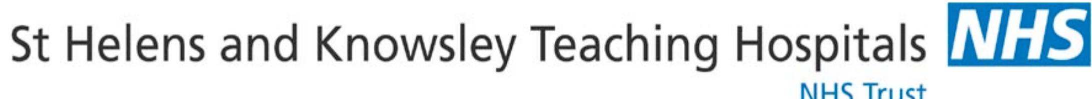


Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 26TH OCTOBER 2016
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

AGENDA				Paper	Presenter
08:45	1.	Apologies for Absence			Richard Fraser
	2.	Declaration of Interests			
	3.	Minutes of the previous Meeting held on 28th September 2016		Attached	
		3.1	Correct record & Matters Arising		
		3.2	Action list	Attached	
08:55	4.	Employee of the Month			
		4.1	October		
Performance Reports					
09:00	5.	Integrated Performance Report		NHST(16) 098	Nik Khashu
		5.1	Quality Indicators		Sue Redfern/Kevin Hardy
		5.2	Operational indicators		Nik Khashu
		5.3	Financial indicators		Nik Khashu
		5.4	Workforce indicators		Anne-Marie Stretch
09:15	6.	Safer Staffing report		NHST(16) 099	Sue Redfern

09:25	7.	Complaints, Claims & Incidents	NHST(16) 100	Sue Redfern
Committee Assurance Reports				
09:35	8.	Committee report – Executive	NHST(16) 101	Ann Marr
		8.1 Board Assurance Framework	NHST(16) 102	Sue Redfern
		8.2 Corporate Risk Register	NHST(16) 103	Sue Redfern
09:50	9.	Committee report – Audit	NHST(16) 104	Su Rai
09:55	10.	Committee Report – Quality	NHST(16) 105	David Graham
10:00	11.	Committee Report – Finance & Performance	NHST(16) 106	Denis Mahony
10.05	12.	Committee Report – Charitable Funds	NHST(16) 107	Denis Mahony
Other Board Reports				
10:10	13.	FT programme update report	NHST(16) 108	Nik Khashu
Closing Business				
10:20	14.	Effectiveness of meeting		Richard Fraser
	15.	Any other business		
	16.	Date of next Public Board meeting – Wednesday 30th November 2016		
CLOSE				

TRUST PUBLIC BOARD ACTION LOG – 26th OCTOBER 2016

No	Minute	Action	Lead	Date Due
1	29.06.16 (13.4)	Sue Redfern with meet with Anne Rosbotham-Williams and Neal Jones to discuss Quality Ward Round processes. 06.07.16 – Meeting arranged for 9th August	SRe	Action closed
2.	29.06.16 (17.3)	Anne-Marie Stretch with liaise with the Media Office, to prepare a communication to all staff regarding supporting the refreshed Clinical & Quality Strategy. 27.07.16 – AMS has liaised with Kim Hughes, Head of Media, who is working on materials to cascade the message to staff. There will be an item in Team Brief. Action closed.		Action closed
3.	27.07.16 (8.9.3)	Ward Staffing 1:8 ratio. Sue Redfern to provide a commentary to Board regarding wards that have a ratio greater than 1:8.	SRe	Action closed
4.	27.07.16 (11.2.5)	End of Life Care: Richard Fraser will ask for expressions of interest from the NEDS.	RF	Action closed
5.	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	NK	30.11.16

St Helens and Knowsley Teaching Hospitals NHS Trust

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(16)098
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 4 C.Difficile (CDI) positive cases in September. Year to date there have been 15 positive cases. The annual tolerance for 2016-17 is 41 cases.

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

There were 2 falls that resulted in severe harm during August.

Performance for VTE assessment for August was 94.38% a slight improvement on July.

The 2015-16 HSMR is 99.7.

The overall nurse/midwife Safer Staffing fill rate for August was 97%

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: 26th October 2016

Operational Performance

A&E performance was 79.7% (type 1) and 87.5% (type 1 & 3) in month which is an improvement on August performance. 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 deliver the 95% target.

The Trust is also part of the NHSI led A&E improvement programme , working with the Emergency Care Improvement Programme (ECIP) to receive clinically led specialist and practical intensive support to implement evidence based good practice to ensure delivery of safer, faster, better urgent and emergency care for our patients.

Senior leaders across the organisation are working with their teams to deliver and embed the actions from the Trust wide recovery plan, which will result in sustainable improvement, including implementation of the SAFER bundle and rapid senior assessment of patients attending by ambulance.

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 September 2016 (Month 6) 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 this additional activity. 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 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 £6.239m of CIPs which is behind the year to date plan by 2%, a significant improvement against last month (11%). 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 £0.793m out of a revised year forecast total of £4.985m.

Cash

Cash balance at the end of August 2016 is £3.529m which equates to 4 operating days.

Human Resources

Mandatory training compliance has increase slightly and is above target at 93.5%.

Appraisal compliance requires improvement and performance is 71.4%. Recovery plans are in place. Appraisal is a monthly standing item on the Executive Committee agenda. Compliance continues to be impacted by levels of activity and with this is mind, the Trust is implementing a new simplified appraisal process to reduce the time required for the completion of appraisals.

Sickness absence has decreased in August to 4.7 % although it is above the quarter 2 target of 4.35%. 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

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS												
Mortality: Non Elective Crude Mortality Rate	Q	T	Sep-16	2.7%	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 but being addressed by new consultant & his team & coding. Weekend mortality is improving - small numbers make individual months difficult to interpret.	Patient Safety and Clinical Effectiveness	The Trust is exploring an electronic solution to improve capture of comorbidities and their coding. Focus on missing notes (which is improving) as this impacts on R codes (and HSMR). A drive in ED and MAU to reduce excessive use of symptom-diagnoses, as this impacts on HSMR. Palliative care consultant now in post. Work to improve management of AKI and Sepsis is demonstrating early success and will reduce 'observed' mortality.	KH
Mortality: SHMI (Information Centre)	Q	▲	Mar-16	1.03		1.00						
Mortality: HSMR (HED)	Q	▲	Jun-16	87.5	96.6	100.0	99.7					
Mortality: HSMR Weekend Admissions (non-elective) (HED)	Q	T	Jun-16	113.2	108.0	100.0	112.5					
Readmissions: 30 day Relative Risk Score (HED)	Q	T	May-16	99.4	99.3	100.0	96.4		Much improved over last 12 months.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	Work is underway to improve listing of babies returning electively but documented as emergency admissions.	KH
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	May-16	94.4	95.1	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	May-16	95.4	87.1	100.0	97.7					
% Medical Outliers	F&P	T	Sep-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	Sep-16	35.2%	44.5%	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 to evaluate whole system pressures prior to allocation. Critical care rep to attend at 12.30 EAM to discuss step down needs and options. ADO, CD and DM review of process to take place in view of recent deterioration and concerns re step down delays beyond 24 hours	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients)	Q	▲	Aug-16	80.0%	79.1%	90.0%	79.9%		eDischarge performance below target, albeit compares favourably with neighbours. The more significant immediate problem is a backlog of eDischarges that were never sent.		Drive to ensure realtime completion on ward rounds to improve compliance, but trainee doctor numbers is an issue. New report tell wards virtually realtime who needs a summary and there is a medium-term plan to supplement trainee doctor numbers with advanced nurses. Action plan to address unsent eDischarges (backlog clearance and prevention) in place.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients)	Q	▲	Aug-16	87.5%	91.6%	95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E)	Q	▲	Aug-16	98.7%	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	▲	Aug-16	93.0%	96.1%	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												
Number of never events	Q	▲ £	Sep-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	Sep-16	98.7%	98.8%	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	Sep-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	▲ £	Sep-16	1	2	0	0		There was one case of MRSA bacteraemia and 4 C.Difficile (CDI) cases in September. The annual tolerance for 2016-17 MRSA cases is 0 and for CDI is 41 cases. An investigation into the MRASB has commenced.	Quality and patient safety	The Infection Control Team continue to support staff to maintain high standards and practices. Monitor and undertake RCA for any hospital acquired BSI and CDI. CDI and Antibiotic wards rounds continue to be undertaken on appropriate wards.	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲ £	Sep-16	4	15	41	26					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Sep-16	3	11	No Target	28					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Sep-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	Root cause analysis is undertaken for each reported pressure ulcer irrespective of grade, to maximise learning.	SR
Number of falls resulting in severe harm or death	Q	▲	Aug-16	2	8	No Contract target	21		STHK harm from falls YTD is 0.130 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	94.38%	91.70%	95.0%	93.31%		VTE solution has improved A&E underperformance.	Quality and patient safety	Intensive training for new trainees was delivered in August. Execs holding in abeyance decision to reprint drug kardices with VTE assessment on them pending ePrescribing solution, because performance much improved.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Aug-16	3	12		38					
To achieve and maintain CQC registration	Q		Sep-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	Aug-16	97.0%	95.1%		96.8%		Shelford Patient Acuity being undertaken during October 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	Aug-16	0	2		1					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Aug-16	93.9%	94.7%	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	▲ £	Aug-16	98.1%	98.2%	96.0%	97.8%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Aug-16	89.5%	88.3%	85.0%	88.6%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Sep-16	93.2%	93.2%	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	There is a risk due to the current medical bed pressures and the increase in 2ww referrals and activity that the elective programme will be compromised	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. 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.	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Sep-16	100.0%	99.99%	99.0%	99.99%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Sep-16	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Sep-16	0.6%	0.7%	0.8%	0.9%		Target achieved in September 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	▲ £	Aug-16	100.0%	100.0%	100.0%	99.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Sep-16	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Sep-16	79.7%	77.7%	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. 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	▲	Sep-16	87.5%	86.2%	95.0%	89.4%					
A&E: 12 hour trolley waits	F&P	▲	Sep-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	▲ £	Sep-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	Sep-16	23	163		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 improvements in complaints response will be implemented imminently, however this will need a period of time to further embed and deliver a sustained improvement.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Sep-16	24	157		372					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Sep-16	45.8%	59.9%		42.7%					
Friends and Family Test: % recommended - A&E	Q	▲	Sep-16	85.8%	86.4%	90.0%	91.5%			Patient experience & reputation	Scores have been fed back to the ED and Maternity departments.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Sep-16	96.0%	95.1%	90.0%	96.4%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Sep-16	96.4%	97.7%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Sep-16	95.7%	97.8%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Sep-16	100.0%	100.0%	95.1%	95.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Sep-16	95.6%	92.0%	98.6%	98.6%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Sep-16	94.1%	94.3%	95.0%	94.7%					

Sep-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												
Sickness: All Staff Sickness Rate	Q F&P	▲	Aug-16	4.7%	4.6%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.9%		Absence has decreased in August to 4.7% which is 0.35% above the Q2 target of 4.35%. 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.	Listening events with HCAs are scheduled for October . There is currently a drive on managers carrying out Return to Work interviews as quickly as possible and logging these on the system -these are a key part of managing absence. The HR Absence Support Team is carrying out (RTW) audits week commencing 10 October 2016 and will take place on an ad hoc basis moving forward. The roles of the Absence Support Team have been reconfigured so that part of this Team are also supporting managers with welfare meetings and soon with meetings where staff are hitting trigger points in the Attendance Management Policy	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P	T	Aug-16	5.9%	5.6%	5.3%	6.0%					
Staffing: % Staff received appraisals	Q F&P	T	Sep-16	71.4%	71.4%	85.0%	87.2%		Mandatory Training compliance has increased in month and now exceeds the target by 8.5%. Appraisal compliance has declined slightly in month and is now 13.6% behind target.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The L&OD team are working with managers of poorly performing areas to ensuring that all staff that are non compliant for Appraisal are appraisal and recorded on ESR to improve compliance. Appraisal data down to department level was reviewed at the Executive Committee during September and will remain 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	Sep-16	93.5%	93.5%	85.0%	77.6%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q1	94.9%					The Trusts Staff Friends and Family Test results in Q1 again exceed the 2014/15 results and the 2015/16 national average for each question, with staff recommending the Trust as a place to receive care having a very positive score.		Staff in Surgical Care Group are currently undertaking the Q2 SFFT, with results expected in early October 2016.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q1	89.2%								
Staffing: Turnover rate	Q F&P	T	Aug-16	1.9%			8.9%		Staff turnover remains stable and well below the national average of 14%.	Quality and patient experience, staff morale	Turnover is monitored across all departments as part of the Trusts Recruitment & Retention Strategy with action plans to address areas where turnover is higher than the trust average. Further action is required by Ward Managers to provide more support to newly qualified nurses.	AMS
FINANCE & EFFICIENCY												
FSRR - Overall Rating	F&P	T	Sep-16	2.0	2.0	2.0	2.0		The Trust's year to date performance is slightly ahead of plan. The Trust has significant contractual agreements with other NHS organisations which may impact on our ability to achieve Better Payment compliance.	Financial	Adherence against the submitted plan and delivery of CIP. Maintaining control on Trust expenditure. Agreeing with Commissioners and NHSE a more advantageous profile for receipt of planned income.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Sep-16	6,239	6,239	15,248	13,043					
Reported surplus/(deficit) to plan (000's)	F&P	T	Sep-16	1,366	1,366	3,328	(9,551)					
Cash balances - Number of days to cover operating expenses	F&P	T	Sep-16	4	4	2	2					
Capital spend £ YTD (000's)	F&P	T	Sep-16	793	793	4,985	4,169					
Financial forecast outturn & performance against plan	F&P	T	Sep-16	3,328	3,328	3,328	(9,551)					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Sep-16	94.7%	94.7%	95.0%	94.2%					

