					
10:50	9.	Committee report – Executive		NHST(16) 112	Ann Marr
10:55	10.	Committee Report – Quality		NHST(16) 113	David Graham
11:00	11.	Committee Report – Finance & Performance		NHST(16) 114	Denis Mahony
Other Board Reports					
11:05	12.	FT programme update report		NHST(16) 115	Nik Khashu
		12.1	Sustainability & Transformation Plan	NHST(16) 115a	
11:10	13.	Charitable Funds Accounts & Annual Report		NHST(16) 116 (This was presented at October Board)	
11:15	14.	Research & Development statement		NHST(16) 117	Kevin Hardy
11:20	15.	Trust Objectives – review of current year		NHST(16) 118	Ann Marr
11:30	16.	Junior Doctor contract implementation		NHST(16) 119	Anne-Marie Stretch
11:40	17.	Trust board meeting arrangements		NHST(16) 120	Peter Williams
Closing Business					
11:45	18.	Effectiveness of meeting			Richard Fraser
	19.	Any other business			
	20.	Date of next Public Board meeting – Wednesday 25th January 2017			
LUNCH					

St Helens and Knowsley Teaching Hospitals NHS Trust

Minutes of the St Helens and Knowsley Hospitals NHS Trust Board meeting held on Wednesday 26th October 2016 in the Boardroom, Whiston Hospital

PUBLIC BOARD

Chair:	Mr R Fraser (RF)	Chairman
Members:	Ms A Marr (AM)	Chief Executive
	Mrs A-M Stretch (AMS)	Director of HR/Deputy Chief Executive
	Mrs A Risino (AR)	Director of Strategy
	Mr B Hobden (BH)	Non-Executive Director
	Mrs C Walters (CW)	Director of Informatics
	Prof D Graham (DG)	Non-Executive Director
	Mr D Mahony (DM)	Non-Executive Director
	Mr G Marcall (GM)	Non-Executive Director
	Prof K Hardy (KH)	Medical Director
	Mr N Khashu (NK)	Director of Finance
	Mr P Williams (PW)	Director of Corporate Services
	Ms S Rai (SR)	Non-Executive Director
	Mrs S Redfern (SRe)	Director of Nursing, Midwifery & Governance
Apologies:	Mr R Cooper (RC)	Acting Chief Operating Officer
	Ms S O'Brien (SOB)	Associate Non-Executive Director
In Attendance:	Mr T Foy (TF)	St Helens CCG
	Mrs K Pryde	Executive Assistant (Minutes)

1. Employee of the Month

The award for Employee of the Month for October 2016 was presented to Debbie Kilshaw, Ward Clerk, Lilac Centre, St Helens Hospital.

2. Apologies for absence

2.1. Apologies as recorded above were noted.

3. Declaration of Interests

3.1. There were no declarations of interest relating to the business to be discussed at the meeting.

4. Minutes of the previous meeting held on 28th September 2016

4.1. Correct Record and Matters Arising

4.1.1. The minutes were approved as a correct record.

4.2. **Matters Arising**

4.2.1. PW informed the Board that in connection with the patient story a patient food tasting session has been arranged for the NEDs during the Board Development Away Day on 10th November.

4.3. **Action List**

5.3.2. Minute 11.2.5 (27.07.16): It was confirmed that SR will be the NED representative for End of Life Care. Action closed.

5.3.3. Minute 6.3.7 (28.09.16): IPR discussion at Board Away Day in November. Action closed.

5. IPR – NHST(16)098

5.1. Quality Indicators

5.1.1. SRe provided a brief update on Quality Indicators. There has been 1 never event in August of this year, which was discussed at the last Board meeting. The investigation report was due to be submitted on 3rd November and there are a number of actions in place.

5.1.2. There have been two MRSA bacteraemia cases to date. There are similar themes including tests not being requested in a timely manner. The post infection review is due to be submitted on 27th October.

5.1.3. There were 4 cases of CDI in September, of which 3 will be appealed. Year to date there have been 15 cases. The Board discussed infection control at great length. AMS informed the Board that infection control had been discussed at the Executive Team meeting, especially regarding the accountability framework.

5.1.4. There were no hospital acquired grade 3/4 pressure ulcers in September and none year to date.

5.1.5. There were 2 falls that resulted in severe harm during August. SRe is addressing issues and remedial actions with the Falls Team.

5.1.6. VTE performance for August is 94.38%, which is slightly better than last month, although we are yet to hit the target.

5.1.7. The 2015-16 HSMR is 99.7%, which is slightly better than average.

5.2. Operational Indicators

5.2.1. SRe provided an update on the Operational Performance. A&E performance was 79.7% (type 1) and 87.5% (type 1 and 3) in month, which is an improvement from August's performance.

5.2.2. The Emergency Care Improvement Programme (ECIP) visited A&E for a system wide review. Following feedback, the overall position is that there is nothing significant that we are not already addressing. Areas were highlighted that we should focus on within the next thirty days, which included AMU appointment schedule, frailty screening tool and pathways, and review of IV antibiotics.

5.2.3. Patrick Johnson has been appointed as a Turnaround Director for A&E.

5.2.4. SRe reported that RTT is in a challenging and delicate position at the present time due to pressure from increased non-elective activity and the effect of the CCG Referral Management Systems.

5.2.5. GM enquired as to the low emergency performance figures on Sunday. AMS replied that RC had carried out a deep dive and the problem of lack of flow started on Saturday which in turn meant that Sunday started with A&E rated black. Attendance wasn't particularly high but there was a shortage of beds. Resus was full all day and there was a serious incident in the department with a mental health patient. The position had recovered by Monday.

5.2.6. GM asked when the extra beds would be available. SRe responded that building and engineering work would start in November and beds should be available mid December.

5.3. Financial Indicators

5.3.1. NK provided an update of the Trust's financial position. The Trust is reporting an overall Income &Expenditure surplus of £1.366m after technical adjustments which is slightly above the agreed plan. Trust income is ahead of plan by £1.485m, while expenditure is overspent by £1.52m, through delivering extra activity often at premium rates. Expenditure on Agency stands at £6.095m for the year against a target for the full year of £7.256m. The Trust Executive Team continues to meet with Specialties on a weekly basis to review the action plans in place to reduce agency expenditure. NK reported that NHSI are very clear that there must be Trust Board involvement in this regard and a report will be presented at the November Board.

5.3.2. The Trust's forecast outturn is to achieve its Annual plan of £3,328m surplus.

5.3.3. To date the Trust has delivered £6.239m of CIPs which is behind the year to date plan by 2%, but a significant improvement against last month (11%). The CIP programme is formally reviewed both at a Trust and Specialty level on a monthly basis at CIP Council and is also part of the Operational Transformation Group agenda.

5.3.4. Capital expenditure to date is £0.793m out of a revised year forecast total of £4.985m. Cash balance at the end of August is £3.529m which equates to 4 operating days.

5.3.5. BH queried the figures on page 8, showing red for 4 days operating expenses when the target is 2. NK said that this was an internal target and acknowledged that the RAG rating was somewhat misleading and would be amended.

5.4. Workforce Indicators

5.4.1. AMS provided an overview of the Workforce Indicators.

5.4.2. Mandatory training compliance has improved slightly and is above target at 93.5%. Appraisal compliance requires improvement; performance is 71.4%. Recovery plans are in place and appraisals will be discussed at the Executive Team meeting on 27th October.

5.4.3. Sickness absence for August has decreased to 4.7%, although it is above the Q2 target of 4.35%. Year to date sickness is 4.6%.

6. Safer Staffing report – NHST(16)099

6.1. SRe presented the Safer Staffing Report to the Trust Board to provide an overview of nursing and midwifery staffing levels in inpatient areas during September 2016.

6.2. The overall headcount fill rate for September was 93.97% for RNs on days; 96.55% for RNs on nights; 106.79% for HCAs on days and 111.79% for HCAs on nights.

6.3. 12 wards had fill rates below 90%; 10 wards for RNs, 1 for care staff and 1 for both.

6.4. A total of 455 RN agency and bank shifts and 1636 HCA bank and agency shifts were employed during September to address shortfalls and patient need.

6.5. In September, there were no falls resulting in severe harm on wards with a fill rate below 90%.

6.6. At present, the Trust is proactively recruiting bank HCAs to meet requirements.

6.7. SRe updated the Board regarding the nurse recruits from India. Slow progress is being made due to circumstances outside of the Trust's control. 122 offers were made last November. Presently 93 remain of which 35 have failed the IELTS first time and are no longer communicating with the agency or local agent in India. 15 nurses have passed the IELTS; 4 are booked onto the CBT course, 9 have passed the CBT course and are now uploading documents onto the NMC portal; 2 have received the decision letter from the NMC and should arrive in the UK at the of end of November 2016.

6.8. SRe informed the Board that work is being carried out by Sally Duce, Deputy Director of Nursing, regarding a rotational programme. SR asked if there

was any additional departmental support for the RNs. SRe advised that the Matrons and Heads of Quality are supporting staff through weekly meetings; every areas has an organisational development plan and Pulse surveys are being carried out.

6.9. A nurse associate role is being piloted at the Trust and SRe will include a paper to January Board regarding the development of nursing roles in the Trust.

7. Complaints, Claims and Incidents – NHST(16)100

7.1. SRe provided an update for the Board.

7.2. The number of incidents raised for this quarter was 3228 compared to 3017 in the same quarter last year (Q1 2015), demonstrating an increase of 209 (7%). This is thought to be associated with the supportive culture of learning and openness and an increase in activity. The top two categories of reported incidents were:

7.2.1. Accidents that may result in personal injury
7.2.2. Implementation of care or ongoing monitoring/review.

7.3. The number of StEIS incidents report this quarter was 9. This is slightly below the normal reporting level.

7.4. The latest published National Reporting and Learning System (NRLS) data shows the organisation's practice in reporting remains excellent.

7.5. 33 new claims were received in Q1 compared to 28 new claims in Q4 2015-16, showing a 19% increase. The top themes for new claims were failure to diagnose/treat; performance of a surgical procedure; and consent - although not necessarily the lead reason for the claim.

7.6. 94 1st stage approved complaints were received during Q1, an increase of:

7.6.1. 11% in comparison to Q1 2015-16 when there were 84.
7.6.2. 55% compared to Q4 2015-16 when there were 60.

7.7. There were 492 PALS contacts/enquiries during Q1, compared to 611 in Q4, reflecting a 24% decrease. This may partially account for the increase in complaints.

7.8. The top complaints themes during the period were:

7.8.1. Clinical treatment.
7.8.2. Values and behaviours (staff).
7.8.3. Admissions and discharges.

7.9. SR commented that it would be more meaningful to include percentages to the Quantitative Analysis data.

7.10. The Board discussed complaints at length. SRe informed the Board that the Patient Experience Manager visits the wards on a regular basis, dealing with problems at ward level.

7.11. SR commented that the figure for reported incidents seemed high. It was clarified that it is generally viewed as a good sign as it indicates a culture of openness that more people are reporting.

8. Committee Report - Executive – NHST(16)101

8.1. AM summarised the report for the Board.

8.2. Between the 16th September and 13th October, four meetings of the Executive Committee have been held.

8.3. Decisions taken by the Committee included measures to improve mandatory training and appraisals and systems for improved avoidance of MRSA.

8.4. Assurances regarding safer staffing; management of agency usage and stroke service developments were obtained.

8.5. Investment decisions included pathology equipment contracts, EPR Programme Director, general surgical staffing and Lilac Centre nursing.

8.6. AM also discussed Stroke Services, changes to mandatory training, maternity birth analysis and the community tender.

8.7. Board Assurance Framework – NHST(16)102

8.7.1. SRe provided an update for the Board. The BAF is reviewed at Risk Management Council and the Executive Committee meeting. There are no proposed changes to the scoring of any risks since the last review but mitigating actions have been updated.

8.8. Corporate Risk Register – NHST(16)103

8.8.1. SRe provided an overview of the Corporate Risk Register to the Board.

8.8.2. All risks have been identified, reported and scored in accordance with the grading matrix.

9. Committee Report – Audit – NHST(16)104

9.1. SR presented the Audit Committee Assurance Report.

9.2. The Committee received an update from External Auditors on progress being made against the 2016/17 accounts plan and received assurance from Trust officers around the emerging issues and developments.

9.3. Reports were received from the Internal Auditors.

9.4. Other items for discussion were Trust governance and assurance; aged debt analysis; tender waivers; external reviews and the re-appointment of Grant Thornton as External Auditors.

10. Committee report – Quality Committee – NHST(16)105

10.1. DG presented the Quality Committee Assurance Report.

10.2. Complaints were still an issue, with the Trust response rate at 55%. DG and Anne Rosbotham-Williams had visited the Complaints team within the Medical Care Group earlier this month. He felt that they are a committed team with the appropriate skills and experience; although resourcing may be an issue. The 25 day timeframe for responses was discussed and how the time is allocated. SRe agreed to research the time frames and report back to the Board.

10.3. An update to Baroness Cumberledge's report was provided to the Committee. Our Maternity service has reviewed the recommendations and developed an action plan for compliance.

10.4. Exercise Lemon Ribbon (planned exercise of a baby abduction) was discussed by the Board. It was identified that some processes need tightening up and an action plan is in place and a full debrief will be given to AM following the Board meeting.

10.5. It was requested that the paragraph pertaining to "Effectiveness of meeting" be reworded.

11. Committee report – Finance & Performance – NHST(16)106

11.1. DM presented the Finance & Performance Committee Report.

11.2. Items discussed and actions agreed included:

- Re-engage the ENT collaboration with local Trusts, given SLR performance and risks.
- Review specialties which generate low contribution to support CCG referral management initiatives.
- Recent NHSI Agency controls to be presented to Executive Committee for final approval.
- 4 year C.Diff performance to be presented at November's meeting.
- CIP performance to be an agenda item at November's meeting.

11.3. NK advised the Board that the Trust will have to inform the regulator if we are accepting control targets for next year by November 24th. Having described the situation Board members approved the proposal that NK will take this to the Executive Committee for agreement.

12. Committee report – Charitable Funds – NHST(16)107

12.1. DM presented the Charitable Funds report.

12.2 The Committee reviewed Income and Expenditure since the previous meeting. Kim Hughes, Head of Media, is to prepare a plan how spend is going to be encouraged in the future as a result of the re-launching of the general charitable fund. A new fundraiser has been appointed and arrangements are in place for RF to meet with her.

12.3. Two funding requests had been approved; 2 cooling systems for patients undergoing chemotherapy and a hairdressing room. Both requests were for the Lilac Centre.

12.4. The Committee agreed that £5.00 per patient is to be spent on Christmas gifts plus biscuits/sweets for visitors. It was also agreed that the money would be increased to £10.00 for the children in Paediatrics, as requested by Sally Duce.

12.5. NK advised the Board that a company is collecting clothes, allegedly on behalf of the Lilac Centre which may, or may not, be bonafide. NK has asked to be informed if there are any more sightings of these collections in the area.

13. FT programme update report – NHST(16)108

13.1. NK updated the Board regarding the FT Programme. Items discussed included operational planning, the development of the Sustainability and Transformation Plan (STP) and the Well Led Framework action plan.

13.2. A draft 2-year Operational Plan for activity, performance, quality, workforce and finance is being submitted on 24th November.

13.3 An Extraordinary Board meeting will be held on 14th December to discuss and approve the final 2 year plan prior to submission.

14. Effectiveness of meeting

14.1. RF concluded that although the meeting ran over time, there were detailed discussions on agenda items, and numerous instances of constructive challenge.

15. AOB

15.1 No other business was discussed

16. Date of next meeting

16.1. The next meeting is scheduled for Wednesday, 30th November 2016 in the Boardroom, Whiston Hospital commencing at 9.00 am.

Chairman: ..... Richard Fe .....

Date: ..... 30/11/16 .....

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 30TH NOVEMBER 2016

No	Minute	Action	Lead	Date Due
1.	27.07.16 (11.2.5)	End of Life Care: Richard Fraser will ask for expressions of interest from the NEDS. Su Rai is to be the NED representative for End of Life Care. Action closed.	RF	Action closed
2.	28.09.16 (6.3.7)	Present national and stretched targets more clearly on the IPR. To be discussed further at the Board Away Day in November. On Board Away Day agenda. Action closed.	NK	Action closed
3.	26.10.16 (5.3.1)	Paper to be presented by Anne-Marie Stretch at November Board regarding agency usage/spend. **Agenda item.**	AMS	30 Nov 16
4.	26.10.16 (6.9)	Sue Redfern to present a paper to January Board regarding nursing roles within the Trust.	SR	25 Jan 17
5.	26.10.16 (10.2)	Sue Redfern to report back to the Board regarding complaint responses and standards.	SR	25 Jan 17

Paper No: NHST(16)109
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) 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 has been 1 never event during 16/17 (August).

YTD there has been two cases of MRSA bacteraemia.

There were 3 C.Difficile (CDI) positive cases in October. Year to date there have been 18 positive cases. The annual tolerance for 2016-17 is 41 cases.

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

There was 1 fall that resulted in severe harm during September.

Performance for VTE assessment for September was 94.31% a slight reduction from August

The 2015-16 HSMR is 99.7.

The overall nurse/midwife Safer Staffing fill rate for October was 95.7%

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 16/17 financial outturn will have implications for the finances of the Trust
Stakeholders: Trust Board, Finance Committee , Commissioners, CQC, TDA, patients.
Recommendation: To note performance for assurance
Presenting Officer: N Khashu
Date of Meeting: 30th November 2016

Operational Performance

A&E performance was 74.4% (type 1) and 84.0% (type 1 & 3) in month . A Trust wide performance recovery plan continues with key, must do actions required for implementation within the A&E department and the wider organisation in order to sustainably deliver the 95% target.

Senior leaders are working with teams to deliver and embed the actions from the 14 individual work streams within the operational turnaround plan which will result in sustainable improvement. The top 5 key areas of focus for improvement within the plan are:

1. Increase number of discharges by 1pm to a minimum of 33% of the daily discharges
2. Increase weekend discharges to 80% of weekday average.
3. Consistent delivery of rapid assessment and treatment in ED
4. Consistent delivery of Ambulatory Emergency care in ED
5. Effective scheduling of seeing power in ED to manage patient flow

The Trust is also part of the NHSI led A&E improvement programme, and continues to work closely with the Emergency Care Improvement Programme (ECIP). This support will remain in place for the forthcoming year and will support the Trust and individual departments in delivering sustainable evidence based change.

Although RTT incomplete performance was achieved in month, this has deteriorated to just above the 92% target. The Dermatology specialty position has had an impact on the overall Trust performance against this target and is receiving intensive support to reduce their backlog. Specialty level plans are in place to address this deterioration, including ongoing data quality of referrals and targeted backlog clearance plans. In addition, collaborative working with the CCG is also underway to improve the quality and effectiveness of patient referral pathways.

All other key national access targets were achieved in month.

Financial Performance

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

Income & Expenditure

As at the month of October 2016 (Month 7) the Trust is reporting an overall Income & Expenditure surplus of £1.812m after technical adjustments which is slightly above the agreed plan. Trust income is ahead of plan by £1.156m, while expenditure is overspent by £1.192m, through delivering this additional activity. Expenditure on Agency stands at £7.027m for the year against a target for the full year of £7.256m. The Trust Executive team continues to meet with Specialties on a weekly basis to review the action plans in place to reduce agency expenditure in 2016/17.

The Trust's forecast outturn is to achieve its Annual plan of £3.328m surplus.

CIP - To date the Trust has delivered £7.861m of CIPs which is now just ahead of the year to date plan. The CIP Programme is formally reviewed both at a Trust and Specialty level on a monthly basis and is also part of the Operational Transformation Group agenda.

Capital - Capital expenditure to date is £0.955m out of a revised year forecast total of £4.1m.

Cash - Cash balance at the end of October 2016 is £9.836m which equates to 11 operating days.

Human Resources

Mandatory training compliance remains above target at 92.3%.

Appraisal compliance has seen significant improvement in month and performance is 83.5%. Recovery plans continue and appraisal remains a monthly standing item on the Executive Committee agenda.

