St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 28TH SEPTEMBER 2016
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

A G E N D A				Paper	Presenter
09:30	1.	Employee of the Month			Richard Fraser
		1.1	August		
		1.2	September		
09:40	2.	Patient Story			Sue Redfern
10:05	3.	Apologies for Absence			Richard Fraser
	4.	Declaration of Interests			
	5.	Minutes of the previous Meeting held on 27th July 2016		Attached	
		5.1	Correct record & Matters Arising		
		5.2	Action list	Attached	
Performance Reports					
10:15	6.	Integrated Performance Report		NHST(16) 087	Nik Khashu
		6.1	Quality Indicators		Sue Redfern/Kevin Hardy
		6.2	Operational indicators		Rob Cooper
		6.3	Financial indicators		Nik Khashu

		6.4	Workforce indicators		Anne-Marie Stretch
10:30	7.	Safer Staffing report		NHST(16) 088	Sue Redfern
10:40	8.	Infection Control Report		NHST(16) 089	Sue Redfern
BREAK					
Committee Assurance Reports					
11:00	9.	Committee report - Executive		NHST(16) 090	Ann Marr
11:05	10.	Committee Report – Quality		NHST(16) 091	David Graham
11:10	11.	Committee Report – Finance & Performance		NHST(16) 092	Su Rai
11.15	12.	Committee Report – Audit		NHST(16) 093	
		12.1	Auditor panel report	NHST(16) 093a	
		12.2	Audit Letter sign off	NHST(16) 094	Nik Khashu
Other Board Reports					
11:25	13.	FT programme update report		NHST(16) 095	Nik Khashu
11:35	14.	E-Rostering report		NHST(16) 096	Anne-Marie Stretch
11:45	15.	STHK Vision for Integrated Care		NHST(16) 097	Amanda Risino
Closing Business					
11:55	16.	Effectiveness of meeting			Richard Fraser
	17.	Any other business			
	18.	Date of next Public Board meeting – Wednesday 26th October 2016			
LUNCH					

TRUST PUBLIC BOARD ACTION LOG – 28th SEPTEMBER 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	28 Sep 16
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	28 Sep 16
4.	27.07.16 (11.2.5)	End of Life Care: Richard Fraser will ask for expressions of interest from the NEDS.	RF	28 Sep 16
5.				
6.				
7.				
8.				
9,				

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(16)087
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

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

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

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

Patient Safety, Patient Experience and Clinical Effectiveness

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

There has been 1 never event during August.

YTD there has been one case of MRSA bacteraemia.

There were 4 C.Difficile (CDI) positive cases in August. Year to date there have been 11 positive cases.
The annual tolerance for 2016-17 is 41 cases.

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

There were 5 falls that resulted in severe harm during July.

Performance for VTE assessment for July was 94.27%

The provisional 2015-16 HSMR is 99.5. It should be noted that the HSMR is only rebased up to Feb-16.

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

Operational Performance

A&E performance was 75.9% (type 1) and 85.4% (type 1 & 3) in month. A Trust wide performance recovery plan is in place 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.
This sustained improvement will also be supported by the strategic accommodation review to identify additional bed capacity and continued close working with system partners to achieve and maintain the reduction in the number of medically optimised patients who require transfer to more appropriate care settings for their needs .
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 August 2016 (Month 5) the Trust is reporting an overall Income & Expenditure surplus of £0.723m after technical adjustments which is slightly above the agreed plan. Trust income is ahead of plan by £2.514m, which is matched to the cost of delivering this additional activity. Expenditure on Agency stands at £5.1m 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 £4.585m of CIPs which is behind the year to date plan by 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 £0.760m out of a revised year forecast total of £4.985m.

Cash
Cash balance at the end of August 2016 is £10.676m which equates to 12 operating days.

Human Resources

Mandatory training compliance is 91.2%.

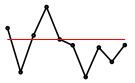
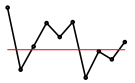
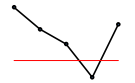
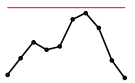
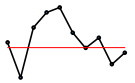
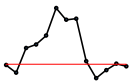
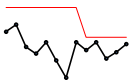
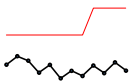
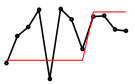
Appraisal compliance requires improvement as performance is 72.1%. Recovery plans are in place. Appraisals is a monthly standing item on the Executive Committee agenda. Compliance continues to be impacted by operational pressures and the recent summer holiday period.

Sickness absence for July was 4.9% compared to the Quarter 2 target of 4.35%. Year to date sickness is 4.6%.

The following key applies to the Integrated Performance Report:

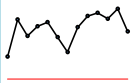
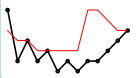
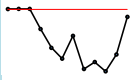
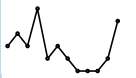
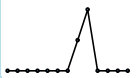
▲ = 2016-17 Contract Indicator
▲ £ = 2016-17 Contract Indicator with financial penalty
● = 2016-17 CQUIN indicator
T = Trust internal target

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	Aug-16	2.5%	2.3%	No Target	2.5%		Overall SHMI and HSMR within control limits. Co-morbidity coding better, but not best in class. Palliative care coding suboptimal but being addressed by new consultant & his team & coding. Weekend admission mortality (Saturday admissions) is much improved.	Patient Safety and Clinical Effectiveness	The Trust is exploring an electronic solution to improve capture of comorbidities and their coding. Focus on missing notes (which is improving) as this impacts on R codes (and HSMR). A drive in ED and MAU to reduce excessive use of symptom-diagnoses, as this impacts on HSMR. Palliative care consultant now in post. Work to improve management of AKI and Sepsis is demonstrating early success and will reduce 'observed' mortality.	KH
Mortality: SHMI (Information Centre)	Q	▲	Dec-15	1.03		1.00						
Mortality: HSMR (Dr Foster)	Q	▲	May-16	97.2	92.9	100.0	99.5					
Mortality: HSMR Weekend Admissions (emergency) (Dr Foster)	Q	T	May-16	106.5	99.0	100.0	112.1					
Readmissions: 28 day Relative Risk Score (Dr Foster)	Q	T	Dec-15	102.7		100.0	101.0		Much improved over last 12 months.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	Work to improve listing of babies returning electively but documented as emergency admissions is underway.	KH
Length of stay: Non Elective - Relative Risk Score (Dr Foster)	F&P	T	May-16	84.5	86.4	100.0	91.0		Sustained reductions in NEL LOS are assurance that medical redesign practices continue to successfully embed. The elective performance is a result of the shifting casemix to daycase, leaving an increasing volume of the more complex patients as inpatients.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties	RC
Length of stay: Elective - Relative Risk Score (Dr Foster)	F&P	T	May-16	96.2	91.8	100.0	105.7					
% Medical Outliers	F&P	T	Aug-16	0.9%	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	Aug-16	49.1%	46.2%	52.5%	50.9%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	The operational turnaround will continue to assist in improving this metric as it is a function of the NEL demand and subsequent impact on patient flow. Critical care step down patients discussed at all Emergency Access Meetings to evaluate whole system pressures prior to allocation.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients)	Q	▲	Jul-16	78.4%	78.9%	90.0%	79.9%		eDischarge performance below target, albeit compares favourably with neighbours. The bigger problem is a rising backlog of eDischarges that were never sent.		Drive to ensure realtime completion on ward rounds to improve compliance. New report should tell wards virtually realtime who needs a summary. 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	▲	Jul-16	91.1%	92.7%	95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E)	Q	▲	Jul-16	98.7%	98.8%	95.0%	98.5%					

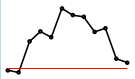
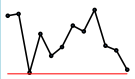
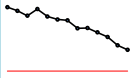
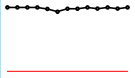
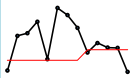
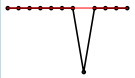
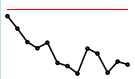
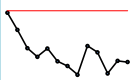
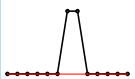
St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

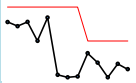
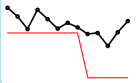
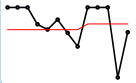
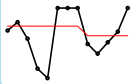
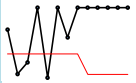
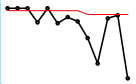
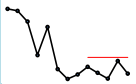
	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Aug-16	93.0%	96.1%	83.0%	92.0%		Target is being achieved	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	This KPI is at risk from significant non-elective demand so the issue is reviewed at every Bed Meeting.	RC
PATIENT SAFETY												
Number of never events	Q	▲ £	Aug-16	1	1	0	0		The 1st never event since May 22nd 2013 took place in August 2016. Zero patient harm occurred as a result of this never event	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	Aug-16	98.1%	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	Aug-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	▲ £	Aug-16	0	1	0	0		There were no cases of MRSA bacteraemia and 4 C.Difficile (CDI) case in August. The annual tolerance for 2016-17 MRSA cases is 0 and for CDI is 41 cases.	Quality and patient safety	The Infection Control Team continue to support staff to maintain high standards and practices. Monitor and undertake RCA for any hospital acquired BSI and CDI. CDI and Antibiotic wards rounds continue to be undertaken on appropriate wards.	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲ £	Aug-16	4	11	41	26					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Aug-16	2	8	No Target	28					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Aug-16	0	0	No Contract target	1		Pressure ulcer performance continues to improve. There were no grade 3 or 4 ulcers reported in August.	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	▲	Jul-16	5	6	No Contract target	21		STHK harm from falls YTD is 0.124 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	▲ £	Jul-16	94.27%	91.03%	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 to make decision about whether to reprint drug kardices with VTE assessment on them pending ePrescribing solution, if performance doesn't improve Aug/Sept.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Jul-16	5	9		38					
To achieve and maintain CQC registration	Q		Aug-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 was undertaken in May 2016. Report taken to Board and CQPG in July and August.	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					

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

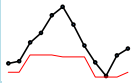
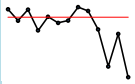
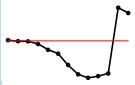
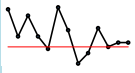
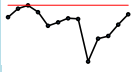
	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Jul-16	93.5%	94.9%	93.0%	95.1%		Key access targets achieved	Quality and patient experience	A Programme approach is being utilised to monitor and improve the timeliness of the patients journey along the Cancer pathways.	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Jul-16	100.0%	98.3%	96.0%	97.8%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Jul-16	85.4%	88.0%	85.0%	88.6%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Aug-16	93.8%	93.8%	92.0%	95.5%		At specialty level Trauma & Orthopaedics and Plastic Surgery continue to fail 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. 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	▲	Aug-16	100.0%	99.99%	99.0%	99.99%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Aug-16	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Aug-16	0.4%	0.7%	0.8%	0.9%		Target achieved in August 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	▲ £	Jul-16	100.0%	100.0%	100.0%	99.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Aug-16	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Aug-16	75.9%	77.4%	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. Identify additional bed capacity through completion of the strategic accommodation review. 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	▲	Aug-16	85.4%	86.0%	95.0%	89.4%					
A&E: 12 hour trolley waits	F&P	▲	Aug-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	▲ £	Aug-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	Aug-16	28	141		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	Aug-16	31	133		372					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Aug-16	64.5%	62.4%		42.7%					
Friends and Family Test: % recommended - A&E	Q	▲	Aug-16	85.8%	86.5%	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	▲	Aug-16	96.3%	94.9%	90.0%	96.4%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Aug-16	97.1%	98.0%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Aug-16	100.0%	98.1%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Aug-16	100.0%	100.0%	95.1%	95.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Aug-16	83.6%	91.4%	98.6%	98.6%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Aug-16	94.1%	94.3%	95.0%	94.7%					

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE												
Sickness: All Staff Sickness Rate	Q F&P	▲	Jul-16	4.9%	4.6%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.9%		Absence has increased in July to 4.9% which is 0.55% above the Q2 target of 4.35%. Absence due to injury/fractures is the third highest reason for absence after stress and muscoskeletal problems in month. Injury/fractures are by their very nature likely to have been fairly long absences, impacting on the overall absence figure.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	Diagnostics have been carried out into each ward/dept's sickness levels with actions agreed to address specific issues. Further listening events with HCAs are in progress and other targeted areas of high sickness have had HR deep dive investigations into team culture with pulse surveys are an ongoing as part of OD action planning. Line managers not demonstrating they are effectively managing sickness absence have also been targeted. It has been identified that there is currently an increase in long term absence in specialist staff groups where absence would normally be low due to very unfortunate personal circumstances in a number of cases.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P	T	Jul-16	5.7%	5.5%	5.3%	6.0%					
Staffing: % Staff received appraisals	Q F&P	T	Aug-16	72.1%	72.1%	85.0%	87.2%		Mandatory Training compliance has increased following a review of the retraining period for clinical staff groups and now exceeds the target by 6.2%. Appraisal compliance has declined in month and is now 12.9% behind target.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The L&OD team are ensuring that all staff who require mandatory training are booked onto courses as far into next year as possible to ensure continued compliance. Appraisal data down to department level was reviewed at the Executive Committee during August 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	Aug-16	91.2%	91.2%	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 preparing to undertake 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	Jul-16	0.8%			8.9%		Staff turnover remains stable and well below the national average of 14%.	Quality and patient experience, staff morale	Turnover is monitored across all departments as part of the Trusts Recruitment & Retention Strategy with action plans to address areas where turnover is higher than the trust average. Further action is required by Ward Managers to provide more support to newly qualified nurses.	AMS
FINANCE & EFFICIENCY												
FSRR - Overall Rating	F&P	T	Aug-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	Aug-16	4,585	4,585	15,248	13,043					
Reported surplus/(deficit) to plan (000's)	F&P	T	Aug-16	723	723	3,328	(9,551)					
Cash balances - Number of days to cover operating expenses	F&P	T	Aug-16	12	12	2	2					
Capital spend £ YTD (000's)	F&P	T	Aug-16	760	760	4,985	4,169					
Financial forecast outturn & performance against plan	F&P	T	Aug-16	3,328	3,328	3,328	(9,551)					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Aug-16	94.5%	94.5%	95.0%	94.2%					

APPENDIX A

			Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	2016-17 YTD	2016-17 Target	FOT	2015-16	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%	95.8%	100.0%	100.0%	100.0%	87.5%	93.1%	89.3%	91.6%	85.0%		99.2%		
	Total > 62 days		0.0	0.0	0.0	0.0	0.0	0.5	0.5	0.0	0.0	0.0	1.5	1.0	1.5	4.0			1.0		
Lower GI	% Within 62 days	▲ £	100.0%	77.8%	100.0%	84.6%	100.0%	100.0%	89.5%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	93.4%	85.0%		94.5%		
	Total > 62 days		0.0	1.0	0.0	1.0	0.0	0.0	1.0	0.0	0.0	0.0	2.0	0.0	0.0	2.0			3.0		
Upper GI	% Within 62 days	▲ £	100.0%	100.0%	85.7%	71.4%	83.3%	100.0%	100.0%	100.0%	81.8%	75.0%	90.9%	0.0%	100.0%	88.0%	85.0%		88.9%		
	Total > 62 days		0.0	0.0	0.5	2.0	0.5	0.0	0.0	0.0	1.0	0.5	0.5	0.5	0.0	1.5			5.0		
Urological	% Within 62 days	▲ £	62.5%	100.0%	83.3%	76.7%	84.0%	79.2%	83.3%	83.3%	84.0%	85.7%	84.6%	81.3%	75.0%	81.7%	85.0%		80.8%		
	Total > 62 days		4.5	0.0	2.0	3.5	2.0	2.5	2.0	2.0	2.0	2.0	3.0	3.0	4.0	12.0			28.0		
Head & Neck	% Within 62 days	▲ £	50.0%	100.0%		83.3%	100.0%	50.0%	57.1%	60.0%	50.0%	50.0%	100.0%	37.5%	62.5%	55.0%	85.0%		71.1%		
	Total > 62 days		0.0	0.0		0.0	0.0	1.0	1.5	1.0	0.5	0.5	0.0	2.5	1.5	4.5			6.5		
Sarcoma	% Within 62 days	▲ £	100.0%			100.0%			100.0%		100.0%		85.7%			85.7%	85.0%		87.5%		
	Total > 62 days		0.0			0.0			0.0		0.0		0.5			0.5			0.5		
Gynaecological	% Within 62 days	▲ £	100.0%	100.0%	40.0%	100.0%	54.5%	50.0%	60.0%	66.7%	71.4%	66.7%	81.8%	100.0%	85.7%	87.5%	85.0%		76.4%		
	Total > 62 days		0.0	0.0	1.5	0.0	2.5	1.5	1.0	0.5	1.0	0.5	1.0	0.0	0.5	2.0			8.5		
Lung	% Within 62 days	▲ £	90.5%	75.0%	100.0%	71.4%	80.0%	100.0%	90.5%	100.0%	88.2%	66.7%	81.5%	90.0%	91.7%	83.6%	85.0%		86.5%		
	Total > 62 days		1.0	1.0	0.0	1.0	1.0	0.0	1.0	0.0	1.0	1.0	2.5	0.5	0.5	4.5			10.5		RC
Haematological	% Within 62 days	▲ £	50.0%	66.7%		60.0%	80.0%	66.7%	83.3%	50.0%	86.7%	100.0%	100.0%	0.0%	50.0%	66.7%	85.0%		70.5%		
	Total > 62 days		1.0	0.5		1.0	1.0	1.0	1.0	2.0	1.0	0.0	0.0	2.5	3.0	5.5			13.0		
Skin	% Within 62 days	▲ £	100.0%	90.0%	94.7%	88.5%	95.9%	95.3%	94.4%	92.5%	96.7%	97.5%	96.0%	100.0%	97.3%	97.7%	85.0%		94.5%		
	Total > 62 days		0.0	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			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%	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			1.5		
All Tumour Sites	% Within 62 days	▲ £	91.0%	91.2%	91.4%	85.1%	89.3%	86.9%	87.9%	90.1%	89.5%	91.8%	88.0%	87.5%	85.4%	88.0%	85.0%		88.6%		
	Total > 62 days		7.0	4.5	5.0	12.5	8.0	8.5	8.5	7.0	7.5	5.0	12.0	10.0	11.5	38.5			90.5		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £		100.0%	100.0%					100.0%	100.0%						85.0%		100.0%		
	Total > 31 days			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)088
Title of paper: Safer Staffing Report for July and August 2016
Purpose: To provide an overview of nursing and midwifery staffing levels in inpatient areas during July and August 2016 and the Trust's ability to provide safe, effective patient care.
Summary: • The Trust's mandated monthly submission of staffing levels to UNIFY for July 2016 indicates an overall fill rate of 102.1%. (RN days 96.38%, nights 96.77%; HCAs days 109.11%, nights 115.83%); for August an overall fill rate of 102.7%. (RN days 97.49%, nights 96.12%; HCAs days 109.31%, nights 117.61%) • In July 9 wards had fill rates below 90%; 6 for RNs, 2 for care staff and 1 for both. In August 12 wards had fill rates below 90%; 10 for RNs, 1 for care staff and 1 for both. • The overall fill rates for care staff are very high because they are over-inflated by the high numbers of 'specials' (i.e. 1 patient to 1 staff member) employed to protect vulnerable patients and a particularly challenging patient on ward 2D. • Workforce data shows 48.68wte RN and 6.77wte HCA vacancies as of July 2016. 58.2wte RN and 103.5wte HCA bank, agency, additional time and overtime was employed during July 2016 to address shortfalls and requests for specials • In July, there were 5 incidents of moderate harm, in August, there were 2, all 7 resulting from falls. • A Recruitment day was held on September 3rd 2016, 17 offers of jobs made to RNs.
Corporate objectives met or risks addressed: Care, Safety
Financial implications: None directly from report, indirectly the use of specials to provide one to one care is a cost pressure on current ward establishments
Stakeholders: Patients, public, staff, commissioners, Trust Board
Recommendation(s): Members are asked to approve the report
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 28th September 2016

Trust Safer Staffing Report July and August 2016

The purpose of this paper is to set out the nursing and midwifery ward staffing levels across the Trust during July and August and to provide assurance that shortages were addressed as far as possible. Staffing levels fill rates are an indication of the Trust's capacity to provide safe, high quality care across all wards at St Helens and Knowsley Teaching Hospitals NHS Trust on a shift basis on every ward.