APPENDIX A

			Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	2016-17 YTD	2016-17 Target	FOT	2015-16	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	100.0%	100.0%	100.0%	100.0%	94.1%	95.8%	100.0%	100.0%	100.0%	87.5%	93.1%	89.3%	100.0%	92.8%	85.0%		99.2%		
	Total > 62 days		0.0	0.0	0.0	0.0	0.5	0.5	0.0	0.0	0.0	1.5	1.0	1.5	0.0	4.0			1.0		
Lower GI	% Within 62 days	▲ £	77.8%	100.0%	84.6%	100.0%	100.0%	89.5%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	93.3%	93.4%	85.0%		94.5%		
	Total > 62 days		1.0	0.0	1.0	0.0	0.0	1.0	0.0	0.0	0.0	2.0	0.0	0.0	0.5	2.5			3.0		
Upper GI	% Within 62 days	▲ £	100.0%	85.7%	71.4%	83.3%	100.0%	100.0%	100.0%	81.8%	75.0%	90.9%	0.0%	100.0%	100.0%	91.4%	85.0%		88.9%		
	Total > 62 days		0.0	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			5.0		
Urological	% Within 62 days	▲ £	100.0%	83.3%	76.7%	84.0%	79.2%	83.3%	83.3%	84.0%	85.7%	84.6%	81.3%	75.0%	79.3%	81.3%	85.0%		80.8%		
	Total > 62 days		0.0	2.0	3.5	2.0	2.5	2.0	2.0	2.0	2.0	3.0	3.0	4.0	3.0	15.0			28.0		
Head & Neck	% Within 62 days	▲ £	100.0%		83.3%	100.0%	50.0%	57.1%	60.0%	50.0%	50.0%	100.0%	37.5%	62.5%	66.7%	56.5%	85.0%		71.1%		
	Total > 62 days		0.0		0.0	0.0	1.0	1.5	1.0	0.5	0.5	0.0	2.5	1.5	0.5	5.0			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	▲ £	100.0%	40.0%	100.0%	54.5%	50.0%	60.0%	66.7%	71.4%	66.7%	81.8%	100.0%	85.7%	92.3%	88.9%	85.0%		76.4%		
	Total > 62 days		0.0	1.5	0.0	2.5	1.5	1.0	0.5	1.0	0.5	1.0	0.0	0.5	0.5	2.5			8.5		
Lung	% Within 62 days	▲ £	75.0%	100.0%	71.4%	80.0%	100.0%	90.5%	100.0%	88.2%	66.7%	81.5%	90.0%	91.7%	82.6%	83.3%	85.0%		86.5%		
	Total > 62 days		1.0	0.0	1.0	1.0	0.0	1.0	0.0	1.0	1.0	2.5	0.5	0.5	2.0	6.5			10.5		RC
Haematological	% Within 62 days	▲ £	66.7%		60.0%	80.0%	66.7%	83.3%	50.0%	86.7%	100.0%	100.0%	0.0%	50.0%	50.0%	64.9%	85.0%		70.5%		
	Total > 62 days		0.5		1.0	1.0	1.0	1.0	2.0	1.0	0.0	0.0	2.5	3.0	1.0	6.5			13.0		
Skin	% Within 62 days	▲ £	90.0%	94.7%	88.5%	95.9%	95.3%	94.4%	92.5%	96.7%	97.5%	96.0%	100.0%	97.3%	93.8%	96.6%	85.0%		94.5%		
	Total > 62 days		2.0	1.0	3.5	1.0	1.0	0.5	1.5	0.5	0.5	1.0	0.0	0.5	2.0	4.0			13.0		
Unknown	% Within 62 days	▲ £	100.0%	100.0%	100.0%	100.0%	33.3%	100.0%		50.0%		100.0%	100.0%	100.0%	100.0%	100.0%	85.0%		83.3%		
	Total > 62 days		0.0	0.0	0.0	0.0	1.0	0.0		0.5		0.0	0.0	0.0	0.0	0.0			1.5		
All Tumour Sites	% Within 62 days	▲ £	91.2%	91.4%	85.1%	89.3%	86.9%	87.9%	90.1%	89.5%	91.8%	88.0%	87.5%	85.4%	89.5%	88.3%	85.0%		88.6%		
	Total > 62 days		4.5	5.0	12.5	8.0	8.5	8.5	7.0	7.5	5.0	12.0	10.0	11.5	9.5	48.0			90.5		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £	100.0%	100.0%					100.0%	100.0%					100.0%	100.0%	85.0%		100.0%		
	Total > 31 days		0.0	0.0					0.0	0.0					0.0	0.0			0.0		
Acute Leukaemia	% Within 31 days	▲ £				100.0%	100.0%					100.0%				100.0%	85.0%		100.0%		
	Total > 31 days					0.0	0.0					0.0				0.0			0.0		
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)099
Title of paper: Safer Staffing Report for September 2016
Purpose: To provide an overview of nursing and midwifery staffing levels in inpatient areas during September 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 the NHS Choices for September 2016 indicates an overall headcount fill rate of 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. • In September, 12 wards had fill rates below 90%; 10 wards for RNs, 1 for care staff 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 bank RN , the shift is backfilled with a health care assistant. • 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. • In September, there were no falls resulting in severe harm on wards with a fill rate below 90%. • At present the Trust is proactively recruiting bank HCAs to meet requirements.
Corporate objectives met or risks addressed: Care, Safety
Financial implications: None directly from report.
Stakeholders: Patients, public, staff, commissioners, Trust Board
Recommendation(s): Members are asked to approve the report
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 26th October 2016

Trust Safer Staffing Report September 2016

The purpose of this paper is to set out the nursing and midwifery ward staffing levels across the Trust during September 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 (September 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 shifts figures in accordance with guidance.

Staffing levels is a 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 and 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 night duty instead of 3 which is a fill rate of 66% which may not be reflected in an overall monthly average.

1. **The September Submission** indicates an overall fill rate of 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. The overall fill rates for care staff are high because the figures are raised by both 'specials' (i.e. 1 patient to 1 staff member) employed to protect vulnerable patients and wards increasing shift headcount reductions caused by trained staff gaps when unable to backfill with a trained member of staff. 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 reflected by other trusts that use this.

2. **Recruitment and Retention** of nursing and midwifery staff remains a priority for the Trust and remains an on-going challenge nationally. Trust workforce data shows 66.41wte RN and 5.61wte HCA vacancies as of the end of August 2016 in spite of on-going recruitment. 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. **A Recruitment Event** was held on Saturday 3rd September 2016 targeting Trauma and Orthopaedics, Care of the Elderly and General Surgery, at which 17 job offers were made on the day.

   2.2. **Nurse Recruits from India.** Slow progress is being made with the recent nurse recruits from India due to circumstances outside of the Trust's control. 122 offers were made last November 2015. 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 bringing into question if they are still interested. 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 UK at the end of November 2016.

2.3. **The Recruitment of Bank HCAs** has recently successfully been increased from four campaigns each year to monthly. In September, 228 applications were received and 150 interviews were arranged. To date, 56 HCA bank post offers have been made and accepted and pre-employment checks are underway. Further interviews are taking place this month and 80 candidates have been invited to interview. 69 bank HCAs have completed the Fundamentals of Care course in Quarter 2, a requirement prior to commencing in post and are now actively employed on bank shifts. Staffing Solutions is currently working through a number of student nurse applications enrolling them onto the bank as HCAs whilst they are training. Based on the current demand and to achieve 100% HCA bank fill rate, analysis confirmed the need to increase the number of bank HCA's to 700; at present there are 476 individuals registered on the bank.

3. **Care Hours Per Patient Per Day** (CHPPD) in month averaged 10.99 CHPPD hours for the entire nursing and midwifery workforce and 7.04 CHPPD for the registered workforce. This mandated reporting is acknowledged nationally as difficult to interpret as to what 'good' looks like at present as it does not recognise acuity, dependency or turnover of patients plus other variables. Depending on how many intensive care beds there on in each Trust will unhelpfully inflate the CHPPD figures. 5 pilot sites are presently looking at CHPPD in detail using the Allocate SaferCare module as part of the Carter Model hospital work to be shared in early 2017.

4. **Shelford Patient Acuity Audit -** The fourth Shelford patient acuity audit commenced at the start of October 2016 which looks at all patient acuity and available staff hours over a 20 consecutive day period to enable a review of current ward staff establishments as to whether they meet patient demand.

5. **Fill rates below 90%** occurred on 12 wards in September; 10 for RNs, 1 for care staff and 1 for both RNs and care staff. There are 7 wards with fill rates of less than 90% for the last 3 months (Appendix 2). Of the 10 wards with a fill rate of less than 90% for RNs, 9 of them had fill rates above 100% for care staff in attempt to maintain headcount numbers appreciating skill mix is compromised.

6. **Bank and Agency Requests Filled and Unfilled for September 2016**
   The extra shifts are employed to fill either gaps in the planned shift numbers (due to short notice absence, vacancies, unfilled maternity leave) or to special vulnerable patients in addition to the usual shift numbers. In addition to bank and agency shifts, staff are also employed to work overtime and extra time if required and available. The table below sets outs the band and agency shift employed during September.

Sep-16

Shifts	Bank HCA	Agency HCA	Bank RN	Agency RN
Employed	1529	117	246	209

7. **Wards with a fill rate of less than 90% where patients have experienced severe harm**

No patient on the wards with a fill rate less than 90% experienced a fall resulting in severe harm. In September, 1 patient experienced severe harm as a result of an inpatient fall but this was on a ward where the staffing levels were above the 90% fill rate, ward 3B. A level 2 serious incident review investigation is on-going into this

incident when a detailed review of staffing levels and skill mix on the shift when the harm occurred will be undertaken.

8. Staffing Related Reported Incidents

A total of 16 incidents were reported in September directly relating to staffing, (Appendix 3) of which none are reported as resulting in patient harm. Staff are encouraged to reports shifts where there are skill mix issues or the actual headcount on shift is less than the planned.

9. Future Developments.

9.1. 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 part of the Carter Recommendations. This 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 after each acuity and staffing entry. This would enable efficient and effective use of staff across all wards as a Trust-wide picture of current staffing levels on each shift and patient numbers and acuity would be available. 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.

9.2. Student Nurse 'In-House' Training Proposal – Discussions are presently on-going with local HEIs to increase the number of student nurses presently accommodated within the Trust who would be cohorted and attached to this Trust only throughout their training (except for non-acute Trust elements of training), guaranteed employment once registered and potentially a partial reimbursement of tuition fees (no bursary available for this cohort) after 24 months registered employment at the Trust to promote allegiance to this Trust. The first cohort of 20 students could potentially commence in March 2017.

9.3. 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.

9.4. 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.