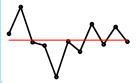
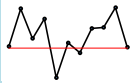
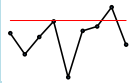
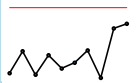
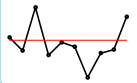
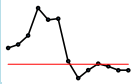
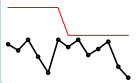
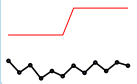
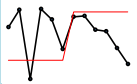
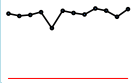
Sickness absence has slightly increased in October to 4.6 % although it is less than the quarter 3 target of 4.72%. Year to date sickness is 4.6 %.

The following key applies to the Integrated Performance Report:

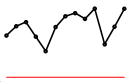
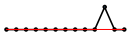
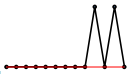
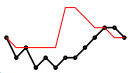
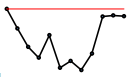
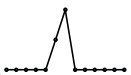
▲ = 2016-17 Contract Indicator
▲£ = 2016-17 Contract Indicator with financial penalty
● = 2016-17 CQUIN indicator
T = Trust internal target

Oct-16

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

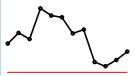
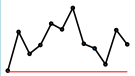
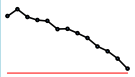
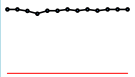
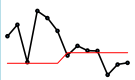
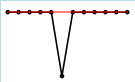
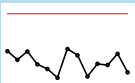
	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 30-34)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Oct-16	2.4%	2.4%	No Target	2.5%		Overall SHMI and HSMR within control limits. Co-morbidity coding better, but not best in class. Palliative care coding suboptimal. Weekend mortality is improving - small numbers make individual months difficult to interpret.	Patient Safety and Clinical Effectiveness	Trust is exploring an electronic solution to improve capture of comorbidities and their coding. Focus on missing notes (which is improving) to reduce R codes use (and improve HSMR). A drive in ED and MAU to reduce excessive use of symptom-diagnoses, as this impacts on HSMR. Major initiatives to improve management of AKI and Sepsis.	KH
Mortality: SHMI (Information Centre)	Q	▲	Mar-16	1.03		1.00						
Mortality: HSMR (HED)	Q	▲	Aug-16	99.2	100.9	100.0	99.7					
Mortality: HSMR Weekend Admissions (non-elective) (HED)	Q	T	Aug-16	100.7	110.7	100.0	112.5					
Readmissions: 30 day Relative Risk Score (HED)	Q	T	Jun-16	95.9	99.0	100.0	96.4		Much improved over last 12 months.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	Investigation to establish whether listing of babies returning electively but documented as emergency admissions has improved.	KH
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Jul-16	98.1	95.4	100.0	92.2		Sustained reductions in NEL LOS are assurance that medical redesign practices continue to successfully embed. The elective performance is a result of the shifting casemix to daycase, leaving an increasing volume of the more complex patients as inpatients.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Jul-16	114.4	93.8	100.0	97.7					
% Medical Outliers	F&P	T	Oct-16	0.7%	0.8%	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	Oct-16	29.2%	42.6%	52.5%	50.9%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. Critical care rep attending at 12.30 EAM to agree plan and to highlight patients who will require transfer over the coming 24 hours. Review of critical care processes undertaken by clinical and managerial team with specific recommendations made relating to optimal utilisation of capacity.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients)	Q	▲	Sep-16	79.3%	79.1%	90.0%	79.9%		eDischarge performance poor. Historic backlog now quantified.		Pending ePR, ongoing drive to improve realtime completion on ward rounds, but trainee doctor numbers is an issue. Medium-term plan to supplement trainee doctor numbers with advanced nurses. Action plan to address unsent eDischarges to be discussed with commissioners at next CQPG.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients)	Q	▲	Sep-16	84.2%	90.4%	95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E)	Q	▲	Sep-16	99.2%	99.0%	95.0%	98.5%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

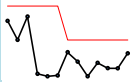
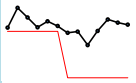
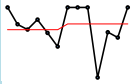
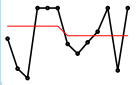
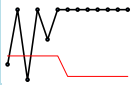
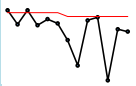
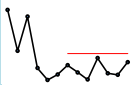
	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Oct-16	97.9%	95.6%	83.0%	92.0%		Target is being achieved	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Continued focus on delivery of this KPI to ensure our patients continue to receive the best possible care	RC
PATIENT SAFETY (appendices pages 37-39)												
Number of never events	Q	▲£	Oct-16	0	1	0	0		The National safety standards for invasive procedures will provide further mitigation against future never events.	Quality and patient safety	A Full level 2 root cause analysis has commenced to identify both causation and preventative measures.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Oct-16	98.3%	98.7%	98.9%	98.9%		Figures quoted relate to all harms excluding those documented on admission. StHK performs well against its neighbours.	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	Oct-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	▲£	Oct-16	0	2	0	0		There was zero cases of MRSA bacteraemia and 3 C.Difficile (CDI) cases in October. The annual tolerance for 2016-17 MRSA cases is 0 and for CDI is 41 cases. Both cases of hospital acquired MRSA bacteraemia have been investigated and Trust-wide action plans are in place to reduce the risk of any further 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. Action plans to reduce the risk of MRSA infections are currently being implemented Trust-wide.	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲£	Oct-16	3	18	41	26					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Oct-16	2	13	No Target	28					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Oct-16	0	0	No Contract target	1		Pressure ulcer performance continues to improve. There have been no grade 3 or 4 ulcers reported YTD.	Quality and patient safety	A Full level 2 root cause analysis has commenced to identify both causation and preventative measures.	SR
Number of falls resulting in severe harm or death	Q	▲	Sep-16	1	9	No Contract target	21		STHK harm from falls YTD is 0.134 per thousand bed days(YTD) against a 0.19 national bench mark and a 0.15 internal target	Quality and patient safety	Level 2 root cause analysis investigations have commenced to identify the causation factors and mitigate against future episodes of harm from falls.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲£	Aug-16	94.31%	92.14%	95.0%	93.31%		VTE solution to improve A&E underperformance implemented but activity has not been being captured because of software interface issue.	Quality and patient safety	VTE solutions for all patients in all areas re-examined in November 2016. Work on targeting individual solutions to individual areas commenced November 2016. ePrescribing solution will resolve issue in 2017. Solutions to software interface issue being explored and manual work arounds being put in place.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Aug-16	3	12	No Target	38					
To achieve and maintain CQC registration	Q		Oct-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	Oct-16	95.7%	95.1%	No Target	96.8%		Shelford Patient Acuity has been completed in October 2016, the results are currently being collated and will be reported in December 2016	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	Oct-16	0	2	No Target	1					

Oct-16

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 (appendices pages 41-48)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Sep-16	94.6%	94.6%	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	▲ £	Sep-16	97.8%	98.2%	96.0%	97.8%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Sep-16	87.9%	88.3%	85.0%	88.6%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Oct-16	92.4%	92.4%	92.0%	95.5%		At specialty level Trauma & Orthopaedics, Plastic Surgery and General Surgery are failing the incomplete target. The impact of the RMS scheme introduced in July by St Helens CCG is also impacting on RTT performance due to new referral drop. Dermatology RTT performance has worsened impacting on the Trust overall RTT incomplete position.	There is a risk due to the current medical bed pressures and the increase in 2ww referrals and activity that the elective programme will be compromised. Dermatology's position worsens the overall incomplete position	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. A backlog management plan is in place and alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand. Dermatology to commence some intensive support and collaborative working with CCG to manage pathways and activity levels	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Oct-16	100.0%	99.99%	99.0%	99.99%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Oct-16	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Oct-16	0.6%	0.7%	0.8%	0.9%		Target achieved again in October but this metric continues to be directly impacted by increases in NEL demand (both surgical and medical patients).	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. Continued analysis of the referral drop and impact on RTT underway to include forecast year end position	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Sep-16	100.0%	100.0%	100.0%	99.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Oct-16	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Oct-16	74.4%	77.3%	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	Senior leaders to work with teams to deliver and embed the actions from operational turnaround plan which will result in sustainable improvement. 5 key areas of focus for improvement: 1. Increase number of discharges by 1pm to a minimum of 33% of the daily discharges 2. Increase weekend discharges to 80% of weekday average. 3. Consistent delivery of rapid assessment and treatment in ED 4. Consistent delivery of Ambulatory Emergency care in ED 5. Effective scheduling of seeing power in ED to manage patient flow Continue work with system partners to achieve and maintain reduction in medically optimised patients.	RC
A&E: Total time in A&E: % < 4 hours (All Types)	F&P	▲	Oct-16	84.0%	85.9%	95.0%	89.4%					
A&E: 12 hour trolley waits	F&P	▲	Oct-16	0	0	0	2					

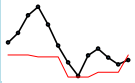
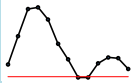
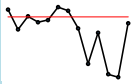
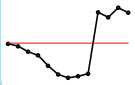
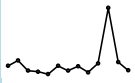
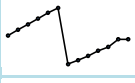
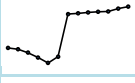
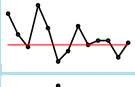
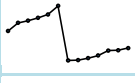
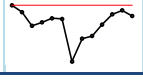
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	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	▲ £	Oct-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	Oct-16	32	195	No Target	291		A delay in responding to patient complaints leads to a poor patient experience. The 2015 - 16 resolution rate of 42.7% includes all stage 1 complaints resolved in 15-16 regardless of when the complaint was received. For stage 1 complaints both received and resolved in 15-16 the resolution rate was 61.4%	Patient experience	A revised structure to support performance has been implemented, but will require time to embed.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Oct-16	23	183	No Target	372					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Oct-16	78.3%	62.8%	No Target	42.7%					
Friends and Family Test: % recommended - A&E	Q	▲	Oct-16	88.0%	86.6%	90.0%	91.5%		For October the recommendation rates are slightly below target for A&E, postnatal community maternity services and outpatients, but are above target for in-patients and other maternity services.	Patient experience & reputation	Feedback from the FFT responses are fed back to individual areas to enable actions to be taken to address negative feedback, as well as using positive feedback. The Patient Experience Manager is working with individual services, including the Emergency Department, to look at key areas of concern and the actions that need to be taken to address these. This will be monitored via the Patient Experience Council monthly.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Oct-16	95.7%	95.2%	90.0%	96.4%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Oct-16	100.0%	97.8%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Oct-16	100.0%	97.9%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Oct-16	100.0%	100.0%	95.1%	95.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Oct-16	95.0%	92.2%	98.6%	98.6%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Oct-16	94.6%	94.3%	95.0%	94.7%					

Oct-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
WORKFORCE (appendices pages 51-55)												
Sickness: All Staff Sickness Rate	Q F&P	▲	Oct-16	4.6%	4.6%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.9%		Absence has increased in October to 4.6% which is 0.12% less than the Q3 target of 4.72%. Anxiety/Stress is the top reason for absence followed by Musculoskeletal problems.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	Further ongoing listening events with HCAs are scheduled for November/early December. A drive continues on managers carrying out Return to Work interviews more quickly & to log on ESR immediately. The HR Absence Support Team carried out (RTW) audits w/c 10/10/16, thereafter quarterly.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P	T	Oct-16	5.6%	5.7%	5.3%	6.0%					
Staffing: % Staff received appraisals	Q F&P	T	Oct-16	83.5%	83.5%	85.0%	87.2%		Mandatory Training compliance has dipped slightly in month but continues to exceed the target by 7.3%. Appraisal compliance has improved significantly in month and is now just 1.5% behind target.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The L&OD team continue to work with managers to ensure that all non compliant staff receive an appraisal and are recorded on ESR . Appraisal data down to department level will be reviewed at the Executive Committee as a monthly standing item on the agenda to ensure an increased focus and oversight on the timely completion of appraisals.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Oct-16	92.3%	92.3%	85.0%	77.6%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2	90.2%		No Contract Target			The Trusts Staff friends and family test results in Q2 focussed on the Surgical Care Group and remain positive. A significant number of staff continue to recommend the Trust as a place to receive care. There has however, been a reduction in the number of staff recommending the Trust as a place to work. The response rate was low but comparable to acute trusts nationally	Staff engagement, recruitment and retention.	Interrogation of the data is underway to establish possible reasons for the reduction in staff recommending the Trust as a place to work, with any necessary actions forming the basis of a targeted action plan to be monitored through Workforce Council.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2	69.0%		No Contract Target						
Staffing: Turnover rate	Q F&P	T	Oct-16	0.7%		No Target	8.9%		Staff turnover remains stable and well below the national average of 14%.		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 (appendices pages 58-62)												
UoRR - Overall Rating	F&P	T	Oct-16	3.0	3.0	3.0			The Trust's year to date performance is slightly ahead of plan. The Trust has significant contractual agreements with other NHS organisations which may impact on our ability to achieve Better Payment compliance.	Financial	Adherence against the submitted plan and delivery of CIP. Maintaining control on Trust expenditure. Agreeing with Commissioners and NHSE a more advantageous profile for receipt of planned income.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Oct-16	6,239	6,239	15,248	13,043					
Reported surplus/(deficit) to plan (000's)	F&P	T	Oct-16	1,812	1,812	3,328	(9,551)					
Cash balances - Number of days to cover operating expenses	F&P	T	Oct-16	11	11	2	2					
Capital spend £ YTD (000's)	F&P	T	Oct-16	955	955	4,985	4,169					
Financial forecast outturn & performance against plan	F&P	T	Oct-16	3,328	3,328	3,328	(9,551)					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Oct-16	94.4%	94.4%	95.0%	94.2%					

APPENDIX A

St Helens and Knowsley Teaching Hospitals NHS Trust

			Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	2016-17 YTD	2016-17 Target	FOT	2015-16	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	100.0%	100.0%	100.0%	94.1%	95.8%	100.0%	100.0%	100.0%	87.5%	93.1%	89.3%	100.0%	100.0%	94.2%	85.0%		99.2%		
	Total > 62 days		0.0	0.0	0.0	0.5	0.5	0.0	0.0	0.0	1.5	1.0	1.5	0.0	0.0	4.0			1.0		
Lower GI	% Within 62 days	▲ £	100.0%	84.6%	100.0%	100.0%	89.5%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	93.3%	81.8%	92.0%	85.0%		94.5%		
	Total > 62 days		0.0	1.0	0.0	0.0	1.0	0.0	0.0	0.0	2.0	0.0	0.0	0.5	1.0	3.5			3.0		
Upper GI	% Within 62 days	▲ £	85.7%	71.4%	83.3%	100.0%	100.0%	100.0%	81.8%	75.0%	90.9%	0.0%	100.0%	100.0%	0.0%	83.8%	85.0%		88.9%		
	Total > 62 days		0.5	2.0	0.5	0.0	0.0	0.0	1.0	0.5	0.5	0.5	0.0	0.0	1.5	3.0			5.0		
Urological	% Within 62 days	▲ £	83.3%	76.7%	84.0%	79.2%	83.3%	83.3%	84.0%	85.7%	84.6%	81.3%	75.0%	79.3%	76.9%	80.4%	85.0%		80.8%		
	Total > 62 days		2.0	3.5	2.0	2.5	2.0	2.0	2.0	2.0	3.0	3.0	4.0	3.0	4.5	19.5			28.0		
Head & Neck	% Within 62 days	▲ £		83.3%	100.0%	50.0%	57.1%	60.0%	50.0%	50.0%	100.0%	37.5%	71.4%	66.7%	100.0%	64.0%	85.0%		71.1%		
	Total > 62 days			0.0	0.0	1.0	1.5	1.0	0.5	0.5	0.0	2.5	1.0	0.5	0.0	4.5			6.5		
Sarcoma	% Within 62 days	▲ £		100.0%			100.0%		100.0%		85.7%			100.0%		87.5%	85.0%		87.5%		
	Total > 62 days			0.0			0.0		0.0		0.5			0.0		0.5			0.5		
Gynaecological	% Within 62 days	▲ £	40.0%	100.0%	54.5%	50.0%	60.0%	66.7%	71.4%	66.7%	81.8%	100.0%	85.7%	92.3%	33.3%	85.4%	85.0%		76.4%		
	Total > 62 days		1.5	0.0	2.5	1.5	1.0	0.5	1.0	0.5	1.0	0.0	0.5	0.5	1.0	3.5			8.5		
Lung	% Within 62 days	▲ £	100.0%	71.4%	80.0%	100.0%	90.5%	100.0%	88.2%	66.7%	81.5%	90.0%	91.7%	82.6%	100.0%	84.3%	85.0%		86.5%		
	Total > 62 days		0.0	1.0	1.0	0.0	1.0	0.0	1.0	1.0	2.5	0.5	0.5	2.0	0.0	6.5			10.5		RC
Haematological	% Within 62 days	▲ £		60.0%	80.0%	66.7%	83.3%	50.0%	86.7%	100.0%	100.0%	0.0%	50.0%	50.0%	100.0%	71.1%	85.0%		70.5%		
	Total > 62 days			1.0	1.0	1.0	1.0	2.0	1.0	0.0	0.0	2.5	3.0	1.0	0.0	6.5			13.0		
Skin	% Within 62 days	▲ £	94.7%	88.5%	95.9%	95.3%	94.4%	92.5%	96.7%	97.5%	96.0%	100.0%	97.3%	93.7%	95.7%	96.5%	85.0%		94.5%		
	Total > 62 days		1.0	3.5	1.0	1.0	0.5	1.5	0.5	0.5	1.0	0.0	0.5	2.0	1.0	5.0			13.0		
Unknown	% Within 62 days	▲ £	100.0%	100.0%	100.0%	33.3%	100.0%		50.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	85.0%		83.3%		
	Total > 62 days		0.0	0.0	0.0	1.0	0.0		0.5		0.0	0.0	0.0	0.0	0.0	0.0			1.5		
All Tumour Sites	% Within 62 days	▲ £	91.4%	85.1%	89.3%	86.9%	87.9%	90.1%	89.5%	91.8%	88.0%	87.5%	85.9%	89.4%	87.9%	88.3%	85.0%		88.6%		
	Total > 62 days		5.0	12.5	8.0	8.5	8.5	7.0	7.5	5.0	12.0	10.0	11.0	9.5	9.0	56.5			90.5		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £	100.0%					100.0%	100.0%					100.0%		100.0%	85.0%		100.0%		
	Total > 31 days		0.0					0.0	0.0					0.0		0.0			0.0		
Acute Leukaemia	% Within 31 days	▲ £			100.0%	100.0%					100.0%					100.0%	85.0%		100.0%		
	Total > 31 days				0.0	0.0					0.0					0.0			0.0		
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)110
Title of paper: Safer Staffing Report for October 2016
Purpose: To provide an overview of nursing and midwifery staffing levels (headcount only) in inpatient areas during October 2016 to provide assurance that every effort was made to address any shortages. Safer Staffing levels are one indication of the Trust's ability to provide safe, effective inpatient care.
Summary: • The Trust's mandated monthly submission of staffing headcount levels to NHS Choices for October 2016 indicates an overall headcount fill rate of 94.45% for RNs on days, 98.32% for RNs on nights, 104.84% for HCAs on days and 114.99% for HCAs on nights. • In October, 13 wards had fill rates below 90%; 12 wards for RNs and 1 for both. • The overall headcount fill rate for care staff is higher than the ward establishment. This relates to the need for 'specials' (i.e. 1 patient to 1 staff member) who are employed to protect vulnerable patients and when there is a trained staff shortfall and the shift cannot be filled with a bank or agency RN , the shift is backfilled with a health care assistant. • A month on month CHPPD RN/RM is included for each ward from commencement of the mandated collection (NHSI) in May 2016. • In October, there were no inpatient falls resulting in severe harm on wards with a fill rate below 90%.
Corporate objectives met or risks addressed: Care, Safety
Financial implications: None directly from report.
Stakeholders: Patients, public, staff, commissioners, Trust Board
Recommendation(s): Board Members are asked to approve the report
Presenting officer: Rob Cooper, Acting Chief Operating Officer
Date of meeting: 30th November 2016

Trust Safer Staffing Report for October 2016

The purpose of this paper is to set out the nursing and midwifery ward staffing levels across the Trust during October 2016 and to provide assurance that shortages on each shift were addressed as far as possible. It is a national requirement of all Trusts to submit this data to the NHS Choices (October submission, Appendix 1).

Safer staffing levels are the actual number of hours worked by registered and care staff on a shift basis measured against the number of planned hours to produce a monthly fill rate for nights and days on each ward. A monthly ward fill rate of 90% and over is considered acceptable nationally. Agency, bank, overtime, extra time hours and ward managers management days are included on each shift's figures in accordance with NHSI guidance.