1. **The Trust's mandated monthly submission of staffing levels to UNIFY** for July 2016 indicated an overall fill rate of 102.1% (RN days 96.38%, nights 96.77%; HCAs days 109.11%, nights 115.83%) and for August an overall fill rate of 102.7% (RN days 97.49%, nights 96.12%; HCAs days 109.31%, nights 117.61%). This is an indication that every effort was made to address staffing shortages on a shift by shift basis. The HCA fill rates are over-inflated by the number of 'specials' (1 to 1 care) employed over daily staffing levels to safeguard vulnerable patients in a further attempt to minimise risk to these patients.

2. **The recruitment and retention** of nursing and midwifery staff remains a priority for the Trust and remains an on-going challenge nationally. Workforce data shows 48.68wte RN and 6.77wte HCA vacancies in July. Staffing remains on the Corporate Risk Register which is reviewed monthly. Stabilising and retaining the nursing and midwifery workforce in clinical areas continues to be an area of increased focus throughout 2016/17.
   2.1. A recruitment event was held on Saturday 3rd September 2016 targeting Trauma and Orthopaedics, Care of the Elderly and General Surgery, where 17 job offers were made on the day and more could follow at subsequent interviews. Recruitment is on-going at all times and as of July, 64.4wte RN job offers and 10.2wte HCA job offers had been made. There were 8.1wte RN and 6.4wte HCA new starters offset by 10.2wte RN and 5.2wte HCA leavers.

   2.2. Progress is being made with the recent nurse recruits from India; two nurses have received the NMC decision letter and are now ready to enter the UK to commence the OSCE training; eight nurses are in the process of submitting their information to the NMC; three have passed the English International Language Test (EILT) and have commenced the Computer Based Training; the other 97 are still at the stage of trying to pass the EILT.

3. **Care Hours Per Patient Per Day** (CHPPD) in month averaged 10.3 hours, median 7.1 hours, lowest was 4.4 hours on ward 5C and 30 hours on ward 4E (Intensive care) was the highest. 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. Carter's pilot sites for the 'model hospitals' CHPPD results are being monitored closely and more advice is to be circulated in November / December 2016.

4. **Fill rates below 90%** occurred on 9 wards in July; 6 for RNs, 2 for care staff and 1 for both and in August on12 wards; 10 for RNs, 1 for care staff and 1 for both .Five wards have had fill rates of less than 90% consistently for the last 5 months (Appendix 1)

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

In July, 2 of the 5 patients experiencing severe harm were on wards with a fill rate of RNs less than 90%, wards 1A and 2B. In August 1 of these wards (2B) with a fill rate of less than 90% for RNs had 2 episodes of patients experiencing severe harm.

In an attempt to mitigate the risk of a less than 90% RN fill rate on these wards:

- In July, ward 1A had an HCA fill rate of 101.17% days and 106.42% for nights and ward 2B had an HCA fill rate of 122.14% days and 165.93% for.
- In August, ward 2Bhad an HCA fill rate of 106.96% days and 130.54% for nights.

Level 2 serious incident review investigations are on-going into all episodes of severe harm and a review of staffing levels on the shift when the harm occurred will be undertaken as part of the investigation.

6. **Staffing Related Reported Incidents**
   A total of 22 incidents were reported in July and 33 in August directly relating to staffing of which none resulted in patient harm.

7. **Future Developments.**
   A meeting to establish if the Allocate E-Roster patient dependency module (which allows real time entry by shift leaders of staff moves to other wards and has the facility to allow the inputting of patient dependency and acuity at all times which would indicate Care Hours Per Patient per Ward continuously) is to be held in September to compare to other available systems prior to a business case submission. This would allow efficient and effective use of staff across all wards at all times as a whole Trust view would potentially be available of current staffing levels and patient dependency.

Summary

This report provides assurance that every effort was made to provide safe staffing levels across all wards daily during July and August 2016 in spite of the current shortfalls in staffing due to vacancies and other gaps.

05 - August 2016
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Appendix 1

The 6 wards with fill rates below 90% for RNs for July 2016

Ward	July 2016			
	RN Days	RN Nights	HCA Days	HCA Nights
1A	80.32	84.78	101.17	106.42
2B	83.28	92.99	122.14	165.93
2C	83.06	88.92	103.63	111.45
2D	86.30	102.98	138.72	160.28
4C	85.09	100	104.97	99.09
5A	89.50	92.08	119.56	144.09

The 10 Wards with fill rates below 90% for RNs for August 2016

Ward	August 2016			
	RN Days	RN Nights	HCA Days	HCA Nights
1A	88.29	88.04	112.38	107.53
1D	84.27	85.27	128.46	116.94
2B	76.96	94.7	106.96	130.54
2C	87.72	81.72	120.7	135.73
2D	85.16	118.9	137.82	161.01
3D	88.96	80.65	110.44	145.16
3E	96.64	83.77	100	90.32
4D	128.9	82.8	109.8	96.8
5A	91.52	80.7	107.17	140.27
5C	87.18	100.52	134.6	167.74

The 2 wards with fill rates below 90% for HCAs in July 2016

Ward	July 2016			
	RN Days	RN Nights	HCA Days	HCA Nights
2E	95.37	99.25	86.10	97.74
4D	126.22	108.06	82.52	90.32

The 1 ward with a fill rate below 90% for HCAs in August 2016

Ward	August 2016			
	RN Days	RN Nights	HCA Days	HCA Nights
2E	102.8	100	83.05	100

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

Ward	July 2016			
	RN Days	RN Nights	HCA Days	HCA Nights
1D	83.64	88.23	126.07	106.45

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

Ward	August 2016			
	RN Days	RN Nights	HCA Days	HCA Nights
1E	93.87	85.83	88.00	92.86

The 5 wards with fill rates consistently less than 90% during the last 3 months

Ward	June 2016				July 2016				August 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	81.2	95.2	89.8	107.8	80.32	84.78	101.17	106.42	88.29	88.04	112.38	107.53
2B	85.7	94.7	101.2	139.8	83.28	92.99	122.14	165.93	76.96	94.7	106.96	130.54
2C	82.2	111.8	93.3	108.3	83.06	88.92	103.63	111.45	87.72	81.72	120.7	135.73
2D	81.4	133.2	103.7	108.2	86.30	102.98	138.72	160.28	85.16	118.9	137.82	161.01
4D	115.9	70	118.3	56.7	126.22	108.06	82.52	90.32	128.9	82.8	109.8	96.8

Ward	Specialty	Monthly Hours - Days						Monthly Hours - Nights						Care Hours Per Patient Day (CHPPD)			
		Qualified staff			HCA's			Qualified staff			HCA's			Monthly Pat's	Qual. staff	HCAs	Total
		Plan	Actual	Rate	Plan	Actual	Rate	Plan	Actual	Rate	Plan	Actual	Rate				
1A	Geriatric Medicine	1,956	1,727	88%	2,077	2,334	112%	920	810	88%	930	1,000	108%	870	2.9	3.6	6.7
1B	General Medicine	2,823	3,314	117%	1,645	1,876	114%	910	921	101%	620	659	106%	688	6.2	4.1	9.8
1C	General Medicine	3,183	3,106	98%	1,627	1,909	117%	1,550	1,574	102%	620	790	127%	859	5.4	4.1	8.6
1D	Cardiology	2,030	1,711	84%	1,372	1,763	128%	930	793	85%	620	725	117%	853	2.9	3.0	5.9
1E	Cardiology	2,294	2,153	94%	734	630	86%	1,240	1,091	88%	140	130	93%	451	7.2	3.8	8.9
2A	Gen. Medicine / Haematology	1,880	1,935	103%	894	841	94%	620	622	100%	330	330	100%	535	4.8	2.7	7.0
2B	Gen. Medicine / Respiratory	1,999	1,538	77%	1,542	1,649	107%	930	881	95%	603	787	131%	885	2.7	2.9	5.5
2C	Gen. Medicine / Respiratory	2,026	1,777	88%	1,607	1,939	121%	930	760	82%	620	842	136%	910	2.8	3.0	5.8
2D	General Medicine	1,391	1,184	85%	1,150	1,584	138%	620	737	119%	620	998	161%	561	3.4	4.1	8.0
2E	Obstetrics	3,052	3,137	103%	1,350	1,121	83%	1,240	1,240	100%	620	620	100%	782	5.6	3.0	7.8
3A	Plastic Surgery	1,820	1,799	99%	1,221	1,373	112%	670	710	106%	740	790	107%	546	4.6	3.8	8.6
3Alpha	Trauma & Orthopaedics	1,532	1,582	103%	1,164	1,231	106%	620	640	103%	310	290	94%	426	5.2	4.4	8.8
3B	Trauma & Orthopaedics	1,374	1,300	95%	2,089	2,140	102%	920	870	95%	620	822	133%	673	3.2	4.5	7.6
3C	Trauma & Orthopaedics	1,877	1,797	96%	1,602	2,061	129%	930	940	101%	930	1,230	132%	770	3.6	3.9	7.8
3D	Gen. Medicine / Gastro.	2,038	1,813	89%	1,362	1,504	110%	930	750	81%	620	900	145%	847	3.0	2.7	5.9
3E	Gynaecology	1,387	1,336	96%	997	835	84%	620	620	100%	310	280	90%	581	3.4	2.5	5.3
3F	Paediatrics	2,270	2,410	106%	375	348	93%	1,240	1,244	100%	310	310	100%	342	10.7	4.7	12.6
4A	101 - UROLOGY	1,936	1,765	91%	1,367	1,538	113%	930	910	98%	930	1,181	127%	864	3.1	2.8	6.2
4B	General Surgery / Urology	2,497	2,354	94%	1,800	1,835	102%	1,090	1,080	99%	480	450	94%	399	8.6	7.3	14.3
4C	General Surgery	2,040	1,872	92%	1,388	1,343	97%	930	930	100%	930	930	100%	927	3.0	2.5	5.5
4D	Plastic Surgery	1,422	1,832	129%	480	398	83%	620	681	110%	310	300	97%	152	16.5	7.1	21.1
4E	Critical Care	5,565	5,255	94%	956	934	98%	3,720	3,419	92%	580	550	95%	332	26.1	13.1	30.6
4F	Paediatrics	2,251	2,212	98%	755	734	97%	620	630	102%	310	310	100%	170	16.7	8.0	22.9
5A	Gen. Medicine / Geriatric	1,570	1,437	92%	2,504	2,683	107%	930	751	81%	930	1,305	140%	741	3.0	4.6	8.3
5B	Geriatric Medicine	1,610	1,598	99%	2,289	2,386	104%	930	850	91%	930	1,145	123%	746	3.3	4.3	8.0
5C	Geriatric Medicine	1,102	960	87%	895	1,204	135%	620	623	101%	310	520	168%	756	2.1	2.4	4.4
5D	Gen. Medicine / Geriatric	1,588	1,740	110%	1,527	2,006	131%	620	620	100%	620	590	95%	455	5.2	5.8	10.9
Duffy	Gen. Medicine / Geriatric	1,079	1,041	96%	1,700	1,865	110%	620	622	100%	930	960	103%	655	2.5	3.8	6.9
SCBU	Paediatrics	1,870	1,853	99%	347	329	95%	970	941	97%	310	303	98%	183	15.3	6.9	18.7
Delivery	Obstetrics	3,310	3,389	102%	926	889	96%	2,170	2,120	98%	490	470	96%	302	18.2	10.0	22.7
Seddon	Rehabilitation	1,442	1,671	116%	1,511	1,805	119%	620	620	100%	620	940	152%	503	4.6	4.8	10.0

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)089
Title of paper: Infection Prevention & Control Report
Purpose: To provide the Trust Board with an update on the current Trust infection control status against Department of Health objectives.
Summary **Number of cases for financial year 2015-16:** • **HCAI MRSA bacteraemia**: 0 cases (target 0) • **HCAI CDI**: 39 Positive samples (target 41) of which the Trust has successfully appealed: 13 cases in total. Total hospital attributable cases was 26 against a target of 41. Compared to 2014/15 hospital attributable cases of 35. • **HCAI MSSA bacteraemia** - total number of cases for financial year 2015-16: 28 • **HCAI E coli bacteraemia** - total number of cases for financial year 2015-16: 61 **2016-17 Trajectory** • **HCAI MRSA bacteraemia**: (target 0) 1 case in July. • **HCAI CDI**: (target 41) cases to the end of August : 11 • **HCAI MSSA bacteraemia** (internal target of 15% reduction) Number of HCAI MSSA bacteraemia to the end of August 2016: 7 • **HCAI E coli bacteraemia** in August 2016: 3
Corporate objectives met or risks addressed: Patient Safety and Patient Care
Financial implications: There is a risk of financial penalties if the Trust does not achieve the CDI target.
Stakeholders: Trust, patients and stakeholders
Recommendation(s): That the Trust Board receive the report and discuss the contents to identify any actions required.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance
Date of meeting: 28th September 2016

INFECTION CONTROL REPORT

1. Meticillin-resistant Staphylococcus Aureus (MRSA) bacteraemia

1.1. All Trusts have been given the target of zero hospital-acquired cases.
1.2. In 2015-16 the Trust had zero cases.
1.3. There has been 1 case of HCAI MRSA bacteraemia in July this year. An RCA was conducted and an Action Plan generated identifying the key themes (Appendix 1).
1.4. This action is being monitored through Quality Committee, Patient Safety Council. Care Group Governance meetings and Hospital Infection Infection Prevention Group (HIPG).

2. Meticillin Sensitive Staph Aureus (MSSA) bacteraemia

2.1. The Trust is now required to report all MSSA blood cultures. There is currently no external target.
2.2. During the period 1st April 2015 to 31st March 2016, there were 28 hospital acquired cases.
2.3. This was a 65% increase compared with the 2014-2015 (17 cases).
2.4. In 2015-2016, although the numbers of cases had increased, the number of avoidable cases was the same as the previous year. The increase in total numbers accounted for by unavoidable cases e.g. pneumonia, bone/joint infections, neutropenic sepsis etc.
2.5. To the end of August, there have been 7 cases of MSSA bacteraemia. Of the 4 RCAs conducted so far 3 cases were deemed to be unavoidable (leg ulcers, wounds and patient non-compliance), 1 deemed to be avoidable – vascular device and wound care related), Consultant requested to review and discuss as a case study.
2.6. This is an area for improvement during 2016-17, to support this and action plan has been generated.
2.7. The action plan is being monitored through HIPG.

3. MRSA hospital acquired colonisation

3.1. There were no cases of hospital-acquired MRSA (non-bacteraemia) in August 2016.
3.2. Total for the financial year is 8.

4. E coli bacteraemia.

4.1 There is no external target for E coli bacteraemia.
4.2 There were 33 E coli bacteraemia in August 2016, 30 (91%) of which were community acquired and 3 (9%) were hospital acquired.
4.3 The mid Mersey HCAI collaborative are in the process of undertaking a 3 month retrospective audit to review all community E coli bacteraemia. To date there have been no results released.

4.4 There were 3 hospital-acquired E coli bacteraemia cases in the month of August,

Which were related to:

- 1 patient with biliary sepsis unrelated to any invasive procedure (unavoidable).

- 1 patient with intra-abdominal sepsis related to metastatic malignant melanoma but unrelated to any invasive procedure (unavoidable).
- 1 patient with pneumonia unrelated to ventilation (unavoidable).

5. **Vancomycin-resistant Enterococcal (VRE) bacteraemia.**

5.1. No cases of hospital acquired VRE bacteraemia in August.
5.2. Surgery, orthopaedics, 2A, 4D and 4E are all currently screening patients on admission for VRE following a rise in cases in the Trust (not bacteraemia) and nationally .

6. **Clostridium difficile infection (CDI)**

2016-2017

6.1 The target for 2016-2017 is no more than 41 cases of hospital acquired cases.
6.2 To date, at the end of August, there have been 11 confirmed positive cases of which the Trust is to appeal 1 case (Appeals panel 19th October) from the RCA that have taken place.
6.3 Recurring themes for the RCAs that have taken place:

- All HCAI cases this year have been attributable to the MCG.
- Delays in obtaining faecal samples
- Inappropriate prescribing of antibiotics.

6.4 An action plan has been requested from the MCG to address these lapses in care. This is being led by Head of Quality for MCG supported by the IPCT.
6.5 Action plan to be monitored through the MCG governance meetings and the HIPG.

7. **Outbreaks.**

7.1 There has been an increased incidence of infection related to MDR Pseudomonas on wards 4D and 4E.
7.2 This involved 6 patients who acquired MDR Pseudomonas and were colonised in their wounds between the timeframe of November 2015 to June 2016.
7.3 The Index case was a transfer from Romania and was colonised on admission.
7.4 Typing results confirmed that all were the same strain of MDR Pseudomonas.
7.6 Actions implemented included:

- Review of patients with pseudomonas over last 12 months for any other multi-resistant cases which may be related – no cases of the same type identified.
- Water sampling was carried out on all outlets on 4D and relevant outlets on 4E – 4 outlets on 4D were found to be positive for pseudomonas (although none of the strains isolated were related to the outbreak strain). Remedial action taken including replacing filters and taps on the positive outlets. Several repeat sampling results since then have been now negative.
- Review of clinical practice including hand hygiene and wound care/ANTT on 4D – no issues identified, in fact the standards of practice were excellent.
- Review of sink cleaning practices by unannounced audit – no issues identified.
- Review of flushing regimes – flushing temporarily increased when positive water samples were identified on 4D but has now been returned to base line levels (except

for the burns bath which will remain as 7 min per day flushing due to being a high risk water outlet).

- Review of cleaning mechanism for bath hoist straps – recommended that these should be single patient use and sufficient straps need to be purchased by 4D for this purpose.
- 4D medical staff made aware that antibiotic treatment for any patients with or suspected to have multi-resistant pseudomonas infection must be discussed with a microbiologist (they do this anyway for most burns patients prior to starting or changing antibiotics).
- Environmental sampling carried out on 4D in rooms 5 and 7 plus bath room – no positives isolated from swabs of surfaces and equipment. All drains (sinks/bath/showers) are positive for pseudomonas, which is as expected as these are dirty areas normally colonised with biofilm including pseudomonas. However, sensitivity testing currently indicates that these pseudomonads are not the same as the outbreak strain but they will be sent for typing next week for definitive confirmation which can take up to 2 weeks.
- IPCT are working with the clinical team on 4D to produce a summary discharge cleaning chart and also a bespoke education package for the burns unit staff.

- Rooms 5 and 7 on 4D and the burns bath on 4D plus room 18 on 4E these areas should undergo a deep clean followed by hydrogen peroxide decontamination..
- Public Health England/Consultant in Communicable Disease Control has been informed. This enabled us to seek advice from national experts who have experience of dealing with similar situations.
- **A supportive visit from Public Health England/ Consultant in Communicable Disease Control was undertaken on the 30th June, a draft report has been sent for the Trust's comments and we are now awaiting the final report.**
- **A SUI panel meeting has been undertaken and the report for the CCG has been delayed until the final report from PHE has been received.**

8. **Carbapenemase – producing Enterobacteriasceae (CPE)**

8.1 There have been no cases of hospital acquired CPE in August.

8.2 There have been no hospital acquired CPE this financial year to date.

9. **NHSI 90 day rapid HCAI improvement event**

9.1. The NHSI invited the Trust to present at the HCAI 90 day rapid improvement event; this was in relation to Executive leadership and accountability.