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 September 2016 Unify Safer Staffing Submission

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff									
Ward name	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
1A	1900.25	1665	2035	2089.83333	890	670	900	1020	87.6%	102.7%	75.3%	113.3%	801	2.9	3.9	6.8
1B	3368.75	3244.4167	1602.75	1812	880	863.25	600	541.5	96.3%	113.1%	98.1%	90.3%	710	5.8	3.3	9.1
1C	3070	2987.75	1575.9833	2240	1500	1600	600	730	97.3%	142.1%	106.7%	121.7%	808	5.7	3.7	9.4
1D	1971	1644.25	1323.5	1907.75	900	820	600	817.4667	83.4%	144.1%	91.1%	136.2%	783	3.1	3.5	6.6
1E	2221.75	2162.75	724.75	765.75	1200	1190	90	90	97.3%	105.7%	99.2%	100.0%	444	7.6	1.9	9.5
2A	1812.47	1775.8333	843.25	887.5	600	614	320	290	98.0%	105.2%	102.3%	90.6%	515	4.6	2.3	6.9
2B	1962	1710.8333	1503.25	1601.75	900	840.75	583.25	859.5	87.2%	106.6%	93.4%	147.4%	847	3.0	2.9	5.9
2C	1960.5	1741.75	1539	1842	900	831	600	870	88.8%	119.7%	92.3%	145.0%	751	3.4	3.6	7.0
2D	1352.635	1152.4667	1142.05	1177.25	600	650.25	600	610	85.2%	103.1%	108.4%	101.7%	509	3.5	3.5	7.1
2E	2951.25	2492.5	1293	1227	1200	1199.75	600	548	84.5%	94.9%	100.0%	91.3%	830	4.4	2.1	6.6
3A	1783	1770	1207.5	1247.25	650	690	610	610	99.3%	103.3%	106.2%	100.0%	466	5.3	4.0	9.3
3Alpha	1493	1502.4833	1110	1209.5	600	620	300	300	100.6%	109.0%	103.3%	100.0%	372	5.7	4.1	9.8
3B	1352.25	1290.25	2027	2106.23333	890	910	600	731.5	95.4%	103.9%	102.2%	121.9%	560	3.9	5.1	9.0
3C	1812.75	1643	1553.5	1865.25	900	910	900	1159.5	90.6%	120.1%	101.1%	128.8%	722	3.5	4.2	7.7
3D	1974.5	1712.4167	1328	1440.25	900	750.75	600	809.5	86.7%	108.5%	83.4%	134.9%	850	2.9	2.6	5.5
3E	1531.9	1441.5	956.75	861.5	600	590	300	280	94.1%	90.0%	98.3%	93.3%	538	3.8	2.1	5.9
3F	2206.05	2163	441.75	404.5	1200	1190.25	300	290	98.0%	91.6%	99.2%	96.7%	395	8.5	1.8	10.2
4A	1882.7	1715.6	1311.25	1518.73333	900	890	900	1030	91.1%	115.8%	98.9%	114.4%	823	3.2	3.1	6.3
4B	2453	2490.5	1753.75	1720.65	1050	1040	460	400	101.5%	98.1%	99.0%	87.0%	402	8.8	5.3	14.1
4C	1963.5	1850.25	1339	1283.75	900	867.5	900	890	94.2%	95.9%	96.4%	98.9%	855	3.2	2.5	5.7
4D	1366.5	1537.5	561.25	568	600	619.5	300	280	112.5%	101.2%	103.3%	93.3%	65	33.2	13.0	46.2
4E	5395	5117.5	938.25	874	3600	3309	560	540	94.9%	93.2%	91.9%	96.4%	302	27.9	4.7	32.6
4F	2192.75	2082	563.25	548	600	603.25	380	361.25	94.9%	97.3%	100.5%	95.1%	174	15.4	5.2	20.7
5A	1529.75	1419.6833	2434	2440.5	900	770	900	1089	92.8%	100.3%	85.6%	121.0%	790	2.8	4.5	7.2
5B	1617.2	1604.5	2231	2214.75	900	800	900	1050	99.2%	99.3%	88.9%	116.7%	704	3.4	4.6	8.1
5C	2825	2430.25	2506	2445	1200	1230	1200	1260.75	86.0%	97.6%	102.5%	105.1%	685	5.3	5.4	10.8
5D	1086.75	1038.5	871.5	1209.7	600	641	300	530	95.6%	138.8%	106.8%	176.7%	682	2.5	2.6	5.0
Duffy Ward	1043.5	1066.75	1651.7333	1835.66667	600	590.75	900	810.5	102.2%	111.1%	98.5%	90.1%	585	2.8	4.5	7.4
SCBU	1695.485	1619.25	463.4	421.5	930	930	300	270	95.5%	91.0%	100.0%	90.0%	239	10.7	2.9	13.6
Delivery Suite	3210.78	2765.75	862.375	679.25	2100	1898	580	550	86.1%	78.8%	90.4%	94.8%	290	16.1	4.2	20.3
Seddon	1468.5	1727.75	1573.5	1622.75	600	599.5	600	820.25	117.7%	103.1%	99.9%	136.7%	441	5.3	5.5	10.8

Appendix 2

The 10 wards with fill rates below 90% for RNs for September 2016

Ward	September 2016			
	RN Days	RN Nights	HCA Days	HCA Nights
1A	87.62	75.28	102.69	113.33
1D	83.42	91.11	144.14	121.67
2B	87.2	93.42	106.55	147.36
2C	88.84	92.33	119.69	145
2D	85.2	108.38	103.08	101.67
2E	84.48	99.98	94.9	91.33
3D	86.73	83.42	108.45	134.92
5A	92.8	85.56	100.27	121

5B	99.21	88.89	99.27	116.67
5C	86.03	102.5	97.57	105.06

The 1 ward with fill rates below 90% for HCAs in September 2016

Ward	September 2016			
	RN Days	RN Nights	HCA Days	HCA Nights
4B	101.53	99.05	98.11	86.96

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

Ward	September 2016			
	RM Days	RM Nights	HCA Days	HCA Nights
DS	86.14	90.38	78.77	94.83

The 7 wards with fill rates consistently less than 90% during the last 3 months

Ward	July 2016				August 2016				September 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	80.32	84.8	101.2	106.4	88.3	88	112.4	107.5	87.62	75.28	102.69	113.33
1D	83.6	88.2	126.1	106.5	84.3	85.3	128.5	116.9	83.42	91.11	144.14	121.67
2B	83.3	92.9	122.1	165.9	77	94.7	107	130.5	87.2	93.42	106.55	147.36
2C	83.1	88.9	103.6	111.5	87.7	81.7	120.7	135.7	88.84	92.33	119.69	145
2D	86.3	102.9	138.7	160.3	85.2	118.9	138.8	161	85.2	108.38	103.08	101.67
2E	95.4	99.3	86.1	97.7	102.8	100	83	100	84.48	99.98	94.9	91.33
5A	92.8	89.5	119.6	144.1	91.5	80.7	107.2	140.3	92.8	85.56	100.27	121

Appendix 3 – 16 Staffing Related Reported Incidents September 2016

staffing datix
incidents Sept 2016.x

TRUST BOARD PAPER

Paper No: NHST(16)100

Title of paper:

Aggregated Incidents, Complaints and Claims Report Q1 2016-17

Purpose:

To highlight trends and learning obtained from the aggregation and analysis of complaints, claims, internal incident reporting and PALS enquiries received by the Trust in the period 1st April – 30th June 2016 (Quarter 1).

Summary:

Activity
To set the context, there has been a 6% increase in spells, an increase of 11% in outpatient attendances and 2.7% increase in A&E Attendances (Type 1) in Q1 compared to Q1 2015-16

Incidents

1. 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 associated with the supportive culture of learning and openness and an increase in activity.
2. The level of harm for incidents of moderate harm and above has reduced
3. The top two categories of reported incidents were:
    a. Accident that may result in personal injury
    b. Implementation of care or on-going monitoring/review
4. The number of Strategic Executive Information System (StEIS) incidents reported this quarter was 9. This is slightly below the normal reporting level of 10 to 12 reported each quarter.
5. National Reporting and Learning System (NRLS) reporting for the latest published data April – September 2015, shows the organisation's practice in reporting to the NRLS remains excellent with the mean number of days to report being 13 days against national average of 30 days.

Claims

6. There are 416 active clinical negligence claims on-going, compared to 406 in the last quarter.
7. 33 new claims (all clinical negligence) were received in Q1 compared to:
    a. 28 new claims received in Q4 2015-16, showing a 19% increase
    b. 27 new claims received in Q1 last year, representing a 22% increase this year.
8. The top themes for new claims were the same as Q4 and were failure to diagnose/treat (14) and performance of surgical procedure (10). Consent issues, although not necessarily the lead reason for a claim are featuring more frequently in particulars of claim.

Complaints and Patient Advice Liaison Service (PALS)

9. 94 1st stage approved complaints were received during Q1, an increase of:

c. 11% in comparison to Q1 2015-16, when there were 84
d. 55% compared to Q4 2015-16, when there were 60

10. There were 492 PALS contacts/enquiries during Q1, compared to 611 in Q4 2015-16, reflecting a 24% decrease. This may partially account for the increase in complaints.
11. The top complaints themes during the period were:
    i. 43% - clinical treatment
    ii. 14% - values and behaviours (Staff)
    iii. 13% - admissions and discharges (excl. delayed discharge re care package)
12. During the quarter, there were 20 complaints linked to 39 Incidents; there were 25 complaints linked to previous PALS contacts/enquiries, and 5 complaints linked to 5 claims. There were 13 claims linked to 13 incidents.

Corporate objectives met or risks addressed:

Safety – We will embed a learning culture that reduces harm, achieves good outcomes and enhances the patient experience.

Financial implications:

There are no direct financial implications arising from this report

Stakeholders:

Patients, carers, commissioners, CQC and Trust staff.

Recommendation(s)/issues to escalate:

Members are asked to consider and note the report.

Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance

Date of meeting: 26th October 2016

1. Introduction

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

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

The data included in this report covers 1st April to 30th June 2016 (Q1)

2. Quantitative analysis

1st April – 30th June 2016 (Q1)	Incidents	StEIS	1st stage complaints	PALS	New claims
Total number reported	**3228**	**9**	**94**	**461**	**33**
Accident & Emergency	305		22	62	1
Anaesthetics	2				
Burns	16	1		8	2
Cancer Services	29		1	2	
Cardio Respiratory	25			1	
Cardiology	94		2	16	
Critical Care	31				
Dermatology	16		1	8	1
Diabetes	5			2	
Ear, Nose & Throat (ENT)	11		3	14	1
Facilities	153			4	
Finance	0				
Gastroenterology	93		8	16	1
General Medicine	380	2	10	45	2
General Surgery	150	2	9	80	4
Genito-urinary Medicine	0				
Gynaecology	31		1	10	2
Haematology	34			5	1
Human Resources	0			1	
Informatics	3			1	
Information Governance	0		2		
Medicine for Older People	423		7	24	1
Neurophysiology	1				
Obstetrics	177		3	16	5
Operational	8				
Ophthalmology	17		1	11	
Orthodontics & Oral Surgery	3			1	
Orthopaedic	136	1	9	54	4
Paediatrics	276		3	5	
Pain Services	0				
Palliative Care	0				

1st April – 30th June 2016 (Q1)	Incidents	StEIS	1st stage complaints	PALS	New claims
Pathology	270	1	1	3	
Pharmacy	31			1	
Plastics	45	1	3	14	2
Psychology	1				
Quality & Risk	20			25	1
Radiology	77		3	8	
Rehabilitation	35				
Respiratory	118		2	9	1
Resuscitation	1				
Rheumatology	10		1	3	
Sexual Health	26				
Theatres	151				
Therapy Services	15		1	6	
Unknown	0				1
Urology	9	1	1	6	3

3. Top 10 Themes

Incidents		Complaints		PALS		New clinical negligence claims	
Accident that may result in personal injury	799	Clinical Treatment	41	Admissions and Discharges (excl. delayed discharge re care package)	91	Failure to diagnose/ treat	14
Implementation of care or on-going monitoring/review	479	Values and Behaviours (Staff)	13	Communications	75	Performance of surgical procedure	10
Medication	331	Admissions and Discharges (excl. delayed discharge re care package)	12	Clinical Treatment	67	Performance of medical procedure	2
Access, Appointment, Admission, Transfer, Discharge	308	Communications	10	Patient Care/ Nursing Care	45	Delay	2
Infrastructure or resources	123	Patient Care/ Nursing Care	6	Appointments	51	Nursing care	1