Staffing levels is the head count on each shift and is only one indication of the Trust's ability to provide safe, high quality care across all wards. Safer staffing does not analyse skill mix, the impact of temporary staff on a shift by shift basis or being short of a member of staff on a shift if it has been unsuccessfully backfilled, e.g. only two trained staff on a night shift instead of 3 which for that shift is a fill rate of 66%. This may not be reflected in the ward's overall monthly average.

1. **The October Submission** indicates an overall fill rate of 94.45% for RNs on days, 98.32% for RNs on nights, 104.84% for HCAs on days and 114.99% for HCAs on nights. The overall fill rates for care staff are high because the figures are raised by both the employment of 'specials' (i.e. 1 patient to 1 care staff member) to protect vulnerable patients and the wards maintaining the shift's headcount by employing an HCA when there is a trained staff shortfall on a shift which has remained unfilled in spite of trying to backfill with a bank and/or agency RN or the permanent RNs being offered extra time or overtime. E-rostering does not currently have the functionality to separate out staff employed for specials from the actual shift requirements. This is widely recognised constraint on the E roster system and is reported by other trusts.

2. **Recruitment and Retention** of nursing and midwifery staff remains a priority for the Trust and is an on-going challenge nationally. Trust workforce data shows there were 60.37wte RN and 16.31wte HCA vacancies as of the end of September 2016 in spite of an active on-going recruitment programme. Staffing remains on the Corporate Risk Register (CRR) which is reviewed monthly. Stabilising and retaining the nursing and midwifery workforce in clinical areas continues to be an area of increased focus:-

    2.1. **Nurse Recruits from India.** Slow but continued progress is being made with the 122 nurses offered posts from India. 85 are still in the process. 2 commence in the Trust on 4th December, 4 have received their decision letter from the NMC, 3 are in the process of uploading their documentation to the NMC, 5 have passed the IELTS and are booked onto the Computer Based Test and 71 are still trying to succeed at the IELTS.

    2.2. **The Recruitment of Bank HCAs Update.** Interview dates to be sent out shortly as part of the November recruitment campaign. Recruitment is on-going, advertising on 1st of every month to recruit HCAs to the nurse bank.

    2.3. **Student Nurse Recruitment Update.** HR Recruitment and the Trust's Student Nurse Practice Education Facilitators have met and arranged optimum

Recruitment Open Day dates for 2017 to link with the stage in students training when they are job seeking. The dates for 2017 are 25th February and 3rd June.

2.4. Recruitment Events Update for Stroke, Theatres and Maternity. Two events are planned on 6th (1 – 4pm) and 8th (5-8pm) December 2016 targeting Stroke. A successful open evening was held for Theatres two weeks ago where posts were offered to fill all current vacancies. Open events were held on 4th and 5th November 2016 to recruit midwives. 14 qualified midwives have now been invited to interview following these events.

2.5. International Nurse Recruitment. Approval has just been given for the Trust's Recruitment Department to commence working with TTM HealthCare who are a specialise in the recruitment of international qualified nurses to work in the NHS. The majority of these nurses are already registered with the NMC.

3. **RN / RM Care Hours Per Patient Per Day (CHPPD) May – October 2016** . (appendix 4) . The RN/RM CHPPDs for each ward are calculated by taking the actual hours worked divided by the number of patients at midnight split by registered nurses/midwives hours worked during the month and was mandated as part of the Safer Staffing submission from May 2016 by NHSI. The monthly totals for RNs and RMs hours available per patient each month are similar for the Trust's DMOP, respiratory, general medicine, gastro and cardiology wards. CHPPDs are higher on CCU, the assessment wards (higher turnover of patients) 1B, 1C, 4B, SCBU, DS, Burns and neuro rehab wards as expected. The Paediatric wards have higher staffing establishments in accordance with guidance and 4F is higher than 3F as it includes the Children's Observations Unit with a higher patient turnover and this is reflected in their monthly CHPPD figures. The T&O and general surgical wards have similar CHPPDs each month. More information is expected to facilitate hopefully meaningful national benchmarking when the Carter Model hospitals report on their findings early in 2017. It is essential to ensure comparisons of like with like, i.e same specialty comparisons.

4. **Shelford Patient Acuity Audit -** The nationally mandated bi-annual Shelford patient acuity audit was completed on the wards during October 2016. This audit collates patient acuity levels and actual staff hours over a 20 consecutive day period to enable a review of current ward staff establishments against patient demand. The report will be taken to Quality Committee in January 2017.

5. **Fill rates below 90%** occurred on 13 wards in October; 12 for RNs and 1 for both RNs and care staff. There are 8 wards with fill rates of less than 90% consistently for the last 3 months (Appendix 2). Of the 11 wards with a fill rate of less than 90% for RNs, 9 of them had fill rates above 100% for care staff to maintain the headcount numbers on a shift, fully appreciating skill mix is compromised.

6. **Wards with a fill rate of less than 90% where patients have experienced severe harm from an inpatient fall**

No patient on the wards with a fill rate less than 90% experienced a fall resulting in severe harm. In October, 2 patients experienced severe harm as a result of an inpatient fall on Duffy and ward 3E medical. Both wards had the correct staffing headcount levels at the time of the patient fall. Level 2 serious incident review

investigations are on-going into these incidents when a detailed review of staffing skill mix on the shift when the harm occurred will be undertaken as part of the review.

7. Staffing Related Reported Incidents

A total of 22 incidents were reported in October directly relating to staffing on the wards included in the Safer Staffing submission, (Appendix 3) of which none are reported as resulting in patient harm. Staff are requested to complete an incident form for shifts where there are skill mix issues or the actual headcount on shift is less than the planned.

8. Future Developments.

8.1. Allocate E-Roster System - A business case is to be taken to the Trust's Executive Committee to consider the value of purchasing the Allocate E-Roster SaferCare module piloted in 5 Trusts nationally at present to address some of the Carter Recommendations. This system allows real time entry by shift leaders of staffing levels, skill mix, the number of specials employed, staff moves to other wards and has the facility to allow the inputting of patient acuity which provides a summary meaningful view of Care Hours Per Patient available on each ward. The successful implementation of this system requires a senior clinical project lead and is not an overnight implementation as a culture change is required across the wards. Once successfully implemented, the system provides efficient and effective use of staff across all wards as a Trust-wide picture of current staffing levels and skill mix on each shift and patient numbers and acuity. The SaferCare module then creates a summary to allow matrons at the daily mandated Staffing levels review meeting to employ their professional judgement to the information to deploy staff accordingly to provide safe care.

8.2. 'In-House' Student Nurse Training Academy Proposal – A business case is being to the Trust's Executive Committee at the end of November 2016. The Trust's Academy pilot programme would consist of an additional cohort of 20 student nurses commencing in March 2017 who would be attached to this Trust for all their clinical placements throughout their training (except for non-acute Trust elements of training) and guaranteed employment at the outset of their training once NMC registered with the promise of a partial reimbursement of tuition fees (fee paying students only) after 24 months registered employment at the Trust to promote allegiance to this Trust.

8.3. Band 4 payment to new recruits working as care staff whilst awaiting NMC PIN. Once a student nurse has successfully completed their training and is awaiting confirmation of NMC registration, there is a four to six week maximum period where they may choose for financial reasons to commence in post employed as care staff. Other Trusts locally are enticing newly qualified staff into employment by paying these new recruits at a band 4 for this period of time whilst this Trust is currently paying at a band 2. Students have reported that this is why they take jobs in other Trusts on completion of training, for financial reasons. Agreement is required to pay newly qualified staff recruits at band 4 until NMC PIN confirmation.

8.4. **NHS Improvement Safer Staffing Guidance** for emergency departments, maternity, paediatrics and adult inpatients is presently being developed and due to be published later this year or early 2017.

Review of whether the Discharge Coordinator Role is included in the monthly Safer Staffing figures and the impact their inclusion could have on fill rates

There are 9.8wte funded band 5 registered nurse discharge coordinator roles for wards 1A, 1D, 2B, 2C, 2D, 3D, 5A, 5B, 5CDMOP and Stroke (5C stroke and 5D combined). There are currently 3wte vacant discharge coordinator posts on wards 2D, 5A and 5CDMOP.
Confirmation is unavailable as to whether the discharge coordinators are included in the 'actual' registered nurse headcounts for the above wards each month because the Head of the E-Roster team who supplies the safer staffing information for each ward, including all the relevant nursing and midwifery roles as set out by NHSI Safer Staffing guidance, is presently on compassionate leave.. On review of the e-roster information received for October 2016, confirmation can be provided that they are **not** included in the 'planned' hours for the above wards. Therefore:-

- If the occupied posts **are** presently included in the 'actual' headcount, the 'planned' head count needs increasing going forward to reflect their inclusion which will further decrease the RN fill rate on days for these wards.
- If the occupied posts **are not** included in the 'actual' headcount, there will be no effect on the RN days fill rate because if a decision is made to include them going forward because both the RN 'planned' and 'actual' headcounts will increase with net gain.
- If wards 2D, 5A and 5CDMOP recruited to the posts, both the 'planned' and 'actual' headcount will increase, again resulting in no change to the RN days fill rate.

Confirmation will be obtained as soon as available. A decision is required as to whether they are to be included going forward, which requires including them in both 'planned' and 'actual' headcounts which will impact as outlined above accordingly.

Summary

This report provides assurance that every effort is being made to provide safe staffing headcount levels across all wards daily in spite of the current shortfalls in staffing due to vacancies or other gaps or short notice absence both on a shift by shift basis and long term.

Appendix 1 – Trust's October 2016 NHS Choices Safer Staffing Submission

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

Org: RBN St Helens And Knowsley Hospitals NHS Trust

Period: October_2016-17

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

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

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

Comments

Validation alerts (see control panel)	Only complete either your organisation is accountable for	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
							Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff									
		Site code (The Site code is automatically populated when a Site	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/nurses	Care Staff	Overall
		RBN01	WHISTON HOSPITAL - RBN01	1A	430 - GERIATRIC MEDICINE		1981.75	1952.5	2107.5	2162.25	920	762.5	930	1100	98.5%	102.6%	82.9%	118.3%	801	3.4	4.1	7.5
		RBN01	WHISTON HOSPITAL - RBN01	1B	300 - GENERAL MEDICINE		3255.65	3146.66667	1789.25	1892	910	857.5	530	569.75	96.7%	105.7%	94.2%	107.5%	710	5.6	3.5	9.1
		RBN01	WHISTON HOSPITAL - RBN01	1C	300 - GENERAL MEDICINE		3122	3032	1790.75	2043.83333	1550	1710	620	860	97.1%	114.1%	110.3%	138.7%	808	5.9	3.6	9.5
		RBN01	WHISTON HOSPITAL - RBN01	1D	320 - CARDIOLOGY		2058	1770.5	1373.75	1884.5	930	840	620	790	86.0%	137.2%	90.3%	127.4%	783	3.3	3.4	6.7
		RBN01	WHISTON HOSPITAL - RBN01	1E	320 - CARDIOLOGY		2293.75	2430.75	765.25	821.25	1240	1183.75	120	110	106.0%	107.3%	95.5%	91.7%	444	8.1	2.1	10.2
		RBN01	WHISTON HOSPITAL - RBN01	2A	303 - CLINICAL HAEMATOLOGY	300 - GENERAL MEDICINE	1852.25	1881.58333	921.25	931.25	620	601.75	310	361	101.6%	101.1%	97.1%	116.5%	515	4.8	2.5	7.3
		RBN01	WHISTON HOSPITAL - RBN01	2B	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	2054.902	1862.58333	1541.75	1705.16667	930	830.333333	620.75	1033	90.6%	110.6%	89.3%	166.4%	847	3.2	3.2	6.4
		RBN01	WHISTON HOSPITAL - RBN01	2C	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	2053.75	1857.75	1609	1934.75	930	829.8	620	1130	90.5%	120.2%	89.2%	182.3%	751	3.6	4.1	7.7
		RBN01	WHISTON HOSPITAL - RBN01	2D	300 - GENERAL MEDICINE		1432.885	1140.75	1163.8	1500.41667	620	731.75	620	619.5	79.6%	128.9%	118.0%	99.9%	509	3.7	4.2	7.8
		RBN01	WHISTON HOSPITAL - RBN01	2E	501 - OBSTETRICS		3025.5	2798.75	1323	1190.25	1240	1345.25	620	700.5	92.5%	90.0%	108.5%	113.0%	830	5.0	2.3	7.3
		RBN01	WHISTON HOSPITAL - RBN01	3A	160 - PLASTIC SURGERY		1931	1926.5	1314	1233	740	722	620	682	99.8%	93.8%	97.6%	110.0%	466	5.7	4.1	9.8
		RBN01	WHISTON HOSPITAL - RBN01	3Alpha	110 - TRAUMA & ORTHOPAEDICS		1505	1459.76667	1149.25	1225.5	620	640	310	310	97.0%	106.6%	103.2%	100.0%	372	5.6	4.1	9.8
		RBN01	WHISTON HOSPITAL - RBN01	3B	110 - TRAUMA & ORTHOPAEDICS		1435.75	1372.5	2098.5	2036.25	920	912.5	620	600	95.6%	97.0%	99.2%	96.8%	560	4.1	4.7	8.8
		RBN01	WHISTON HOSPITAL - RBN01	3C	110 - TRAUMA & ORTHOPAEDICS		2028.25	1541	1602	2108.33333	930	930	930	1140	76.0%	131.6%	100.0%	122.6%	722	3.4	4.5	7.9
		RBN01	WHISTON HOSPITAL - RBN01	3D	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	2026.5	1758.5	1394.0985	1427.25	930	940	620	760	86.8%	102.4%	101.1%	122.6%	850	3.2	2.6	5.7
		RBN01	WHISTON HOSPITAL - RBN01	3E	502 - GYNAECOLOGY		1583.735	1331.375	977	902	620	598.5	310	280	84.1%	92.3%	96.5%	90.3%	538	3.6	2.2	5.8
		RBN01	WHISTON HOSPITAL - RBN01	3F	420 - PAEDIATRICS		2199.8	2116.33333	452.75	444	1240	1211.5	310	290	96.2%	98.1%	97.7%	93.5%	395	8.4	1.9	10.3
		RBN01	WHISTON HOSPITAL - RBN01	4A	101 - UROLOGY	100 - GENERAL SURGERY	1992	1875.75	1254.5	1447.375	930	929.5	930	909.5	94.2%	106.9%	99.9%	97.8%	823	3.4	2.9	6.3
		RBN01	WHISTON HOSPITAL - RBN01	4B	100 - GENERAL SURGERY	101 - UROLOGY	2542.785	2482.95	1817.875	1786.75	1120	1081	410	516	97.6%	98.3%	96.5%	125.9%	402	8.9	5.7	14.6
		RBN01	WHISTON HOSPITAL - RBN01	4C	100 - GENERAL SURGERY		2257.725	2097.25	1377	1347.75	930	909.5	930	870	92.9%	97.9%	97.8%	93.5%	855	3.5	2.6	6.1
		RBN01	WHISTON HOSPITAL - RBN01	4D	160 - PLASTIC SURGERY		1895.65	1972.41667	502.5	487.5	660	660	280	280	104.0%	97.0%	100.0%	100.0%	65	40.5	11.8	52.3
		RBN01	WHISTON HOSPITAL - RBN01	4E	192 - CRITICAL CARE MEDICINE		5496.25	5519.25	953	875	3720	3532.5	580	580	100.4%	91.8%	95.0%	100.0%	302	30.0	4.8	34.8
		RBN01	WHISTON HOSPITAL - RBN01	4F	420 - PAEDIATRICS		2226.123	2113.75	544.25	533	620	619.25	310	300	95.0%	97.9%	99.9%	96.8%	174	15.7	4.8	20.5
		RBN01	WHISTON HOSPITAL - RBN01	5A	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1615.465	1537.16667	2535.5	2613.25	930	795.75	930	1199.5	95.2%	103.1%	85.6%	129.0%	790	3.0	4.8	7.8
		RBN01	WHISTON HOSPITAL - RBN01	5B	430 - GERIATRIC MEDICINE		1676.1625	1632.25	2306	2182	930	820	930	890	97.4%	94.6%	88.2%	95.7%	704	3.5	4.4	7.8
		RBN01	WHISTON HOSPITAL - RBN01	5C	430 - GERIATRIC MEDICINE		2474.75	2110.75	1760.75	2196.16667	1240	1349.5	930	1170	85.3%	124.7%	108.8%	125.8%	685	5.1	4.9	10.0
		RBN01	WHISTON HOSPITAL - RBN01	5D	430 - GERIATRIC MEDICINE		1555.5	1320.5	1736	1530	620	719.5	620	760	84.9%	88.1%	116.0%	122.6%	682	3.0	3.4	6.3
		RBN02	ST HELENS HOSPITAL - RBN02	Duffy Ward	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1431	1307.5	1741.73333	1742.91667	620	621	620	630	91.4%	100.1%	100.2%	101.6%	585	3.3	4.1	7.4
		RBN01	WHISTON HOSPITAL - RBN01	SCBU	420 - PAEDIATRICS		1624.084	1605.16667	511.52	495.5	972	971	260	260	98.8%	96.9%	99.9%	100.0%	239	10.8	3.2	13.9
		RBN01	WHISTON HOSPITAL - RBN01	Delivery Suite	501 - OBSTETRICS		3398.25	3254.7	902.05	894.25	2170	2157.75	600	580.75	95.8%	99.1%	99.4%	96.8%	290	18.7	5.1	23.7
		RBN02	ST HELENS HOSPITAL - RBN02	Seddon	314 - REHABILITATION		1726	1781.25	1623	1547.5	620	620	620	740	103.2%	95.3%	100.0%	119.4%	441	5.4	5.2	10.6

Appendix 2

The 12 wards with fill rates below 90% for RNs for October 2016

Ward	October 2016			
	RN Days	RN Nights	HCA Days	HCA Nights
1A	98.52	82.88	102.6	118.28
1D	86.03	90.32	137.18	127.42
2B	90.64	89.23	110.60	166.41
2C	90.46	89.23	120.25	182.26
2D	79.61	118.02	128.92	99.92
2E	92.51	89.97	108.49	112.98
3D	86.73	101.08	102.38	122.58
3C	75.98	100	131.61	122.58
3E	84.07	96.53	92.32	90.32
5A	95.51	85.56	103.07	128.98
5B	97.38	88.17	94.62	95.70
5C	85.29	108.83	124.73	125.81

The 1 ward with a fill rate below 90% for both RNs and HCAs in October 2016

Ward	October 2016			
	RN Days	RN Nights	HCA Days	HCA Nights
5D	84.89	116.05	88.13	122.59

The 8 wards with fill rates consistently less than 90% during the last 3 months

Ward	August 2016				September 2016				October 2016			
	RN Days	RN Nights	HCA Days	HCA Nights	RN Days	RN Nights	HCA Days	HCA Nights	RN Days	RN Nights	HCA Days	HCA Nights
1A	88.3%	88.0%	112.4%	107.5%	87.6%	75.3%	102.7%	113.3%	98.5%	82.9%	102.6%	118.3%
1D	84.3%	85.3%	128.5%	116.9%	83.4%	91.1%	144.1%	136.2%	86.0%	90.3%	137.2%	127.4%
2B	77%	94.7%	107%	130.5%	87.2%	93.4%	106.6%	147.4%	90.6%	89.3%	110.6%	166.4%
2C	87.7%	81.7%	120.7%	135.7%	88.8%	92.3%	119.7%	145.0%	90.5%	89.2%	120.2%	182.3%
2D	85.2%	118.9%	137.8%	161.0%	85.2%	108.4%	103.1%	101.7%	79.6%	118.0%	128.9%	99.9%
3D	89.0%	80.6%	110.4%	145.2%	86.7%	83.4%	108.5%	134.9%	86.8%	101.1%	102.4%	122.6%
5A	91.5%	80.7%	107.2%	140.3%	92.8%	85.6%	100.3%	121.0%	95.2%	85.6%	103.1%	129.0%
5C	87.2%	100.5%	134.6%	167.7%	86.0%	102.5%	97.6%	105.1%	85.3%	108.8%	124.7%	125.8%