9.2. The Lead Nurse for IPC has participated in the final 2 events.

9.3. There were 16 different NHS hospital IPC teams from across the country present.

9.4 The feedback was positive and the Trust has been asked to buddy up with 2 Hospitals to offer support and share best practice.

MRSA bacteraemia Trust Action Plan July 2016

Issue Identified from PIR Process	Recommendations	Actions	Lead Person	Timescale	Evidence	Monitoring Process	Progress to Date
1. The challenge across a large organisation to ensure all Trust staff are made aware made aware of the recent MRSA bacteraemia case and the highlighted gaps in care and lessons learned	Ensure ALL Trust staff are made aware of recent MRSA bacteraemia case	Information from the recent PIR process to be circulated from the Trust DIPC via the global email system	Dr K Allen DIPC	July 2016	Global Email		Completed Email sent 04/08/2016 and repeated on the 08/08/2016
		Presentation of sentinel event	Neal Jones	August 2016	Record of attendance		Presentation at Grand Round 27.09.2016
		CDs, IC Champion Clinicians, ADOs, Matrons Heads of Quality, Directorate Managers, Ward and Departmental managers, IC Link Nurses to reinforce and disseminate to their clinical teams	All Consultants ADOs Heads of Quality Directorate Managers Matrons Ward and Departmental managers IC Link Nurses	August 2016	Minutes of Directorate and Departmental meetings	Assurance feedback to be provided to the Trust through SCG/MCG/CSS care group governance structure	Case discussed in SCG Risk meeting in August 2016 Action plan shared with key staff in SCG and across MCG and CSS.
		Extraordinary edition of	Neal Jones,	End July	Newsletter		Newsletter

		Patient Safety Newsletter to be circulated across all ward and departments Trust	Assistant Director Patient Safety Ali Kennah SCG Heads of Quality	2016	Team Brief August 2016		distributed across all clinical areas early September 2016
	Ensure wider learning across the Health Economy	To disseminate at Health Economy Collaborative and National DONs meeting	Sue Redfern Director of Nursing	Dates TBC			Awaiting date for confirmation of DONS and HCAI collaborative

2. Non-adherence to Trust IC Policy MRSA chapter 14 Control Of MRSA	Trust staff to be aware of and adhere at all times to Chapter 14 of Trust IC policy	Circulate chapter 14 of Trust IC policy via global email to all Trust staff	Dr K Allen DIPC	July 2016	Email		Email sent 04/08/2016 and repeated on the 08/08/2016
		CDs, IC Champion Clinicians, ADOs, Matrons Heads of Quality, Directorate Managers, Ward and Departmental managers, IC Link Nurses to reinforce and disseminate to their clinical teams	All Consultants ADOs Heads of Quality Directorate Managers Matrons Ward and Departmental managers IC Link Nurses	August 2016	Minutes of Directorate and Departmental meetings	Assurance feedback to be provided to the Trust through care group governance structure	Case discussed in SCG Risk meeting in August 2016 Action plan shared with key staff in SCG and across MCG and CSS.
2a. Failure to	All Trust staff adhere	Introduce new Trust MRSA	Valya Weston	December	New	Feedback from	Pathway

prescribe and administer suppression therapy for patients with a history of MRSA	to timely identification, prescribing and administration of Suppression Therapy for newly identified and patients with a history of MRSA	pathway to replace current care plan: Pathway to include initial actions, screening, and evidence of completed actions	Lead Nurse for IPC Karen Barker Matron General Surgical Care Debbie Ball Matron Medical Care Jane Osthoff Senior Nursing Team	2016		Initial Pilot on wards 4B and 1B Bi-annual audit of compliance to commence June 2017	currently with key staff for comments
		Ensure all inpatient clinical areas have MRSA prescription stickers as stock items	Ward/ Departmental Managers	August 2016	Stickers in use across the Trust	Bi-annual audit of compliance to commence June 2017	Stickers in use across all wards and ordering details publicised by global email and Team Brief.
		Review transfer of care document to provide assurance of effective communication in relation to infection status	Valya Weston Lead Nurse ICP Chakri Molugu Consultant Debbie Ball Matron Medical Care	July 2016	Email confirming review completed	Audit of compliance	Meeting to be held with Dr Molugu to proceed with update of document – meeting booked for the 29th

							September
		Ward Round checklists to be implemented Trust wide to include prompt re infected patients	Karen Barker Matron Surgical Care Nominate Matron Medical Care Julie Hendry Divisional Medical Director Medical Care Group Samantha Pedder Divisional Medical Director Surgical Care Group	September 2016	Implementation of new ward round checklist	Audit of compliance TBC	Review of current documents in use commenced by Matrons
		Ward coordinator checklists to be implemented Trust wide also to include prompt for MRSA patients	Karen Barker Matron Surgical Care Group Matron Medical Care	August 2016	Implementation of new co-ordinators checklist	Audit of compliance	Review of current documents in use commenced by Matrons. Pilot of updated document in progress on General Surgical wards
		Reinforce bed to bed handovers/huddles	Karen Barker Matron Surgical	August 2016	Ward meeting minutes to provide	Ward and Departmental	Awaiting email confirmation

			Care Nominated Matron Medical Care		assurance of on-going compliance	meetings	from ward managers
		Nursing staff to administer first dose once allergies have been checked – need to clarify whether this is on sticker	Sue Redfern Director of Nursing Simon Gelder Head of Pharmacy Adam Ruddock Head of Learning and Development	October 2016	Directive to be included in new MRSA pathway	Bi-annual audit of compliance commencing June 2017	Information and Chapter 14 e mailed to all matrons – 13/09/2016. MRSA policy already states suppression can be commenced with verbal order from doctor.
2b. Failure to obtain appropriate screening samples in a timely manner i.e. Urine sample Swabs from leg wounds	Ensure all Trust staff are aware of the MRSA screening process	Circulate chapter 14 of Trust IC policy via global email to all Trust staff Introduce new Trust MRSA pathway to replace current care plan: Pathway to include initial actions, screening, and evidence of completed	Dr K Allen DIPC Valya Weston Lead Nurse IPC Karen Barker Matron Surgical Care Debbie Ball	21 July 2016 December 2016	Email New MRSA Pathway in use across the Trust	Bi-annual audit of compliance to commence June 2017	Completed Email sent 04/08/2016 and repeated on the 08/08/2016 Draft pathway currently under consultation with key staff

		actions	Matron Medical Care Jane Osthoff				
	Full skin assessment to be completed on all patients in all clinical areas inclusive of the Emergency Department	Implementation of Trust Catheter policy Education of Trust staff in relation to skin assessment	Angela Sharman Continence Lead Nurse Debbie Gleeson Lead Nurse Tissue Viability	August 2016 September 2016	Policy in circulation across the Trust Written record	Harm Free Care Policy audit recommendations Bi-annual audit of new Trust MRSA Pathway to commence June 2017	Awaiting update from ED department and TVN
3. Increased risk of infection due to multiple urethral catheterisations and bladder washouts **Failure to commence UCAM documentation Failure to record adherence to ANTT practice in relation to urethral bladder washouts**	Ensure appropriate assessment and documentation of practice is adhered to in relation to insertion and care of urethral catheters	Implementation of Trust Updated Urinary Catheter Policy	Angela Sharman Lead Nurse Continence	August 2016	Completion of UCAM documentation Trust wide use of Catheter Passport	Monthly IPC report Annual IPC UCAM audit	Trust Catheter Policy going through final review. Catheter passport usage to be audited – Audit planned for the end of November.
4. Increased risk of infection due to multiple IV cannulation	Ensure all patients are a correctly assessed for appropriate vascular access devices	Introduction of vessel Health Preservation across the Trust via: Education sessions Awareness campaign	Valya Weston Lead Nurse IPC	December 2016	Documented assessments	Monthly IPC report	Training date booked for ward 4A, 4B and 4C staff on the 12th October.

							Pilot study on 1D completed 30/09/2016 – findings to be communicated to the Patient Safety council.
	To ensure ANTT practice is adhered to at all times and assurance of compliance with Trust monitoring systems	Monitor of compliance with ANTT across staff groups.	IPC Lead; Divisional Medical Director and Head of Quality for each care group	August 2016	Audit results	Monthly compliance data from ESR reviewed by the Infection Prevention and Control Team	Update of MCG and SCG ANTT compliance is e mailed to the matrons and ward managers on a monthly basis. (latest compliance end August 2016 = 67%)
5. Failure to adhere to Trust blood culture policy	All clinical staff with a responsibility to obtain blood cultures to be aware of and adhere at all times to the Trust:	Reinforcement of Trust blood culture policy to include clinical staff teaching sessions	Dr Mortimer Consultant Microbiologist Adam Ruddock Head of Learning and Development	September 2016	Team Brief List of attendees		Case presented at Team Brief August 2016

Failure to obtain blood cultures in a timely manner Clinical staff not ANTT trained	Blood Culture Policy ANTT policy	Formal documentation of Trust expectations to be provided to new doctors in relation to their responsibilities for own ANTT training.	Valya Weston Lead Nurse IPC	August 2016	Message reinforced in junior doctor induction session.	Appraisal Clinical supervisor	Appraisal Clinical supervisor
		Letter from Medical Director to all new doctors	Professor Hardy Medical Director	August 2016	Letter sent to new doctors		
	Clinical staff to be aware of and adhere at all times to the Trust ANTT training requirements	Introduce stickers Trust wide to all ANTT trained staff to demonstrate compliance	Valya Weston Lead Nurse IPC	August 2016	Stickers now available to ANTT key trainers		Complete
6. Non-adherence to Trust Antibiotic Policy: Incorrect prescription of antibiotics to cover MRSA status	All clinical staff with prescriber responsibilities to be aware of and adhere at all times to the Trust Antibiotic Policy	Case review with parent team to understand/clarify failure to follow Policy	Hosea Gana Consultant Surgeon Urology	July 2016	Written Record of case review to include reflective piece of written work	Appraisal/ consultant lead	**In progress**
		Meeting to be arranged for CDs/IC Champions to discuss the case and	Professor Hardy Julie Hendry	September 2016	Minutes of meeting		IC champions meeting to be held on the 16

		highlight learning points for dissemination to Juniors	Samantha Pedder Karen Allen				September
		Re-launch of Trust antibiotic prescribing campaign to include doctor's teaching sessions	Dr Mortimer Andrew Lewis	September 2016	Campaign Highlighted in Team Brief in August 2016 and publicised via global email; also highlighted at new junior doctor induction		Completed
7. Non-adherence to Trust Policy and guidance for the management of in patients with Diabetes	To ensure all applicable clinical staff are aware of and adhere at all times to Trust Diabetes Policy	Targeted training utilising Trust E-Learning package for clinical staff involved in this case with a plan to roll out trust wide	Adam Ruddock Head of Learning and Development	August 2016	ESR	ESR reporting	Staff training in progress
8. No notification of MRSA status on electronic discharge summary to GP	To ensure infection status is recorded on Trust discharge information	To add a mandatory field to record infection status on the Trust electronic discharge summary system	Christine Walters Executive Director Informatics	December 2016	System in place		Director of IT currently scoping

9. Failure to adhere to Trust assessment documentation in relation to IPC practices	To ensure all clinical Trust staff adhere to expected practice in relation to assessment documentation	Audit of documentation in ED 4B 1B	Carole Nolan Karen Barker Debbie Ball	August 2016	Completed audit	Monthly IC report	IPC monthly report sent to all matrons and ward managers on a monthly basis.

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)090
Title of paper: Executive Committee Assurance Report.
Purpose: To feedback to members key issues arising from the Executive Committee meetings.
Summary: 1. Between the 15th July and 15th September six 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; the Outlier Policy; MES equipment replacement; arrangements for MITC and IT reporting; management of QWR; and application of DoLS. 3. Assurances regarding progress in support of an additional Haematologist; safer staffing; LDS/STP workstreams; management of risk; Specialist Commissioning compliance; CQUIN performance including prescribing; and QCC action plan were obtained. 4. Investment decisions included PAS support for 2017/18 (c.£200k). 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: 28th September 2016.

EXECUTIVE COMMITTEE REPORT (15th July to 15th September 2016)

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

21 July 2016

1. Local Digital Roadmap (LDR)

   1.1. CW gave an overview on the recently devised Merseyside LDR. Cheshire and Warrington have made separate proposals and she has expressed her concerns that these groupings do not mirror the LDS footprints.

   1.2. Kate Warriner described the development of the footprints and confirmed that input from providers had been exceptional and that Trust representatives are proactively involved. The submission has now been shared with all providers and CCGs. AM confirmed organisational commitment to the LDR, on the basis of a collaborative approach.

   1.3. The Trust data previously submitted regarding digital maturity was discussed and concerns expressed that this was not verified.

2. Haematology service review

   2.1. Toby Nicholson (TN), Natalie Gilmore and Ian Young updated the Committee on the status of the Haematology Service.

   2.2. The historical growth and increase in spells was described. TN also noted the increase in malignancies, and the more aggressive treatment being used for elderly patients, with the numbers of Level 2 patients having doubled in the last two years. Outpatient capacity, achievement of CQUIN targets, and Consultant cover in the Lilac Centre were also discussed.

   2.3. TN described the short-term fix in place and the long term innovative opportunities many of which are subject to identifying additional capacity.

   2.4. It was acknowledged that the requirement for a further Consultant, included in the October 2015 business case, had been evidenced and could proceed.

3. St Helens Hospital organisational change

   3.1. Pat Keeley (PK) attended the meeting to put forward a proposal for an organisational change at St Helens Hospital.

   3.2. Following long debate the Committee concluded it represented a fundamental shift in the governance structure, which was difficult to support and that SR and RC would liaise with PK on alternative options.

4. Vacancy dashboard / Safer Staffing

   4.1. SR presented the month of June 2016 data and the areas failing to meet the 90% fill-rate were discussed in detail.

   4.2. Noted that on 16th July the National Quality Board published a new guidance document, ‘Supporting NHS Providers to Deliver the Right Staff, with the Right Skills, in the Right Place at the Right Time’. SR reported that as a result the Directors of Nursing are collaborating on a joint template for completion.

   4.3. The Committee requested more interpretation of the data in future in order to provide appropriate assurance.

5. IMS Maxims

   5.1. CW described the risk on the Corporate Risk Register related to IMS Maxims and the lack of breakdown support at night time and weekends, which has been

previously debated by the Committee. It was concluded that the current arrangements should continue.

28th July 2016

6. Report writing

   6.1. The standard of effective report writing by senior managers was discussed and it was agreed that additional coaching is needed. AMS will follow up.

7. NHSI Strengthening Financial Performance and Accountability 2016/17

   7.1. Sue Hill (SH) summarised the publication which sets out the agreed legal responsibilities of individual NHS bodies to live within their funding, with a series of actions designed to support them to achieve financial sustainability and improve operational performance. From a provider perspective, the objective is to reduce the planned deficit in 2016/17 from £550m to £250m.

   7.2. Planned surpluses / deficits, expenditure control totals, outliers for pay-bill growth, off-payroll controls, and performance trajectories were also included.

   7.3. NK also noted the expectation that contracts are signed by December 2016.

8. NHSI response to back office, pathology and unsustainable services letter

   8.1. Wayne Longshaw updated on progress with the LDS/STP plans including Community Services and A&E.

   8.2. AM reported that following Bob Alexander's letter regarding the consolidation of back office and pathology services and the re-provision of unsustainable services, Louise Shepherd (STP Lead) is responding on behalf of all CE's.

   8.3. It was noted that NK is to lead on the back-office workstream for the STP, and Simon Constable would lead on hospital reconfiguration.

   8.4. Timelines were noted for the next STP submission, and it was acknowledged that faster progress is needed with a focus on the clinical model.

   8.5. Mid office/back office work was discussed and it was agreed to liaise with 5BP and Bridgewater on their involvement at LDS level. AMS and NK will meet to discuss potential Alliance level savings.

9. VTE flow diagram

   9.1. CW described the VTE process and commented that she had discussed non-completion with users and the main explanation was capacity constraints.

   9.2. Noted that KH has written to doctors and also spoken to Clinical Directors. It was agreed to revisit this item at a later date and in the interim SR will visit Southport and Ormskirk Trust to see how they undertake the assessments.

25th August

10. Corporate Risk Register (CRR)

    10.1. PW presented the CRR and highlighted a number of issues from the Risk Management Council (RMC) meeting.

    10.2. The RMC have agreed revised categories for reporting risks which should improve interrogation of the risk register.

    10.3. The number of risks overdue for review was highlighted as an area for escalation, as was compliance with the CIP approval process, which is being picked up at the CIP Council.

11. Self-declaration of compliance – Cancer Specialist Commissioning

    11.1. Pat Gillies (PG) provided an update on Cancer Specialist Commissioning and sought approval for the self-certification.

    11.2. PG provided a summary of the Trust's current level of compliance against each of the national cancer quality indicators. The main issues with non-compliance are due to MDT meetings not being quorate and her department is looking into video conferencing options.

12. Workforce Streamlining Programme

    12.1. AMS presented the NW Workforce Streaming Programme which aims to streamline the recruitment management documentation across all the North West Trusts.

    12.2. Executives agreed to sign-up to the Memorandum of Understanding.

13. Mandatory training and appraisal targets

    13.1. AMS presented the Trust figures showing overall non-compliance. It was agreed that performance figures, broken down by Director, will be presented each month, and members would concentrate on improvements.

14. Volunteer Strategy

    14.1. Claire Scrafton presented the Strategy which promotes better use of volunteers with expanded roles; in particular providing a meet and greet service for wards.

    14.2. It was agreed to carry out a pilot of a "model ward" to review the benefits.

15. Dermatology

    15.1. The growing Dermatology referral rate was discussed. Whilst one additional consultant has been recruited, a further vacancy exists. AMS advised that a Job Plan review is taking place which might improve productivity.

    15.2. It was agreed to review out of area referrals and our core catchment referrals against our current establishment.

1st September 2016

16. Trust CQUIN compliance: Antimicrobial Resistance

    16.1. Andrew Lewis provided a verbal update on prescribing and agreed to send out the report that was presented to HIPG. Across the health community there has been a 1% reduction in antibiotic prescribing, but an increase in Carbapenemase Producing Enterobacteriaceae (CPE), related to IV's at home.

    16.2. Currently, the service is failing the national CQUIN target but the CCG may be amenable to a contract variance. An interim report will be taken to the Executive Committee before it is presented at CQPG.

17. Outlier Policy

    17.1. RC presented the Outlier Policy which has been updated to reflect appropriate tracking and management of patients who have been lodged in specialty wards. It was agreed that the policy would be approved with minor changes.

18. VTE update and process discussion

18.1. KH provided a verbal update and indicated that until e-prescribing has been rolled out throughout the Trust we are unlikely to routinely meet the target for 95% of patients to be assessed within 24 hours of admission.

18.2. Feedback from Southport suggests they use the drug Kardex to capture data but this doesn't explain how compliance is evidenced. SR will explore this on her follow-up visit.

18.3. It was decided that IT trainers will meet with junior doctors to demonstrate the system again and re-iterate the importance of completing the assessments.

18.4. Julie Hendry agreed to discuss the matter with junior doctors, and to provide an update at the next Clinical Senate.

19. Burns & Plastic Surgery Department

19.1. Alex Benson (AB) and Tracey Walker provided an overview of Burns & Plastics covering delivery of services, Regional services, challenges, admissions, and LOS. Payments and outstanding debts from Walton Neuro were also discussed.

19.2. AB stated that the department required a bigger footprint; more ward and theatre capacity; and ideally an admissions area for low risk patients. The proposal to establish a surgical admission unit on the 4th Floor, as part of the accommodation review, was discussed, but it was noted that the high specification currently made the proposal unaffordable and clinical staff were being urged to reconsider the use and resulting design criteria.