Clinical assessment (investigations, images and lab tests)	267	End of Life Care	3	Access to Treatment or Drugs	24	Consent	1
Abusive, violent, disruptive or self-harming behaviour	230	Trust Admin/ Policies/ Procedures (Inc. Patient Record Management)	2	Values and Behaviours (Staff)	19	Medication errors	1
Treatment, procedure	181	Waiting Times	2	Other (e.g. abuse/ behaviour/Theft/ Benefits)	12	Not enough detail	1
Patient Information (records, documents, test results, scans)	140	Access to Treatment or Drugs	2	Waiting Times	10	Other	1
Consent, Confidentiality or Communication	123	Privacy and Dignity	2	Privacy and Dignity	7		

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

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

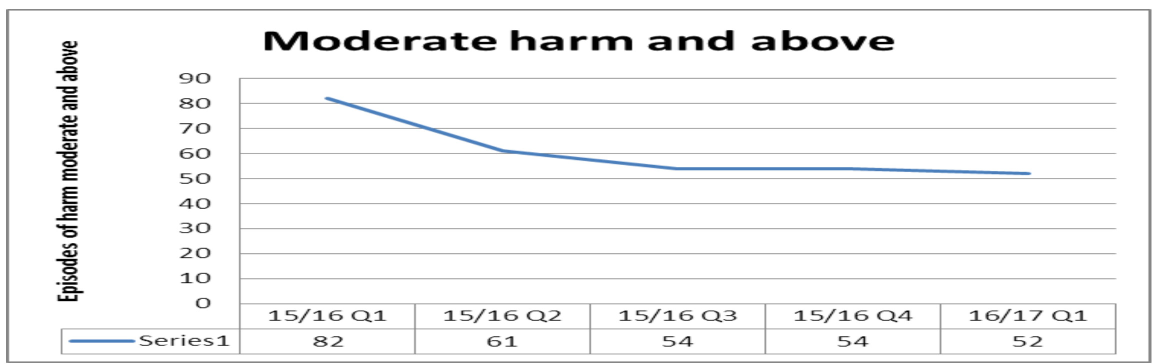
3.1. Incident data

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

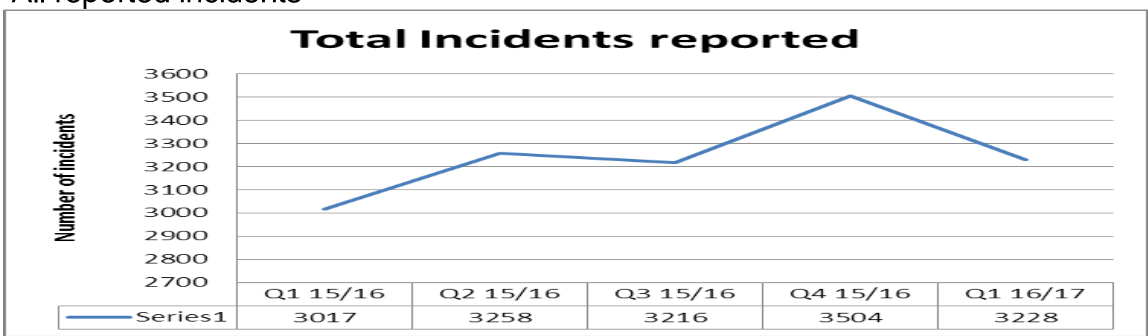
The Trust has increased its reporting of patient incidents with a no or low harm over the last three years, which demonstrates an improved culture of reporting. The Trust reported 37.73 incidents per 1,000 bed days for the period April 2015 – September 2015, which is comparable to local Trusts and the national rate of 38.35 per 1,000 bed days. Our mean number of days for reporting incidents to the NRLS is 13, which is substantially under the expected which is 30 days.

The charts below shows the organisation's activity for reporting against harms (moderate, severe and death) for Q1 2016-17 and Q1, Q2, Q3 and Q4 2015-16.

Moderate, Severe and Death Harms reported



All reported incidents



3.2. Lessons learnt from incidents

A serious harm from a fall occurred and was investigated and report submitted within Q1
The lessons learnt are detailed below:

- Conflicting information noted within the health care records in relation to cognitive status
- Challenges with cross boundary working
- Delays in attending emergency trauma theatre
- Inconsistent process for checking PPM devices for patients attending theatre
- Lack of written record of family concerns
- Poor compliance with Trust policies for:
  - Fasting Patients
  - Policy for the Safe Use of Bedrails for Adults
  - Policy for the Reduction and Management of Patient Falls (including falls from height)
  - MEWS

The lessons learnt from harm that occurred due to the potential delay in managing respiratory symptoms are detailed below:

- Nursing documentation must be completed as soon as is practicable and explicit detail of conditional change and actions taken must be documented in the nursing record.
- Oxygen is considered a medicine and as such must be prescribed on the medicines kardex as per Trust policy for medicines management.

- Nursing staff must ensure that they are aware of the specific target oxygen saturation levels for patients with lung disease, and recognise their autonomy in correcting the rate and concentration of inspired oxygen to achieve the target state.
- Staff should be aware that the clinical decision on a ceiling of care ‘not for critical care treatment’ does not include the removal the Medical Emergency Team referral process.

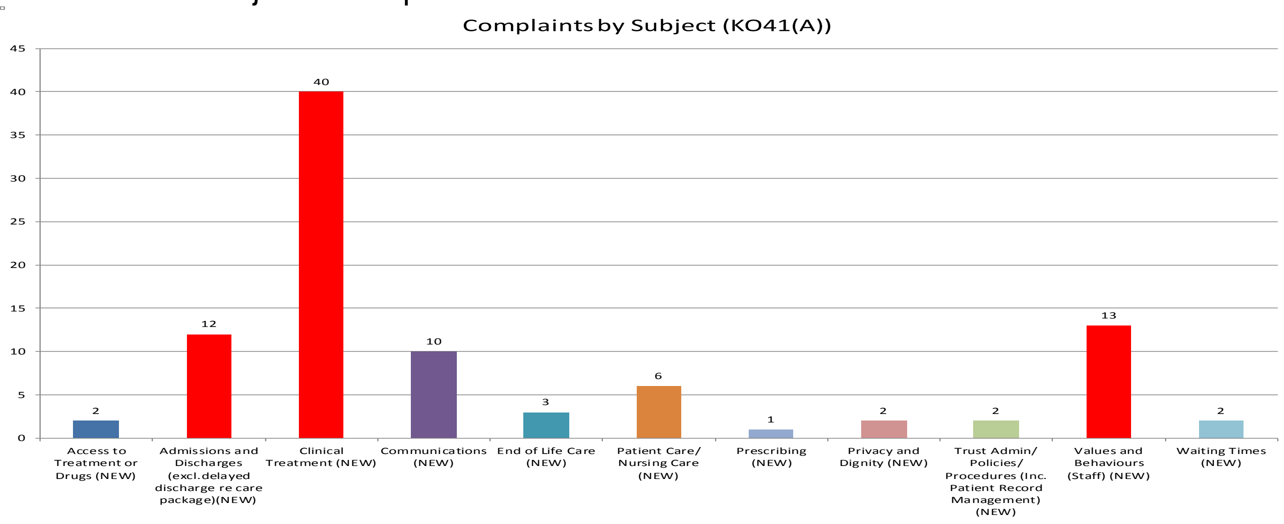
4. Complaints and PALS

The following data is based on figures that are generated via DatixWeb. The table below shows the cumulative monthly totals of **1st Stage, approved** complaints received by the Central Complaints team during Q1 2016.

	Apr 2016	May 2016	Jun 2016	Total
Medical Care Group	14	18	23	55
Surgical Care Group	9	11	10	30
Clinical Support Group/ Services	3	2	1	6
Operational	0	1	0	1
Information Governance	2	0	0	2
Total	28	32	34	94

Chart 1 below shows the main subject of complaints received during Q1. This shows the top themes were clinical treatment (40), values and behaviours (Staff) (13) and admissions and discharges (excl. delayed discharge re care package) (12) and are highlighted in red.

Chart 1: Main subject of complaints



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

There were three complaints that were escalated as SIRIs during Q1 as shown below:

Complaints escalated as serious incidents in Q1 2016-17

Received	Closed	Summary	Care Group	Subject
20/06/16		Concern relating to lack of physiotherapy input and possible missed diagnosis.	Medical Care Group	Admissions and discharges (excl. delayed discharge re care package)

16/05/16	13/06/16	Concern with all aspects of the care received by late patient as his illness was not diagnosed and felt he did not get the care needed.	Surgical Care Group	Clinical Treatment
28/04/16	12/05/16	Concerns with clinical care, including checking of drain, cause of death, lack of communication and discrepancies in health records.	Medical Care Group	Clinical Treatment

4.2. Actions/lessons learnt

There were 60 1st Stage complaints cases closed during Q1. The following table shows what actions were taken following the completion of investigation for the Medical Care Group which uses the DatixWeb module to record these.

Table 7: Complaints by action taken codes and first received (Month and year)

	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Total
Ward meetings	1	5	1	5	3	1	16
Reflective practice	0	2	1	4	4	0	11
Training related	0	1	0	0	1	0	2
Training (Undertaken)	0	1	0	0	0	0	1
Governance meetings	0	0	0	0	0	1	1
Matron meetings	0	0	0	1	0	0	1
SIRI	0	0	0	1	0	0	1
Investigation	0	0	1	0	0	0	1
Audit	1	2	0	0	0	1	4
Policy	0	0	0	0	1	0	1
Documentation	1	1	0	0	0	0	2
No action required/ proposed	0	1	0	0	0	0	1
Other	0	0	1	0	2	1	4
Total	3	13	4	11	11	4	46

The table below shows lessons learnt codes. The lessons are more than the number of complaints as each complaint has many subjects/issues.

Table 8: Complaints by lessons code and first received (Month and year)

	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Total
Discharge (unsafe)	0	0	0	1	0	0	1
Clinical Practice	1	4	2	2	2	0	11
Communication	1	4	2	7	5	0	19
Delivery of care	0	2	0	0	1	0	3
Patient / staff engagement involvement	0	1	0	0	0	0	1
Staff Education/Knowledge/Training	0	2	0	1	1	0	4
Training needs to be completed in induction	0	1	0	0	0	0	1
Attitude (staff)	1	2	1	1	1	0	6
Falls	0	1	0	0	0	0	1
Privacy and dignity	1	1	0	0	0	0	2
Breaking bad news	0	0	0	1	1	0	2

Documentation	0	3	1	2	1	1	8
Infection control	1	0	0	0	0	0	1
Equipment/Resources	0	1	0	0	0	0	1
Other	0	1	0	0	1	2	4
Total	5	23	6	15	13	3	65

5. PALS Data

There were 492 PALS contacts/enquiries during Q1, compared to 611 in Q4 2015-16, reflecting a 24% decrease, which may explain the increase in the number of complaints.

The main KO41(a) subjects that were raised within these PALS enquiries during the period are given in the table below. It can be noted that highest PALS subject area was admissions and discharges (excl. delayed discharge re care package).

Table 12: PALS by subject (KO41(A)) and first received (month and year)

	Apr 2016	May 2016	Jun 2016	Total
Access to Treatment or Drugs	14	2	8	24
Admissions and Discharges (excl. delayed discharge re care package)	32	32	27	91
Appointments	18	9	24	51
Clinical Treatment	23	22	22	67
Communications	34	11	30	75
End of Life Care	1	2	0	3
Facilities	1	0	3	4
Patient Care/ Nursing Care	22	14	9	45
Prescribing	1	0	0	1
Privacy and Dignity	3	3	1	7
Trust Admin/ Policies/ Procedures (Inc. Patient Record Management)	1	2	2	5
Values and Behaviours (Staff)	8	9	2	19
Waiting Times	2	6	2	10
Other (e.g. abuse/behaviour/Theft/Benefits)	5	3	4	12
Total	165	115	134	414

Please note that not all PALS contacts align to a subject area.