Appendix 3 – 22 Staffing Related Reported Incidents October 2016

Copy of Staffing Incidents Oct 16.xlsx

Appendix 4

RN Care Hours Per Patient Day (CHPPD) Monthly to date

Ward Name	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
1A DMOP		2.6	2.8	2.6	2.9	2.9	3.4
1B GPAU		5.9	5.7	4.6	6.2	5.8	5.6
1C MAU		5.8	5.6	5.4	5.4	5.7	5.9
1D Cardiology		2.8	2.8	3.0	2.9	3.1	3.3
1E CCU		7.6	7.0	6.8	7.2	7.6	8.1
2A Haem		3.6	3.7	3.9	4.8	4.6	4.8
2B Resp		2.8	3.0	2.9	2.7	3.0	3.2
2C Resp		2.7	2.8	2.8	2.8	3.4	3.6
2D Gen med		2.9	2.8	3.1	3.4	3.5	3.7
2E Mat		4.9	4.6	5.1	5.6	4.4	5.0
3A Plastics		5.1	4.3	4.6	4.6	5.3	5.7
3Alpha T&O		4.8	4.2	4.9	5.2	5.7	5.6
3B T&O		3.6	3.3	3.5	3.2	3.9	4.1
3C T&O		3.4	2.9	3.2	3.6	3.5	3.4
3D gastro		2.8	2.8	3.1	3.0	2.9	3.2
3E Gynaey		3.4	3.4	3.1	3.4	3.8	3.6
3F Paeds		7.4	9.1	7.1	10.7	8.5	8.4
4A gen surg		3.3	3.2	3.2	3.1	3.2	3.4
4B gen surg		7.6	7.0	7.6	8.6	8.8	8.9
4C gen surg		3.2	3.1	3.2	3.0	3.2	3.5
4D Burns		12.6	16.9	15.5	16.5	33.2	40.5
4E Crit Care		27.7	25.2	26.0	26.1	27.9	30.0
4F Paed/CHOB		7.9	10.0	11.5	16.7	15.4	15.7
5A DMOP		3.5	3.6	2.7	3.0	2.8	3.0
5B DMOP		2.6	3.8	3.4	3.3	3.4	3.5
5C stroke/DMOP		4.8	4.7	2.0	2.1	5.3	5.1
5D stroke		3.7	3.4	4.4	5.2	2.5	3.0
Duffy Ward inter		2.7	2.7	2.5	2.5	2.8	3.3
SCBU		7.5	8.1	12.6	15.3	10.7	10.8
Delivery Suite		17.0	15.8	18.6	18.2	16.1	18.7
Seddon neuro		5.2	5.5	5.5	4.6	5.3	5.4

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)111
Agency Staffing Self Certification Checklist
Purpose: To present to the Committee the recent guidance from NHSI on Agency expenditure and the associated actions required from the Trust, as well as details of year to date expenditure
Summary: In 2015/16 the Trust spent £12.2m on Agency and the forecast outturn for the current year is currently £10.6m, against an Agency cap set by NHSI of £7.256m. The Trust has been informed through the Planning guidance that the agency spend cap will remain in place and unchanged for the next two years, 2017/18 and 2018/19. In October NHSI wrote to all Trusts on two separate occasions, detailing additional actions to reduce agency spending which are summarised below: • **Strengthening financial performance and accountability in 2016/17; next steps (7th Oct)** o for Quarter 2 reporting: ▫ List of 20 highest earning Agency staff (anonymised) ▫ List of Agency staff employed for more than six consecutive months ▫ Monthly agency spend broken down by cost centre • **Taking further action to reduce agency spending (17th Oct)** o Self-certification Check list to be Board approved by **30th November** o Chief Executive sign-off from **22nd November** for: ▫ All agency shifts costing more than £120/ hour ▫ All framework overrides above price cap o NHSI approval for new or extended contracts for agency Senior Managers costing more than £750/day (including on costs), from **31 October 2016** These documents are in addition to the existing guidance in relation to agency expenditure, which are collectively known as the 'agency rules'. Agency expenditure and the additional guidance were discussed at the Finance and Performance Committee in November and all submitted reports were reviewed. The paper also included details of expenditure to date by specialty and action plans in place to reduce current levels of expenditure going forward. NHSI have issued performance against Agency Ceilings in the North; the Trust was 69/73 for *agency spend against ceiling % rank* and 49/73 for *agency spend / total staff cost % rank.* The Self certification Check list was reviewed by the Finance and Performance Committee and approved for presentation at Trust Board and appears as Appendix A to this report.

Corporate objective met or risk addressed: Financial performance and efficiency
Financial implications: The Trust has an agency cap in place of £7.256m and the current level of agency expenditure adds risk to the delivery of the planned £3.328m surplus in 2016/17.
Stakeholders: Trust Board / Trust-Wide
Recommendation(s): To note the NHSI Agency guidance issued in October 2016 and approve the Self Certification Check List which is to be submitted to NHSI on 30th November 2016
Presenting Officer: Anne-Marie Stretch, Deputy Chief Executive and Human Resources Director
Meeting date: 30th November 2016

Self-certification checklist		Yes - please specify steps taken	No. We will put this in place - please list actions
Governance and accountability			
1	Our trust chief executive has a strong grip on agency spending and the support of the agency executive lead, the nursing director, medical director, finance director and HR director in reducing agency spending.	A quarterly deep dive into agency spend is conducted, presented and reviewed by the Chief Executive. The monthly Agency Spend executive report has been developed further to provide an extensive overview on spend, breaches and the actions taken and progress made towards reducing agency usage and spend. This paper is discussed by the executives, finance and performance and the Trust board.	
2	Reducing nursing agency spending is formally included as an objective for the nursing director and reducing medical agency spending is formally included as an objective for the medical director.	Yes, the nursing and medical directors are required to personally sign off agency breaches of either off-framework usgage or price cap breaches. All requests are challendged to ensure that all options have been explored before resorting to agency usage.	
3	The agency executive lead, the medical director and nursing director meet at least monthly to discuss harmonising workforce management and agency procurement processes to reduce agency spending.	Executive Monthly Meetings are attended by all of the executive team monthly, where the detailed agency spend executive report it discussed.	
4	We are not engaging in any workarounds to the agency rules.		No
High quality timely data			
5	We know what our biggest challenges are and receive regular (eg monthly) data on: - which divisions/service lines spend most on agency staff or engage with the most agency staff - who our highest cost and longest serving agency individuals are - what the biggest causes of agency spend are (eg vacancy, sickness) and how this differs across service lines.	The monthly Executive Agency Report details the areas of high spend, the reasons for agency usage within those areas, the top 20 high cost agency staff along details about their length of service. The report also details the actions taken in order to replace the locums with either fixed term or permanent recruitment or where that has been unsuccessful the other actions taken. high spend departments are also subject to regular review meetings with the Director of Finance and the Director of HR in order to stringently monitor progress.	
Clear process for approving agency use			
6	The trust has a centralised agency staff booking team for booking all agency staff. Individual service lines and administrators are not booking agency staff.	The Trust has a centralised Staffing Solutions Bookings Team in hours , out of hours this is managed by a centralised bed managers team. This is reflected in the Trusts Agency Booking Service Operating Procedure.	
7	There is a standard agency staff request process that is well understood by all staff. This process requires requestors and approvers to certify that they have considered all alternatives to using agency staff.	The Trusts Agency Booking Service Oprerating Procedure is circulated and easily accessible for all. Only Ward Managers/Matrons or service managers can request agency staff and the sign off pro-forma details the reasons for the agency request and the alternaitves explored.	
8	There is a clearly defined approvals process with only senior staff approving agency staff requests. The nursing and medical directors personally approve the most expensive clinical shifts.	The Nursing and Medical Directors sign off all requests to breach the price-cap or go off-framework for their relevant areas. No bookings will be made until the approval has been granted by the relevant Director.	
Actions to reducing demand for agency staffing			
9	There are tough plans in place for tackling unacceptable spending; eg exceptional over-reliance on agency staffing services radiology, very high spending on on-call staff.	Executive-led Review meetings are held weekly with those specialties with high agency usage and operational managers and clinicians attend. During these meetings, Divisional Managers and Clinical Directors present their agency usage and performance against the national price caps. Where usage is over cap, the Executive team have asked for detailed action plans to cease or significantly reduce spending. The Trust also monitor agency exenditure at the Finance & Performance Committee meeting as well as at monthly review meetings held at both Care Group and Specialty level.	
10	There is a functional staff bank for all clinical staff and endeavour to promote bank working and bank fill through weekly payment, auto-enrolment, simplifying bank shift alerts and request process.	The Staff Bank is available for all staff groups, Auto enrollment has beeen implemented and is successful. All new staff are auto enrolled unless they sign an opt out form. Weekly pay is provided on the bank, where the Medical Staff have the option of choice of either weekly or monthly pay. All requests for bank staff are done through the Erostering and Bank Staff system and all bank staff can view and book into available shifts through their Employee Online Accounts.	
11	All service lines do rostering at least 6 weeks in advance on a rolling basis for all staff. The majority of service lines and staff groups are supported by eRostering.	Rostering for nurses now have an 8 week approvals deadline. All other Staff Groups have their Rosters provided a minimum of 6 weeks in advance. Erostering is in place for all nursing wards and is currently in the intial phases of being implemented for Junior Doctors and Non-Clinical Support Areas.	
12	There is a clear process for filling vacancies with a time to recruit (from when post is needed to when it is filled) of less than 21 days.	There is clear recruitment process as outlined in the Trust Recruitment Policy. The Trust utilisies the Trac E-recruitment system to to support and outline the recruitment process to all users.	
13	The board and executives adequately support staff members in designing innovative solutions to workforce challenges, including redesigning roles to better sustain services and recruiting differently.	The Trust has supported several innovative schemes to address shortages in specialty expertise: the use of Paediatric ACP's to allow the service to respond to SHO gaps; International Recruitment to support other junior doctor rota gaps with doctors from both India and the Czech republic; the recruitment of Surgical Assistant posts to reduce the reliance on junior medical staff	
14	The board takes an active involvement in workforce planning and is confident that planning is clinically led, conducted in teams and based on solid data on demand and commissioning intentions.	The Annual plan is reviewed and presented at both Finance & Performance Committee and Trust Board and workforce planning is a key component of that plan. The Trust continues to improve its approach to workforce planning, to ensure it is aligned with both the financial and operational performance of the Trust. Workforce planning methodology will be reviewed during the year by a mutli-disciplinary team which includes the clinical leads.	
Working with your local health economy			
15	The board and executives have a good understanding of which service lines are fragile and currently being sustained by agency staffing.	The monthly Executive Agency report provides this data.	
16	The trust has regular (eg monthly) executive-level conversations with neighbouring trusts to tackle agency spend together.	The Trust is part of an Alliance (LDS) project working closely with Warrington and Southport in order to share data and reduce agency spend. The Trust has also formed part of a cluster agreement with other Trusts within Merseyside to use a preferred suppliers list for agency in order to drive the costs down of agency bookings.	

Signed by [Date]

Trust Chair: [Signature]

Trust Chief Executive: [Signature]

Please submit signed and completed checklist to the agency inbox (NHSI.agencyrules@nhs.net) by 30 November 2016

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)112
Title of paper: Executive Committee Assurance Report.
Purpose: To feedback to members key issues arising from the Executive Committee meetings.
Summary: 1. Between the 14th October and 17th November five 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 agreement to the HIS Shared Service Agreement, actions to address A&E waiting times, and use of agency HCAs. 3. Assurances regarding management of CQUIN, breast referrals, safeguarding, management of risks, improvements in mandatory training and appraisals were obtained. 4. No significant investment decisions were made, however the EPR Business Case was agreed for consideration by the Trust Board. 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: 30th November 2016.

EXECUTIVE COMMITTEE REPORT (14th October to 17th November 2016)

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

20th October

1. Antibiotic prescribing CQUIN

    1.1. KH advised that the directive, designed to reduce antibiotic prescribing, does not have the appropriate incentives. The CCG are aware of the issue and support the Trust in pursuing a change

2. Friends and Family Test

    2.1. Anne Rosbotham-Williams presented an update and described the measures to address the reduction in performance.

3. Mandatory Training and Appraisal data

    3.1. It was noted that Mandatory Training performance had improved. There was concern with the validity of the appraisal data from the ESR system primarily from the delay in proof of appraisals being uploaded onto the system. It was agreed the reports would be rerun on 27th October for further analysis.

4. Premium payments

    4.1. Sue Hill (SH) reported on expenditure on premium payments (agency, locum, WLI, additional PAs, enhancements, overtime and LLP, plus Bank). Further information was requested, and it was agreed that a benefits realisation exercise should be carried out on the original business case for the LLP.

    4.2. A meeting is scheduled with NHS Professionals, a provider of managed flexible worker services, to explore their proposals for managing temporary staffing.

5. Endoscope decontamination

    5.1. SRe reported on an incident on 13th October where a scope was inappropriately cleaned. This is Steis and SIRI reportable and an RCA has commenced.

6. Maternity Unit training exercise

    6.1. SR reported on Exercise Lemon Ribbon, a Maternity Unit training exercise which took place on 20th October; designed to test our response to an attempted abduction of a baby. A number of lessons were learned and the full debrief will be shared with staff and an action plan developed.

7. IT developments

    7.1. CW briefed members on EDMs, the Theatre system, and the EPR Business Case development. In addition, CW reported back from the STP IM&T Sub-group, set up to determine IT systems across Cheshire and Merseyside.

8. Sustainability and Transformation Plans

    8.1. The latest developments were discussed including feedback from the Alliance LDS Project Leads meeting, pharmacy and pathology collaboration, and back office services.

27th October

9. Stroke services

    9.1. KH provided an update on the rationalisation of hyper acute stroke services and the ongoing work to model the bed requirement. The shortage of stroke consultants to maintain an independent rota was acknowledged.

10. CQUIN

    10.1. Nicola Broderick provided an update on the current year CQUIN performance and contract penalties, plus proposals for the next two years. Two KPIs have been missed; readmissions and the non-elective threshold cap, resulting in penalties of c£624k year to date. In addition the two MRSA cases and the never event resulted in £20k and £3.4k penalties respectively. Detailed reviews and mitigation plans have been put in place.

    10.2. Following intervention from the Trust clinical champion, local CCGs have jointly agreed to change the original CQUIN targets for Sepsis and AKI, to be more representative of the Trust and its population.

11. VTE update

    11.1. KH reported an improvement in performance to 94% and CW added that this was largely down to additional training of junior doctors in the relevant IT systems. CW confirmed that ePrescribing will improve this performance, and it is hoped that the pilot can commence at the end of March 2017.

12. Clinical Quality Performance Group (CQPG)

    12.1. KH provided feedback including the CCG provider site inspection monitoring tool, and consultant to consultant referrals.

3rd November

13. Accommodation review

    13.1. Nicola Bunce, Geoff Hunter and Diane Stafford provided an update on schemes being pursued to deliver additional beds, covering design development and appointment of contractors.

    13.2. Options for Ward 3E, the surgical admissions lounge, Plastics Trauma Assessment Unit, and usage of relatives and on-call accommodation were discussed and proposals progressed.

14. Chlorhexidine

    14.1. John Clayton and Kalani Mortimer briefed the Committee on changes in best practice guidance from NICE for pre-operative skin preparations and the possible options and related costs. It was agreed that SR will seek legal advice on the regulations surrounding usage prior to a decision being made.

15. Surgical referrals by specialty

    15.1. Data on referrals was discussed with reference to the impact of the Referral Management System. KH confirmed that he has asked the CCG to review the consequences of their scheme and in particular to provide assurances that patient safety is not being compromised or treatment being simply delayed.

    15.2. Further interrogation of the figures regarding breast referrals was agreed.

16. Bed occupancy

    16.1. Data on bed occupancy was discussed, and the lack of correlation between the figures reported and operational pressures from bed availability. RC agreed to undertake a further review.

17. Sustainability and Transformation Plans

    17.1. The latest situation was discussed along with the recent leaking of the plans to the media.

18. Premium payment expenditure

18.1. Latest data was discussed. Changes to the information presented were agreed along with the requirement for a regular monthly report.

18.2. AMS agreed to develop a revised system for coding the type of premium payment by ADOs using a multiple-choice tick box.

19. Oncology services

19.1. KH reported back on his meeting with Peter Kirkbride and Simon Constable on future plans for oncology services. In principle it was agreed that the 'Eastern Hub' would be best located at St Helens Hospital.

10th November

20. EPR business case

20.1. Francis Andrews, Rowan Pritchard-Jones, and Mark Hogg attended to provide an update and run through the presentation proposed for the November Trust Board meeting.

21. HIS Shared Service Agreement

21.1. KH briefed members on the document which captured the rules of engagement drawn up by the HIS Board and sought and received Committee approval.

22. Premium payments expenditure – LLP review

22.1. Phil Nee and John Foo presented the findings of the evaluation of the 2015 business case for Orthopaedic Consultants in light of ongoing LLP expenditure. Further information was requested.

23. Agency HCAs

23.1. SRe provided an update. In summary, all areas have virtually ceased using agencies to provide HCAs with the exception of theatres where it is claimed that skills are required which are not present in staff available through the Trust bank. It was agreed that this needs to be explored further, and if necessary training provided to staff to enable cover in-house.

24. Dermatology

24.1. An email covering a range of pressures in dermatology including referrals, waiting lists, equipment, workforce and accommodation was discussed. It was agreed that RC would pick this up directly with the relevant people.

25. Staff Accountability Framework

25.1. SRe presented a paper designed to provide clarity to managers on the appropriate actions to be taken following an investigation or RCA. It was agreed that further work is required on the proposal.

26. Safeguarding review

26.1. SRe provided initial feedback from the CQC review. Paediatrics appeared to perform well, and minor administrative improvements were noted for A&E. The majority of the time was spent reviewing maternity where a few recommendations were suggested. The formal report is expected in February.

27. Endoscope decontamination

27.1. SRe provided a brief update on the proposed vaccination plans associated with the decontamination incident.

17th November

28. Risk Report

    28.1. PW presented the Risk Report on the total number of risks on the register and then focussed on the 10 high-level risks.

    28.2. Key issues escalated from the Risk Management Council for attention were: overdue review dates; action plans; the CIP sign-off process; and a potential elevated risk regarding cyber security.

29. Breast referral data

    29.1. RC reported on the investigation into the reduction in referrals to the breast service since the introduction of the Referral Management System.

    29.2. In summary, a number of patients had been referred to the Plastic Surgery Service rather than the Breast Service due to a misunderstanding of the treatments provided as detailed in our Directory of Services, which has subsequently been rectified.

    29.3. In addition, the slightly extended waiting time for appointments to our Breast Service had led to some referrals going to alternative providers.

30. Bed occupancy data

    30.1. RC provided further analysis of our bed availability information in connection with the NHS England data on bed occupancy. Whilst some explanation for the lack of correlation was provided it remains work in progress.

31. Turnaround Director progress report

    31.1. Data regarding A&E waiting time performance and remedial actions were discussed in detail. The main points covered were: staff seeing power comparison with attendances; the effectiveness of the regular bed meetings; automating management information; and measures to improve discharges including the red and green day pilot.

    31.2. A number of actions were agreed. It was noted that Patrick Johnson would be reporting on patient flows at the next meeting.

32. Mandatory Training and Appraisal targets

    32.1. The latest performance data was discussed and the improving position noted.

33. EPR business case

    33.1. The latest iteration of the proposal was discussed focussing on 2 main areas: lessons learned from other sites; and the financial statement.

    33.2. The financial data, showing a £1m surplus over 10 years, was based on prudent saving figures which were deemed as “worse case”. Further work on smoothing out costs between years, and reviewing the OP benefit figures was agreed.

34. Integrated Performance Report (IPR)

    34.1. CY took members through the draft November report. Key areas discussed were: RTT which is now nearing the 92% limit; timeliness of ICU discharges; and eDischarge letters for both OP and IP which require attention.

35. Agency usage

    35.1. SH and Pauline Jones presented the work-in-progress on the agency report and self-certification to be presented to the November Board.

35.2. This remains an area of concern as expenditure is continuing above the agreed cap, and we continue to employ agency staff in a small number of specialties, and rely on a number of doctors on premium payments. Measures to improve recruitment were discussed along with other alternatives to agency usage.