20. Trust IT Strategy

20.1. CW presented an update to the Trust IT Strategy stating that her staff are working on a business case and this will be presented to Trust Board in October. CW and Francis Andrews have met with Medical Directors from Liverpool Hospitals to discuss different systems.

21. NHSI

21.1. The proposed agenda for the forthcoming regular meeting with NHSI, to be attended by NK, SRe and PW was discussed and actions agreed.

8th September

22. CQUIN update

22.1. Nicola Broderick (NB) provided an update on CQUIN performance.

22.2. The Q1 profile is worth c.£1.1m (19% of the annual total annual total) and 96% has been agreed as achieved with the remaining 4% awaiting decisions from Specialised Commissioners. It was noted that the targets become more challenging for the Trust from Q2 onwards.

22.3. NB reported that the CCGs had been very helpful and have jointly agreed with the Trust to change the original CQUIN targets for both national Sepsis and local AKI to be more reflective of the Trust and its current population.

22.4. AM agreed to write to Trust CQUIN clinical champions regarding this success.

23. Trust Board Agenda

23.1. PW presented the draft Board agendas which were approved with minor amendments.

24. MES equipment replacement

24.1. Mark Hogg and Gill Holroyd (GH) presented an over view of the current MES contract and the medium-term annual equipment refresh.

24.2. Contractually GE Medical are only obliged to replace the assets originally included within the MES programme; however, more recently the procurement of additional equipment has been negotiated where replacement costs have been lower than those stated within the original financial model.

24.3. The increase in demand for CT and MR has been the subject of previous reports to Executive Committee. This latest proposal has resulted from the remodelling of the MES contract to provide additional equipment within the financial envelope and performance regime of the MES deal, including the replacement of MR and CT equipment previously procured by the Trust.

24.4. It was confirmed that the proposal 'future proofs' the service for 10 years; supports the strategic direction of the Trust particularly in relation to the LDS; and supports patient flow in both elective and non-elective pathways.

24.5. The resulting workforce implications were raised and GH reported on the ongoing training programme in place, along with a skill mix breakthrough.

24.6. The Committee approved the proposal for further development.

25. Extension to PAS support

25.1. CW provided a summary of the increased cost of PAS support for 2017/18.

25.2. It was noted that the IT supplier (IMS) previously gave notification to cease support from 1st April 2017; however they have now agreed to a 1 year extension at an increased cost of c.£200k (50%).

25.3. Given that the Trust is only licensed to use the software with a formal support and maintenance contract with IMS in place, and that PAS is business critical to the Trust, the Committee approved the extension to the Contract.

26. Teletracking

26.1. CW fed back on a presentation she attended on patient tracking which may have LDS benefits. CW is meeting the supplier for further discussions and will report back to Committee at a later date.

27. Review of MITC and IT reporting

27.1. PW reported on the review of the reporting arrangements for MITC and IT undertaken with NK and CW. It was evidenced that this currently does not comply with the organisational structure.

27.2. It was confirmed that this can be addressed by redefining the MITC as a "working group" with reporting by exception to the Executive Committee. Similarly, reporting on IT KPIs and developments from both a "whole system" and local Trust angle could follow this pattern.

27.3. Chairs reports from the Executive Committee are routinely reviewed by the Board and assurance that IT and information is being appropriately managed can be addressed in this way.

27.4. The proposals were agreed, for parallel consideration by the Finance & Performance Committee on 22nd September.

28. Junior Doctors Industrial Action

28.1. AMS confirmed that the industrial action proposed for September has been cancelled, but the plans developed would be used for any similar future action.

29. Exec to Exec with Halton CCG – agenda items

29.1. Proposals from Simon Banks to include LDS, STP and Stroke as agenda items were noted, and the Committee agreed that further information from Halton on the implications of their proposal to be an Accountable Care Organisation would be useful.

30. Quality Ward Rounds

30.1. The late cancellation of Quality Ward Rounds, and the impact this has upon NEDs commitments was discussed. It was agreed that this should only be permitted in extreme circumstances and AMS will follow up with SR.

31. Deprivation of Liberty Safeguards

31.1. The impact from the recent admission of a patient who was restricted in his best interest under the Mental Capacity Act for almost seven weeks was discussed. This was disruptive to staff, other patients and visitors, and moving the patient to a more appropriate organisation for his care proved extremely difficult.

31.2. Lessons learned were noted and SR confirmed that arrangements would be put in place to prevent a reoccurrence.

15th September

32. CQC action plan

32.1. Anne Rosbotham-Williams (ARW) reported that 49 of the 57 actions have been closed out.

32.2. Of the three overdue actions, the Maternity Strategy and End of Life Strategy are due to be approved at the next Quality Committee, and measures to achieve the A&E appraisal target are in place, although ARW was asked to review the low medical staff figures as these appeared unexplainably low.

32.3. Progress within the Maternity Unit is ongoing. Whilst improvements with medicines management have been evidenced it is still not at the required standard and firmer executive action was agreed.

33. Corporate Risk Register (CRR)

33.1. PW presented the CRR and highlighted a number of issues from the Risk Management Council (RMC) meeting.

33.2. Risks regarding VTE assessment and security of mobile devices have been downgraded whereas Gynae cancer targets and prosthetic staffing have been escalated.

33.3. The number of risks overdue for review has improved but requires further action and the process for CIP approval remains inadequate but is being addressed.

33.4. The Trust's Emergency Planning Core Standards passed external review.

34. Specialist services self-declarations

34.1. The self-declarations for Neonatal Critical Care and Specialised Burn Care, completed by ARW, were approved. The only area of non-compliance noted was with respect to the designation of burns centres, units and facilities which purely reflects the fact that for the North of England these haven't been decided.

35. Integrated Performance Report (IPR)

35.1. Chris Yates briefed on the latest report and changes to the text were agreed, along with actions to address any deteriorating KPIs.

36. Community Tender

36.1. AR and Mark Hogg briefed on progress with responding to the 3-year St Helens Community Services Tender, valued at c.£10.8m p.a..

36.2. A listening event has been held with stakeholders and a clear action plan for completing the tender submission drawn up.

36.3. Clarification questions are permitted until 30th September with a Tender return date of 14th October, and service commencement in April 2017.

37. Vision for Integrated Care to Improve Health and Wellbieng

37.1. AR presented the "visioning document" designed for staff and stakeholders to explain how the Trust plans to meet the changing needs of healthcare.

37.2. Factors such as collaboration, sustainability, population, demography, primary and social care are all considered in the 16 page document.

38. PA Consulting "Corporate Transformation Project" report

38.1. Derek Nott and Rachel Hurst presented their final report which is the culmination of nearly a years' work.

38.2. The report indicated that the Trust has high performing corporate functions with clear alignment to best practice principles, however, there was evidence of "silo working" which created some fragmentation & duplication and missed opportunities to share good practice. Some savings were suggested that will be included in CIP discussions.

38.3. The proposed next step was for the Trust to agree its corporate services strategy going forward showing how these services will contribute in the wider collaborative STP landscape.

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)091
Title of paper: Quality Committee Assurance Report.
Purpose: The purpose of this paper is to summarise the Quality Committee meeting held on 20th September 2016 and escalate issues of concern.
Summary: Key items discussed were: 1. MRSA action plan update 2. Complaints 3. CQC action plan update 4. Safer staffing 5. IPR 6. Pharmacy check list audit update 7. End of Life Strategy 8. Draft Maternity strategy
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: 28th September 2016

QUALITY COMMITTEE ASSURANCE REPORT

Summary of the discussions and outcomes from the Quality Committee meeting held on 20th September 2016.

Action Log

1. All actions on the log were reviewed.

MRSA action plan update

2. Kalani Mortimer (KM) provided an update.

   2.1. This is the first case of MRSA since September 2014. An RCA panel meeting was held and an action plan developed. The action highlighted red is now in progress.

   2.2. As a result of the RCA, several documents are being reviewed, including Transfer of Care. A more comprehensive MRSA care plan has been developed and the Catheter Policy is almost complete for ratification.

   2.3. The Committee discussed at length the adherence to policies and the need for sanctions and accountability. Ali Kennah (AK) informed the Committee that verbal feedback had been given to medical staff following the RCA meeting. Rani Thind (RT) questioned as to whether there were new actions within the plan, as this ground had been covered previously and asked what mechanisms are in place to prevent this happening again.

   2.4. Ann Marr (AM) asked that MRSA and the action plan be put on the Executive Committee agenda, to discuss in further detail.

Complaints Report

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

   3.1. There has been a significant improvement in monitoring complaints and the system is much more efficient.

   3.2. There were 29 1st stage approved complaints in August 2016; an increase of 8 in comparison to last year and an increase of 9 compared to July 2016. At the end of August there were 46 open 1st stage approved complaints, including 4 overdue.

   3.3. The Trust responded to 64.5% of 1st stage complaints within agreed time frames during August, leading to a year to date response rate of 62.4%.

   3.4. Top complaint themes during August were:

      3.4.1. Clinical treatment.

      3.4.2. Values and behaviours.

      3.4.3. Patient care/nursing care.

   3.5. There were 203 PALS contacts/enquiries during August; an increase of 57 in comparison to July's figure of 146. George Marcall (GM) commented on the increase in PALS enquiries and that communication would appear to be the key area for complaints. ARW said that 2% of concerns raised at PALS become formal complaints. Feedback is given to wards and there is a Complaints sub group.

3.6. AM pointed out that it would be useful to have a breakdown of PALS contact to see if it is a particular department. ARW reported that David Graham (DG) will be carrying out a sample review of complaints and responses.

3.7. ARW explained why complaints are listed as “unapproved” or “rejected”.

3.7.1. Complaints awaiting consent are “unapproved”.

3.7.2. If a complaint is subject to safeguarding or a SIRI panel is taking place, the complaint is “rejected” until the issues have been resolved. A complaint will also be rejected if it is out of time.

3.8. AM asked that the language be changed regarding the term “rejected” as this would appear to external agencies that the Trust are rejecting certain complaints. It was agreed that the term “rejected” would not be used in the future.

CQC action plan update

4. ARW provided an update.

4.1. 49 of the total 57 actions have now been completed. 5 actions are in progress and remain on course to be completed by the original or approved, revised deadline. 3 actions are overdue, which are:

4.1.1. Completion of Maternity strategy – agenda item.

4.1.2. End of Life strategy – agenda item.

4.1.3. Achievement of appraisal target of 85% with the ED. In order to improve medical staff compliance, each consultant has been allocated a group of appraisees and SPC time will be spent undertaking the appraisals. Management changes will support the delivery of the target for nurses by the end of October. The mandatory training target was achieved.

4.2. MIAA completed a review of the Maternity Department in July, as part of the annual audit plan. A number of areas reviewed are contained within the CQC action plan and the findings highlighted the need for additional controls. A management action plan is in place that is addressing these areas, notably:

4.2.1. Security of medical records.

4.2.2. Training HCA’s to input into electronic patient admission, discharge and transfer.

4.2.3. Regular audits regarding emergency equipment.

4.2.4. Embedding of lessons learnt.

4.3. GM asked why, after nearly a year, the action plan was not complete. ARW replied that a lot of progress has been made and the last action is due for completion in March 2017.

Ward Dashboard

5. Neal Jones (NJ) provided a verbal update and explained the progress made with the dashboard.

5.1. The measures below will be updated into the ward dashboard to improve the quality and achievability of surveillance.

5.1.1. eVTE less than 95% = red or more than 95% = green

5.1.2. Infection control more than 0 = red.

5.1.3. Medication error reporting:

5.1.3.1. Less than 5 = red

5.1.3.2. 5/6/7 = amber

5.1.3.3. More than 8 = green

5.1.4. Medication error causing harm more than 0 = red

5.1.5. Pressure ulcers more than 0 = red

5.1.6. Falls reported, bespoke target per ward = 10% reduction target 6 monthly.

5.1.7. Falls moderate or above more than 0 = red

5.2. DG asked that a report be brought back to Quality Committee in the first quarter to review progress.

Safer Staffing report

6. SD provided an update for the July and August.

6.1. Overall Trust fill rate for July was 102.1% and 102.7% for August. In July, 9 wards had fill rates below 90% and in August 12 wards had fill rates below 90%.

6.2. In July, there were 5 incidents of moderate harm and 2 in August. All 7 incidents resulting from falls.

6.3. A recruitment day was held on 3rd September and 17 offers of jobs were made to RN's.

6.4. Progress is being made with the recent nurse recruits from India; two nurses have received the NMC decision letter and are now ready to enter the UK to commence the OSCE training; eight nurses are in the process of submitting their information to the NMC; three nurses have passed the English International Language Test (EILT) and have commenced the computer based training; the other 97 are still at the sage of trying to pass the EILT.

6.5. Anne-Marie Stretch (AMS) reported that there is a national push to get the English test made easier, although there is no local solution to the problem; the national test must be passed if you are outside the EU. AMS also said that the Trust are looking to open its own school of nursing and dialogue with Southport and Warrington is ongoing regarding collaboration.

6.6. In July, 2 out of 5 patients experiencing severe harm were on wards with a fill rate of RN's less than 90%. Level 2 Serious Incident Review Investigations are ongoing into all episodes of severe hard and a review of staffing levels on the shift when the harm occurred will be undertaken as part of the investigation.

6.7. AM expressed ongoing concern regarding the fill rate numbers.

IPR

7. Sarah Clarke (SC) summarised the report.

7.1. There has been 1 never event during August. This involved a patient on ICU who required a central line insertion. A trainee was carrying out this procedure, supervised by another trainee. On completion of the procedure, the wire was not removed and this was discovered when the patient had an x-ray performed. The patient was transferred to the Royal to have the wire removed then transferred back to the Trust. KH reported that no serious harm was suffered by the patient. There were, however, failings in the processes but safeguards

are now in place and appropriate education has been given to the individuals concerned.

7.2. Year to date there has been one case of MRSA bacteraemia.

7.3. There were 4 CDI positive cases in August. Year to date there have been 11 positive cases.

7.4. There were no hospital acquired grade 3/4 pressure ulcers in August. There were 5 falls that resulted in severe harm in July. NJ reported that of the 5 falls, 2 were pathological. Of the remaining 3 falls, 2 occurred on a late shift and 1 on an early shift. None of the patients had cognitive impairment and are now recovering. There have been a further 2 falls in August.

7.5. Performance for VTE assessment for July was 94.27%. The provisional 2015-16 HSMR is 99.5.

7.6. Kevin Hardy (KH) reported that there have been 5 cases of hospital acquired thrombosis. 2 were obstetric cases; 3rd was a surgical patient who refused all medication for the length of their stay; 4th was a medical patient, who again refused medication and the 5th was an orthopaedic patient. The policy was followed in each case.

7.7. A&E performance was 75.9%. A Trust wide performance recovery plan is in place with key, must do actions required for implementation with the A&E department and the wider organisation in order to deliver the 95% target.

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

7.9. As at the month of August 2016, the Trust is reporting an overall Income & Expenditure surplus of £0.723m after technical adjustments, which is slightly above the agreed plan. Trust income is ahead of plan by £2.514m, which is matched to the cost of delivering this additional activity. Expenditure on agency stands at £5.1m 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.

7.10. To date the Trust has delivered £4.585m of CIPs, which is behind the year to date plan by 11%. Capital expenditure to date is £0.760m out of a revised year forecast total of £4.985m.

7.11. Mandatory training compliance has improved significantly and now exceeds the 85% target by 6.2%. Appraisal compliance requires improvement and is below the 85% target. Recovery plans are in place.

7.12. Sickness absence for July was 4.9% compared to the Quarter 2 target of 4.35%. Year to date sickness is 4.6%.

Pharmacy check list audit update

8. Simon Gelder (SG) provided an update

8.1. The report summarises overall performance against the Trust's standards for medicines storage and security. Overall the Trust performance is 82%.
8.2. A revised scoring system has been devised to indicate % compliance with the standards. A RAG rating system has been used to categorise performance.

8.3. It is recommended that areas that are amber or red rated need to be targeted, but the care groups need to take ownership.

8.4. Two Omnicell computer controlled medicines storage systems have been under trail within ED since June; one in Resus and one for "out of hours take home" medicines. Feedback from the ED is very positive.

8.5. Ward 1C has had swipe card access installed to control access to their IV fluids store room. This has been set up as a trial location and has been successful. If this is to be rolled out across the Trust, a business case/capital bid would need to be submitted for the next financial year.

8.6. A re-audit will be carried out in October and the results reported back to Quality Committee in November.

8.7. AK said that actions plans have been started within Surgical Care Group and these would be shared with SG.

End of Life Strategy – for ratification

DG congratulated Dr Thompson on his successful interview for Consultant in Palliative Care. He confirmed that a specific NED will have responsibility for EOLC.

9. Dr Anthony Thompson (AT) summarised the strategy.

9.1. The strategy has been devised to define a framework and plan for the delivery and ongoing development of End of Life care in the Trust.

9.2. AT explained the ambitions and foundations of the strategy.

9.3. The strategy was approved by the Quality Committee.

Draft Maternity Strategy

10. Tina Bogle (TB) summarised the strategy.

10.1. This is the final draft of the Maternity Strategy for approval.

10.2. The draft provides the output of the consultation and the high level action plan for Maternity Services from the time of approval to 2020.

10.3. The agreed vision for the service is: *"We will enable women's dreams and wishes for their pregnancy and birth to be realised."* Complimenting this vision are 8 priorities and 26 objectives and desired outcomes. The 8 priorities are:

10.3.1. Increase personalised care for women and their families.
10.3.2. Improve safety
10.3.3. Improve quality of care
10.3.4. Ensure equal access to high quality care
10.3.5. Strengthen integrated care via more robust multidisciplinary, partnership working
10.3.6. Ensure the right staffing is in place
10.3.7. Ensure effective leadership
10.3.8. Ensure financial sustainability

10.4. DG said that he had a concern with the vision statement and its sensitivity, with regards to the phrase "will enable women's dreams" particularly, if a patient has a stillbirth, perinatal death, or birth defect. TB said that it is the vision but we may not achieve it for every woman.

10.5. The Committee approved the strategy, but DG would discuss with the Board the sensitivity regarding the vision statement.

Feedback from Patient Safety Council

11. NJ reported:

11.1. A question was raised related to ADT issues not only for eVTE but also for eMEWS. In admission areas such as AED, AMU and SAU, patients are often not on ADT which is forcing staff to revert to a paper based observation and MEWS system. It was noted that in a recent SUI investigation the paper observations had been misplaced creating a considerable gap in retrospective review of patient care.

11.2. NJ will raise the issue again with IT and report back to Quality Committee.

Feedback from Patient Experience Council

12. ARW reported:

12.1. Improvements have been made in triangulating data for patients with learning disabilities.

12.2. The Patient Experience strategy has been approved.

Feedback from Clinical Effectiveness Council

13. SD reported:

13.1. SHMI data – COPD and Bronchiectasis. Dr Twite provided the results of an investigation into the SHMI data which indicates that death rates were higher in adult patients with COPD and Bronchiectasis than expected. Further analysis is required and Dr Twite agreed to take this forward with Kevin Hardy.

Feedback from CQPG Meeting

14. There was nothing to escalate to the Committee.

Feedback from Executive Committee

15. Peter Williams (PW) reported on meetings of the Executive Committee between 15th July and 8th September.

    15.1. Decisions taken by the Committee included measures to improve mandatory training and appraisals, the Outlier Policy and application of DoLS.

    15.2. Assurances regarding progress in support of an additional Haematologist, safer staffing, Cancer Specialist commissioning and CQUIN performance were obtained.

    15.3. A good report was provided regarding CQUINS – targets have been achieved in the first quarter.

    15.4. No significant quality related investment decisions were made and there were no specific items requiring escalation to the Board.