6. Legal Services Department Activity

6.1. Claims

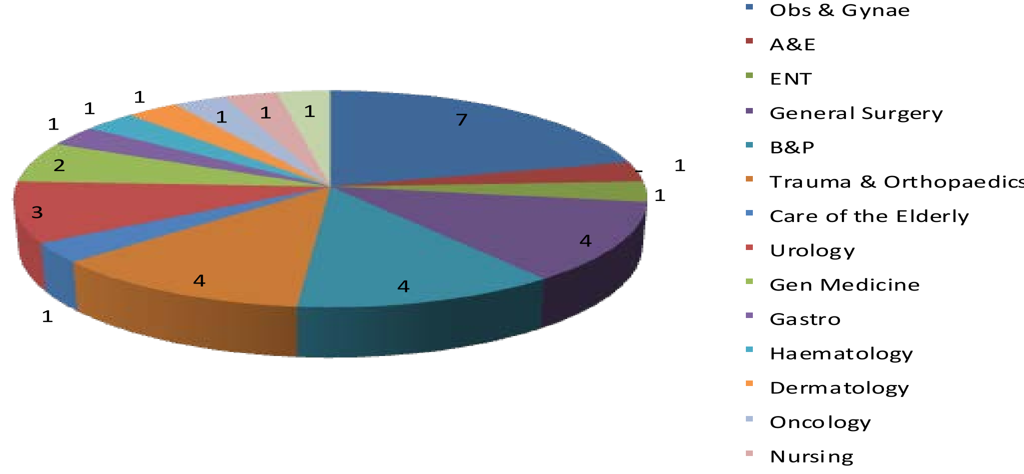
The Trust currently has 416 active clinical negligence claims on-going. This includes those in the pre-action stage through to those which are in the final stages of settlement. The Trust continues to deal with approximately 70% of claims "in house" in order to ensure continuity and cost reduction.

Activity during Q1 includes:

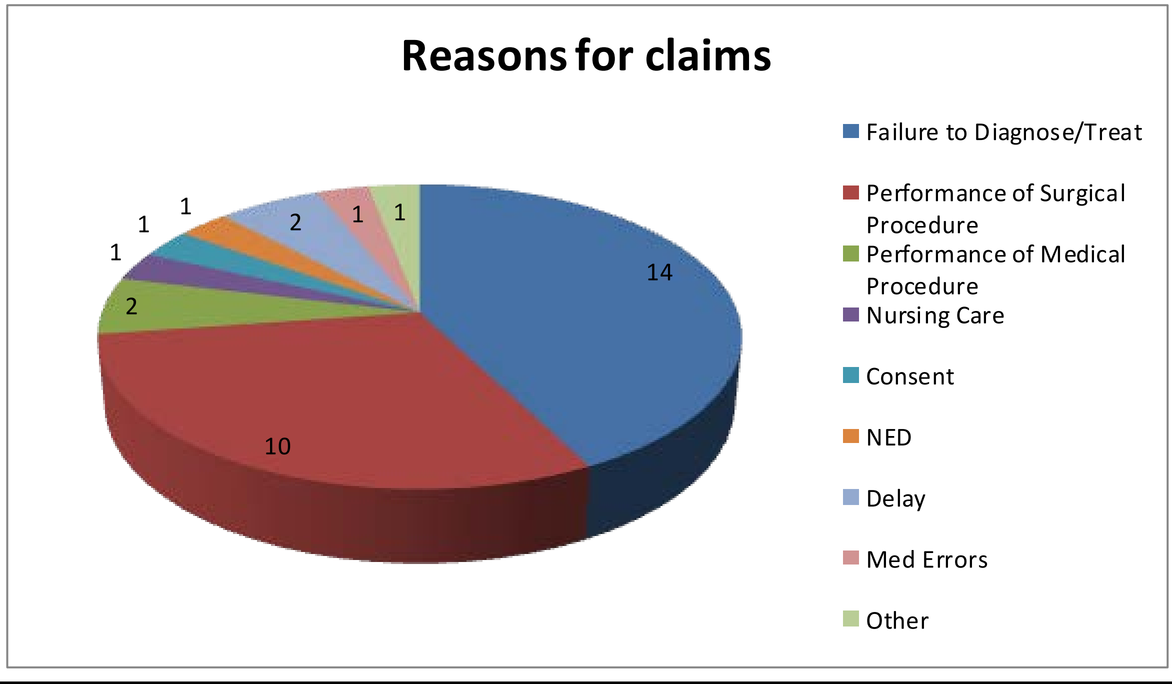
- 33 new claims (all clinical negligence claims) were received in Q1 compared to 28 received in Q4 2015-16, showing a 19% increase. 27 new claims were received in the Q1 last year, representing a 22% increase this year.
- The majority of these were for the Surgical Care Group

- Surgical Care Group – 24 compared to 19 in the last quarter, a 26% increase. This is the second quarter that Surgery have seen an increase. There is no identifiable reason for this but may be being affected by the recent Montgomery ruling.
- Medical Care Group – 8 compared to 8 in the last quarter
- Clinical Services Support Care Group - 1

The chart below shows the breakdown of the 33 new clinical negligence claims by specialty.



The chart below highlights the breakdown in the reasons for the 33 new clinical negligence claims. (Please note NED is not enough detail)



This shows that failure to diagnose/treat and performance of surgery remain high litigation areas, as in the previous quarter. However, it must be noted that these figures relate to the

time when the claim was received rather that the index event which could have been some time earlier. Consent issues, although not necessarily the lead reason for a claim are featuring more frequently in particulars of claim.

6.2. Clinical negligence claims closed in the period

A total of 23 claims were closed in Q1 2016-17.

- 6 claims were closed with payment of damages. The total amount paid in damages on behalf of the Trust was ££131,500.00. In the same period last year £56,560.00 was paid out on the Trust's behalf. This represents a 132% increase however is not indicative of performance.
- 17 claims were closed without payment of damages. These claims were either withdrawn, successfully defended or closed after file review.

6.3. Lessons learned from claims and on-going developments

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

Some directorates have requested more input in the selection of experts wherever possible due to previous problems with experts used by Hill Dickinson. This has been implemented where feasible, however requires rapid turnaround by the clinicians concerned.

Training sessions continue to be provided for clinician staff to facilitate statement writing and development of understanding of the claims process. A presentation on claims has been arranged by Hill Dickinson for the Board in October. An evening training session is to be arranged for staff on claims (why we advise settlement/what makes the difference on those that can be defended successfully) and reminders relating to record keeping and consent. Consent continues to be a developing issue and the Montgomery Judgement tested through the Courts. It is intended that further training sessions will be provided in the future according to demands and developments.

The Claims Governance Group consisting of senior managers and clinicians, review all new claims received in the preceding month and advise on claim defendability. The NHSLA attended a recent meeting to discuss risk management and claims and outlined the Trust position in this area.

6.4. Insurance claims

The Trust currently has 49 open insurance claims, compared to 42 in Q4 last year's data, with 41 employer's liability claims and 8 public liability.

6.5. Insurance claims closed in the period

0 insurance claims were closed in Q1 compared to 11 closed in the last quarter Q4. The total paid in damages in the previous quarter was £49,695.00.

6.6. Inquests

The Trust, via the Legal Department, proactively manages non-routine inquests. These inquests are where members of our staff are being called to give evidence and/or there are novel or contentious issues. In many cases there are lessons to be learned and require a corporate witness to inform the Coroner of these lessons and what action has been subsequently taken to prevent recurrence. The Press and Public Relations Office are also kept informed if there is any potential for media interest and, therefore, a risk to the organisation's reputation. Currently there are 9 open inquests that fall within the above criteria. This is an increase of 2 on the previous quarter.

6.7. Police

New requests in this period = 74 (90 Q4)
Re-opened in this period = 22 (23 Q4)
Outstanding in this period = 33 (30 Q4)
Closed in this period = 108 (106 Q4)

6.8. Access to Health Records

New requests in this period = 139 (115 Q4)
Closed out in this period = 119 (75 Q4)
Targets breached in this period = 4 (6 Q4)

Request by patients and/or carers have increased this quarter, although there has been a slight reduction in the number of breaches.

6.9. Third Party

New requests within this period = 551 (515 Q4)
Closed out in this period = 573 (560 Q4)
Targets breached in this period = 24 (34 Q4)

There has been a significant increase in this area of requests but again a decrease in targets breached, which are generally due to factors outside the control of the Trust.

ENDS

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)101
Title of paper: Executive Committee Assurance Report.
Purpose: To feedback to members key issues arising from the Executive Committee meetings.
Summary: 1. Between the 16th September and 13th October four meetings of the Executive Committee have been held. The attached paper summarises the issues discussed at the meetings. 2. Decisions taken by the Committee included measures to improve mandatory training and appraisals; and systems for improved avoidance of MRSA. 3. Assurances regarding safer staffing; management of agency usage; and stroke service developments were obtained. 4. Investment decisions included pathology equipment contracts; EPR Programme Director bridging loan; general surgical staffing; and Lilac Centre nursing. 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: 26th October 2016.

EXECUTIVE COMMITTEE REPORT (16th September to 13th October 2016)

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

22nd September 2016

1. Accommodation Review
   1.1. Nicola Bunce and Geoff Hunter provided an update on progress.
   1.2. Schemes approved in July are progressing with user groups in place and architects appointed, briefed and technical designs agreed. Contractors will be asked to work within the timescales with incentives for a timely completion and financial penalties for late completion.
   1.3. Saatchi Suite/ICU, was discussed at length and it was ultimately agreed that this scheme should be deferred in favour of proposals offering better VFM.
2. Mandatory Training and Appraisal
   2.1. Latest information on performance across the Trust was shared and Directors charged with delivering improvements.
3. E learning for Mandatory Training
   3.1. Adam Rudduck provided analysis of the different options available. The preferred option is e-learning through ESR/OLM, and a pilot scheme is scheduled to take place in December for the medical workforce.
4. Safer Staffing/Vacancy Dashboard
   4.1. The latest report was reviewed along with scrutiny of the wards falling below the 90% fill rate. The Committee once again and asked for greater emphasis on drawing conclusions from the data.
   4.2. AMS discussed the vacancy dashboard and agreed further work was required to assimilate the dashboard with safer staffing data.
5. Pathology presentation
   5.1. David Nixon (DN) and Mark Hogg (MH) presented two business cases regarding a Chemistry Analyser contract and the Histopathology contract. The proposals both related to the replacement of existing equipment and services already funded, and implementation will produce savings.
   5.2. There was in depth discussion regarding service contract proposals, activity trends, finances and benefits. In addition, the impact on the wider health economy was discussed. Following discussions the Committee approved the new contracts and concluded that Board approval was not required.
6. Resource Funding EPR programme
   6.1. CW sought approval for £39,408 to temporarily fund the role of EPR Programme Director for the period October 2016 to March 2017. As the recurrent funding for the post will be included in the EPR business case, the Committee agreed that a bridging loan arrangement will be put into place.

29th September

7. Stroke Services
   7.1. Andrew Hill and Janet Sumner provided an update on stroke services.
   7.2. Collaboration between Whiston and Warrington hospitals and the implementation of a single hyper-acute stroke pathway, based at Whiston

hospital is ongoing but constraints to progress such as capacity and financial and performance risks to the organisation were noted.

7.3. The Committee concluded that some sharing of the overall activity will be required in order for it to be safely and economically accommodated and that more definitive proposals should be brought back.

8. Flows management

8.1. Diane Stafford, Bongi Gbadebo and Natalie Gilmore presented a report showing the work undertaken to manage patient flows by bed managers, site managers and discharge coordinators, and suggested an alternative structure.

8.2. Following discussion the Committee had a number of unresolved concerns and it was agreed that further discussion was required outside of the meeting.

9. VTE update

9.1. KH provided an update on measures to improve VTE assessment performance.

10. Lilac Centre

10.1. Pat Gillis, Jeanette Ribton and Mark Hogg presented a business case which demonstrated significant growth in the service and opportunities for further development including extended weekday opening hours and weekend working.

10.2. The phased recruitment of nursing and support staff over 18 months to match the rate of growth in activity, and providing a surplus, was approved.

6th October

11. MRSA Action Plan

11.1. Karen Allen, Val Weston and Ali Kennah provided an update on the action plan from the July MRSA; the subsequent case in September was also discussed.

11.2. Both occurrences involved a number of potential contributing factors, and forensic review of every aspect of the process was undertaken and clear actions regarding training, systems and documentation agreed.

12. Agency usage

12.1. Pauline Jones provided the regular monthly report.

12.2. Positive progress regarding a shift of medical agency staff to the Trust bank; nurse and HCA recruitment; and the reduction in requests for nursing agency was noted. However, the continued use of agency HCA's requires attention and SR agreed to develop a proposal to address this.