36. IT issues

36.1. CW highlighted a couple of IT issues that may require addressing by the Committee. These concerned the new theatre management system currently being piloted, and the Pathology IT system which is old and may need some interim investment to support it in advance of a longer-term EPR related solution.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)113
Title of paper: Quality Committee Assurance Report.
Purpose: The purpose of this paper is to summarise the Quality Committee meeting held on 22nd November 2016 and escalate issues of concern.
Summary: Key items discussed were: 1. Complaints 2. Safer Staffing 3. MRSA action plan update 4. IPR 5. Exercise Lemon Ribbon update 6. Lord Carter review update 7. Francis action plan update 8. Safeguarding update 9. Pharmacy check list audit update 10. Inpatient Kardex redesign
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: 30th November 2016

QUALITY COMMITTEE ASSURANCE REPORT

Summary of the discussions and outcomes from the Quality Committee meeting held on 22nd November 2016.

Action Log

1. All actions on the log were reviewed.

Complaints Report

2. Anne Rosbotham-Williams (ARW) summarised the report:

   2.1. 31 1st stage complaints were received and opened during October 2016; an increase of 10 (45%) in comparison to October 2015 and an increase of 9 (39%) compared to September 2016.

   2.2. At the end of October there were 49 open 1st stage complaints, including 8 overdue.

   2.3. The Trust responded to 78.3% of 1st stage complaints within agreed time frames during October, leading to a year to date response rate of 62.8%.

   2.4. The top complaints themes during the period were:

   2.4.1. Clinical treatment.

   2.4.2. Patient care/nursing care.

   2.5. There were 191 PALS contacts/enquiries during October 2016; an increase of 15 in comparison to September 2016 and an increase of 51 during October 2015.

   2.6. The majority (82%) of PALS contacts were concerns or complaints resolved locally, as opposed to signposting or dealing with enquiries (18%).

   2.7. The Committee discussed at length the response times for complaints and it was agreed that the Trust's 25 day timeframe for non complex complaints was not a national standard. Sue Redfern (SR) informed the Committee that agreement had been reached with the CCG through the Clinical Quality Performance Group meeting that the timeframe for non complex cases could be 30 days, but the timeframe of 60 days for complex complaints must remain the same.

   2.8. It was agreed that there should be enhanced emphasis on "lessons learnt" and remedial action planning.

Safer Staffing report

3. Sally Duce (SD) provided an update.

   3.1. The overall headcount fill rate for October was 94.45% for RNs on days; 98.32% for RNs on nights; 104.84% for HCAs on days and 114.99% for HCAs on nights.

   3.2. 13 wards had fill rates below 90%; 12 wards for RNs and 1 for both.

   3.3. In October, there were no inpatient falls resulting in severe harm on wards with a fill rate below 90%.

   3.4. The Committee discussed the RN Care Hours Per Patient Day (CHPPD) figures. Although the Trust has been collating the figures since May 2016, the five hospital pilot is still ongoing and there has not been any guidance from NHSI on how the figures will be reported.

3.5. Nik Khashu (NK) and his team agreed to provide additional information on the benchmarking for the next report.

3.6. Kevin Hardy (KH) queried the steep rise in the Burns Unit figures. SD will check the figures and report back.

3.7. SR informed the Committee that a review has taken place of all the nursing establishment and a revised report for safer staffing will be brought to the meeting in January. The role of the Discharge Co-ordinator was also discussed.

MRSA action plan update

4. SR provided an update on the current status of the action plan following the two Trust acquired MRSA bacteraemias.

4.1. The action plan is owned by the Medical and Surgical Care groups and has been developed following the MRSA bacteraemias. The majority of actions are complete or in progress. The actions are directed at increasing awareness of staff about the appropriate management of patients with MRSA and adherence to existing Trust policy with regards to MRSA.

4.2. An MRSA pathway has been implemented and the policy has been updated. 1:1 discussions have been conducted with the doctors involved in prescribing the antibiotic medication and a staff assurance framework has been presented to the Executive Committee.

4.3. Ann Marr (AM) will meet with SR outside of the meeting to discuss the action plan.

4.4. The proposed new prescription Kardex will provide alerts and guidance with regards to antibiotic prescribing. See item 11.

IPR

5. NK summarised the report.

5.1. There has been 1 never event during August.

5.2. Year to date there have been two cases of MRSA bacteraemia.

5.3. There were 3 CDI positive cases in October. Year to date there have been 18 positive cases. The annual tolerance for 2016-17 is 41 cases.

5.4. There were no hospital acquired grade 3/4 pressure ulcers in September. There was 1 fall that resulted in severe harm in September.

5.5. Performance for VTE assessment for August was 94.31%, a slight reduction from August. The 2015-16 HSMR is 99.7.

5.6. A&E performance was 74.4%. A Trust wide performance recovery plan continues with key, must do actions required for implementation with the A&E department and the wider organisation in order to deliver the 95% target.

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

5.8. As at the month of October 2016, the Trust is reporting an overall Income & Expenditure surplus of £1.812m after technical adjustments, which is slightly above the agreed plan. Trust income is ahead of plan by £1.156m, while expenditure is overspent by £1.192m, through delivering additional activity. Expenditure on agency stands at £7.027m for the year against a target for the full year of £7.256m. The Trust Executive team continues to meet with specialties on a weekly basis to review the action plans in place to reduce agency expenditure in 2016/17. The Trust's forecast outturn is to achieve its Annual plan of £3.328m surplus.

5.9. To date the Trust has delivered £7.861m of CIPs, which is n ow just ahead of the year to date plan. The CIP programme is formally reviewed both at a Trust and Specialty level on a monthly basis and is also part of the Operational Transformation Group agenda.

5.10. Capital expenditure to date is £0.955m out of a revised year forecast total of £4.1m. Cash balance at the end of October is £9.836m which equates to 11 operating days.

5.11. Mandatory training compliance remains above target at 92.3%. Appraisal compliance has seen significant improvement in month and performance is 83.5%. Recovery plans continue and appraisal remains a monthly standing item on the Executive Committee agenda. David Graham (DG) expressed concern regarding appraisals not being carried out; figures being lowest in A&E. NK said that figures are improving but we are not yet at the target level.

5.12. DG also enquired about ANTT training figures. SR will get the exact figures and report back to the next meeting.

5.13. Sickness absence for October has slightly increased to 4.6% although it is less the Q3 target of 4.72%. Year to date sickness is 4.6%.

Exercise Lemon Ribbon update

6. SR provided an update

6.1. Exercise Lemon Ribbon was planned to practice and test the Trust's Infant Abduction policy. This provided an opportunity to test resilience, identify gaps and find practical solutions for a revised infant abduction plan which is aligned to the Major Incident Plan.

6.2. The exercise identified areas for improvement:

6.2.1. Communication could have been better co-ordinated – action cards are now in place.
6.2.2. Slight delay (15 seconds) on the baby tagging system – this is now set at 0 seconds.
6.2.3. Development of procedures including the use of cameras and how we report to the Police.
6.2.4. The role of security.
6.2.5. Communication with patients and families and how we manage the situation.

6.3. An action plan is in place and an informal test was carried out this week and a formal test will take place in December. Leaflets have been produced for all women who visit the unit.

6.4. SR assured the Committee that cameras are now in place and still photographs can be taken from the cameras.

Lord Carter review – update

7. SR provided an update on behalf of Anne-Marie Stretch:

7.1. The paper is to provide the Committee with an overview of the recommendations following the publication of the Carter report, with specific reference to the two recommendations relating to the Trust's workforce.

7.2. Unwarranted variation: This is a review of operational productivity and performance in NHS acute hospitals. The report identified significant and unwarranted variation in costs and practice, which, if addressed, could save the NHS £5bn. Of these savings up to £2bn comes from the workforce budget through:

7.2.1. Better use of clinical staff.
7.2.2. Reducing agency spend and absenteeism
7.2.3. Adopting good people management practices.

7.3. SR and SD are working closely with all wards to ensure policies are adhered to regarding enhanced care or "specialing".

Francis action plan – update

8. Neal Jones (NJ) provided an update.

8.1. There is one outstanding element of the plan regarding the Guardian's role. The Trust originally appointed 5 guardians in March 2015, but the successor to NJ's role will also take on the role of the principal Guardian.

8.2. The Guardian will report to the Board, through Quality Committee on a quarterly basis, but will act independently and hold the Executive Team and Board to account for issues raised.

Safeguarding update

9. SD provided an update.

9.1. There are issues with safeguarding training levels 2 and 3; it has been difficult to meet compliance targets due to a lack of clarity on who should do the training. Discussions are being held with Safeguarding Commissioners to change the trajectory to 80% by the end of March.

9.2. The resources for training remains problematic; Level 2 is a workbook and Level 3 is a full day's training. A&E staff need Level 3 training.

9.3. Trajectories will be reset in the next couple of weeks. SR will action this and provide an update at January board. DG will bring the issue to the attention of Board members at November board.

Pharmacy check list audit update

10. Simon Gelder (SG) provided an update; overall, there has been an improvement.

10.1. Matrons have been tasked with providing action plans and carrying out audits within their own areas.

10.1.1. 58% of wards were green
10.1.2. 22% of wards were amber
10.1.3. 20% of wards were red

10.2. AM commented that persistent offenders appear to be Care of the Elderly and General Surgery – SR will speak to the Matrons.

10.3. Following discussion amongst Committee members, it was agreed that SG would report back to the Quality Committee in February 2017 and this would be a "Red letter" report – any ward/area not green would be sent a letter.

Inpatient Kardex redesign

11. SG provided an update on the medication administration chart.

11.1. Following the recent RCA meetings reviewing the MRSA bacteraemia cases, a recommendation to revise the Trust's inpatient medicines prescription Kardex was made.

11.2. Andrew Lewis and Dr Kalani Mortimer produced a draft redesign to incorporate new features prompting good antimicrobial prescribing practice.

11.3. The revised Kardex was reviewed at the Drug and Therapeutics group and approved. KH approved the Kardex on behalf of the Clinical Effectiveness Council and it was ratified by the Quality Committee.

Feedback from Patient Safety Council

12. Neal Jones (NJ) provided an update.

12.1. NJ wanted to bring to the Committee's attention, the number of medically optimised patients, awaiting discharge/delayed discharge, who were suffering falls. Causation could be cognitive impairment/dementia, but environment and surveillance could also be a factor.

12.2. SR agreed to present to the Clinical Quality Performance Group the number of patients that have been harmed because of delayed discharge.

Feedback from Patient Experience Council

13. ARW provided an update on key issues:

13.1. The Council had received a letter outlining concerns that changes to the recruitment of volunteers were having a negative impact on the numbers of volunteers available to support patients with dementia and delirium. The new Volunteer Manager went through the action plan in place to raise the profile of volunteering and plans to increase the number of volunteers across the Trust.

Feedback from Clinical Effectiveness Council

14. Kevin Hardy (KH) reported on key issues:

14.1. National Hip Fracture (NHFD) report: Excellent presentation and demonstration of continuing improvement against national standards in the last 12 months. Service would improve by having ortho-geriatrician input, the post is funded but, as yet, unsuccessfully recruited to. A further issue is addressing Orthopaedic Consultant skill mix at weekends, in order to offer consistent ability to do total hip replacements at weekends.

Feedback from CQPG Meeting

15. SR provided an update. Key issues discussed were:

15.1. NICE TA for Sacubitril/Valsartan – the Trust remains compliant.
15.2. Provider Quality Assurance report.
15.3. Month 4 KPIs
15.4. Serious incidents
15.5. Infection Prevention and Control report.
15.6. Safety thermometer report.
15.7. Mortality report.
15.8. CQC action plan update
15.9. Cancer breach report
15.10. Stroke update.

15.11. CCG provider site inspection tool. SR had asked for the monitoring tool to be brought back to the CQPG for further discussion. SR had queried why the monitoring tool was being introduced? The Trust and CCGs have developed an open and honest relationship where concerns can be discussed at CQPG meetings or individually. There is already an independent, shared inspection process carried out by CQC. In addition, SR was concerned about the amount of extra work a further inspection would create and the effect it would have on staff. It was agreed to not introduce the monitoring tool.

Feedback from Executive Committee

16. SR reported on meetings of the Executive Committee between 7th October and 10th November.

16.1. Decisions taken by the Committee included measures to reduce agency expenditure.

16.2. Assurances regarding mandatory training and appraisal performance, CQUIN performance, VTE performance, and safeguarding were obtained.

16.3. Investment decisions included minor works to create additional bed capacity.

16.4. SR also informed the Committee of a decontamination incident involving Endoscopy. This has been Steised and SIRI reportable. An RCA has commenced.

16.5. All CQUINS in Q2 have been achieved.

Feedback from Workforce Council

17. SR provided an update.

17.1. Nothing to escalate, but there was a discussion regarding implementation of the Smoke Free Policy.

Effectiveness of meeting

18. PW said that the meeting was kept to the timing schedule as members were reporting by exception. Format of the majority of papers was correct, but there were minor grammatical errors in some. As there is no meeting until January, it was agreed that required actions will be taken to the Executive Team in the interim.

AOB

19. DG informed the Committee that this would by Neal Jones's last meeting before he left the Trust. DG thanked him for his service to the Committee and on behalf of the Trust, commended his contribution to patient safety.

Date of next meeting

20. Tuesday, 17th January 2017.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)114

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 November 2016

Summary: Agenda Items

For Information

- C-Diff performance over 4 years was presented and discussed.
- Q1 SLR Medical – generally good performance with agreed risks of winter pressures
- CIP performance – slightly ahead of plan: Risk of having more
- CIPs as non-recurrent was identified and to be monitored.
- Forecast outturn 2016/17 with risks and values noted: Areas of specific risk were STF funding regarding A&E and RTT trajectory achievement; CQUIN and CIP delivery.
- Update on Carter Recommendations; committee welcomed focus on Critical Care variance.

For Assurance

- A & E update – detailed consideration of plans to improve performance immediately
- Integrated Performance Report Month 7 2016/17 – RTT performance 92% - good assurance around action plan but note risk as we approach Winter period.
- Month 7 2016/17 Finance Report – good performance against year to date plan while noting financial risks for remaining of year.
- Governance Committee Briefing Papers:
  - CIP Council
  - Procurement Council
- Agency Usage – Committee considered report and our relative performance as per NHSI correspondence. Committee assured by detailed review of internal governance, review of actions plans and recent reporting requirement to NHSI.

For Approval

- Visiting Sales Rep policy approved, subject to Audit Committee review

Actions Agreed

- A&E performance update – Key 3 actions to be described which must have immediate impact on performance. Issue to be noted for Board.
- RTT performance – Board to be briefed on issue and risk (financial and non-financial)
- NHSI Agency Guidance – self certification checklist to be presented to Board

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: 30th November 2016

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)115
Title of paper: Foundation Trust Application Programme – Update Report
Purpose: To provide the Board with assurance of the draft operational plans for 2017/18 and 2018/19 which were submitted on 24th November 2016. To confirm the Trusts segmentation by NHSI under the new single oversight framework and the implications of this for the Trusts on-going relationship with the regulator. To update the Board on the progress of the St Helens Community Services bid.
Summary: 1. The draft two year operational plans were submitted on 24th November 2016 in accordance with the national planning timetable. The plan reflected the assumptions agreed by the Board at the development session held on 10th November 2016. The process and underlying assumptions supporting the development of the final plan submission for 23rd December are included for the Board to review and approve. 2. The Trust has now been formally notified that NHSI has allocated the Trust to segment two in its single oversight framework for Foundation Trusts and NHS Trusts. 3. The Trust has been successful in reaching the interview stage of the bidding process to deliver St Helens Community Services, with its bid partners.
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 approve the assumptions and caveats for the final two year operational plan submission, and to approve Chairman's action to approve the final plan within these parameters.
Presenting officer: Nik Khashu, Director of Finance and Information
Date of meeting: 30th November 2016

Foundation Trust Application Programme – November 2016

1. Operational Plans and Contract Agreement 2017/18 & 2018/19

1.1 The planning guidance published in September 2016 sets out the requirement to agree two year contracts and operational plans for 2017/18 and 2018/19 by 23rd December 2016.

1.2 A draft operational plan for activity, performance, quality, workforce and finance was submitted on 24th November 2016, with the final Board approved plan reflecting agreed contracts to be submitted by 23rd December 2016.

1.3 The Board held a development session on 10th November 2016 to review the progress in developing the plan, to agree the planning assumptions including the acceptance of the proposed control total and associated conditions.

1.4 In summary the Board agreed;

1.4.1 To plan for activity and inflation in line with the national planning assumption of a 2.2% increase in 2017/18 and 2.3% in 2018/19 (this is subject to contract negotiations currently on-going).

1.4.2 The Trust has provisionally accepted the Sustainability and Transformation Funding (STF) offer and proposed control total of £8.5m surplus in 2017/18. This is subject to clarification by NHS Improvement (NHSI) of the treatment of the technical adjustment for issue such as PFI inflation (A formal clarification letter has been sent to NHSI about this issue).

1.4.3 Since the Board development session NHSI have issued updated guidance relating to the control totals for 2018/19. This enables the Trust to set the control total for the 2nd year of the plan to be better than the scheduled £8.5m control total for 2017/18. In the draft plan submission the Trust has submitted a plan with the minimum improvement allowed at this stage (£8.6m surplus). This will be reviewed as the risks associated with contract negotiations are understood and subject to further agreements.

1.4.4 The impact of the October 2016 tariff prices (HRG4 +) would not have a material detrimental effect on the overall financial planning assumptions.

1.4.5 Following several years of continued high levels of CIPS (4%+) the Board recognised the risk of the continuing efficiencies at this rate in the plans.

1.4.6 Cost pressures including the apprenticeship levy, rates increases, implementing the new Junior Doctors contract, CNST premium increases and the cost of the replacement EPR system are built into the plans.

1.4.7 The Trust will achieve the access target performance improvement trajectories negotiated in each of the years.

1.4.8 It is expected for all Trusts to achieve minimum national access performance standards by March 2018.

1.4.9 The control total for agency spending for the two years has been set at £7.2m each year. Whilst there is no financial penalty if this control total is not achieved any variation could impact on the Trusts overall financial risk score, which might affect our segmentation under the single oversight framework.

1.5 The draft narrative operational plan has been written with several variables still to be resolved and therefore remains subject to a number of identified risks. These limit the Trusts ability to deliver against the key performance measures, principally; final agreement of acceptable contracts with commissioners, activity remaining within the contracted levels in each of the years and material variation in tariff prices.

1.6 If there is material change between the draft plans to the final plan submission on 23rd December 2016, there is provision for an extraordinary Board meeting on 14th December 2016 to approve the changes or reject current agreements. However, assuming the key planning assumptions are maintained it is suggested that the Board formally approve the plan and agree chairman's action to sign off the final submission.

2. NHSI Single Oversight Framework

2.1. The Trust has now received formal confirmation that it has been assessed, on the basis of current performance across the five assessment domains (Quality of care, Finance and use of resources, Operational performance, Strategic change, Leadership and improvement capability) to be in segment 2 (of 4).

2.2. This means that NHSI currently has no significant concerns about the Trusts performance, but has identified some areas where the Trust will be offered support on focused areas for improvement. It also means that the Trust has a higher level of autonomy, will be subject to less frequent monitoring and is recognised as a leader in the health system, providing support to other organisations locally

2.3. The segmentation assessment is reviewed by NHSI each quarter.

2.4. Southport and Ormskirk NHST and Warrington and Halton NHSFT have both been rated as segment 3.

3. St Helens CCG Community Services

The Trust was notified on 21st November that its bid, with 5 Boroughs Partnership NHSFT and St Helens Rota had been shortlisted to move to the next stage of the selection process.

This involves a presentation and interview on 28th November.

The notification of the successful bidders is expected on 6th January 2017.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)115a

Title of paper: Cheshire and Merseyside Sustainability and Transformation Plan

Purpose:

The purpose of this report is to share the Cheshire and Merseyside Sustainability and Transformation Plan (STP) with the board in order to raise awareness of the challenges that STPs are designed to address; to understand and support the key priorities in the plan and to commit to whole-system partnership working to deliver the changes that are required.