Feedback from Workforce Council

16. PW reported:

    16.1. A paper regarding e-rostering will be presented at Trust Board this month.

17. **Effectiveness of meeting**

    17.1. Good level of discussion and challenge from Committee members. Presentation of papers was excellent and the agenda was adhered to.

18. **AOB**

    None noted.

19. **Date of Next Meeting**

Tuesday, 18th October 2016.

TRUST BOARD PAPER

Paper No: NHST(16)092
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 September 2016
Summary: **Agenda Items** o **For Information** o Q1 SLR o Mandatory Training Options o PA Consulting o Review of MITC and IT Reporting o Review of Agency expenditure o Commercial Strategy o Forecast outturn 2016/17 o **For Assurance** o A&E Update o IT update o Integrated Performance Report Month 5 2016/17 o Month 5 2016/17 Finance Report o Governance Committee Briefing Papers: ▪ CIP Council ▪ Procurement Council o **For approval** o Estates Return Information Collection **Actions Agreed** • Appraisals and Mandatory Training Compliance review in February 2017 • Action plan to deliver Corporate Services efficiency savings to be presented as part of 2017/18 overall CIP programme. • Winter plan to be presented to Trust Board in October 2016
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: Su Rai Non-Executive Director
Date of meeting: 28th September 2016

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)093

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 17th August 2016. The following matters were discussed and reviewed:

External Audit (Grant Thornton):

- The Committee received and accepted the annual audit letter in respect of the audit of the Trust's accounts, value for money and quality account for 2015/16 which was very positive.
- 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 and follow-up reviews. They requested that the senior manager overseeing the audit with limited assurance (Locality review - Maternity) come to the next committee to provide assurance on addressing the recommendations.

Anti-Fraud Service (MIAA):

- The Committee received an update on progress with the annual counter fraud plan which is currently going to plan.
- The Committee also received for information a report on the top 10 frauds in the NHS in 2015/16 and a briefing note on changes to NHS Protect.

Trust Governance and Assurance:

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

Standing Items:

- The audit log (report on current status of audit recommendations) (ADoF)
- The losses, compensation and write-offs report for the quarter ending June 2016 (ADoF).
- Aged debt analysis as at end of July 2016 (ADoF).
- Tender and quotation waivers (ADoF).
- External reviews (DoF).

Under "any other business" the following items were discussed:

- Updated Corporate Governance Manual for minor changes, mainly references to new Trust auditor panel and its responsibilities and changes in name from TDA to

NHSI). These changes were agreed by the Committee. (ADoF).

- The recent consultation re new DH Group Accounting Manual for information (ie. the merging of Monitor's and the DH finance manuals for 2016/17 onwards).

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): Members are asked to ratify the following item:

1. The minor changes to the Trust's Corporate Governance Manual

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

Date of meeting: 28th September 2016

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)093a

Title of paper: Auditor Panel Report.

Purpose: To feedback to members key issues arising from the Auditor Panel including recent activity regarding the appointment of the Trust's external auditors

Summary: The Auditor Panel met for the first time on 17th August 2016 following approval of its terms of reference in May (included as an appendix to the Audit Committee Terms of Reference). For the financial reporting years 2017/18 onwards, the Trust is now responsible for appointing its own external auditors and must have made their appointment by 31st December 2016. The following matters were discussed:

- Election of the Auditor Panel Chair. (The Panel agreed that the Chair would be Su Rai, Chair of the Audit Committee.)
- The Auditor Panel Terms of Reference.
- Appointment options, timeline and specification of the external audit service.(The Panel agreed to appoint using the NHS SBS Framework Agreement, ref SBS/16/PC/ZY/8952 with a three-year contract with the option to extend for up to two years.)
- Appointment of the Trust's internal auditors. (The current contract with Mersey Internal Audit Agency is for three years with the option of extending to up to a further two years. The end of March is the point at which three years will have expired. The Panel agreed to extend the contract for 12 months with a further review in 12 months' time.)

Since the above meeting the Auditor Panel has interviewed and selected the Trust's current external auditors, Grant Thornton. The appointment will generate savings of just under £10,000 per year for the Trust's statutory accounts audit and Quality account audit. In addition, the appointment will generate savings of just under £1,400 per year for the independent review of the Trust's charitable funds. For further note, Grant Thornton's new engagement lead will be Karen Murray, who will be replacing Jackie Bellard. The precise timing of this change will be confirmed in due course. The Panel is therefore recommending the Trust Board to approve its selection, after which the appointment will be notified to Grant Thornton.

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

Financial implications: Financial savings on appointment

Stakeholders: The Trust, its staff and all stakeholders

Recommendation(s):

1. Members are asked to note the contents of this report and to be assured that processes are in place to appoint the Trust's external auditors now and in the future. **2.** To approve the appointment of Grant Thornton as its external auditors as recommended by the Auditor Panel.
Presenting officer: Su Rai, NED and Chair of Audit Committee
Date of meeting: 28th September 2016

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)094
Title of paper: Annual Audit Letter 2015/16
Purpose: This report summarises the work your external auditor, Grant Thornton has performed at the Trust for the Audit year 2015/16
Summary: The Annual Audit Letter was discussed and accepted at the Audit Committee on the 17th August. The key points to note from the Audit are that the Auditors issued: **Financial statements opinion** An unqualified opinion on the Trust's financial statements on 26th May 2016. **Value for money conclusion** Satisfied that the Trust put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources. **Quality Accounts** The Quality Account and the indicators we reviewed and were prepared in line with the Regulations and guidance.
Corporate objectives met or risks addressed: N/A
Financial implications: N/A
Stakeholders: N/A
Recommendation(s): That the Trust Board sign off the Annual Audit Letter
Presenting officer: Nik Khashu, Director of Finance
Date of meeting: 28th September 2016

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)095
Title of paper: Foundation Trust Application Programme – Update Report
Purpose: To provide the Board with a progress report on the Foundation Trust (FT) application programme, the development of the Sustainability and Transformation Plan (STP) for Cheshire and Merseyside, and the continued development of the organisations governance and leadership capability for the future.
Summary: This paper reports on the progress in responding to the national planning guidance, the requirement to develop place based 5 year sustainability and transformation plans and the on-going elements of the FT development programme. NHS Improvement (NHSI) final Single Oversight Framework (SOF) has now been published following the consultation. The overall intention and operation of the final framework is in line with the consultation document that was detailed in the July report to the Board. The new framework will become operational from Q3 and the Trusts reporting and performance management systems are being reviewed to ensure that all the required metrics to be reported to NHSI are visible to the Board. At this stage the new SOF does not specifically require Boards to make monthly declarations confirming compliance with the Provider Licence conditions, although the Provider Licence will still be in force (in shadow form for NHS Trusts). 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: 28th September 2016

Foundation Trust Application Programme – Update August 2016

1. Operational Planning

1.1 The Trusts 2016/17 Operational Plan has now been published on the Trusts website in accordance with NHSI requirements.

1.2 The Trusts control total was not amended as a result of the review undertaken by NHSI of provider sector pay cost growth and the opportunity to bring forward plans for back office and unsustainable services.

1.3 The Trust has received ¼ of the sustainability and transformation fund (STF) allocation.

1.4 Planning guidance for 2017/18 is due to be issued during September that will require;

- 2 year operational plans to be agreed by Boards by December 2016 that align to the STP level plans
- 2 year contracts to be agreed with commissioners by December 2016 that align to the STP level plans
- A continuation of STF funding for providers for 2017/18 and 2018/19
- The introduction of system control totals for some key targets

2. Sustainability and Transformation Plan development

2.1. The Cheshire and Merseyside STP received formal feedback in August, which set out a number of areas where the National Leadership bodies wanted to see improvements or further development;

General;

- *Have greater depth and specificity, with clear and realistic actions, timelines, benefits (financial and non-financial outcomes), resources and owners.*
- *Provide year on year financial trajectories that, when aggregated nationally, will enable us to test for overall affordability.*
- *Articulate more clearly the impact on quality of care.*
- *Include stronger plans for primary care and wider community services that reflect the General Practice Forward View, drawing on the advice of the RCGP ambassadors and engaging with Local Medical Committees.*
- *Set out more fully your plans for engagement with local communities, clinicians and staff and the implication for the timing of implementation.*

Specific to the Cheshire and Merseyside STP;

- *Strengthen cross-organisational engagement and working, particularly with the Local Authorities, to drive and deliver results as a single, unified system.*

- *Reconcile further the service strategy and the financial model to demonstrate financial resilience and balance across the system.*

- *Ensure that the plans for each LDS are equally well developed.*

- *Include stronger plans for mental health drawing on the recent publication of the Forward View for Mental Health that are supported by appropriate investment including national funding set out for this purpose.*

2.2. The next iteration of the STP is to be submitted on 21st October, and to inform the STP submission the Alliance LDS level plan will be updated by 12th October.

2.3. Over the summer the project structure at both STP and LDS level has been clarified and strengthened (appendix 1 and 2)

2.4. A number of supporting work streams have also been established for finance, HR, IT, Communications and Engagement and Estates.

2.5. The Trust is represented at STP and at LDS levels across a number of the key work streams, and has also put forward staff to support with programme and project management.

2.6. There has been interest both nationally and locally in the implications of the STP plans on service configuration and future service developments, and a communications strategy is being developed for the Cheshire and Merseyside STP to support individual organisations to respond consistently and to coordinate the consultation processes that are needed at STP, LDS and individual organisational level.

3. Well Led Framework Action Plan

There are 47 identified actions on the Trust well led framework action plan, all of which were due for completion by the end of July 2016. 42 of these actions have been completed, 3 are in progress and 2 have not been completed. These are; a regular external benchmarking report that is considered by the Board and having an up to date Communications and Engagement Strategy. The Executive are cognisant of both these requirements and are considering how they are both impacted or overtaken by the STP. Both requirements will be considered as part of the new self–assessment and either carried forward to the next action plan in their current form, or evolved to reflect an alternative route for delivery.

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

July 2016 – Summary Progress Report

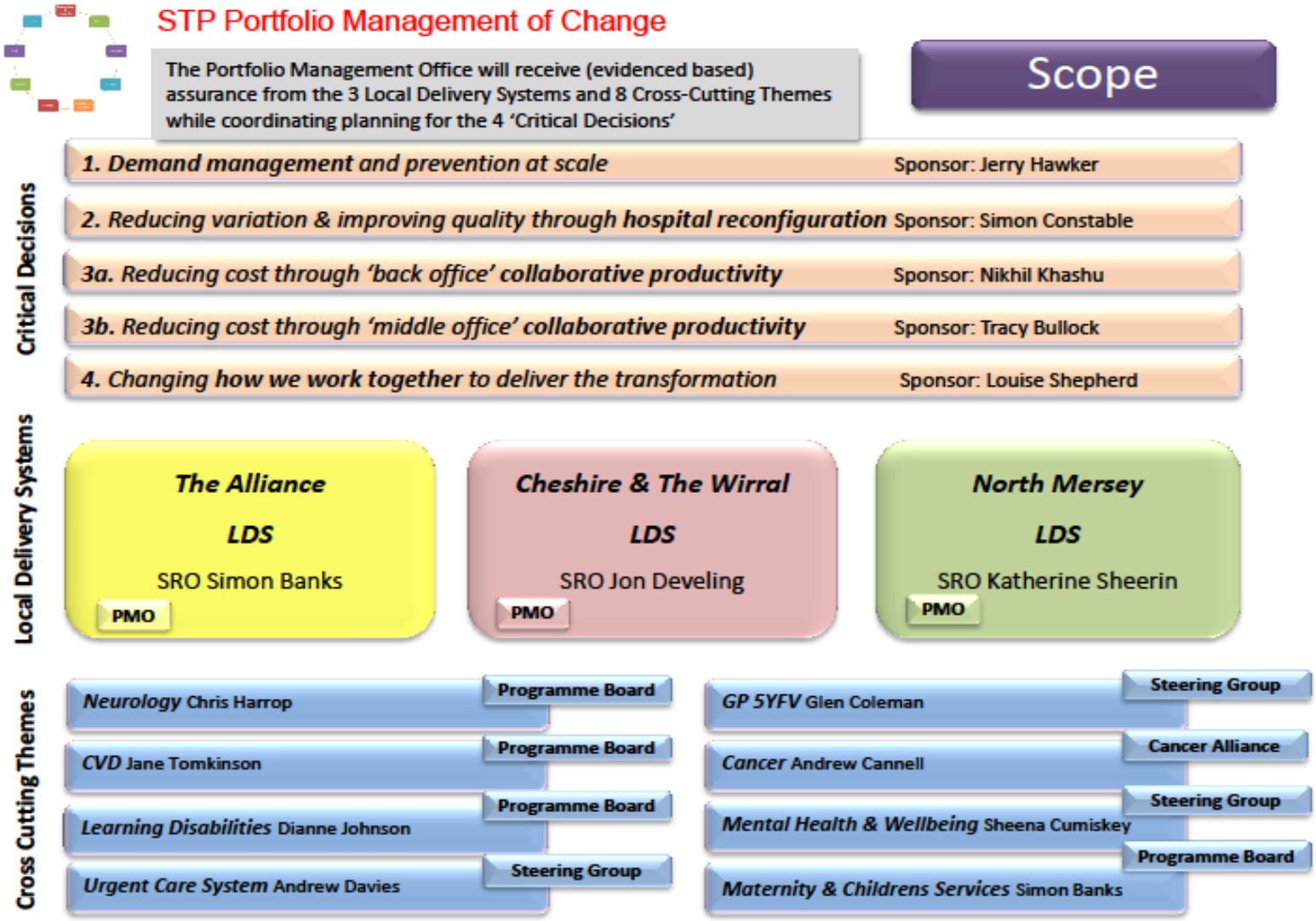
Domain	Total No of Actions	Actions Due to be Completed	Actions Completed (Green)	Actions due and in progress (Amber)	Actions not completed and overdue (Red)
Planning and Strategy	18	18	14	3	1
Capability and Culture	15*	15	14	0	1
Process and Structure	12	12	12	0	0
Measurement	2	2	2	0	0
Total	**47**	**47**	**42**	**3**	**2**

In line with best practice a further self-assessment against the well led domains is being undertaken. Bill Hobden has agreed to be the NED member of the review group as the SID, but other Board members are invited to participate if they wish.

To supplement the self- assessment and to comply with the proposals in the draft NHSI Single Oversight Framework an element of independent observation and review is also being proposed, as this has not happened for almost two years. This will be built into the forthcoming board development programme.

ENDS

Cheshire and Merseyside STP Structure



Alliance Local Delivery System Structure

Alliance LDS input into STP

Governance

Leadership Group/Programme Board
Chief Executives/Chief Officers of each organisation
Work stream SRO's

Project Working Group
Simon Banks (SRO)
Programme Directors/Managers

Critical Decision Work Streams

Demand management and prevention at scale	Leigh Thompson & Colin Scales
Reducing variation and improving quality through hospital reconfiguration	Ann Marr
Reducing cost through back and middle office collaborative productivity	Andrea Chadwick
Changing how we work together to deliver the transformation	Dianne Johnson

Cross Cutting Themes

GP 5YFV	Glenn Coleman and Mark Pilling
Cancer	Dr Paul Morris
Neurology	Mel Pickup
Cardiac	Dr Mick O'Connor, Dr Ifeoma Onyia
Learning Disabilities	Dianne Johnson
Urgent Care System	Andrew Davies
Mental Health & Wellbeing	Craig Porter/Simon Barber
Maternity & Children's Services	Mel Pickup, Rob Gillies, Simon Banks, Steve Tatham, Eileen O'Meara

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)096

Subject: E-Rostering KPI update report

Purpose: To update the Board on the progress made following the implementation of e-Roster, to explain the key performance indicators used to date and outline the Trust's performance against those indicators for the reference period 17th May 2015 to 9th July 2016

Summary:

47 clinical areas are now using e-Roster system. Other areas have been timetabled to rollout the system and work in currently underway with Sexual Health.

With the support of the system provider, Allocate, five key performance indicators have been selected;

- How long it takes the Matron to approve and then publish the planned roster for next 4 week roster period (Trust Roster Approval Lead Time in days)
- How many shifts that have been identified as required by the ward, have actually been assigned to staff for the roster period (Trust Filled Duty Count %)
- How many staff contracted hours have been assigned to those shifts that month and are there hours owing by either the employee or the Trust (Trust Hours Balance %),
- How many shifts were assigned to bank and agency staff (Trust Bank/Agency %)
- How effective has the management of annual leave been in the reporting period (Trust Annual Leave %);

Performance against these indicators is tabled at paragraph 4 which shows areas still requiring improvement. During the reference period the Trust did not meet the 28 day target for publishing rosters for staff. The Trust met its' 'Filled Duty' count target of 80%. Much work has been carried out by the e-Roster Team and Ward Managers in addressing the Trust Hours Balances i.e. the number of contracted hours not used and this figure continues to decline. Bank and agency usage fluctuated during the reference period. The percentage of staff taking annual leave should range between 11%-17%. During the reference period overall performance was good but there were several breaches.

The Trust is able to compare performance against 90 other similar sized organisations. Comparison data provided by Allocate for the reference period 12 June 2016 – 09 July 2016 indicates that the Trust performed well in reducing the Hours Balances %, however 24.6% of shifts remained unfilled compared to other comparators whose rates were between 19.5%-21.6%. Although Bank and Agency usage is a concern for the Trust, the Trust is performing better that the majority of the comparators. The Trust was above average in managing annual leave.

Corporate Objectives met: Financial performance and efficiency. Risk to Operational performance

Financial Implications:
Stakeholders: The Trust Board/ Trust Wide
Recommendation(s): To note report
Presenting Officer: Anne-Marie Stretch, Deputy Chief Executive and HR Director
Board date: 28th September 2016

1. Introduction - E-Roster (Nursing & Midwifery)

Following the implementation of the e-Rostering tool across 47 clinical areas, a set of key metrics have been identified to monitor performance to drive best practice across the organisation, facilitate cost effective utilisation of the workforce through robust e-rostering and ultimately, ensure we have the right number of staff, with the right skills, in the right place, at the right time to deliver first quality patient care and minimise the need for agency staff.

This report explains the key metrics used, provides an overall view of the Trust's performance for the period 17th May 2015 to 9th July 2016, together with a comparison between the Care Groups and also provides a performance management framework to be implemented in order to further embed working practices and enable the Trust to realise the benefits of the E-roster system.

2. KPI Indicators (KPIs)

Following best practice guidance from the system provider Allocate, and in line with 90 other Trusts, five KPIs are used to create the Trust's E-Rostering monthly KPI dashboard. These KPIs are designed to triangulate specific areas of potential development and challenge that a Trust can tackle as part of its journey towards greater efficiency and effectiveness.