13. Trust Board Agenda

13.1. PW outlined the draft agendas for the October board. It was noted that this is an extremely heavy agenda, and it was agreed that in future Board Development sessions should not be scheduled to immediately follow Board meetings.

13.2. A paper outlining board commitments over the next 4 months with high-level strategic planning requirements overlaid was discussed. It was concluded that the 10th November development day should proceed and an extraordinary Board pencilled in for 14th December to potentially sign-off the 2 year plan.

14. Audit actions

14.1. NK provided the regular update on outstanding actions. As the backlog has now been eradicated the proposal to report by exception in future was agreed. NK

went on to highlight two recent audit reports providing limited assurance and actions required by Directors were agreed.

15. Colorectal business case

15.1. Mike Scott, Gwen Pantak and David Miles presented the business case for increased staffing to meet the growing general surgery demand. Some of the data provided in support was not readily available and it was agreed that future business cases must be based on Trust data confirmed through the IPR.

15.2. Whilst the historical activity growth was clear, the potential impact from CCG Referral Management Schemes was discussed. The imminent retirement of staff members indicated that any risk from referral reductions was small and therefore proleptic appointments were appropriate.

16. Exec to Exec meeting with Knowsley CCG

16.1. Agenda items for the forthcoming meeting on 28th October were agreed.

17. Trust CQUIN Compliance – Antimicrobial Resistance

17.1. KH briefed members on the CQUIN designed to reduce antibiotic prescribing. KH concluded that the requirements did not provide the appropriate incentives and that he was escalating this with CCGs and through national discussions.

18. Planning Guidance

18.1. Sue Hill briefed members on the recently published planning guidance covering 2 financial years. STP funding, CQUIN and Control Total offers were discussed, along with the timescales for agreeing contracts.

18.2. It was agreed that NK and AM would meet to better understand the impact of the STP offer and the resulting CIP requirement for the Trust.

13th October

19. Maternity Birth Analysis

19.1. Sue Mundy provided information on predicted birth rates in support of the business case previously presented for additional midwives. In addition, the implications of exceeding 4,000 births p.a., was discussed as this would necessitate additional consultant obstetrician and midwifery cover, plus expansion of the delivery suite in order to meet Safer Childbirth Standards.

19.2. It was noted that the substantive Head of Midwifery interviews are imminent and some midwifery appointments have been made.

19.3. Further scrutiny of the guidance, and activity levels was requested along with measures to prevent over-resourcing the service given birth-rate fluctuations.

20. Community Tender

20.1. AR presented a progress report on drafting of the tender for St Helens community services and the potential risks. It was note that the CCG have extended the tender deadline to 21st October 2016.

20.2. Regular Clinical Advisory meetings have been taking place to develop the models of care, pathways and staffing requirements.

21. IPR

21.1. Chris Yates attended to take members through the draft IPR.

21.2. Further work was agreed to address the metrics used in Critical Care data, discharges, the falls strategy, VTE auto inclusions, Family and Friends Test processes, complaints not resolved in month and head and neck and Haematology cancer figures.

22. Corporate Risk Report and BAF

22.1. The latest reports were reviewed.

22.2. Measures to address overdue review dates, improve action plans and resolve sign-off for CIPs were discussed and agreed.

23. Opera theatre software

23.1. The launch date of the system on 17/10 was discussed.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)102
Title of paper: Review of the Board Assurance Framework (BAF) – October 2016
Purpose: For the Board to review the BAF and agree proposed changes.
Summary: The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its strategic plans and key long term objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in July 2016. The Executive Committee are asked to review the BAF in advance of its presentation to the Trust Board and confirm that the appropriate strategic risks are captured, and that the proposed actions and additional controls are sufficient to mitigate the risks being managed by the Trust, in accordance with the level of risk appetite acceptable to the Board. **Key to Changes:** ~~Score through~~ = proposed deletions Blue Text = proposed additions Red = overdue actions There are no proposed changes to the scoring of any of the risks (either to increase or to decrease the scores), since the last review.
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to ensure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSI, CQC, Commissioners.
Recommendation(s): To approve the proposed changes to the BAF
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance.
Date of meeting: 26th October 2016.

Strategic Risks - Summary Matrix

Vision: 5 Star Patient Care

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

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

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

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

Risk Scoring Matrix

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

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

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

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

Risk 3 - Sustained failure to maintain operational performance/deliver contracts	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to deliver against national performance targets (ED, RTT, Cancer etc) • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting Effects; • Reduced patient experience • Poor quality and timeliness of care leading to poorer outcomes • Failure of KPIs and self-certification returns • Increases in staff workload/stress Impact; • Potential patient harm • Loss of reputation • Loss of market share/contracts • External intervention	4 x 4 = 16	• NHS Constitutional Standards • Care group activity profiles and work plans • Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIST review of A&E performance • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • Membership of CCG System Resilience Groups • Internal Urgent Care Action Group (UCAG) • Data Quality Policy	To Board; • Finance and Performance Committee • IPR • System Resilience Plan • Annual Operational Plan • Data Quality audits Other; • Contract review meetings/CQPG • NHSI monitoring and escalation returns/sitreps • CCG CEO Meetings	4x4 = 16	Mid-Mersey SRG Emergency Access Target action plan to reduce NEL hospital admission rate Speciality level capacity and demand delivery plans for 2016/17	Long term health economy emergency access resilience and urgent care services plans	Agreement of a Whiston Hospital medium term Accommodation Development plan - September 2016 Implementation of the DTOC Rapid Improvement Event Action Plan - September 2016 Work with NHSI and ECIP for practical intensive support to achieve 4-hour trajectory – Jan 2017	4 x 3 = 12	PJW

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

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

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

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

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

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)103
Title of paper: Corporate Risk Register Report – October 2016.
Purpose: For the Trust Board to review the Trusts Risk Register to ensure it is accurate and reflective of the risks faced by the Trust.

Summary: The following report from the Risk Management Council (RMC) seeks to assure the Trust Board that risks are appropriately managed within the Trust and that all risks:

- Have been identified, reported, and scored in accordance with the grading matrix
- Rated as high or extreme have been escalated and reviewed by the appropriate Executive Director, who has approved the planned mitigations and action plan
- Are reviewed on a regular basis and the action plans are being delivered
- Have a realistic and achievable target risk score given the proposed actions.

This report is based on Datix information as at 3rd October 2016 and shows that the total number of risks on the risk register is 635.

There are 10 high risks that have been escalated to the CRR: 5 in Corporate Services, 2 in the Medical Care Group, 2 in the Surgical Care Group, and 1 in Clinical Support.

Nine risks have been downgraded from the CRR since the last meeting (see 4.1 of the report). The RMC asked all risk leads to review the reasons for these changes and ensure that there was a robust audit trail in Datix.

No new risks have been added to the CRR since the last report.

Issues requiring highlighting to the Trust Board from the RMC are:

1. The proportion of risks with an overdue review date is worsening and is now at 21% and requires prompt action.
2. Three risks on the CRR had no recorded action plan on Datix. This has now been addressed.
3. An increase with incorrect details being recorded on theatre lists was raised and it was confirmed that this has been escalated within the Surgical Care Group.
4. The compliance with the Clinical Risk Assessment process for sign-off of CIPs still requires action with almost 80% outstanding. Further details on where the bottlenecks are occurring in the process are to be shared.
5. The Council discussed Medicines Management in some detail, which is captured in the Pharmacy risk report, but reflects a Trust-wide issue. The continuing failure to resolve this issue, and the potential impact was felt by some to justify a higher score and escalation to the CRR although this view was not unanimous. It was agreed that this should be flagged up to the Trust Board.

Corporate objectives met or risks addressed: The Trust has in place effective systems and processes to identify manage and escalate risks to the delivery of high quality patient care.
Financial implications: None directly from this report.
Stakeholders: Staff, Patients, Executive Committee, Trust Board, Commissioners.
Recommendation(s): The Trust Board are asked to approve the risks that have been escalated to the CRR and the mitigating actions and target risk scores.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance
Date of meeting: 26th October 2016.

CORPORATE RISK REGISTER REPORT – OCTOBER 2016

1. Purpose

The purpose of this report is to provide an overview of the changes to the Trust's risks, and to focus on those risks which score 15 or above which are included on the Corporate Risk Register and are escalated to the Executive Committee. This report is based on DATIX data extracted on 3rd October 2016, and covers the changes to the risk register reported in September.

2. Risk Register Summary for the Reporting Period

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

RISK REGISTER	Current Reporting Period 03.10.16	Previous Reporting Period 01.09.16	Previous Reporting Period 04.08.16
Number of new risks reported	14	31	45
Number of risks closed or removed	19	8	24
Number of increased risk scores	3	4	2
Number of decreased risk scores	14	11	4
Number of risks overdue for review	131	96	120
Total Number of Datix risks	**635***	**640***	**615***

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

3. Trust Risk Profile and breakdown across care groups and Corporate Services

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
49	27	26	76	9	140	53	105	38	95	5	5	0	0
102 = 16.2%			225 = 35.8%			291 = 46.3%				10 = 1.6%			

3.1 Surgical Care Group - 226 risks reported 36.0% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
7	10	9	31	3	55	21	41	16	31	1	1	0	0
26 = 11.5%			89 = 39.4%			109 = 48.2%				2 = 0.9%			

3.2 Medical Care Group - 115 risks reported 18.3% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
8	6	1	13	2	15	11	21	16	20	2	0	0	0
15 = 13.0%			30 = 26.1%			68 = 59.1%				2 = 1.7%			

3.3 Clinical Support Care Group - 43 risks reported 6.9% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
8	1	1	6	0	7	4	8	1	6	1	0	0	0
10 = 23.3%			13 = 30.2%			19 = 44.1%				1 = 2.3%			

3.4 Corporate - 244 reported 38.9% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
26	10	15	26	4	63	17	35	5	38	1	4	0	0
51 = 20.9%			93 = 38.1%			95 = 38.9%				5 = 2.1%			

Department	Very Low	Low	Moderate	High	Total
Health Informatics/ Health Records	1	3	14	1	**19**
Facilities (Medirest/TWFM)	11	14	4	0	**29**
Nursing, Governance, Quality & Risk	4	9	24	0	**37**
Finance	21	22	6	1	**50**
Operational	12	28	17	0	**57**
Human Resource	1	16	30	3	**50**
Information Governance	1	1	0	0	**2**
Total	**51**	**93**	**95**	**5**	**244**

4. The Trusts Highest Scoring Risks

Risks of 15 or above are added to the Corporate Risk Register (CRR). New risks reported in the month are formally reviewed and consistency checked by the Risk Management Council prior to escalation to the Executive Committee (Appendix 1).