Summary:

1. The draft two year operational plans were submitted on 24th November 2016 in accordance with the national planning timetable. The plan reflected the assumptions agreed by the Board at the development session held on 10th November 2016. The process and underlying assumptions supporting the development of the final plan submission for 23rd December are included for the Board to review and approve.
2. The Trust has now been formally notified that NHSI has allocated the Trust to segment two in its single oversight framework for Foundation Trusts and NHS Trusts.
3. The Trust has been successful in reaching the interview stage of the bidding process to deliver St Helens Community Services, with its bid partners.

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) The Board is asked to:

- Note the priorities and proposals set out in the Cheshire & Merseyside Sustainability & Transformation Plan;
- Support the vision, ambition and priorities of the STP and to commit to partnership working to deliver the change that is required;
- Note the commitment to continued local engagement and the requirement to comply with statutory requirements for public involvement.

Presenting officer: Nik Khashu, Director of Finance and Information

Date of meeting: 30th November 2016

Cheshire and Merseyside Sustainability and Transformation Plan

1. Background

The NHS Five Year Forward View, published in October 2014, set out strategic intentions to ensure the NHS remains clinically and financially sustainable. The Forward View highlighted three key areas:

1. The health and wellbeing of the population;
2. The quality of care that is provided; and
3. NHS finance and efficiency of services.

Subsequently, the 2015/16 NHS planning Guidance set out the steps for local health systems to deliver the Five Year Forward View, backed up by a new Sustainability and Transformation Fund intended to support financial balance and to enable new investment in key priorities. As part of the planning process, health and care systems were asked to develop 'Sustainability and Transformation Plans' to cover the period from 2016/17 to 2020/21.

44 areas (or 'footprints') were identified across England to work together as health and care systems to develop Sustainability and Transformation Plans (STPs) that set out how these gaps can be addressed. STPs represent a change in the way that the NHS in England plans its services; with a stronger emphasis on collaboration to respond to the challenges facing local services and a focus on place-based planning for whole systems of health and care.

The Cheshire and Merseyside Sustainability and Transformation Plan is the second largest STP in England. It covers a population of 2.5 million, has 12 CCGs, 20 providers and 9 local authorities.

The Cheshire and Merseyside STP was submitted to NHS England on 21October and was formally published on 16 November 2016 (appendix 1). The STP is a technical document which met the specific information requirements of NHS England. A public summary (appendix 2) and frequently asked questions document (appendix 3) have been produced to support public understanding of the rationale and the content of the plan.

2. The Case for Change

The NHS faces the most significant challenge for a generation. The NHS must continue to innovate and improve to meet the needs of the population, in the face of significant financial constraint. Demand for services is growing faster than resources. Services in some places are not designed to meet modern standards and local people want things to be better, joined up, and more aligned to their needs.

An ageing population, people living longer with complex health and social care needs, points to the need for change to enable the health and care system to improve quality of life and to meet the challenges with the funding that is available.

Although extra money has been allocated to support the NHS, growth in funding is not keeping pace with rising demand. Budgets in social care, training, and public health are also under pressure. If no action is taken the NHS faces a £30 billion funding gap by 2021. The Cheshire & Merseyside share of this funding gap is £908million.

It is clear that the scale of the challenge is too big to be resolved by organisations making changes in isolation. Working differently together offers new opportunities. Together health and care systems could share learning, expertise and skills – as well as making better use of technology and introducing new models of care.

3. STP Priorities

The STP sets out four strategic priorities for Cheshire and Merseyside:

I. **Support for people to live better quality lives by actively promoting health and wellbeing.** The plan sets out priorities to address the factors that have a negative impact on population health and that are increasing pressure on services.

II. **The NHS working together with partners in local government and the voluntary sector to develop joined up care**, with more care accessible outside of hospitals to give people the support they need when and where they need it.

III. **Designing hospital services to meet modern clinical standards and reducing variation in quality;** to establish consistency and improvement in clinical standards for hospital care across Cheshire and Merseyside.

IV. **Becoming more efficient by reducing costs, maximising value and using the latest technology;** reducing unnecessary costs in managerial and administrative areas, maximising the value of clinical support services and adopting innovative new ways of working, including sharing electronic information across all parts of the health and care system.

4. Local Delivery Systems

The Cheshire and Merseyside STP is designed to address the challenges of the region in terms of population health and wellbeing, quality of care and financial sustainability. The majority of delivery will be through the plans developed by the three local delivery systems (LDS): North Mersey; the Alliance; and unified Cheshire & Wirral.

All three local delivery systems will deliver the same four key priorities set out in the Cheshire and Merseyside plan. However, each local plan will tailor the way these priorities are delivered to reflect the particular needs of their population and the local health and care system. The three Local Delivery Systems are at different stages of development. For areas with established system partnerships, existing plans which are in phases of design or implementation have been incorporated into LDS plans. For other areas where system collaboration is at an early stage their LDS plan represents more of a range of ideas

aligned to the four STP priorities, which will be developed further into proposals with leadership from clinicians and involvement from patients and stakeholders.

5. The Alliance Local Delivery System Plan

The challenge for the Alliance LDS system is to;

- Prevent the demand from materialising (Prevention at scale)
- Provide more (cost) effective ways of responding to the demand (OHH Care)
- Find more productive/efficient ways of delivering acute hospital care (Reducing Variation & Improving Quality, Clinical Support Service Collaboration)
- Making our overhead and running costs as efficient as possible (Back Office Collaboration and Working Together more effectively)

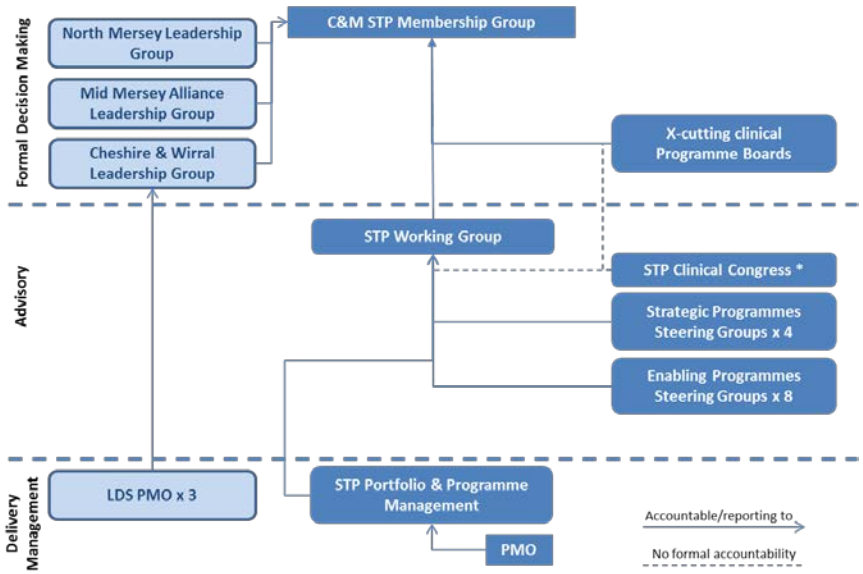
The overall the ambition of the Alliance LDS is;

- To stabilise the acute hospital based activity and cost base
- To maximise the use of alternative care settings to meet urgent care needs, care for older people and people living with long term conditions
- To help the population to stay well for longer

The Alliance LDS has aligned its transformational work streams and delivery structure to mirror that of the C&M STP to ensure that delivery will be at the most appropriate level – organisational, LDS level or STP footprint.

6. Delivering the Change

The Cheshire and Merseyside STP represents a significant portfolio of programmes to be delivered across a large and diverse footprint. All NHS providers, commissioners and local authorities are partners in the STP and will collaborate to deliver the change. This requires a robust governance structure to enable sound decision-making. The role of a central STP portfolio programme office is to co-ordinate effort and performance management, with delivery of plans predominantly taking place at LDS level. The STP governance and delivery structure is set out in the diagram below:



7. STP Engagement

It is recognised that there is significant public interest in STPs and the process by which proposals have been developed to date. Following publication of the plan, preparations are underway to begin public conversations; to raise awareness of the challenges facing the NHS and social care and to gain views on the proposals contained in the STP, including plans at LDS level.

The STP is a planning footprint and not a statutory entity. Consequently, with regard to accountability, individual NHS organisations will remain responsible for ensuring their legal duties to involve are met during the design, delivery and implementation process of specific proposals. This includes ensuring that any reconfiguration proposals which represent a substantial variation in service are subject to public and local authority overview and scrutiny and formal public consultation.

8. Conclusion

The Cheshire and Merseyside STP sets out the significant challenges to be addressed around poor health and the need for broad ranging solutions to address clinical and financial sustainability.

Health and care partners from across the region have come together to develop a plan to address the challenges to be faced over the next five years, which aligns with the Five Year Forward View.

The STP has a clear vision and there is a strong commitment from partners to collaborate within systems to address the wellbeing, quality and financial gap for Cheshire and Merseyside.

ENDS

Appendix 1

Cheshire Merseyside STP_Issue_Version 4

Appendix 2

final full STP Plan public facing version 1

Appendix 3

Final STP FAQ 161116.DOCX

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)117
Title of paper: Research Development & Innovation Strategy – Action Log
Purpose: The purpose of the 3 year strategy is to clearly state our vision for the continued advancement of Research Development and Innovation at St Helens & Knowsley Teaching Hospitals NHS Trust, and to set clear goals and objectives that will enable us to promote a culture where RDI drives better patient care and to improve the Trust's capacity, capability and delivery of clinical research. The Action log provides the Trust Board with assurance that STHK is working towards the aims and objectives of the strategy.
Summary: 24 of the objectives on the action log have been completed so far. There are plans to produce a new RDI Strategy for presentation/ review by the RDI Group in December 2016. Since the last update to the Board in November 2015 the following has been achieved: • In August 2016 the Cancer Trials Team were the first Research Team in the country to achieve MacMillan Status, this was a huge achievement for the Trust. • In line with NIHR objectives we have increased our commercial portfolio. A decision was made to employ our first Commercial Research Nurse, funded by STHK. In March 2016 the Trust successfully recruited to this post. • We now work with 2Bio our new Intellectual Property (IP) Advisors. A new IP policy was released in October 2016 and we have a number of potential projects in the pipeline. • In February 2016 we hosted a road show run by the NWC CRN. This was a practical work based event focusing on sharing best practice and engagement with research colleagues.
Corporate objectives met or risks addressed: Contributes towards good governance arrangements; providing assurance on the quality of the research conducted to the Board and Commissioners and in doing so helps in our transition to FT Status.
Financial implications: None as a direct consequence of this paper
Stakeholders: Council (CEC) members; Research Staff; other Trust staff; Commissioners; and Regulators.
Recommendation(s): Members are asked to read the report with a view to further dissemination across clinical areas.
Presenting officer: Kevin Hardy, Medical Director
Date of meeting: 30th November 2016

Action log - Research Development and Innovation (RDI) Strategy 2015 – 2017

Lead / Responsible Person for Actions **Jeanette Anders, RDI Manager**

Specialty: **Research Development & Innovation**

Date **Updated 11th November 2016**

For Trust Board, 30th November 2016

KEY (action status)

1 Recommendation agreed but not yet actioned

2 Action in Progress

3 Recommendation fully implemented

4 Recommendation never actioned (state why)

5 No actions needed

Actions Required	
Foster a vibrant Research, Development and Innovation culture across all areas.	
T**he Trust will endeavour to hold research and innovation events:** Dates are booked for 3 monthly research promotion stands, for 2015, at Whiston and St Helens Hospitals. The first research promotion stand took place at Whiston hospital on 27.01.15 and subsequently on the 24.03.15 the next one will be on the 13.05.15. The research promotion stands STHK are now well established, we have regular stands every 3 months, these alternate between St Helens and Whiston Hospital. On Saturday and Sunday 26th & 27th September 2015, STHK took part in the Widnes Vintage Rally, staff from across the Trust volunteered to work in the Health Zone marquee, promoting Trust services and celebrating the excellent work of their staff. Members of the Research Team attended on both days and promoted research to members of the public. Their enthusiasm in promoting the OK to Ask message was second to none and generated a lot of interest. The event was a great success and feedback from organisers is that the health zone really helped visitors and the local community to consider their health needs and provide valuable feedback about the services provided. This will be an annual event for research to attend. On the 29th February 2016 we hosted a road show run by the NWC CRN. This was a practical work based event focusing	**3**

on sharing best practice and engagement with research colleagues.	
On 25.02.15 a Research Awareness session was delivered to Pharmacists at STHK. We will continue to deliver these sessions. A date has been set for a member of the Clinical Research Network along with the RDI Manager to attend the Support Services Operation Group meeting on the 08.05.15 to highlight the work of the RDI Department and the Clinical Research Network. The meeting on the 08.05.15 was cancelled. RDI office to re-arrange new dates. Due to the volume of work in the RDI office it has been difficult to re-arrange these sessions. However we hope put some dates in the diary for 2017.	**2**
We will encourage Research Nurses to be research champions to help promote research. On the 05.05.15 the Research Nurses attend Nurses Day at STHK where they showcased the work of the Research Team and promoted research to both new and established nurses. There are regular awareness days and dates are in the diary for 2016. In August 2016, the Cancer Trials Team were the first Research Team in the country to achieve MacMillan Status, this was a huge achievement for the Trust.	**3**
Pull up posters promoting research are now visible at both Whiston and St Helens Hospital.	**3**
Updates and bulletins will be disseminated via team brief, grand rounds, study days and publication of relevant documents on the hospital intranet. This will be conducted with the help of the RDI department and Research Nurses. The RDI department has started to post updated on Facebook at STHK. We have stated to send good news stories to the CRN for their newsletter and have had articles published in April and May 2015. We continue to submit articles to the CRN and have recently submitted an article in January 2016. We continue to use Facebook to promote the good news stories	**3**
Provision of GCP training – RDI Manager trained as a GCP Facilitator in December 2014 and is contracted to deliver 4 courses per year by the Clinical Research Network. 4 sessions already booked for 2015. There is a GCP event planned for 14th April 2016, this is an event that is held every 2 years. An external GCP Facilitator will deliver this course; we have over 100 confirmed attendees.	**3**
Communication and networking between investigators and research teams. We will introduce regular Investigator meetings. A template will be designed to record any discussion/ actions from the meetings. The template is now is use and all of our research nurses have regular meetings with the Principal Investigators.	**3**
We will design a leaflet explaining research in the Trust and include this in a new starter induction pack.	**3**
The RDI Office has links with Library and Knowledge Service and has a specific section on their website where staff can now access information about research services and resources. This is an on-going project which we will continue to develop and update. JA met the new Clinical Outreach Librarian on the 31.10.16, the Research Page has been updated.	**3**
We will encourage Trust Clinicians to take up clinical leadership positions in the CRN structures (e.g. at divisional and	**3**

speciality level). Himanshu Kataria, Consultant in A& E appointed as Local Specialty Lead (Injuries & Emergencies).	
Work in partnership with Local Clinical Research Network to ensure the NIHR high level objectives are met	
We will encourage our Research Nurses to work generically across specialties. Nurses have started to work across specialties; we will continue to encourage this.	**3**
The RDI office staff will strive to streamline processes and update systems to ensure the quick and timely permission of research studies and the monitoring of recruiting to time and target, including first patient recruited. Systems are already in place to notify Investigators of the time line and countdown to first patient recruited. We will continue to improve and update systems where possible.	**3**
Trust aims to increase its commercial research activity and we will liaise closely with the Clinical Research Network Industry Manager to facilitate this. RDI Manager sits on the CRN commercial working group which aims to identify best practice with regards to attracting and running commercial trials. The RDI Manager will feedback to Investigators and Research teams. The RDI office has implemented and streamlined systems to deal with Expressions of Interest from commercial companies. In 2016 the Trust has increased its commercial activity and how has a healthy portfolio of commercial studies in gastroenterology. We have also increased the number of commercial studies in other specialist areas such as urology. A decision was made to employ the first Commercial Research Nurse, funded by STHK. In March 2016 the Trust successfully recruited to this post.	**3**
Collaborate with the Academic Health Science Network to drive the adoption and spread of innovation across the Trust	
We work with the Clinical Research Network, North West Coast, and the AHSNs to bring research findings into practice and improve the health of our patients. The RDI Manager will feedback to Investigators and Research teams. The RDI Manager has contacted the AHSN and invited a representative to attend the RDI Group to give an overview of their work and to establish how we can engage with them.	**2**
The Trust will Design and implement a customised innovation pathway to ensure that all staff are aware of the processes, tools and support available to them. The pathway was approved in December 2014 and is in now currently in use.	**3**
We explore the idea of Innovation Champions from a range of disciplines who are committed to facilitating innovation activities within the Trust. We are in negotiations with a new company 2Bio who will manage our innovation and IP. One of the objectives is to seek innovation champions. In June 2016 the Trust entered into a new contract with 2Bio, the Trust has identified a number of clinicians who will be	**2**

approached to act as Innovation champions. A new IP policy was released in October 2016 and we have a number of potential projects in the pipeline.	
We will work with our Communications Team to publicise and celebrate innovations that are adopted, provide feedback on outcomes, and increase awareness. Research champions will be responsible for liaising with the communications team to promote good news via facebook and other methods of social media. The RDI Office continues to work with the Communications team; a request had been submitted to produce a short film about the benefits of participating in research.	**3**
To ensure activities are managed appropriately, we will work with Trustech, our IP advisors, to ensure the current Intellectual Policy is fit-for-purpose and review. IP Policy was reviewed in December 2014 with input from Trustech, to be reviewed in 2017. The Trust has changed advisors to 2Bio, a new IP Policy was approved by the RDI Group in October 2016.	**3**
Pursue appropriate research partnerships and collaborations with Universities, Clinical Commissioning groups (CCGs) and Collaborations for Leadership in Applied Health Research and Care (CLAHRC)	
We will encourage Senior Research Nurses to liaise with the University and act as a link for collaborations between the LJMU and STHK. One of our Senior Research Nurses is now on a working group at LJMU.	**2**
The Trust will engage with CCGs to promote collaborative research and we will seek representation on our Research Development & Innovation Group to ensure that channels of communications are open, and that opportunities for research are identified. Regular meetings with St Helens CCG are now in place where we identify any potential areas for growth in research.	**3**
Nine Collaborations for Leadership in Applied Health Research and Care (CLAHRC) have been established to undertake high-quality research. Supported by the National Institute for Health Research (NIHR), and with funding from the Department of Health, they are aimed at tackling inequalities and addressing long-term health conditions. STHK will seek representation on the CLAHRC hosted by Liverpool University. Representatives from the CLAHRC and the AHSN have invited a representative to attend the RDI Group in June 2016 to give an overview of their work and to establish how we can engage with them. The RDI group was cancelled in June and the representatives have been invited to the next meeting in October 2016. The CLARCH representative was unable to attend the RDI Group in October 2016 and has been invited to attend the next meeting in December 2016.	**2**
Grow staff capability and capacity to undertake research	
One important area that we have identified for growth is Burns and Plastics research and as a Regional Burns Unit we aim to grow the amount of research activity undertaken within the department. We have appointed a Burns and Plastics	**2**