The KPIs measure performance against the following:

- How long it takes the Matron to approve and then publish the planned roster for next 4 week roster period (Trust Roster Approval Lead Time in days)
- How many shifts that have been identified as required by the ward, have actually been assigned to staff for the roster period (Trust Filled Duty Count %)
- How many staff contracted hours have been assigned to those shifts that month and are there hours owing by either the employee or the Trust (Trust Hours Balance %),
- How many shifts were assigned to bank and agency staff (Trust Bank/Agency %)
- How effective has the management of annual leave been in the reporting period (Trust Annual Leave %);

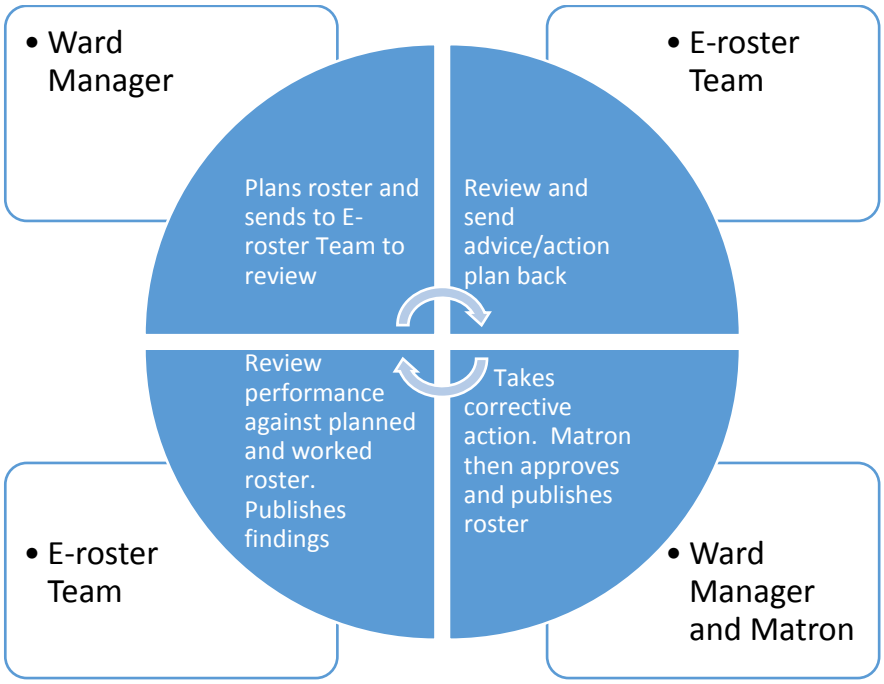
These metrics provide a rounded view of rostering practices at both ward and care group level and highlight areas of good people management practice and identify areas requiring development. These KPIs also allow the Trust to compare performance against similar sized Trusts.

3. Monitoring and Reporting

Following the introduction of the e-Rostering dashboard, the e-Rostering team monitor at two stages; initial monitoring of the planned rosters and second review of the actual rosters worked.

Planned rosters are sent to the e-Roster team to review. If exceptions are identified, action plans are produced to enable the Ward Manager to take remedial action before submitting the roster to the Matron for approval.

At month end, reports are then produced and metrics from the planned and actual phases are reviewed to determine the success of any corrective measures advised by the team at stage 1. See diagram below:-



Since implementation, three dashboards have so far been published showing 'planned' positions. One additional dashboard has also recently been developed showing both the planned and actual positions for both Medical and Surgical Care Groups and by ward and these will now be issued automatically each month. The reports are issued to all Assistant Director of Operations, Directorate Managers, Matrons and Ward Managers and highlight areas for improvement.

4. Performance

Table 1 below shows roster data at Trust level from 17th May 2015 to 9th July 2016; trend analysis of each KPI at both Trust and Care Group levels can be found at Appendix 1.

Roster Period	Trust Roster Approval Lead Time (Days)	Trust Filled Duty Count %	Trust Hours Balances %	Trust Bank/Agency Use %	Trust Annual Leave %
Compliant Target (Green)	*28 or more*	*91% or more*	*2% or less*	*10% or lower*	*Between 11% and 17%*
17/05/2015 - 13/06/2015	n/a	77	3	5.7	12.7
14/06/2015 - 11/07/2015	n/a	81.6	3.3	7.4	14.1
12/07/2015 - 08/08/2015	24	82.2	3.9	8.1	15.6
09/08/2015 - 05/09/2015	17	80.2	2.8	8.5	16.3
06/09/2015 - 03/10/2015	18	81.5	3.3	8.8	14.2
04/10/2015 - 31/10/2015	10	83.2	2.1	10.2	12.8
01/11/2015 - 28/11/2015	21	84.4	2.3	10.2	11.6
29/11/2015 - 26/12/2015	21	80.5	2.7	9.5	14.6
27/12/2015 - 23/01/2016	22	77.8	2.7	8.8	13.5
24/01/2016 - 20/02/2016	19	79.8	2.4	11	14.6
21/02/2016 - 19/03/2016	21	79.6	2.1	12.3	17.1
20/03/2016 - 16/04/2016	13	77.3	2	11.3	17.2
17/04/2016 - 14/05/2016	19	78.9	1.8	9.3	11.7
15/05/2016 - 11/06/2016	24	73.4	1.9	9.7	14.8
12/06/2016 - 09/07/2016	23	74.7	1.4	9.8	12.8

Table 1

Comparison data has been provided by Allocate and although it is for a different reference period i.e. 12 June 2016 – 9 July 2016 it does provide an up to date view of the Trust performance against similar sized Trusts. These results are shown in Appendix 2.

5. Conclusion

The KPI dashboards have proved to be an effective way for e-Rostering practices and utilisation of the workforce to be monitored. Much work has been undertaken by the e-Roster team working with key staff within the directorates to drive improvements, however further work is necessary to enable the Trust to fully realise the benefits of the system. This will include implementing the system across other areas of the organisation

6. Next Stages

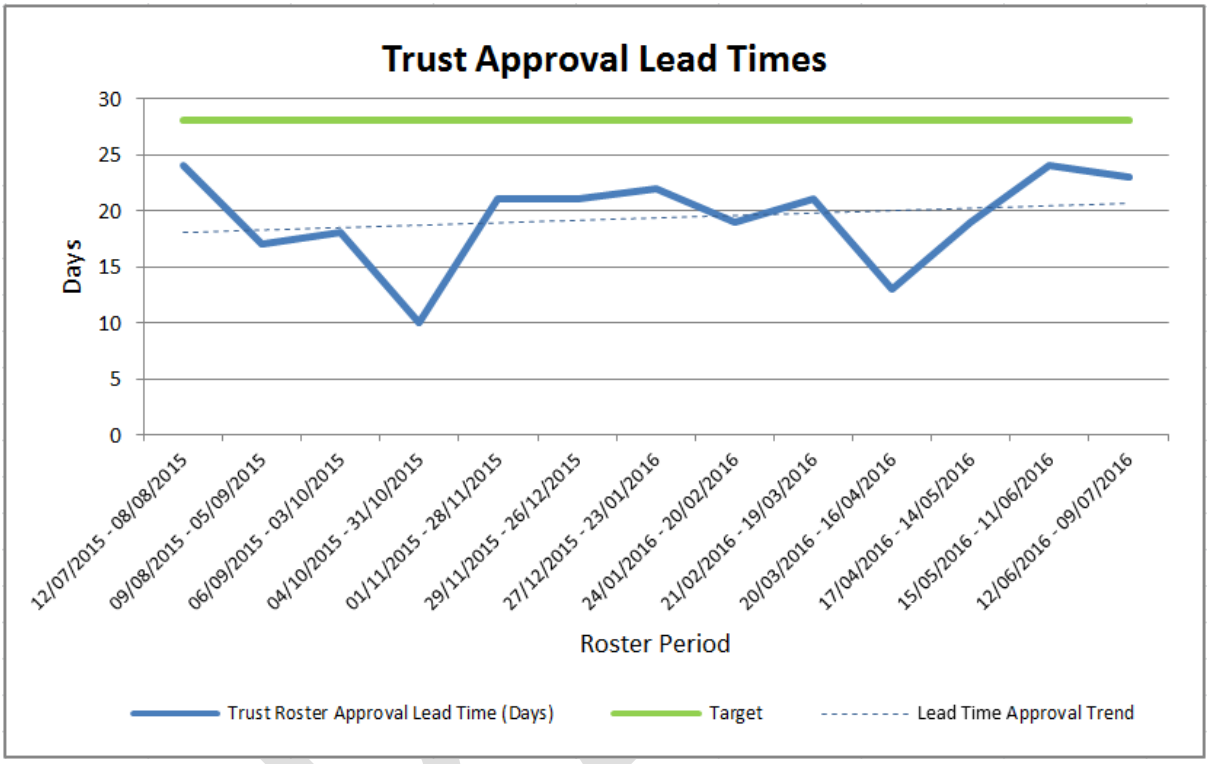
The Trust is now data rich but we must ensure that managers are not knowledge poor. Further work is required in educating Matrons, Directorate Managers and ADOs in data analysis, sharing good practice and driving a continuous culture of performance improvement. This can be achieved in part by setting key work objectives from Ward to Executive Board and providing further support from the e-Rostering team with attendance at business meetings along with other support function colleagues.

Reviewing the optimisation of rostering and unused hours balance data will be carried out to establish where these hours can be utilised in place of using bank or agency.

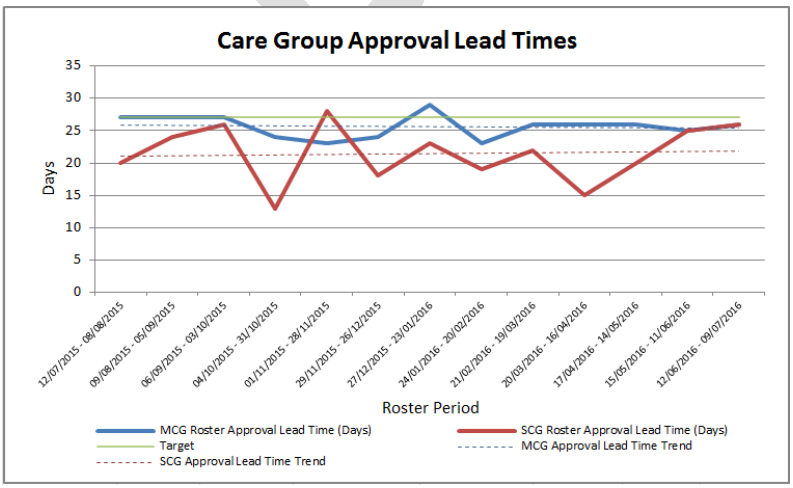
Work has commenced on developing a performance improvement plan to build upon the success of the project implementation and to realise the benefits of e-Rostering; this can be found at Appendix 3. It should be noted that this work is required in conjunction with the further roll out of the system across other areas of the business as well as carrying out 'business as usual' by the team. A review of the composition of the small e-rostering team will be carried out to ensure it can meet the needs of the Trust.

Trust wide and Care Group E-Rostering Breakdown 17th May 2015 to 9th July 2016

Roster Approval Lead Times - Approval given and publication of rosters 28 days or more before staff are due to work

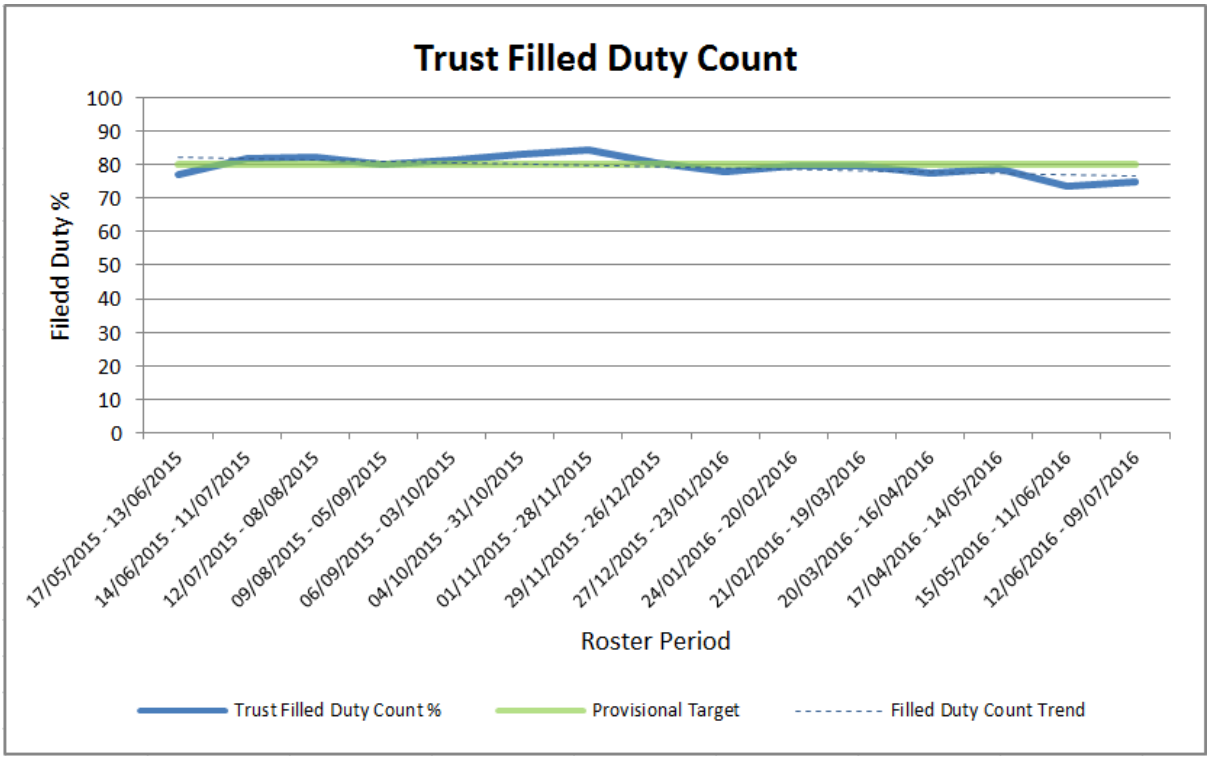


On average over the past twelve months, the lead time for roster full approval has fluctuated. The aim is for full approval to be made 28 days or more before the rosters become live and the trend line indicates a gradual but faltering move towards this target. Clearly further work by the Ward Managers and Matrons to improve performance is required. Advice from Allocate suggests that for maximum utilisation of the workforce Trusts should aim for a 6 week lead time. Comparison data does show that this is achievable.



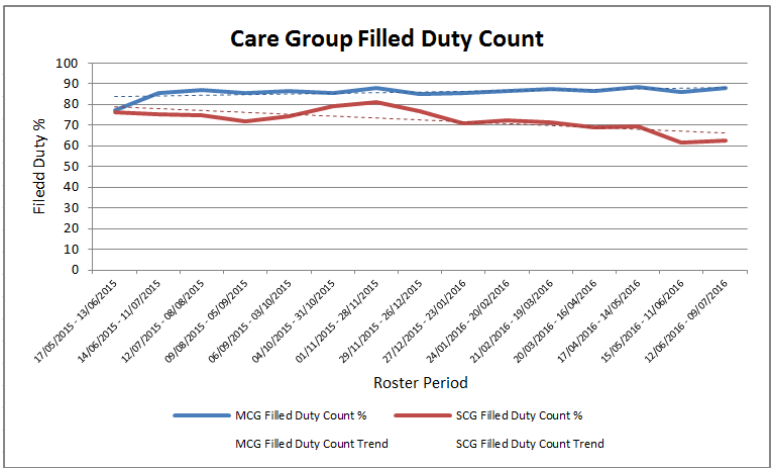
Approval lead times in the Medical Care Group have been fairly consistent during the reference period, but Surgical Care Group performance has been somewhat erratic.

Filled Duty Count % - national target 91%-100% (provisional target of 80%) – shifts that the wards have identified as being required



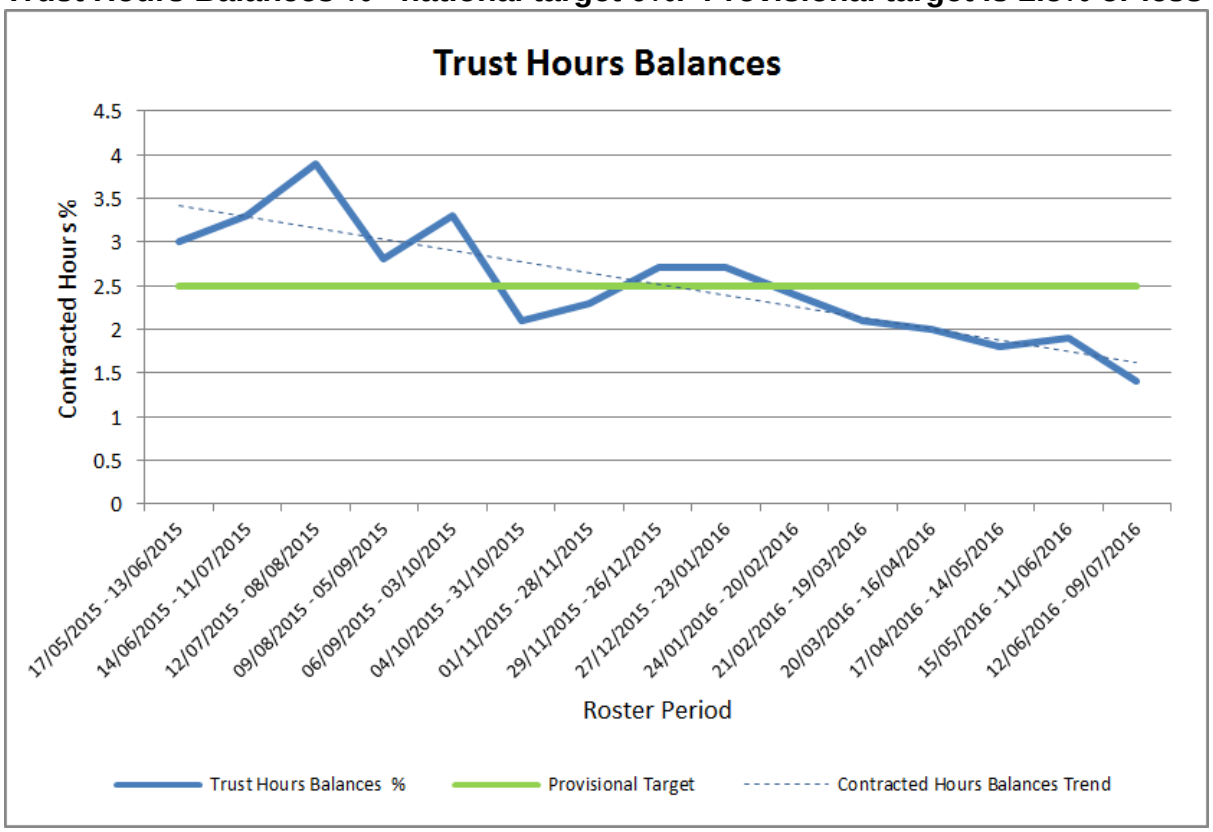
This metric includes both qualified and unqualified staff as well as Bank and agency staff. It compares the required shifts, which have previously been agreed by the ward/department and set in the system, against the number of staff who have been assigned to those shifts; this is displayed as a filled rate percentage. This indicator is used to determine whether correct shift demand has been set.

The average percentage of filled duties for the Trust as a whole during the reference period is on or around the provisional target of 80%. There is a slight downward trend covering an approximate range of 5% over the period.



When comparing Care Groups there is a slight upward trend within the Medical Care Group, however a more pronounced downward trend is evident within the Surgical Care Group. Work will be on-going as part of the Ward KPI Dashboards to review shift demand templates and shift allocation to drive more effective rostering against this metric.

Trust Hours Balances % - national target 0%. Provisional target is 2.5% or less

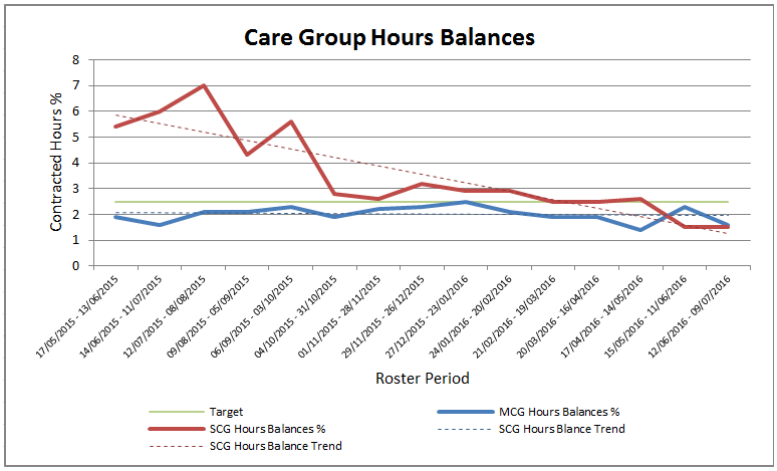


Also known as Hours Accounts or Unused Contracted Hours, this metric calculates the total number of contracted hours an individual *should* work in a given period based on their contract of employment and the total number of hours assigned to that individual in the form of shifts and non-attendance (sickness, annual leave, study, maternity etc.).