4.1 Risks of 15 or above (previous score) removed from the CRR

Datix Ref	Risk Title	Current Risk Score	Comments
1727	Reduce therapy support cost budget	3 x 4 = 12	Downgraded by David Anwyl
1647	Risk of multi resistant pseudomonas on ward 4D and ward 4E	4 x 3 = 12	Downgraded by Sue Redfern
1697	Unable to meet 10 day cancer referral target	3 x 3 = 9	Downgraded by Ann Stott
351	Service to GP referrals when GPAU is used at times of escalation	3 x 4 = 12	Downgraded by Diane Stafford
962	Risk from the physical layout on 1B not been conducive	3 x 3 = 9	Downgraded by Diane Stafford
1696	Communication failure plan gaps identified following a comms outage	4 x 3 = 12	Downgraded by Paul Craven
1621	Risk from staff shortage on Ward 3E	3 x 3 = 9	Downgraded by Debbie Stanway
1337	Risk from staff shortage on Ward 3D	3 x 3 = 9	Downgraded by Debbie Stanway
1080	Risk from staff shortage on Ward 2B / 2C	3 x 3 = 9	Downgraded by Mike Babbs

5. Points of escalation

a) There continue to be a large number of risks on the risk register that have missed their review date.

b) There are no new issues on the CRR that have implications for the BAF

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Appendix 1

Summary of current CRR

Proposed Risk Category	Datix Ref	Risk	Description	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Review dates	Target Risk Score I x L	Action plan in place with target completion date	Risk /Issue
Money	1152	Potential impact on quality of care, contract delivery and finance due to increased use of bank and agency	Reliance on bank and agency staff risks continuity of care; ability to deliver activity; breaching the agency cap; failure to meet agency spend controls	4 x 4 = 16	4 x 4 = 16	08/07/2015 - AMS	Last 21/09/2016 Next 25/11/16	4 x 2 = 8	Not recorded on Datix but escalation procedures in place	Issue
Money	1555	Failure to achieve financial plan in 2017/18 due to cost pressure from the introduction of an apprenticeship levy	From April 2017 a new apprenticeship levy is being introduced. This is likely to be a cost pressure of £1m per annum for the Trust.	3 x 5 = 15	3 x 5 = 15	01/04/2016 - AMS	Last 03/04/2016 Next 01/12/2016	3 x 4 = 12	Not recorded on DATIX. Cost pressure will form part of financial plan	Issue
Money	209	Risk of failure to deliver the annual financial plan 2016/17	If the Trust does not deliver its CIP, activity and income plans, it will fail to achieve the control total outturn agreed with NHSI.	5 x 4 = 20	4 x 4 = 16	08/07/2015 - NK	Last 30/06/2016 Next 21/10/2016	4 x 3 = 12	Action plan in place	Risk
Governance	1237	IG risk due to the use of unencrypted USB drives	If the Trust continues to allow non- informatics and unencrypted USB drives to be used on the network , there is increased risk of a data breach	4 x 3 = 12	4 x 4 = 16	15/01/2016 - CW	Last 29/09/2016 Next 01/11/16	3 x 2 = 6	Action plan in place	Risk
Patient Care	1285	Insufficient staffing levels on the frailty unit (1A) affecting patient safety and operational effectiveness	There are insufficient staff to meet the establishment staffing levels leading to an increased risk of patients not receiving the quality of care expected.	4 x 4 = 16	3 x 5 = 15	12/04/2016 - SR	Last 13/09/2016 Next 11/10/16	3 x 3 = 6	Action plan in place	Issue
Patient Care	913	Patient safety risk due to staffing levels below establishment on DMOP	There are insufficient staff leading to an increased risk of patients not receiving the quality of care expected.	3 x 5 = 15	3 x 5 = 15	12/04/2016 - SR	Last 11/07/2016 Next 13/09/2016	2 x 2 = 4	Action plan in place	Issue
Workforce	762	Potential risk of the Trust not being able to provide safe levels of staffing	Unable to recruit with the knowledge, skills and experience required	4 x 4 = 16	4 x 4 = 16	08/07/2015 - AMS	Last 26/08/2016 Next 25/11/16	4 x 2 = 8	Staffing levels monitored and reported to the QC and Board .	Risk
Patient Care	1523	Risk to patient outcomes due to the inability to consistently fill all 3 blood science rotas	Insufficient BMS staff to cover 24hr rota that may result in reduced or no service. This applies to services at Southport and Ormskirk Hospitals.	3 x 4 = 12	3 x 5 = 15	04/01/2016 - AMS	Last 31/08/2016 Next 25/10/16	3 x 3 = 9	Action plan in place	Issue
Activity	1700	CCG Referral management system and referral deferral schemes	St Helens CCG have introduced a Referral Management System in July 2016 with an expected reduction in referrals to the Trust.	3 x 4 = 12	3 x 5 = 15	05/08/2016 - RC	Last 18/08/2016 Next 01/11/16	3 x 2 = 6	None recorded in Datix	

Patient Care	1205	B & P Prosthetic service – staffing situation, service delivery pressures	Vulnerabilities to existing staff - coping with extra demands and pressures in a service that is currently understaffed.	4 x 4 = 16	4 x 4 = 16	16/08/2016 AMS	Last 01/09/2016 Next 12/10/16	4 x 2 = 8	None recorded in Datix	

*blue text denotes new risks that have been escalated this month

ENDS

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)104
Title of paper: Audit Committee Assurance Report.
Purpose: To feedback to members key issues arising from the Audit Committee.

Summary: The Audit Committee met on 11th October 2016. The following matters were discussed and reviewed:

External Audit (Grant Thornton):

- The Committee received an update on progress being made against the 2016/17 accounts plan and received assurance from Trust officers around the emerging issues and developments (referred to in the update report by Grant Thornton for the Committee's consideration).

Internal Audit (Mersey Internal Audit Agency – MIAA):

- The Committee were apprised of recent final audit reviews, with particular reference made to the limited assurance report for the recent Discharge Planning review.
- Updates were given by Trust officers with regard to action plans and progress against the recommendations made in the recent limited assurance reports for Maternity and Discharge Planning.
- MIAA provided two further reports for the Audit Committee to note:
  - Benchmarking of 2015/16 Assurance Framework Reviews across MIAA's NHS client base.
  - Notes of events and briefing notes that may be of interest to the Audit Committee.

Trust Governance and Assurance:

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

Standing Items:

- The audit log (report on current status of audit recommendations) (ADoF)
- The losses, compensation and write-offs report for the quarter ending September 2016 (ADoF).
- Aged debt analysis as at end of September 2016 (ADoF).
- Tender and quotation waivers (ADoF).
- External reviews (DoF) – The Committee was informed of a recent Breast Screening review (a service provided in partnership with Warrington Hospital FT).

Other Business:.

- Reference was made to the recent re-appointment of Grant Thornton as the Trust's external auditors for the 2017/18 to 2019/20 financial years as selected by the Trust Auditor Panel and approved by the Trust Board. (NB. There was no meeting required of the Trust's Auditor Panel this month.)

Key: DoF = Director of Finance
DoN = Director of Nursing, Midwifery & Governance or representative
DoCS = Director of Corporate Services
ADoF = Assistant Director of Finance (Financial Services)

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

Financial implications: None directly from this report

Stakeholders: The Trust, its staff and all stakeholders

Recommendation(s): None

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

Date of meeting: 26th October 2016

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)105
Title of paper: Quality Committee Assurance Report.
Purpose: The purpose of this paper is to summarise the Quality Committee meeting held on 18th October 2016 and escalate issues of concern.
Summary: Key items discussed were: 1. Complaints 2. Safer Staffing 3. IPR 4. Baroness Cumberledge report update
Corporate objectives met or risks addressed: Five star patient care and operational performance.
Financial implications: None directly from this report.
Stakeholders: Patients, the public, staff and commissioners.
Recommendation(s): It is recommended that the Board note this report.
Presenting officer: David Graham, Non-Executive Director
Date of meeting: 26th October 2016

QUALITY COMMITTEE ASSURANCE REPORT

Summary of the discussions and outcomes from the Quality Committee meeting held on 18th October 2016.

Action Log

1. All actions on the log were reviewed.

Complaints Report

2. Anne Rosbotham-Williams (ARW) summarised the report:
   - 2.1. 70 1st stage complaints were opened during Q2. This is a small decrease of 9% in comparison to last year, when there were 77.
   - 2.2. There were a further 24 opened complaints, including 13 2nd stage complaints.
   - 2.3. The Trust responded to 55% of 1st stage complaints within agreed time frames in Q2, compared to 61% in 2015-16. There were 4 overdue 1st stage complaints at the end of September 2016, with none received prior to June 2016.
   - 2.4. The top complaints themes during the period were:
     - 2.4.1. Clinical treatment.
     - 2.4.2. Communication
     - 2.4.3. Values and behaviours (staff)
   - 2.5. There were 462 PALS contacts/enquiries during Q2, compared to 492 in Q1, reflecting a 6% decrease.
   - 2.6. The latest complaints satisfaction survey results show an increase in positive comments, with 81% of respondents stating they were highly satisfied or satisfied with the way their complaint had been handled and 100% felt their complaint had been responded to within a reasonable timescale.
   - 2.7. David Graham (DG) informed the Committee that he and ARW had visited the Complaints team in the MCG earlier that morning. He felt that they are a committed team with the appropriate skills and experience, resourcing may be an ongoing issue. The 25 day timeframe was discussed and how the time is allocated:
     - 2.7.1. Complaints are collated centrally and 3 days are allocated to forward the complaint to the relevant care group.
     - 2.7.2. Complainants are contacted by telephone and complaints are sent to clinicians within 2 days.
     - 2.7.3. Clinicians have 7 working days to respond.
     - 2.7.4. 5 days to write the report.
     - 2.7.5. 5 days to quality check the report.
     - 2.7.6. 5 days in the Executive office for sign off.
   - 2.8. Following a lengthy and indepth discussion, DG said he would raise the matter with the Board next week. Discussion at the board should include:
     - 2.8.1. Increasing the timescale of responding to complaints, particularly the time given to clinicians to respond to the complaint. Timescales should be dependent on the seriousness of the complaint.

2.8.2. Additional support for clinicians to assist in responding to complaints.

Safer Staffing report

3. Sue Redfern (SR) provided an update.

 3.1. 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.

 3.2. 12 wards had fill rates below 90%; 10 wards for RNs, 1 for care staff and 1 for both.

 3.3. 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.

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

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

IPR

4. Nik Khashu (NK) summarised the report.

 4.1. There has been 1 never event during August as discussed Quality Committee last month.

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

 4.3. There were 4 CDI positive cases in September. Year to date there have been 15 positive cases. The annual tolerance for 2016-17 is 41 cases.

 4.4. There were no hospital acquired grade 3/4 pressure ulcers in September. There were 2 falls that resulted in severe harm in August.

 4.5. Performance for VTE assessment for August was 94.38%, a slight improvement on July. The 2015-16 HSMR is 99.7.

 4.6. SR was asked to provide details regarding the second case of MRSA. As with the first case, failings in patient care were identified. These included poor documentation, failure to administer suppression therapy and prescription of inappropriate antibiotics.

 4.7. There have been detailed discussions around the action plan and each individual will get a personal letter outlining failings, this approach is to be seen as a learning curve rather than the apportionment of blame.

 4.8. Further learning for all staff will include presentation at a Grand Round and a newsletter highlighting the problem.

 4.9. A&E performance was 79.7%, which is an improvement of August's performance. 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.

 4.10. Rob Cooper (RC) informed that ECIP visited A&E last week for a system wide review. Following feedback on Friday, the overall position is that there is

nothing apparent that we did not know already. Areas were highlighted that we should focus on within the next thirty days, which included AMU appointment schedule, Frailty screening tool and pathways, review of IV antibiotics and review of pathways.

4.11. Patrick Johnson, the new Turnaround Director for ED commenced in post on 13th October.

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

4.13. As at the month of September 2016, 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 additional activity. 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 in 2016/17. The Trust's forecast outturn is to achieve its Annual plan of £3.328m surplus.

4.14. To date the Trust has delivered £6.239m of CIPs, which is behind the year to date plan by 2%, a significant improvement against last month (11%). 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.

4.15. 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.

4.16. 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.

4.17. 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%.

Baroness Cumberledge report - update

5. Sue Mundy (SM) provided an update

5.1. The report provided the Committee with an update on compliance at Whiston Maternity Unit with the recommendations laid out in Baroness Cumberledge's report on Maternity Services, whilst at the same time the report also examined concerns regarding any issues encountered or expected from the most recent self assessment findings.

5.2. SM reported that underpinning each priority are a number of recommendations (28 in total) of which 16 are applicable for providers/employers. Of the 16 recommendations, the Maternity Unit has RAG rated them as follows:

5.2.1. 10 Green
5.2.2. 5 Amber
5.2.3. 1 Red

5.3. The Committee discussed various aspects of the recommendations. SM confirmed that the recommendations had been embedded in the Maternity Strategy.

5.4. SR advised that the interviews had taken place for the Head of Midwifery post and a successful appointment had been made.

5.5. SM reminded the Committee that Exercise Lemon Ribbon (baby abduction exercise) would be taking place on Thursday, 20th October.

Feedback from Patient Safety Council

6. ARW reported:

6.1. The Council requested approval from the Quality Committee that the ward dashboard safety metrics should be reviewed monthly at PSC. The PSC in turn would highlight important matters to the QC. This was approved by the Quality Committee.

Feedback from Patient Experience Council

7. ARW reported on key items discussed:

7.1. Assurances were provided via feedback from a number of areas, including Healthwatch, Friends and Family Test and 5-a-day programme, that staff attitude is generally positive.

7.2. Decisions were taken to look at initiatives to reduce noise at night, review catering options and increase attendance at the Patient Participation Group.

7.3. Surveys are being repeated for both visitors and ophthalmology patients.

Feedback from Clinical Effectiveness Council

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

8.1. Diabetes and Endocrinology: Activity has gone up in both departments in last three years. National benchmarking shows team is under resourced. As a result of this only one third of eligible patients are seen and medication errors are in the worst quartile. A business case will be presented to the Executive Team for extra nursing staff.