Research Nurse who will start in March 2015. We have also identified a new surgical / cancer trial that will open at STHK in early 2015. The Research Nurse is now in post and is working with potential investigators to identify new studies. The Research nurse is also working collaboratively with Liverpool University on a potential study. The surgical/ cancer trial MelMarT (Melanoma Margins Trial) has been a great success, the study was set up efficiently and the team are recruiting to time and target. Unfortunately the Burns Research Nurse has left the Trust, discussions need to be held as to whether or not keep this post. A new Burns Research Nurse was appointed in October2016. There are plans to meet with the Clinical Research Network to discuss raising the profile of Burns Research at STHK.	
The Trust will continue to invest in training our research staff. We will encourage training in basic and clinical research for new and developing investigators. The Trust now has 2 GCP trained facilitators who have expressed an interest to facilitate a new CRN course specifically designed for Principal Investigators.	**3**
The Trust will commit to offering permanent contracts to research staff; this not only gives security to the workforce but will stabilise, encourage, and in turn provide, vital high quality research. All Research Nurses now have permanent contracts.	**3**
Research Nurses and Data staff will be encouraged to attend the monthly Research Team Meetings and quarterly Research Practitioner Group Meetings. Dates already set for 2015.	**3**
We will grow research income by increasing the number of commercial studies (portfolio and non-portfolio) that we participate in as well as encouraging applications to charities and grant-funding agencies. We will continue to meet with the CRN Delivery and Industry Managers to discuss potential studies and ways of attracting commercial research. The RDI department will also take a proactive approach by contacting commercial companies who we have worked with previously. The Trust has increased its commercial activity and now has a dedicated commercial Research Nurse.	**3**
Engage & communicate with patients, service users	
We will liaise with the Trust's Patient Experience Manager and present the benefits of becoming involved in research to interested patients, carers and members of the public at our Patient Power Group Forum. RDI Manager to contact PEM to find out dates of events being held in 2015. The RDI Manager has requested a recurring slot, to promote the benefits of research, at the patient experience group meetings.	**2**
We will establish a PPI group dedicated to working with the Trust on research developments. RDI Manager to liaise with Investigators to identify how to implement this group. This is a difficult task as we don't initiate many new studies, after discussing this with the Clinical Research Network, we	**2**

should be looking to promote research to the Patients and Public through various media and support groups, therefore we will not be developing a specific PPI group.	
The 20th May is International Clinical Trials Day (ICTD), which the NIHR promote by calling on patients and carers to ask their doctor about NHS research they can take part in. The Trust will participate in this yearly event to increase awareness of the research being conducted at STHK. Due to a busy work schedule, the ICTD did not go ahead in 2016. In view of this 2 research nurses have been appointed with the task of organising next year's event.	**2**
The Research Nurses will be encouraged to promote research in the local area by attending support groups in the community. Any events will be reported via News and Views and the website. The Research Nurses now attend support groups in areas such as Cancers, Diabetes and Rheumatology.	**3**
We will continue to encourage lay member representation on both the Research Governance Working Group and the Research and Development Group who will help oversee the strategic direction of the research programme. We have a lay member who sits on the RDI Group and Research Governance Working Group.	**3**
Maintain Research Governance and Assurance for Trust staff undertaking research	
We will work with the new Health Research Authority to combine and streamline our approvals using national system of research governance. The new approvals process will start a phased implementation process from January 2015. RDI staff will attend any training sessions to ensure that they are fully aware of the new system. RDI staff attended first awareness session in January 2015. The introduction of the new Health Research Authority will have an impact on some of the Trusts SOPs. The advice from the CRN and the HRA is to delay any amendments to our SOPs until the new systems are fully implemented. In the meantime we have been advised to attach file notes to our existing SOPs explaining that we are in a transition period and that the SOPs will up dated in line the HRA roll out, this is expected by March 2016. The Health Research Authority is now fully operational, the transition hasn't been as smooth as expected and we are still working our way through the SOPs we anticipate that these will be implemented in early 2017.	**2**
A Pre-MHRA inspection action plan will play an important role in ensuring that the Trust is prepared for an MHRA inspection. The RDI Manager will liaise with key contacts in the Trust, and lay members to ensure that the actions are updated and agreed. On-going.	**2**
The Trust has a suite of approved Standard Operating Procedures (SOPs). The SOPs cover all aspects of the set up and conduct of a research project and are in place to ensure that all research has followed the research approval process in line with GCP. These will be reviewed and updated every 3 years or in accordance to changes in legislation. Most of the SOPs are due for review in December 2015. The RDI Manager will review the SOPSs prior to the 2015 December deadline. Due to changes in the approval system and the introduction of the Health Research Authority the deadline was put back to June 2016. A full suite has been produced and is awaiting approval.	**2**

The implementation of the SOPs is being staggered of 27 SOPS, 14 have now been approved and 13 are written awaiting review.	
An audit of compliance with research governance will be undertaken annually, to identify any issues and non-compliance with GCP. The RGF audit was last conducted in November 2014. We will that we review the recommendations to ensure that they have been followed up. All of the actions have now been addressed and followed up. The 2015 research governance audit has now been completed for 2014 /15. This is a yearly audit and the next audit for 2015/16 is planned. – Completed.	**3**
The NIHR CRN has launched a suite of e-learning modules designed for CRN and NHS RDI office governance staff. Members of the RDI Office and Research Nurses will be encouraged to complete these modules. We will keep a log of any training that the RDI Office staff complete.	**3**

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)118
Title of paper: Trust Objectives Review
Purpose: To advise Trust Board members of half-yearly progress against Trust 2016/17 objectives.
Summary: 1. The Trust has agreed twenty-seven objectives for 2016/17. 2. The following paper provides an update on progress to date against each one. In addition, progress has been RAG rated where green equates to criteria being fully met; amber being good progress being made; and red indicating insufficient progress, and that year end achievement is at risk. 3. Whilst the rating is subjective the results show: a. 15 objectives (56%) graded green b. 11 objectives (41%) graded amber c. 1 objective (4%), regarding partnership working on patient journeys to improve emergency access performance, graded red.
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 progress being made and the actions proposed to achieve the optimum year-end outturn.
Presenting officer: Ann Marr, Chief Executive.
Date of meeting: 30th November 2016.

PROGRESS AGAINST 2016/17 TRUST OBJECTIVES

The following table summarises progress to date against the Trust's five key objectives linked directly to patient care, and four associated and supporting objectives.

5 STAR PATIENT CARE – Care 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	
1	Improve the patient experience by continued advancements in clinical care and timeliness of discharges and transfers • *Clinical care continues to be evidence-based and of a high quality as verified by Performance Standards, the Integrated Performance Report and the 'Outstanding' care rating from CQC's Chief Inspector of Hospitals report* • *Timeliness of discharges and transfers has improved through collaborative working with ECIP and SRG, however, medically optimised patients still occupy a significant number of acute beds, and resulting internal bed pressures are still delaying timely discharges from ICU* • *Discharge data by time of day is captured in the dashboard reviewed each week at the Executive Operational Turnaround Meeting, and has led to some limited improvement* • *A reduction in LoS has released a number of beds which has been essential for meeting the increases in non-elective admissions* • *A new Maternity Strategy, drafted with significant input from patients and staff and capturing new ways of working, has been launched*
2	Continue to make progress towards the four key 7-day service standards • *Initial consultant review within 14 hours – this is achieved the vast majority of times, but for admissions at certain times, particularly at weekends, this has not always proved possible* • *Improved access to diagnostics – access to diagnostics remains excellent* • *Consultant directed interventions 24/7 – consultant-led Board Round activity is inconsistent and subject to an improvement plan* • *Ongoing consultant review (daily for emergency admissions & twice daily for high-dependency patients) – performance against this standard has improved but is constrained by consultant resource (a combination of lack of posts and lack of appropriate people to fill posts) and competing priorities*
3	Deliver performance indicators as outlined in the nursing strategy, ensuring adequate numbers of nurses are always available and staffing is routinely reviewed using recognised acuity tools • *The Trust continues to monitor safer staffing data where fill rate percentages are consistently in the high 90's. Care hours per patient per day is a further metric being scrutinized* • *Shelford acuity and dependency audits were carried out in June and October to support safer staffing data* • *Optimum employment of substantive staff is pursued* • *The Quality Care Assessment Tool (QCAT) was rolled out to all appropriate wards last year and has now been introduced in outpatient departments* • *Ward managers, matrons, and Maternity band 7's are participating in development programmes* • *The Trust is awaiting receipt of the Nurse Staffing tools being developed by NHSI and reflecting Carter recommendations, which will make reporting more transparent and open to benchmarking*
5 STAR PATIENT CARE - Safety We will embed a learning culture that reduces harm, achieves good outcomes and enhances the patient experience	
4	Further utilise the "sign-up for safety" indicators to improve safety and clinical outcomes and improve processes to raise the Trust's standing in the "learning from mistakes" league table • *The Trust continues to achieve above 98% new harm-free care, outperforming local Trusts* • *There was a never event in August which was very regrettable but did provide lessons* • *Trusts with high incident reporting usually have a better and more effective safety culture and in 2013/14 we were ranked 4th worst of 46 medium-sized acute Trusts. Latest NHS National Reporting and Learning Service league table shows us above the median and improving*

5	Make further improvements regarding effective venous thromboembolism screening, administration of medicines, avoidable hospital acquired infections, pressure ulcers, acute kidney injury and sepsis, and other improvements specified in the Clinical Quality Strategy • *VTE assessment has improved and is virtually meeting the target. The introduction of ePrescribing in early 2017 should ensure that this target is routinely met* • *Available benchmarks suggest excellent progress improving the management of AKI and Sepsis* • *The Trust has had 2 cases MRSA bacteraemia so far this year, and disappointingly some of the causal factors were similar. A renewed effort into infection control has been launched* • *C.difficile rates are within agreed tolerances, but antibiotic prescribing and timeliness of samples remain key targets for further improvement* • *Falls resulting in moderate or severe harm are within national norms, but management action has been stepped-up to improve safety for patients* • *There has been a 50% reduction in grade 3 pressure ulcers and no grade 4 cases* • *The eMews electronic observation and escalation system has been fully implemented and has improved the recognition and speed of response to deteriorating patients* • *The Trust's Medicine's Optimisation Strategy & Action Plan, monitored by QC includes clear actions to reduce medication errors. Safe storage of medicines is still an area requiring improvement, particularly in Whiston Hospital*
6	Maintain in-hospital mortality below the north west average and continue to close the gap between outcomes for weekend and weekday admissions • *HSMR and SHMI mortality indicators are both within national control limits and crude mortality remains better than the NW average* • *Weekend admission mortality is volatile because of the relatively small numbers but has vastly improved and is very close to weekday mortality at present*
5 STAR PATIENT CARE – Pathways As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient	
7	Work closely with CCG colleagues to improve emergency access performance, and explore opportunities for joint working that will simplify the patient journey for example frailty pathways and discharge to assess • *A&E attendances have increased by circa 2.7% in the year and the conversion rate to admission has increased with circa 6% more non-elective admissions to date* • *A review of emergency access in collaboration with ECIP has resulted in the development of a system-wide recovery plan* • *A GP sub-acute service was established for part of 2015/16 and dealt with circa 9% of A&E attenders and improved flows. This is to be re-introduced on 1st December* • *Progress across health and social care organisations to develop new pathways and joint working to benefit patient flows or pathways of care is ongoing, albeit slowly*
8	Continue to develop and embed alternative pathways to benefit patient care such as those related to ambulatory emergency care to reduce non-elective admissions, and midwifery-led care for women having low risk births • *Proposals for further alliance with Warrington Trust regarding the management of their acute stroke cases have been implemented and discussions on expanding the model and providing the appropriate bed-base are being considered* • *Plans to enhance the ambulatory care facilities in A&E and within acute medicine are ongoing to deliver smoother patient journeys and an enhanced patient experience* • *The plans for a midwifery-led facility have been approved and will be implemented in 2 phases starting this year* • *The Trust continues to participate in, and learn lessons from the Cheshire and Merseyside Vanguard for women and children*
9	Use benchmarking data intelligence to reduce variation and improve outcomes • *The Project Management Office actively reviews benchmarking data with care groups to drive improvements, reduce variation and deliver better outcomes by learning from the best*

	• *Specific examples include Orthopaedic surgery where benchmarks have assisted in reducing the fractured neck of femur length of stay and gastroenterology staff have used comparative information to enhance the overall quality of services* • *Most recently outpatient first to follow-up ratios have been explored in detail to identify top performers in order that we can learn lessons* • *Work on STP and LDS proposals has required extensive use of comparative data to identify improvements, especially with respect to radiology, pathology and pharmacy services*
5 STAR PATIENT CARE – Communication We'll be open and inclusive with patients providing them with timely information about their care. We will be courteous in communications and actively seek the views of patients and carers	
10	Continue to improve response rates and outcomes from the Friends & Family Test. Continue to use patient stories to learn lessons and share best practice • *Patient/carer representation and engagement at focus groups is increasing and continues to have a positive impact* • *Initiatives have seen the development of spiritual care volunteers and dining room companions* • *We continue to receive excellent feedback from patient groups* • *Achievement of the family and friends response rates remains challenging in all areas, although circa 93% continue to recommend the Trust for treatment*
11	Improve compliance with the timeliness of responses to complaints and continue to reduce complaints related to staff attitude and behaviour • *Timeliness of complaint responses continues to be a challenge and a focus of management attention, with 62.8% currently meeting the target* • *ACE behavioral standards continue to be reiterated to all staff as part of the appraisal process* • *The management structure and arrangements for handling complaints has seen a complete review with new appointments with the required skills joining the organisation*
12	Improve patient information and communications via the website and other social media channels, as well as more traditional routes. Embrace opportunities for communications with patients and relatives to help the Trust plan future service developments • *In a major initiative in 2015/16 patient information, noticeboard displays and leaflets were reviewed, and measures to maintain these standards are now embedded* • *The Trust overhauled its internet site in 2015/16 ensuring that patient information was accurate, in date and appropriate. Almost 1 in 5 viewers now access the Trust website through mobile systems and this rate is growing* • *Two years on from their launch, the Trust's social media sites have proved to be very popular for staff, patients, and stakeholders with new content added twice daily. Facebook has reached more than 1 million people in the last 12 months and Twitter has 1,348 followers* • *Video is proving to be a successful way of engaging with large groups of people. The Trust's first on-line film (Johnny Vegas visiting the Children's Wards) was uploaded to You Tube in March 2015 since then the channel has had over 20,000 views* • *In September 2016 a Facebook page dedicated to our Maternity Unit was launched receiving over 25,000 views in the first 2 months* • *Improved verbal and written communication is being addressed through a range of staff training modules and monitored through appraisal systems.*
5 STAR PATIENT CARE – Systems We will improve Trust systems and processes, drawing upon best practice to ensure they are efficient, patient-centred and reliable	
13	Continue to implement the next phase of IT systems including: a clinical portal, e-prescribing, electronic medical early warning system, theatre system and next generation Electronic Document Management System • *eMEWS implementation was completed successfully. Phase 2 - fluid balance monitoring is currently in development* • *The pilot for ePrescribing is scheduled for March 2017 with rollout between April and November*

	• *Further development of the EDMS solution is ongoing and is scheduled to go-live in March 2017, followed by the Clinical Portal project* • *The Maternity System offline community module has been implemented* • *The Critical Care Information system has been upgraded* • *The new Trust Intranet is scheduled to go live in January 2017* • *Testing of the Opera Theatre system is ongoing for rollout in the new year*
14	Continue to maintain the national data quality standards encompassed in the IG toolkit • *The Trust continues to benchmark itself using the Information Governance Toolkit, which allows NHS organisations to assess themselves against Department of Health information governance policies and standards* • *This year additional focus has been placed on cyber-security and an enhanced staff education and awareness programme* • *The 2016/17 IG Toolkit assessment will take place in February and we are confident of retaining our 'green rated' overall 80% score achieved in 2015/16*
15	Develop a 3-year IM&T Strategy which builds the foundations to support clinical transformation • *The local and wider informatics strategies are under development and are expected to be approved by the end of February 2017* • *The Strategic Case to replace the IMS with an EPR System was approved by the Trust Board in June 2016, and the Full Business Case is being considered in November 2016. The EPR will be a significant enabler for the Merseyside local digital IT roadmap associated with the Sustainability and Transformation Plans for the area*
DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce that feel valued and supported to care for our patients	
16	Identify creative approaches to recruitment and retention to ensure the Trust remains an employer of choice, ensuring support and training for recruits from overseas. Explore opportunities for increasing our volunteer workforce • *A 5 year Recruitment & Retention Strategy is in place and the 2nd year of its action plan is in progress and on trajectory* • *There is ongoing schedule of recruitment campaigns and open days linked to Universities and Colleges to attract clinical staff* • *An international recruitment campaign to employ over 100 qualified nurses was successful, however passing the tests for access to the UK has proved extremely challenging and to date only 2 RGN are approved and able to travel to the UK. International recruitment difficulties are being raised at national level* • *Collaboration with junior doctor training in the Czech Republic has resulted in the international recruitment of 9 doctors* • *Plans to increase the pool of volunteers (currently c400) are ongoing. A new 5-year Volunteer Strategy has been developed which extends the range of volunteer roles to include increased support on inpatient wards and a year one action plan has been developed* • *On-going leadership development programmes for Ward Managers and Matrons, to ensure they are equipped with the skills to deliver high standards of patient care, are nearing completion* • *A new 5-year Talent Management Strategy has been developed with a year one action plan in progress to support recruitment, retention and succession planning. Coaching and bespoke leadership support interventions are aligned to OD plans* • *Delivery of apprenticeships in a range of subject areas including IT, Healthcare, Business Administration and Customer Service is ongoing. 44 have been completed to date and 75 are programmed to be completed this year*

17	Achieve the planned benefits from the implementation of eRostering, eJob-planning, eTimesheets & eExpenses. Ensure safe staffing levels are maintained, whilst adhering to guidance for agency usage caps & frameworks • *Achievement of the Lord Carter action plan is on target with the development of SOPs and checklists to monitor the adherence to NHSI guidance on back office functions and agency spend* • *eRostering for Nursing & Midwifery has been rolled out in all areas. A benefits realisation programme is ongoing with robust management KPIs to identify and reduce unwarranted variation and reduce bank and agency spend* • *E-timesheets were implemented in June 2016 for bank and additional shifts as part of streamlining back office services* • *E-rota for Junior Doctors in Training was implemented in November 2016* • *The phased implementation of E-Job Planning for Consultants and SAS Doctors with the refreshing of job plans in line with a revised job planning policy is ongoing* • *An e-expenses pilot has commenced as part of a national rollout programme and is on target for completion by March 2017*
18	Develop new approaches to celebrate innovation from front line staff to further enhance public, patient and staff engagement, and also empower staff to easily raise concerns • *Awareness raising of the ACE Behavioural Standards is ongoing through local OD plans, induction and mandatory training and is championed by line managers* • *The Trust's SFFT outcomes remain within the top quartile of responses nationally. The average response across the 3 quarters surveyed for staff recommending the Trust to friends and family if they needed care or treatment was 94% compared to a national average of 79%. The average response across the 3 quarters for staff recommending the Trust to friends and family as a place to work was 84% compared to a national average of 62%* • *Excellent results were achieved in the National Staff Survey with a response rate of 55% compared to a national average of 41% placing us in the best 20% of Acute Trusts nationally. Improved scores across the majority of Key Findings including the overall score for staff engagement above the national average* • *Cultural surveys are ongoing as part of the development of OD plans which will provide a 'pulse' check of the existing cultural style and whether or not ACE behavioural standards are prevalent or if further actions are needed. Intensive OD programmes are in place for 6 departments with additional OD interventions and professional coaches for leaders graded Band 7 and upwards* • *Achievement of the 2016/17 Francis action plan is on trajectory which includes the launch of an new online "Speaking out in Confidence" portal for staff to raise concerns confidentially* • *The Trust continues to develop a culture of "speaking out safely", and strives to embed the principles of human factors in areas such as theatres* • *Staff are encouraged to raise concerns through the Trust's Raising Concerns Policy* • *The Trust has launched a range of social media campaigns and has raised the prolife of fund-raising for the Trusts Charities aligned to the staff engagement strategy*
OPERATIONAL PERFORMANCE We will meet and sustain national and local performance standards	
19	We will pursue all clinically based performance indicators related to the quantity of activity undertaken; the quality of services provided; and the timeliness of diagnosis and treatment • *The Trust continues to monitor performance across many hundred quality parameters which are captured in the monthly Integrated Performance Report* • *Trust performance remains very strong. Actions are in place to improve some cancer 62-day pathways and clinical care in ED remains high quality despite suboptimal flows* • *Stroke care is amongst the best in England and work to understand stroke mortality is on-going*