Expectation is that Hours Balance figures for individual staff will be a close to 0 as possible, with no individual holding +/- 7.5hrs hours balance. When the +/- 7.5hr balance is reached a shift should either be added or removed from the individual's allocation to bring balances as close to zero as possible.

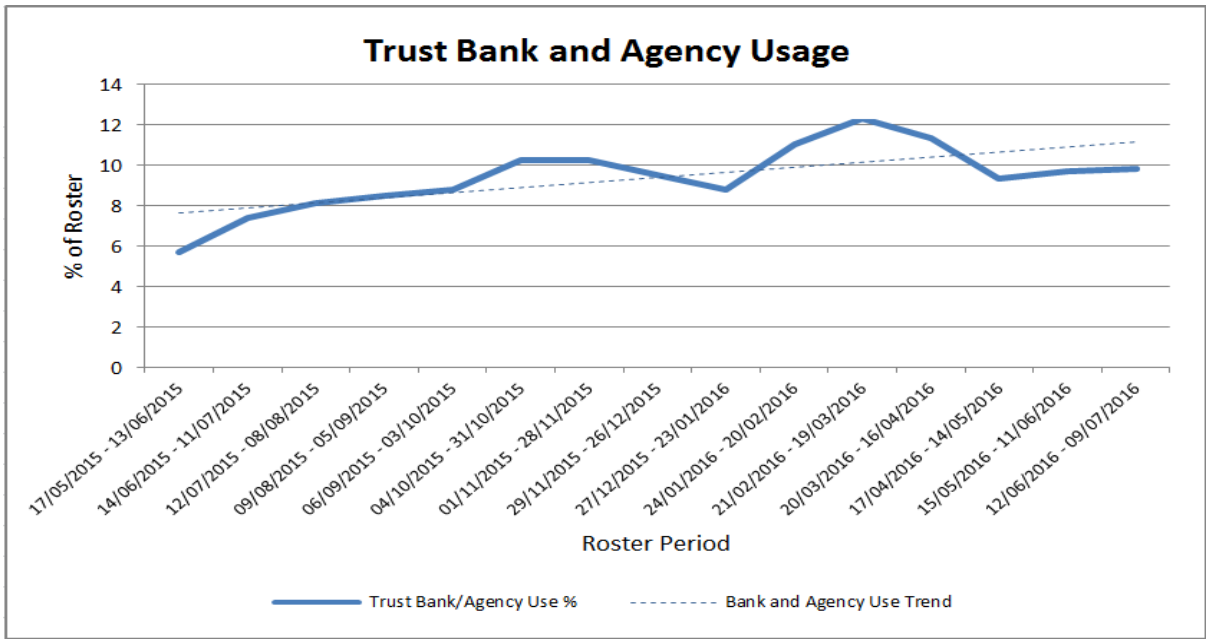
Overall Hours Balances for the Trust indicates a positive downward trend, taking the percentage of unused contracted hours on each roster period well below the provisional target of 2.5%. The final position within the last four week roster period stands at 1.4% which equates to a total 1957.81 unused contracted hours.

The e-Rostering Team and Ward Managers have been working closely to reduce hours balances over the past months, as this is an identified area where benefits can be realised. Ensuring staff work to their contracted hours as much as possible will increase workforce availability whilst reducing reliance on temporary staffing.



Hours Balances are now comparable between the Medical and Surgical Care Groups. The majority of reductions against Hours Balances have been achieved within the Surgical Care Group, which has seen reductions of 5.5% over the reference period.

Trust Bank and Agency Use % - Provisional target of 10% or less



This metric measures the total number of assigned hours and from this total amount how much was attributed to bank and agency workers. This key indicator can primarily be used to monitor overall bank and agency usage. The Trust's compliance rate for this KPI is 10% or lower. Bank and Agency (BA) use over the reference period has fluctuated, but shows an upward trend covering a range of approximately 2.5%.

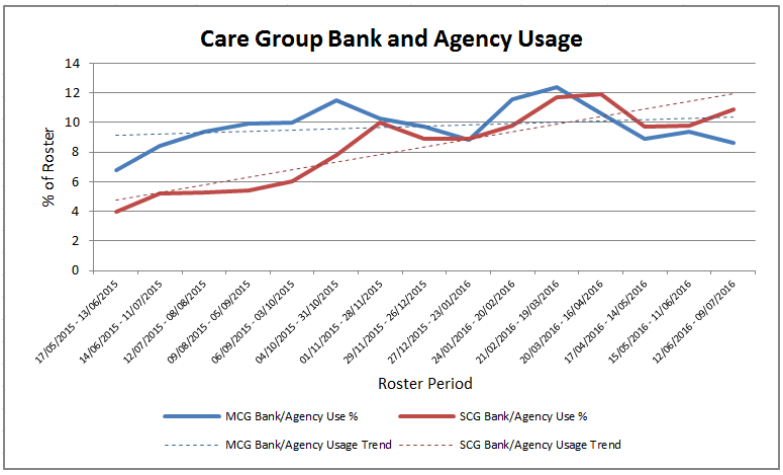
Work has been undertaken by the Staffing Solutions Team following the staged introduction of capped rates for agencies, and this does appear to have impacted the overall BA usage in November and March, where there are clear reductions in BA bookings. On further analysis the 5 top BA request reasons during the reference period were:

Medical Care Group

	Bank and Agency	Bank ONLY	Agency ONLY
1.	Short Term Sickness	Short Term Sickness	Short Term Sickness
2.	Unfilled Funded Vacancy	Unfilled Funded Vacancy	Unfilled Funded Vacancy
3.	Special Shift - Falls	Long Term Sickness	Extra Activity/Escalation
4.	Long Term Sickness	Special Shift - Falls	Special Shift – Falls
5.	Extra Activity/Escalation	Extra Activity/Escalation	Special Shift – Acuity

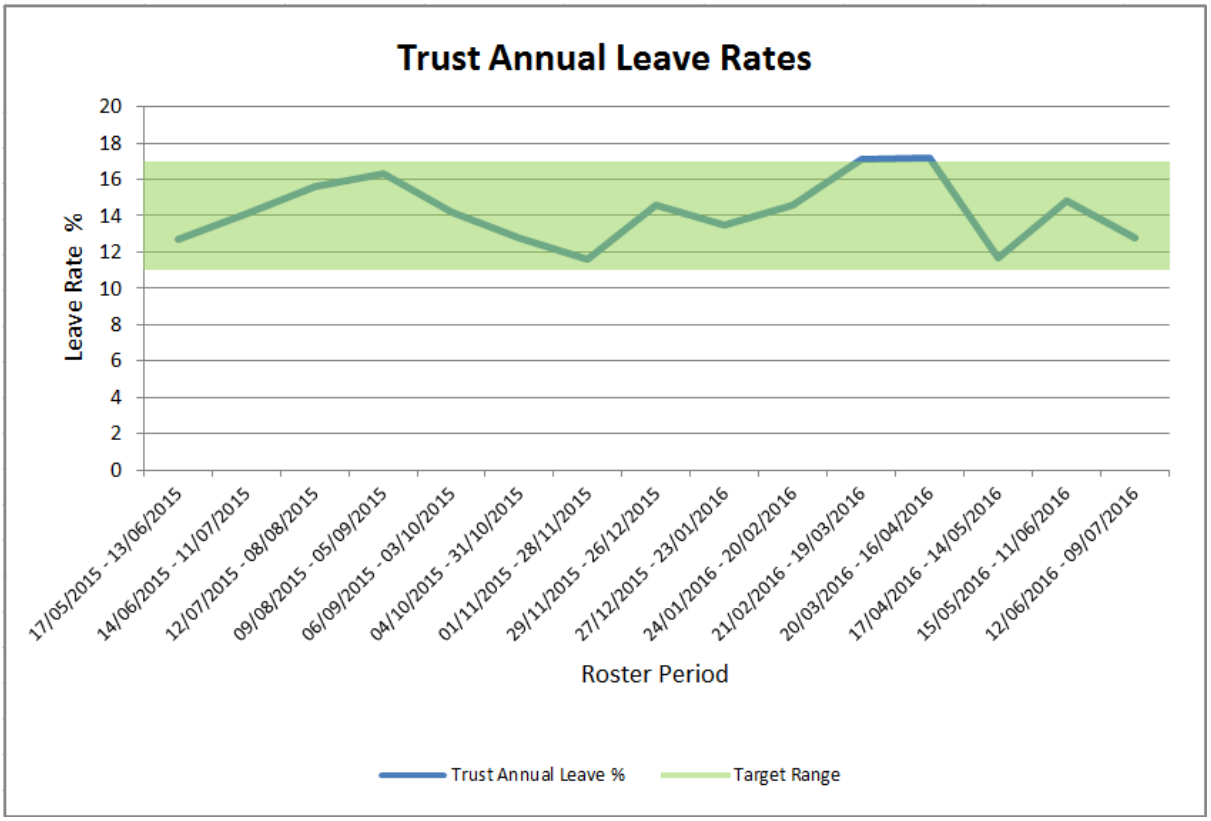
Surgical Care Group

	Bank and Agency	Bank ONLY	Agency ONLY
1.	Unfilled Funded Vacancy	Unfilled Funded Vacancy	Unfilled Funded Vacancy
2.	Short Term Sickness	Short Term Sickness	Extra Activity/Escalation
3.	Extra Activity/Escalation	Extra Activity/Escalation	Short Term Sickness
4.	Long Term Sickness	Long Term Sickness	Special Shift – Acuity
5.	Special Shift - Falls	Extra Activity/Escalation	Special Shift – Falls



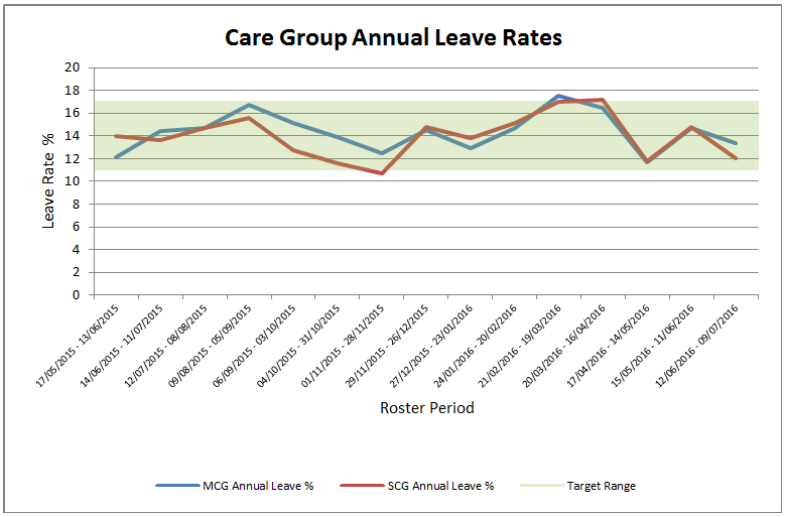
Both Care Groups show upward trends over the reference period however there is a more pronounced upward trend within the Surgical Care Group. There have been reductions in Bank and agency use over the past few roster periods, however the Surgical Care Group is showing a slight increase in the last roster period.

Annual Leave Rates – National target 11%-17%



Robust management of annual leave is key to effective workforce utilisation and ultimately will facilitate control over agency costs. Best practice guidance to organisations is that effective management of annual leave can be achieved by allowing between 11%-17% of the workforce to take annual leave at any one time. Although breaches of the upper annual leave limit may have an immediate effect on staffing, breaches against the lower limit can have detrimental effects on staffing at a later date within the leave year. To ensure that there are no staffing issues managers are advised to spread leave as evenly as possible throughout the leave year

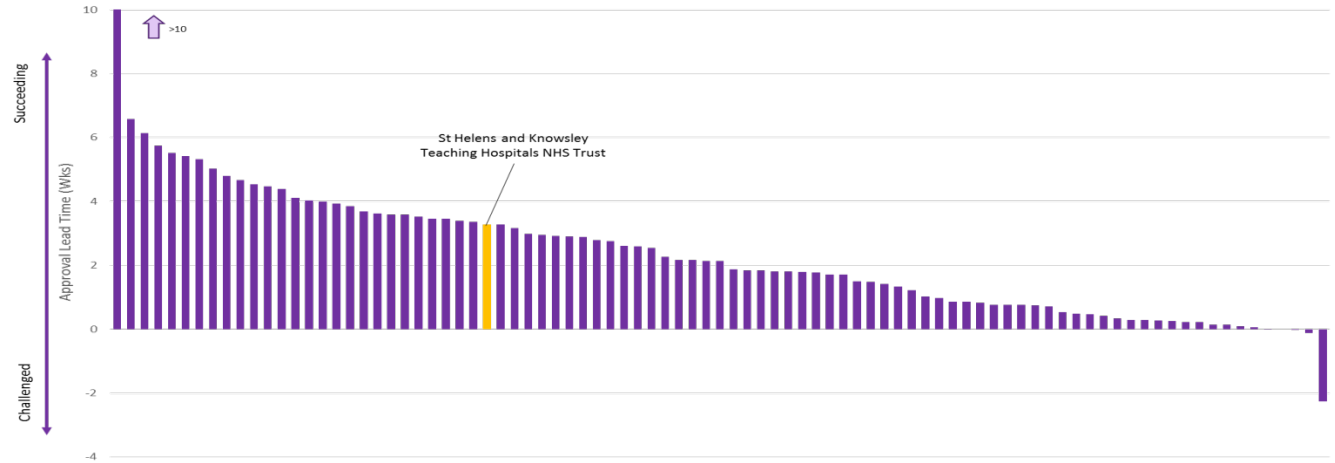
Overall Trust annual leave rates have remained within the guide range throughout the reference period, with the exception of two slight breaches of the upper level of the range between Feb16 and April16. Support has been provided to those areas and as shown above, there have been no further breaches during the reference period.



Comparing Care Groups there is a degree of correlation against their annual leave rates, however the Surgical Care Group had two breaches, one against the upper limit, and one against the lower limit, whereas the Medical Care Group only breached the upper limit on one occasion.

Multi-Trust Comparators - 12/06/2016 -09/07/2016 **Appendix 2**

Roster Approval Lead Time



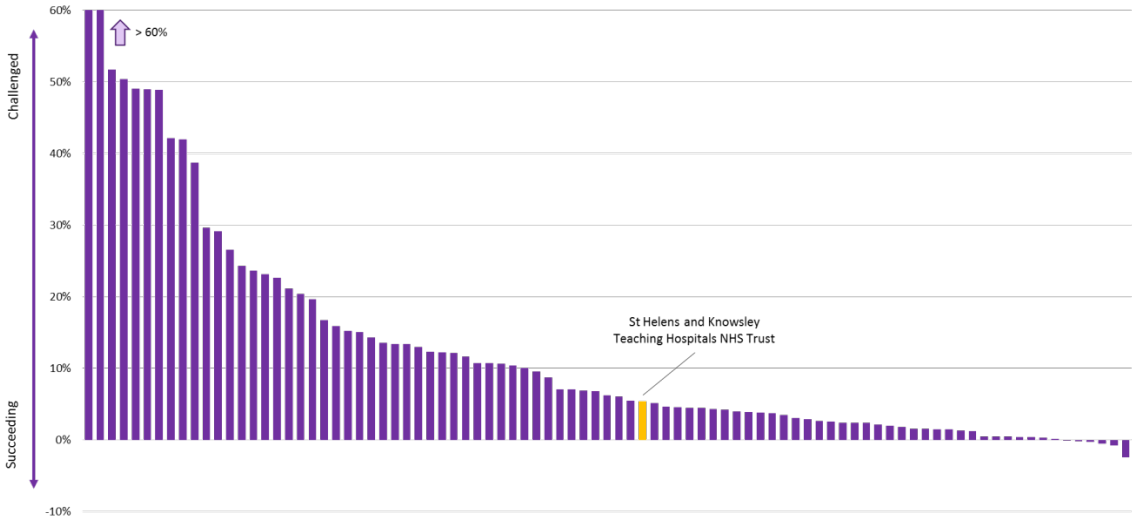
The Trust is performing better than others but as shown above there are trusts who are achieving the 6 week rota approval and publishing target. That said, these organisations have had the system longer than STHK however this Trust should work towards a stretch target.

Filled Duty Count

No slide available however during the reference period, it is reported that 24.6% of Trust shifts remained unfilled. The range for multi-trust comparators was 19.5%-21.6%

Multi-Trust Comparators - 12/06/2016 -09/07/2016

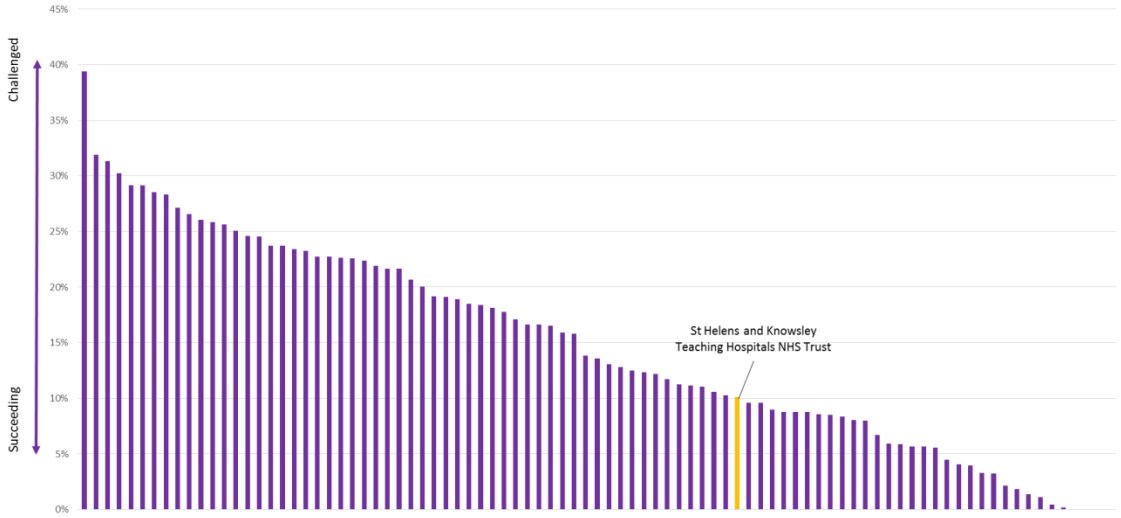
Hours Balances %



Expectation is that the hours incurred or owed by an employee at the end of the roster period should be 0. More work is required by the Ward Managers to either remove or add a shift to maintain the contracted hours of the individual.

Multi-Trust Comparators - 12/06/2016 -09/07/2016

Bank/Agency Use %



The Trust's performance is better than a number of the comparator organisations but given the financial pressures within the NHS, more work is required to reduce this to remain in budget.

Annual Leave

No slide available however during the reference period, it is reported that the Trust is above average compared to other organisations in managing annual leave within the 11%-17% parameters.