8.2. ICNARC data: The Clinical Director for Critical Care has been asked to commission an external review by C&M Intensive Care Network.

8.3. Mortality: Biliary Tract disease mortality is persistently high and alerting. Previous review of all cases found no specific cause for concern. A fresh review was commissioned in view of persistence of problem. It was identified

that 9 cases were not Biliary Tract, and once this was taken into account, the Trust was no longer an outlier.

8.4. Also discussed were Maternity indicators and Histopathology lab times.

Feedback from CQPG Meeting

9. RC provided an update. Key issues discussed were:

9.1. Amber Care bundle roll out.

9.2. Primary Care referrals proforma to be designed to assist GP referrals to GPAU.

9.3. Provider Quality Assurance Report

9.4. Month 4 KPIs

9.5. Safer Staffing

9.6. Smoking Cessation

9.7. Consultant to Consultant referrals

9.8. CCG provider site inspection tool. RC informed the Committee that St Helens CCG wished to carry out "CQC" style inspections four times per year, both announced and unannounced. Following discussion, DG asked RC and SR to feedback to the CQPG meeting (due to be held later this afternoon), that following our recent successful CQC inspection, it did not seem appropriate for the CCG to develop an additional, parallel quality assurance process.

Feedback from Executive Committee

10. SR reported on meetings of the Executive Committee between 9th September and 6th October.

10.1. Decisions taken by the Committee included approval of the Integrated care visioning document, measures to improve mandatory training and appraisals, and systems for improved avoidance of MRSA.

10.2. Assurances regarding safer staffing, management of agency usage, Specialist Commissioning compliance and the CQC action plan were obtained.

10.3. Investment decisions included general surgical staffing which provided a net surplus.

11. **Effectiveness of meeting**

11.1. DG felt that there had been an appropriate "change of pace" within the meeting and two indepth discussions had taken place on important matters including Complaints and MRSA. Peter Williams (PW) agreed that although the agenda appeared light this month, it gave committee members the opportunity for indepth discussion.

12. **AOB**

None noted.

13. **Date of Next Meeting**

Tuesday, 22nd November 2016.

TRUST BOARD PAPER

Paper No: NHST(16)106

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 October 2016

Summary:

Agenda Items

For Information

- Q1 SLR – generally good performance with agreed risks of winter pressures.
- A&E Update, incl. ECIP and their recent reviews
- Planning Guidance 2017/18-2018/19 presented with note of 2 years STF of £9.1m
- Update on CQUIN and Contracting with achievement of Q1 and risks for Q2 to Q4.
- Budget Setting 2017/18 was approved knowing how early it was in the year.
- Forecast outturn 2016/17 with risks and values noted, to be presented each month.

For Assurance

- Integrated Performance Report Month 6 2016/17
- Month 6 2016/17 Finance Report
- Governance Committee Briefing Papers:
  - CIP Council

Actions Agreed

- Re-engage ENT collaboration with local Trusts given SLR performance and risks.
- Review specialties which generate low contribution to support CCG.
- Recent NHSI Agency Controls to be presented to Executive Committee for final approval.
- Updated Forecast Outturn to be presented each month
- Indicative Draft Financial Plan for 2017/18 agreed based on underlying assumptions
- 4 year C:Diff performance to be presented next month
- CIP performance to be an agenda item next month

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: 26th October 2016

TRUST BOARD PAPER

Paper No: NHST(16)107
Title of paper: Committee Report – Charitable Funds Committee
Purpose: To brief the Board on the main issues discussed and decisions made at the Committee meeting on 20th October 2016.
Summary: 1. Mrs D Pye, Financial Accountant, presented a list of dormant funds. The committee decided to write out to the trustees of the funds and ask for their intentions for the funds with a view to moving them to unrestricted funds if there is no definitive use identified. 2. Mrs D Pye, presented the latest positions on the following items: • Investment portfolio – The charitable fund shares are invested in 'Common Investment Funds' (COIFS) and managed on the Trust's behalf by Blackrock Investments who are expert fund managers. (COIFS are very common in the NHS.) Such investments will fluctuate up and down in value over time but hopefully there will be an overall upward gain. o At 31st March 2016, the shares were valued at £552.5k, showing an unrealised gain of £89.5k, since the acquisition of the shares in 1998. (In other words, the value has shown an increase since they were purchased originally.) o In the months since year-end to the valuation, as at 14th October 2016, presented at the October Charitable Funds Sub-Committee, the share value has increased by £61.1k, and overall the unrealised gain (ie. increase in value since purchase) is £150.6k. • Mr N Khashu, Director of Finance, asked that our current fund managers, Blackrock, are asked to attend a future Charitable Funds meeting to present details of the service they provide to us. 3. Financial position - The Committee reviewed Income and Expenditure since the previous meeting. Mr D Mahony raised concerns that not enough is being spent. Ms K Hughes, Head of Media, PR and Communications is to prepare a plan on how spend is going to be encouraged in the future as a result of the relaunching of the charity. She also informed the committee that interviews are being held for a Fundraiser.

4. The Annual Accounts and Report 2015-16 were approved by the Committee on behalf of the Trustee (ie the Trust Board) after the independent examiner's report done by Grant Thornton, external auditors.

5. Approval of Expenditure:
   - Ms L Ditchfield, Ward Sister, Lilac Centre, presented a funding request for 2 cooling systems to reduce hair loss for patients having chemotherapy treatment. The Committee agreed to fund the cost of £15,435.00 (exc. vat).
   - Mr S Grady, Trust Hairdresser, presented a funding request for refurbishment of a storeroom to create a hairdressing room in the Lilac Centre, for the privacy of patients requiring wig fittings etc. The Committee agreed to fund the cost of £5,600.00 (exc vat)

6. Any other business:
   - Mr N Khashu explained that 3 local pubs are being sent letters to request that they remove stickers on clothing collection bins on their property, that refer to the Lilac Centre, as the Trust has no involvement with this activity. Our local fraud officer and trading standards have been involved in the investigation and the Trust has publicised its non-involvement.
   - Christmas monies – the Committee agreed £5.00 per patient to be spent on Christmas gifts, plus biscuits/sweets for visitors. It also agreed that this could be increased to £10.00 (circa £450.00) for the children in paediatrics as requested by Ms S Duce, Interim Deputy Director of Nursing and Quality.

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

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff and all stakeholders.

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

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

Date of meeting: 26th October 2016

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)108
Title of paper: Foundation Trust Application Programme – Update Report
Purpose: To provide the Board with a progress report on the Foundation Trust (FT) application programme, the development of the Sustainability and Transformation Plan (STP) for Cheshire and Merseyside, and the continued development of the organisations governance and leadership capability for the future.
Summary: This paper reports on the progress in responding to the national planning guidance, the requirement to develop place based 5 year sustainability and transformation plans and the on-going elements of the FT development programme. Policy guidance on the future of the FT development pipeline has not yet been published. This report provides an update on; 1. Operational Planning 2. Sustainability and Transformation Plan (STP) Development 3. Well Led Framework Action Plan
Corporate objectives met or risks addressed: Provide high quality sustainable services
Financial implications: This paper does not include a request for additional funding
Stakeholders: Patients, Staff, Alliance LDS Partners, Commissioners, NHSI
Recommendation(s): Members are asked to note the report
Presenting officer: Nik Khashu, Director of Finance and Information
Date of meeting: 26th October 2016

Foundation Trust Application Programme – Update September 2016

1. Operational Plans and Contract Agreement 2017/8 & 2018/19

1.1 The planning guidance was published in September setting out the requirement to agree two year contracts and operational plans for 2017/8 and 2018/19 by 23rd December.

1.2 There are 9 "must do" planning priorities for 2017/8 and 2018/19 which are the same as for 2016/17, and must be delivered within the financial resources available;

1) Implement the STP milestones
2) Finance – achieve system financial control totals
3) Primary care
4) Urgent and emergency Care
5) Referral to treatment times and elective care (including the maternity services review)
6) Cancer
7) Mental health
8) People with learning disabilities
9) Improving quality in organisations

1.3 A draft operational plan for activity, performance, quality, workforce and finance is to be submitted by 24th November, with the final Board approved plan reflecting agreed contracts to be submitted on 23rd December (The detailed timetable is attached – appendix 1)

1.4 The two year operational plans should be consistent with the first two years of the Sustainability and Transformation Plans (STP), and each STP footprint will have an overall financial control total against which it will be performance managed as a health system.

1.5 The STP control total will be the sum of the control totals and sustainability and transformation fund (STF) offers made to NHS Providers by NHS Improvement and the control totals issued to CCGs by NHS England.

1.6 STF offers need to be formally accepted by 24th November.

1.7 Other key performance indicators are to be monitored and performance managed at an STP level;

- Finance
  - Performance against control total
- Quality
  - Operational Performance
  - A&E Performance
  - RTT Performance
- Health outcomes and care design
  - Progress in delivering the cancer taskforce plan
  - Progress in delivering the Mental Health Five Year Forward View (FYFV)
  - Progress in delivering the General Practice (FYFV)

- Hospital bed days per 1,000 population
- Emergency hospital admissions per 1,000 population

1.8 This is a very challenging timescale compared to previous years and also a very complex process to ensure the operational plans and STPs are consistent across the whole system.

1.9 An extra Trust Board meeting has been scheduled for week commencing 12th December to ensure that the full Board has the opportunity to review and approve the final operational plan prior to the submission deadline.

2. Sustainability and Transformation Plan – Delivering the NHS Five Year Forward View

2.1. The Cheshire and Merseyside STP updated sustainability and transformation proposals were submitted to NHSE on 21st October, as the next iteration of the STP responding to the feedback on the June submission.

2.2. The plan includes STP wide proposals and identifies opportunities for service change and development at the Local Delivery System (LDS) level to realise the NHS Five Year Forward View.

2.3. The plan has 4 main stands;

- Out of hospital services
- Acute care
- Support services
- How the system works together differently to achieve the changes

2.4. A comprehensive communications and engagement plan, including plans for formal public consultation processes, where necessary, is being developed to support the STP in the next phase of development.

2.5. Feedback on this iteration of the plans is expected during November.

3. Well Led Framework

The Well Led Framework Action Plan that the Trust developed in response to its self-assessment against the criteria is now completed.

A further self-assessment was planned but NHSI have recently indicated that they are reviewing the Well Led Framework in light of the recently published Single Oversight Framework and the changing requirements for leadership and governance across the NHS to deliver the FYFV. NHSI have also worked with a number of Trusts to develop a new tool "Supporting Culture Change in the NHS".

NHSI plan to consult on their proposals for the new Well Led Framework in December. As a result of this it has been decided to defer the internal self-assessment until the new framework has been launched in the New Year.

ENDS

Appendix 1

Key deadlines for planning and contracting processes and information publication dates	Date
Planning Guidance published + Technical Guidance issued	**22 September**
Draft NHS Standard Contract, national CQUIN scheme guidance and National Tariff draft prices issued	22 September
Initial STF 2017/2018 guidance issued to providers	30 September
Commissioner allocations, provider control totals and STF allocations published	21 October
NHS Standard Contract consultation closes	21 October
Submission of STPs	**21 October**
National Tariff section 118 consultation issued	31 October
Final CCG and specialised services CQUIN scheme guidance issued	31 October
Commissioners (CCGs and direct commissioners) to issue initial contract offers that form a reasonable basis for negotiations to providers	4 November
Final NHS Standard Contract published	**4 November**
Providers to respond to initial offers from commissioners (CCGs and direct commissioners)	11 November
Submission of full draft 2017/18 to 2018/19 operational plans	**24 November**
National Tariff section 118 consultation closes	28 November
Where contract signature deadline of 23 December at risk local decisions to enter mediation	5 December
Contract mediation	5 – 23 December
National Tariff section 118 consultation results announced	w/c 12 December
Final National Tariff published	**20 December**
National deadline for signing of contracts, submission of final approved 2017/18 to 2018/19 operational plans, aligned with contracts (Final contract signature date for avoiding arbitration)	**23 December**
Submission of joint arbitration paperwork by CCGs, direct commissioners and providers where contracts not signed	By 9 January
Arbitration outcomes notified to CCGs, direct commissioners and providers	Within 2 working days after panel
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 31 January