20	We will seek to achieve all relevant standards required of the Trust and our staff, and look to deliver the activity levels required to meet Trust operational plans • *Non-elective activity levels continue to exceed contract levels and adversely impact on our ability to efficiently manage elective referrals* • *Whilst the vast majority of activity performance standards are being met the pressures on income and 18-week waiting targets from Referral Management Systems are growing, bearing in mind the time lag necessary to flex staffing and physical resources to meet alternative trajectories of activity* • *Progress against emergency access targets is currently a regular item for discussion at Committees and the Board* • *Pressures on physical accommodation (beds, theatres, outpatients and scanning) are also being experienced*
21	We will monitor all trends in performance, and take remedial action to improve outcomes and results • *The Integrated Performance Report is monitored at specialty, Care Group and Trust level* • *Areas of concern are thoroughly investigated and reported through Executive, Quality and Finance & Performance Committees prior to review by the Board. In addition, a Board Development session was devoted to exploring the IPR metrics to ensure a consistent understanding by Directors*
FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY We will at all times demonstrate robust financial governance, delivering improved productivity and value for money	
22	Achieve all statutory financial duties and continue to review the financial systems, processes, and controls, to enhance effective financial governance • *The Trust is currently on track to achieve its statutory financial duties with respect to capital cost absorption; external finance limit and capital resource limit, and delivered its predicted financial control total*
23	Continue to refine service and patient level information reporting and develop capacity, and demand modelling capability at divisional and departmental levels, to support decision making at organisational and service level • *Areas for improvement this year include Pathology at test level; Bar coding of equipment used; and Medical Job plans* • *Most recently a tool has been developed internally to model patient flows on bed availability which has helped in articulating the required bed-base to effectively manage activity over winter*
24	Use available benchmarking data to assess performance and underpin service transformation initiatives • *Development of strategic plans on a wider STP footprint has involved robust benchmarking of back-office services to explore where economies of scale and working differently could be beneficial* • *The recent Lord Carter report and development of the 'model hospital' offers greater opportunity to explore relative efficiencies of services and seek to emulate the best* • *The PMO is routinely assisting operational managers with in-depth system and process reviews and achievement of CIP initiatives. The PMO are active members of the Executive Operational Turnaround Group and the CIP Council*
SUSTAINABILITY AND TRANSFORMATION PLANS We will work closely with NHS Improvement, and commissioning, local authority and provider partners in Cheshire and Merseyside to develop plans to deliver sustainable services	
25	Meet all the compliance requirements set by NHS Improvement for long-term sustainability of clinical services • *Joint working initiatives with local providers is ongoing on both Alliance (Southport and Ormskirk, and Warrington and Halton) and STP (Cheshire and Merseyside) footprints* • *The Trust has developed 5 year strategic plans and 2-year operational plans required by commissioners and regulators and met all the required deadlines*

26	Foster positive working relationships with health economy partners and help create the joint strategic vision for health services, incorporating patient pathway improvements from sharing patient information • *The Trust continues to contribute in wider strategic planning discussions with commissioners, providers and other relevant stakeholders* • *The productivity of meetings with our main commissioner has improved. Evidence of the robust relationship was the amicable close-out of the 2015/16 financial year, and agreement of 2016/17 contracts without the need for mediation* • *Executive Team to Team meetings have been held with commissioners and providers during the year, and the regular monthly meeting with NHS Improvement has been maintained*
27	Continue to deliver the Communication and Engagement Strategy to ensure that staff, patients and visitors are kept informed of the Trust's future organisational plans • *Progress has been made against the existing strategy and this will be updated to reflect the outcome of the STP plans in due course* • *Briefing around strategic plans has not commenced in earnest, following advice from the centre, but is hoped that both staff and public briefings and discussions will soon progress* • *Staff engagement through the delivery of regular 'Team Talks' events continues to be seen by staff as a positive process with staff feedback and suggestions being used to make improvements to patient and staff experience*

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)119
Title of paper: Junior Doctors Contract 2016
Purpose: To provide an overview of the new terms and conditions of employment for junior doctors in training, describing the implications for the trust and the implementation timescales.
Summary: • Phasing in of the new terms of conditions of employment for junior doctors over the next 12 months • There are changes to basic pay and enhancements • There will be an increased emphasis on working hours and safety • The introduction of a generic work schedule brings together activities to achieve learning and service objectives within contracted hours for the duration of the training placement. • The role of the Guardian of Safe Working Hours
Corporate objective met or risk addressed: Developing organisational culture and supporting our workforce.
Financial implications: £476k - £700k dependent on ability to recruit at NHS rates.
Stakeholders: Medical and Dental Workforce, Managers, Trust Board, Patients
Recommendation(s): The Board are asked to note the contents of the report
Presenting officer: Anne-Marie Stretch, Deputy CEO & Director of HR
Date of meeting: 30th November 2016

This paper provides an update on the implementation of the 2016 Junior Doctors' contract for both the Trust and STHK Lead Employer.

1.0 Introduction

Prior to August 2016, junior doctors in training were employed under the New Deal 2002 terms and conditions of service. Although the 2016 terms and conditions of service came into effect on 3 August 2016 the phased implementation timetable, provided by NHS Employers, began from October 2016.

This phased implementation plan has been developed to enable employers to introduce the phased working patterns outlined in the 2016 contract. The exact time of transfer for each doctor will depend upon when their current contracts of employment expire and their training programme rotation dates.

Lead Employer (LE) within St Helens and Knowsley Teaching Hospitals NHS Trust is responsible for doctors in training in all specialities across Cheshire and Merseyside and also responsible for GP trainees within the West Midlands. Foundation Year 1 and 2 doctors are employed by individual Trusts.

2.0 Implementation within the Trust and Lead Employer– Update

Both Lead Employer and the Trust as a Host organisation have followed NHS Employers implementation timetable for the introduction of the 2016 contract.

Date	Action
July 2016	Appoint guardians of safe working hours
26 July 2016	Guardian of safe working hours conference, London
3 August 2016	Contract is live
October 2016	Transition to the new terms and conditions of service (TCS) for: • Obstetrics ST3 and above
November - December 2016	Transition to the new TCS for: • F1 doctors taking up next appointments • F2 doctors taking up next appointment and sharing rotas with F1 doctors
February – April 2017	Transition to the new TCS for: • Psychiatry trainees taking up next appointments (all grades) • Pathology trainees (lab based) (all grades) • Paediatrics trainees taking up next appointments (all grades) • Surgical trainees (all disciplines) taking up next appointments (all grades) • F2 doctors and GP trainees (ST1/2) taking up next appointments and sharing rotas with any of the above
August – October 2017	All remaining trainees taking up next appointments (all grades) All new starters (all grades)

3.0 Lead Employer (LE) Doctors

Lead Employee Trainee doctors who had contracts prior to 3rd August 2016 are considered to have "run through" training and as such will remain on the New Deal 2002 terms and conditions of employment until the end of their training. The exception to this is the West Midlands Contract as they are new to LE and therefore fall into the 2016 Terms and Conditions

- As at 21st November 2016 no refusals to accept the 2016 Contract have been received, however Lead Employer staff continue to deal with queries from doctors in training on the 2016 contract.

4.0 Pay

The current system of basic pay and broad banding supplements is being replaced with a new fairer pay structure. The new pay structure rewards doctors for actual work done and directly links pay to the level of responsibility a doctor is required to discharge while employed in a particular post rather than based merely on time served as at present. The table below outlines the key changes.

Significantly Enhanced Basic Pay for a 40-hour week, including paid break	Based on 4 nodal point structure from FY1 £26,350 through to CT3/ST3-8 £45,750, with three progression-linked pay rises as doctors progress through training: from F1 to F2, from F2 to CT1/ST1 and from CT2/ST2 to CT3/ST3.
Night Working Enhancement	All night shift hours 8pm and 10am (must last at least 8 hours) and all other hours between 9pm 7am -37%
Weekend Allowance	Varies between no allowance for a rota with 1 in 8 or less worked to 10% where 1 in 2 (the maximum allowed) is worked
On-call availability allowance	Where applicable varies between £2,108 for FY1 to £3,660 ST3-8
Flexible pay premia	Paid for General Practice, Emergency Medicine, Psychiatry, Oral and Maxillofacial
Non Pensionable Pay for additional rostered hours	Additional rostered hours worked (average weekly hours cannot exceed 48 hours per week) will be paid proportionately at 1/40th of weekly whole-time equivalent pay.
Exceptional, approved time worked to secure patient safety	Paid at prevailing rate unless a breach of WTR 48-hour average working hours, contractual 72-hour weekly limit or reducing rest between shifts to fewer than 8 hours (see below) occurs

This structural change to pay is designed to be cost neutral overall and as such inevitably there will be 'winners' and 'losers' amongst the junior doctors. There will however be an initial period of protection for the majority of doctors currently in training; they will have a cash floor calculated which they will not be able to fall below or for those at ST3 and above they will carry on being paid their current salary on the 2002 TCS plus a banding supplement.

5.0 Safe Working

The 2016 Terms and Conditions puts a considerable emphasis on safe working for the benefit of both junior doctors and their patients. These include:

Weekly Hours	Maximum average working week is 48 hours (with a WTR opt out 56) with a maximum of 72 hours in any one 7 day period.
Daily Hours	Maximum is 13 hours
Consecutive Shifts	Maximum is 8 without a break (night shifts is 4) unless of 10 hours or more when the maximum is 5
Meal Breaks (paid)	30 minutes for any shift of more than 5 hours- two breaks for shifts of more than 9 hours
Break between shifts	Minimum of 11 hours
Break between a run of consecutive shifts	Minimum 48 hours (except for a run of 3 or 4 consecutive night shifts 46 hours)
On call	Maximum length 24 hours, minimum 8 hours rest
Leave	There is a mutual obligation to plan leave around requests, balancing the need for adequate staff cover to provide a safe service while ensuring that all staff can take full leave entitlement

The Trust's rostering system provider has released updated software to support the Trust in designing new working patterns that meet the 2016 contractual rules.

This is key because where limits on safe working hours (48 hours average week; 72 absolute limit in seven calendar days; breach of more than three hours in the 11 hour minimum rest period) are breached, then the doctor will be paid at penalty rates In addition, a financial penalty will be levied on the Trust for each hour above these limits (total of the two will be four times the hourly rate). It is critical that in managing junior doctors on the 2016 TCS that we ensure compliance, particularly in these areas of safe working as the financial and reputational risks are significant. See 'Guardian of Safe Working Hours' below.

6.0 Work Scheduling

The generic work schedule brings together activities to achieve learning and service objectives within contracted hours for the duration of the training placement. A work schedule expressly links work carried out to the training needs identified. This ensures that alongside commitments to patients, the doctor is able to train effectively toward the achievement of the competencies necessary to progress through training.

The generic work schedule must be provided to a doctor prior to starting a placement to ensure that the doctor is informed of the work and range of duties that are expected to be undertaken and will identify:

a. the intended learning outcomes (mapped to the educational curriculum)
b. the scheduled duties of the doctor
c. time for quality improvement and patient safety activities
d. periods of formal study
e. the rota on which the doctor will be working (ensuring compliance with the safety constraints above)
f. the number and distribution of hours for which the doctor is contracted
g. the pay the doctor can expect to receive for the hours set out in the work schedule

The generic work schedule will be adapted into a personalised work schedule when the doctor commences employment/placement and has the opportunity to discuss any personal objectives with the educational supervisor.

Work schedules will be kept up to date through educational reviews and work schedule discussions, supported by exception reporting if the doctor feels that the workload and/or work pattern is deviating significantly or routinely from the intended work schedule, or where they feel that they are unable to access the training specified in the schedule.

It is the Trust's responsibility to ensure that there is a locally agreed process in place to administer and manage work schedule reviews. All educational supervisors will be trained to understand the process.

7.0 Guardian of Safe Working Hours

The Guardian of Safe Working Hours is a new role which will oversee the safeguards outlined in the TCS and will ensure that issues of compliance with safe working hours are addressed by the doctor and the Trust. The recruitment process for appointing the Trust and LE Guardian was completed on the 2nd September 2016. Mr Mike Chadwick, Consultant Surgeon was appointed with effect from 1st September and the post attracts 1.5 PAs per week. The Trust also has responsibility for the Lead Employer GP Guardian of Safe Working hours and Dr Peter Arthur, GP has been appointed with effect from 21st November 2016, this post attracts 1.5 PAs per week.

If concerns have not been resolved through the exception reporting and work schedule review processes, then doctors can escalate their concerns to the Guardian. The Guardian can formally raise concerns regarding safe working hours with Trust management and can insist that steps are taken to resolve matters of concern. The Guardian is empowered to require departments to take necessary steps to improve the working conditions of doctors.

The Guardian will levy a financial penalty on the department where the three key safe working hours limits are breached. This fine will go into a budget administered by the Guardian, to be spent on improvements to the working and training environment of doctors.

The Guardian will present regular reports on working hours to the Trust board and there is a requirement to send copies to HEE and the LNC. The Guardian will also undertake regular consultation with doctors.

8.0 Financial Implications

The new 2016 contract as outlined earlier, sets limits on working hours/patterns requiring changes to rotas, for example, same numbers of doctors on the rota but more days off, and/or limits on hours per week may be required.

It is estimated that the cost of the changes required are within the range of £476k-£700k per annum dependent on ability to recruit at NHS rates.

9.0 Trust Board

The Trust Board are asked to note the progress on implementation of the new junior doctor contract.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(15)120
Title of paper: Arrangements for 2017/18 Board Meetings.
Purpose: To advise Board members of the proposed dates for Trust Board meetings throughout the next Financial Year; the supporting timetable; and scheduled agenda items.
Summary: 1. Currently, Board meetings are held on the last Wednesday of each month and it is proposed that this arrangement will continue during 2017/18. 2. The paper attached confirms the dates for agenda setting, collation and distribution of papers and of actual meetings. 3. The Trust also maintains a schedule of planned papers and agenda items for Board meetings throughout each year and the draft proposal is included.
Corporate objective met or risk addressed: Contributes to the Trust's Governance arrangements which ultimately support the Trust in achieving its Corporate Objectives.
Financial implications: None directly from this report.
Stakeholders: The Trust, its Commissioners, its regulators and other stakeholders.
Recommendation(s): The Trust Board are asked to: 1. Approve the proposed dates and associated administrative timetable for Trust Board meetings. 2. Approve the proposed schedule of planned agenda items for Trust Board meetings.
Presenting officer: Peter Williams, Director of Corporate Services.
Date of meeting: 30th November 2016.

SCHEDULE OF BOARD MEETING DATES (2017/18)

1. Board meetings are held on the last Wednesday of each month with the exception of August and December where no meetings are scheduled.
2. The Trust believes in being open and transparent and therefore all Board meetings include sessions to which members of the public are invited to attend. These Public Board Meetings commencing at 9:30a.m. and run for between 2 and 3 hours.
3. Four meetings (in April, June, October and February) include discrete sessions for discussion on strategy, which are held in private following Public Board Meetings. In addition, where necessary, meetings include discrete sessions for discussion on items of a sensitive or confidential nature, which are held in private following Public Board Meetings.
4. Agendas should be agreed by the Executive Committee on behalf of the Chairman at least ten days in advance of meetings.
5. Hard copies and electronic copies of Board papers are distributed to members on the Friday preceding each Board meeting.
6. Papers for Public Board Meetings are uploaded onto the Trust internet site on the day preceding each meeting.
7. The following table captures the schedule for the 2017/18 Financial Year. Meetings that include a strategy session are shaded grey.

Financial Year 2017/18	Draft Agenda to Executive Committee	Agenda set	Board papers to be received	Electronic & hard copies circulated	Electronic copies on internet	Board date
April	Thu 06 Apr	Fri 14 Apr	Tue 18 Apr	Fri 21 Apr	Tue 25 Apr	Wed 26 Apr
May	Thu 11 May	Fri 19 May	Tue 23 May	Fri 26 May	Tue 30 May	Wed 31 May
June	Thu 08 Jun	Fri 16 Jun	Tue 20 Jun	Fri 23 Jun	Tue 27 Jun	Wed 28 Jun
July	Thu 06 Jul	Fri 14 Jul	Tue 18 Jul	Fri 21 Jul	Tue 25 Jul	Wed 26 Jul
August	No scheduled Board meeting					
September	Thu 07 Sep	Fri 15 Sep	Tue 19 Sep	Fri 22 Sep	Tue 26 Sep	Wed 27 Sep
October	Thu 05 Oct	Fri 13 Oct	Tue 17 Oct	Fri 20 Oct	Tue 24 Oct	Wed 25 Oct
November	Thu 09 Nov	Fri 17 Nov	Tue 21 Nov	Fri 24 Nov	Tue 28 Nov	Wed 29 Nov
December	No scheduled Board meeting					
January	Thu 11 Jan	Fri 19 Jan	Tue 23 Jan	Fri 26 Jan	Tue 30 Jan	Wed 31 Jan
February	Thu 08 Feb	Fri 16 Feb	Tue 20 Feb	Fri 23 Feb	Tue 27 Feb	Wed 28 Feb
March	Thu 08 Mar	Fri 16 Mar	Tue 20 Mar	Fri 23 Mar	Tue 27 Mar	Wed 28 Mar

ANNUAL TRUST BOARD CALENDAR (2017/18)

The table overleaf captures the scheduled agenda items at meetings of the Trust Board along with report lead and presenter.

ANNUAL TRUST BOARD CALENDAR 2017/18																			
Month			**ToR**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**Report**	**Presenter**
Scheduled agenda items	General	Employee of the month		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Anne-Marie	Richard
		Patient story			✔		✔		✔		✔		✔		✔	Sue	Vary
		Apologies		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Declaration of interests	8	✔	✔	✔	✔		✔	✔	✔		✔	✔		Richard	
		Minutes of the previous meeting		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Action list / matters arising		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Review of meeting		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Any other business		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
	Committee Reports	Audit (including CGM & SFI approval)	2,6,7,10,11,14 15,32,33,34	✔		✔			✔	✔				✔		Nik	Su
		Executive (including MIP approval)	3,11,16,18	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Peter	Ann
		Finance and performance	11	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Nik	Denis
		Quality	11,25	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Sue	David
		Charitable Funds	11			✔				✔				✔		Nik	Denis
		Remuneration (or as required)	6,11			✔										Anne-Marie	Richard
	Operational performance reports	Agency staffing self-certificate checklist	3	✔	✔	✔	✔	*	✔	✔	✔	*	✔	✔	✔	Nik	
		FT & STP update	3	✔	✔	✔	✔	*	✔	✔	✔	*	✔	✔	✔	Nik	
		Integrated Performance Report	3,4	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Nik	
		Safer staffing report	3	✔	✔	✔	✔	*	✔	✔	✔	*	✔	✔	✔	Sue	
		Board Assurance Framework	3	✔			✔			✔			✔			Sue	
		Complaints, claims & incidents report	3,9		✔				✔				✔			Sue	
		HR indicators	3				✔						✔			Anne-Marie	
		Infection control report	3				✔				✔				✔	Sue	
	Annual reports	Adoption of Annual Accounts	1		✔											Nik	
		Approval of Quality Account	25		✔											Sue	
		Audit Plan approval	33		✔											Nik	
		Board and Committee Effectiveness Review	5,12,13		✔											Peter	
		Information Governance Report	1,3		✔											Francis Andrews	
		Trust objectives - review of previous year's	3		✔											Peter	Ann
		Medical revalidation	20				✔									Terry Hankin	
		Public Health report	24				✔									Kath	CCG Rep
		Audit Letter sign-off	1,33						✔							Nik	
		Charitable Funds Accounts / Annual Report	1								✔					Nik	Denis
		Research & development statement	4								✔					Kevin	
		Review of NHS Constitution (Bi-annual)	1								✔					Peter	
		Trust Board meeting arrangements	1								✔					Peter	
		Trust objectives - review of current year's	3								✔					Peter	Ann
		Clinical and quality strategy update	24,25										✔			Kevin	
		Research capability statement	3										✔			Kevin	
		Safeguarding report (Adult / Children)	1										✔			Sue	
		Approval of budget plans	1,27,29,30												✔	Nik	
		Board effectiveness review	2												✔	Peter	
		CQC registration	1,25												✔	Sue	
		Mixed sex declaration	1												✔	Sue	
		Review of staff survey	20												✔	Anne-Marie	
		Trust objectives - approval of next year's	3,24,31												✔	Peter	Ann
	Total scheduled items			15	21	16	19	0	17	16	20	0	20	15	20		
Closed Session	Chair and NED meeting			✔		✔				✔				✔		Richard	
	Chief Executives report				✔		✔		✔		✔		✔		✔	Ann	
	Serious untoward incidents		1		✔		✔		✔		✔		✔		✔	Sue	
	Suspensions		17		✔		✔		✔		✔		✔		✔	Anne-Marie	
	Feedback from external meetings and events				✔		✔		✔		✔		✔		✔	All	
	Review of meeting performance				✔		✔		✔		✔		✔		✔	Richard	
	Approval of Strategic Plans (dates TBA)		24,31,33														
	Director mandatory training / Corporate Law update		20							✔						External facilitators	

* To be approved under delegated authority

ENDS