Appendix 3

Benefits Realisation Performance Management Framework – Action Plan

Goal	Rationale	Action Required	Target Date	Lead	Result
Achieve 28 week roster publication target across all directorates	Advice from Allocate indicates that the earlier rosters are planned and approved, the less reliance organisations have on the use of agency staff. The Trust's compliancy rate is for all rosters to be approved and published within 28 days or more. Although much work has been undertaken to address this, further improvements are required	Drive from top down. Communication from Executive Director what Trust expectations are	**Quarter 4 16/17**	. ALL	
Achieve 6 week roster publication target across all directorates	Advice from Allocate indicates that for maximum utilisation of the workforce Trusts should aim for a 6 week lead time. Comparison data does show that this is achievable. This is also in line with the Carter recommendations	Phased target introduced Review E-Roster Policy – managers publish draft rota roster 8 weeks before and issue to staff 6 weeks before	**Quarter 3 16/17**	**HR**	
Reduce Trust Hours Balance to 0%	Evidence suggests that there is a custom and practice of staff owing hours to the Trust (due to rota design) and carrying the	Data cleanse exercise required by Ward Managers.	**Quarter 2 17/18**	**ALL**	

	deficit over to the following roster period, rather than them being deployed elsewhere. Redeployment would enable other wards to utilise this element of the workforce rather than rely on bank or agency workers. This would require consultation with the unions and examine the infrastructure required to support this new way of working.				
Enforce annual leave target of 11-17%	Best practice guidance to organisations is that effective management of annual leave can be achieved by allowing between 11%-17% of the workforce to take annual leave at any one time.	Performance management as below	**Quarter 3 16/17**		
Enforce use of auto roster	Will ensure most cost effect shifts are produced	offer re-training to managers/roster coordinators where required) Monthly report to address auto roster usage.	**Quarter 4 16/17**	**HR** **HR**	
Set clear lines of accountability	The Trust must ensure that there are clear lines of accountability for business	Set KWOs for Ward Managers, Matrons, Matrons, ADOs	**Quarter 3 16/17**	**ALL**	

	performance from ward manager to Director level. It is recommended that all responsible managers are given clear business objectives within the appraisal process to achieve compliance across all the metrics and staff are performance managed against those objectives.				
Improve analysis of data	There is a requirement to examine what education is required of the nursing staff in the analysis of the data. The Roster Policy should be kept alive and an evaluation required to measure how effective this has been to date and through education, ensure that key stakeholders actually understand what the data means and impact on the organisation	Closer working between E-Roster team and Care Group stakeholders. Electronic Resourcing Manager to analyse data report and feedback to Care Groups stakeholders at their Business Meetings with Finance - discuss dashboard results aligned to financial reports, including agency spend in that area. Action plans drawn up by each Directorate Manager	**Quarter 3 16/17**	HR	
Review individual shift patterns	Allocate advise that there is a direct correlation between the high number of shift	A mapping exercise should be undertaken in areas where there are high levels of	**Quarter 3 / 4 17/18**	HR	

/activity	patterns and the requirement for temporary (bank and agency staff) in some areas.	individual shift patterns and flexible working arrangements in place			
Organisation change of shift patterns	Explore if overlap of staff crossing shifts can be eliminated and therefore use time elsewhere on the roster	Establish what standard patterns are used	**Quarter 4 16/17 Quarter 1 17/18**	**HR**	
Share knowledge and good practice	Support for colleagues who are not meeting the targets	Identify areas of good practice and establish a support/buddy system for those who are not effectively managing their workforce against the KPIs.	**Quarter 4 16/17**	**ALL**	
Roll out e-Roster to remaining areas		Planned timetable of rollout Review E-Rostering capacity	**Quarter 3 / 4 16/17**	**HR**	
Set national targets across all 5 KPIs	Implementation began in May 2015 and took 9 months to complete. Provisional targets were set by the Trust which are below the national targets. Advice from Allocate is that other Trusts are successfully achieving the recommended targets albeit they have been using the system longer. This stretch target will drive continuous improvement of the system and subsequently benefits realisation	Communicate targets and continue to monitor	**Quarter 4 16/17**	**HR**	

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)097
Title of paper: A vision for integrated care to improve health and well-being.
Purpose: The purpose of this document is to articulate to staff and stakeholders how the trust will achieve its vision to deliver health and well-being to the population it serves as a response to the NHS five year forward view. It describes the case for change, the need for integrated approaches to new care models and the emerging transformation journey that the trust needs to actively lead, influence and contribute towards, as part of the STP (sustainability and transformation plan) and LDS (local delivery system) footprints.
Summary: The NHS five year forward view has set the context for change both nationally and locally. Health and social care systems are being faced with significant financial and clinical challenges as well as growing expectation from the public regarding improved quality of care. Whole system integration across organisations is being encouraged to ensure sustainability of care services whilst addressing the quality agenda. Prevention and well-being is a key area to be addressed and invested in to manage the growing demand on care services. A vision for integrated care to improve health and well-being has been written in response to the NHS five year forward view. It articulates how the trust will need to change its vision statement and engage in the system changes required to bring about sustainability of hospital and other care services, whilst improving both quality of care and population health. St Helens and Knowsley teaching hospital Trust is a significant organisation in the Merseyside and Cheshire STP and the Alliance LDS. This vision document describes the transformation programmes that the trust is actively engaged in as part of these arrangements.
Corporate objectives met or risks addressed: Contributes to the Trusts Corporate Objectives.
Financial implications: None.
Stakeholders: This document needs to be circulated widely with all stakeholders from commissioning, provision, independent and voluntary sectors. It is also essential that the document is shared and understood by the Trusts staff.
Recommendation(s): Members of the Trust Board are asked to approve the new vision statement and document.
Presenting officer: Amanda Risino, Director of Strategy
Date of meeting: 28th September 2016

NHS
St Helens and Knowsley
Teaching Hospitals
NHS Trust

A Vision for Integrated Care to Improve Health and Wellbeing

Vision Document

September 2016

Forward

We are pleased to present our vision for integrated care. The NHS and local care services are needed by us all. They are valued and trusted, and in St Helens and Knowsley we are proud of the services that are provided to its population. Our doctors, nurses, care workers and health professionals are working hard to provide high quality care, but the way services are to be accessed is changing.

We are living longer; many people want to be treated in their own homes; and medical advances mean that the way hospital services are provided is evolving. We all want high quality services, as local as possible, delivered by motivated, highly skilled and committed staff. We passionately believe that by combining knowledge and understanding of our community's needs with strong skills, awareness of the opportunities to reshape services, we can together define how services need to change, engage the support of the community, and create a health system which will be able to afford and sustain services, which both prevent illness and support those who do fall ill more effectively. This will be to a standard which meets the most demanding expectations of our population. This strategic document helps to articulate how we will achieve our vision "to deliver 5 star population health and wellbeing" amongst our population, partners and stakeholders. It also articulates how the Trust will lead, influence and contribute towards achieving this vision for our health and social care community to integrate care, improve outcomes and our populations experiences of care whilst responding to increasing clinical demands and financial sustainability challenges.

Ann Marr

Ann Marr
Chief Executive

Richard Fraser

Richard Fraser
Chairman

About our Health and Care Systems

Acute hospitals across the country face significant challenges from demographic changes, rising demand and a shortage of certain care professionals. The changes in the needs of the population mean that acute hospitals like St Helens and Knowsley Teaching Hospitals NHS Trust (The Trust), need to be able to provide high-quality care for people with multiple chronic illnesses and chaotic lifestyles, as well as growing numbers of the very frail elderly. The Trust recognises as a major health provider for its local economy of St Helens, Halton and Knowsley; that it must change the way it operates in order to meet the significant health and social care challenges that it faces across these boroughs and beyond.

The Trust provides a full range of acute healthcare services from both Whiston Hospital and St Helens Hospital. It is one of many hospital trusts within the Cheshire and Merseyside area and serves a population of approximately 350,000 from across St Helens, Knowsley and Halton as well as parts of other neighbouring boroughs. The specialist Mersey Regional Burns and Plastic Surgery Unit extends our catchment area across Merseyside, Cheshire, North Wales, the Isle of Man and other parts of the North West.

The Trust works with four local authorities – Knowsley Metropolitan Borough Council, Halton Council, St Helens Council and Liverpool Council in supporting patients who need social care support. . It also works with St Helens, Knowsley and Halton CCGs, local partners in Mental Health, Community, and the independent and voluntary sectors.

Like most other towns and cities across the country, over the next decade the North West of England will see a growing demand for health and social care services.
This rise in demand is a result of demographic changes and there will be a steep rise in the number of old people, who have a larger number of long term conditions than the rest of the population. In addition to the increase in older populations, There are a growing number of families and individuals who are struggling economically and emotionally and are in need of help and advice to meet their health and care needs.

At the same time as the increase in demand for services, the local health and social care system is facing major financial pressures and significant reductions in funding.

It is estimated that the NHS will be approximately £30 billion short of funds by the end of the decade, whilst local authorities have had to make cuts of more than 30% in recent years. Taken together the impact of the funding squeeze affects the financial viability of the system, as it is currently organised.

In order to sustain health and social care services there is a clear need to adopt a different approach; one which upholds the provision of safe and effective health and care services by spending the available funding allocations differently – aiming for a higher impact on health needs and behaviours.

The Trust believes that by working together it can do things differently, creating a new integrated care system, built around the needs of local people. the trust wants the people of the boroughs we serve - children, adults of a working age, and older people, to feel more in control of their lives and able to draw upon their own personal resources, and those of the community, not only when health and social care problems arise but to prevent these problems happening in the first place. The Trust recognises that it needs to do much more and more quickly to support people to be well and independent, so that they do not require the intervention of expensive services. In addition the trust in partnership with others, needs to provide on-going support, anticipating and preventing deterioration and exacerbations of existing conditions, resulting in individual care that is well co-ordinated.

This document describes The Trusts vision in more detail, the context in which it has been developed and the plans for making it happen.

Building on the various borough based Health and Wellbeing Strategies and the Merseyside and Cheshire sustainability and transformation plan; The vision will require large scale transformation of the way that care is delivered in and across the boroughs as well as a change in cultures and behaviours of both system providers, commissioners and the population.

The Trust doesn't underestimate the scale of this challenge which will require the commitment of not only itself, but all of the main health and social organisations across the communities that the trust serves.

Most importantly, transforming our public services needs to be truly person-centred and aligned to the objectives of the various boroughs Health and Wellbeing Strategies.

- Tackling inequalities and the determinants of health
- Promoting prevention and healthy lifestyles
- Providing care closer to home
- Strengthening communications, IT and improving engagement
- Promoting personal responsibility and enabling self-care
- Reduce unnecessary variation in outcomes and ensuring high quality care
- Promoting safety and improved quality of life
- Developing new and innovative delivery models to create integrated services

The support of staff working across health and social care and the views of local people are equally important, therefore the overall transformation programme will be supported by inclusive, two way communication and engagement.

As a health system we now have a real opportunity to change the way in which all parties work and believe that integrated services can secure the future sustainability of the NHS and make people's lives better.

3. Why is there a need to Integrate Care?

The Vision

The Trust has always aimed for "5 star patient care" where it provides an excellent experience, for every patient, every time. We believe that the time is right for The Trust to develop its vision and to now aim for "5 star population health and well-being". Even though The trust is a high performing organisation, it is aware that there are still gaps, not only in the quality of care and health outcomes for our populations, but in the way services are delivered locally and across the whole NHS, as it is currently configured.

Some of this variation is due to duplication of effort between different parts of the health system, inefficient structures and processes and not enough focus on prevention, public health and individualised, person centred care.

Sustainability of the hospital services in a viable health and social care system.

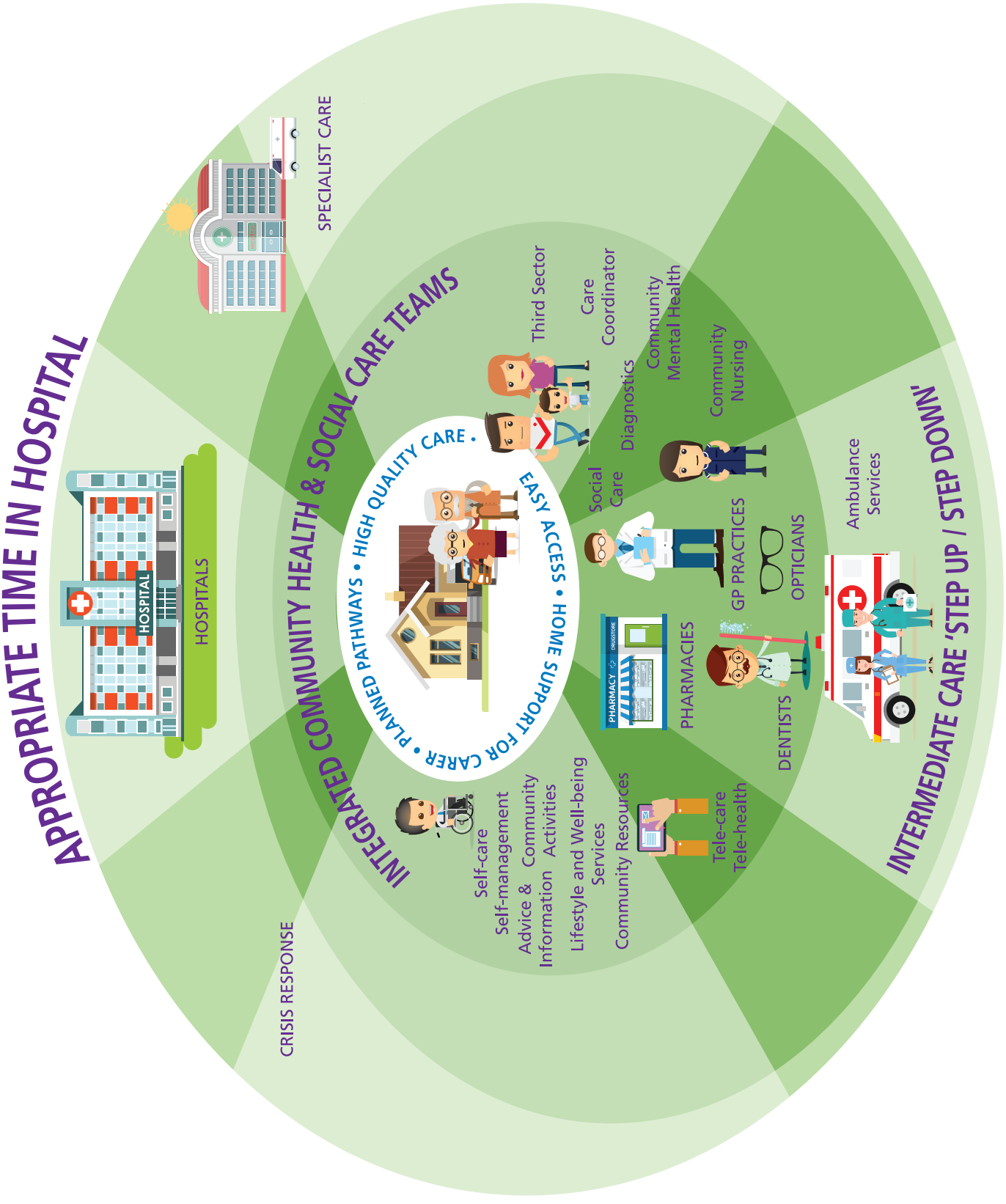
It is vital that our population has continued access to clinically and financially viable secondary care hospital services for the future. A core part of the vision laid out in the NHS Five Year Forward View (FYFV) involves acute hospitals becoming more integrated with other forms of care. If the health and social care system is to respond to the changing needs of the population, and also address the financial challenges faced by the NHS, acute hospitals need to play a fundamentally different role within their local health economies by:

- Moving from an organisational focus to a system wide perspective
- Working more closely with local partners, including primary care, social care, community services and communities themselves
- Developing integrated service models and pathways that span organisational boundaries
- Providing services through horizontal networks with other acute hospitals
- Co-designing care between local people, clinicians, other health and social care professionals as well as the voluntary, independent and community sectors

The Vision for integrated care aims to:

- Break down barriers between primary, community, hospital, mental health and social care, to create a streamlined experience for patients and avoid duplication
- Deliver improved access for patients requiring single or short episodes of care leading to less dependence on Hospital based urgent care and emergency services
- Provide more personalised and co-ordinated care for patients with multiple long–term needs
- Increase the confidence of local people to better manage their own health and well-being and know when it is appropriate to access help
- Reduce variation in health outcomes by linking public health, social care and healthcare more closely
- Deliver a workforce that meets the changing needs of the population, particularly for elderly care
- Improve efficiency and financial sustainability of the health and social care system by enabling access to care in the most appropriate place.
- Organise financial incentives and payments to support co-operation and concentration on sustainability of health and care provision

The system vision can only be delivered through a large scale change programme across the populations to improve services and outcomes by moving from a hospital based model of unplanned care to a preventative, anticipatory, whole person approach to individual care, health management and treatment.


APPROPRIATE TIME IN HOSPITAL
HOSPITAL
HOSPITALS
SPECIALIST CARE
CRISIS RESPONSE
INTEGRATED COMMUNITY HEALTH & SOCIAL CARE TEAMS
• PLANNED PATHWAYS • HIGH QUALITY CARE •
EASY ACCESS • HOME SUPPORT FOR CARER •
Third Sector
Care Coordinator
Community Mental Health
Community Nursing
Diagnostics
Social Care
GP PRACTICES
OPTICIANS
PHARMACIES
DENTISTS
Ambulance Services
INTERMEDIATE CARE 'STEP UP / STEP DOWN'
Self-care
Self-management
Advice & Community Information Activities
Lifestyle and Well-being Services
Community Resources
Tele-care
Tele-health

Why is there a need to Integrate Care?

The case for change

The trust believes the case to transform health and social care is overwhelming. The health and social care economy like many across the NHS in England faces a series of challenges, that if not addressed have the potential to impact the sustainability, delivery and outcomes of local services, and therefore have a detrimental effect on the health and wellbeing of local people.
Increasing numbers of patient and service users are also highlighting the fragmented nature of their health and social care. Whilst many are receiving elements that are very good, the whole pathway of care can at times appear disjointed.

The case for change doesn't stop at just the issues relating to the way in which organisations work, the systems and process, but also reflects the need to address the significant issues across the boroughs:

- Lifestyle-related health issues, health inequalities and health outcomes for our populations are worse than comparative areas in other parts of the country.
- Unemployment is higher than the National and North West averages
- The Trust is the second highest per capita admitting hospital in the North West
- Mortality from all cancers in adults is higher than the National and North West averages
- The percentage of population older than 75 is rising (up to 14.4% over 75 growth in the last 5 years and 25% over 85 growth in the next 5 years)
- Prevalence of Coronary Heart Disease is higher than the national average in Halton, St Helens and Knowsley
- Mortality for all causes of death for all ages is higher than the National and North West averages
- Smoking related deaths are significantly worse than in most other parts of the country
- Life expectancy varies considerably with men in the most affluent communities living more than 10 years longer than those in the most deprived areas
- Significant financial challenges across health providers, commissioners and local authorities.

Population Change

The population is changing; and locally is projected to grow by between 7-10% by 2021. This trend is evident across all ages up to 2021.

Moreover, people are and will be living longer with an expected 25-30% growth in the numbers of people aged 65+ years by 2021 and 60% by 2030 and significant growth in those aged 70-75 and 85+. Frail older people occupy around 70% of acute hospital beds (with up to 60% of over 65's in our hospital having a dementia co-morbidity), and are associated with around 46% of total NHS and around 55% of social care expenditure. Frailty is the underlying cause of death in 25% of the population.

In addition to this growth in the population, changes in the age profile will impact heavily upon health and care service delivery. As the population ages there will be more people living with health conditions and often multiple needs, placing greater demands upon our health and social care system, both in community and in hospital care settings. Informal caring is becoming more pressurised as the numbers of older people in relation to working age adults grows and the conditions with which they are remaining in the community become more challenging. Financial pressures on the working population make it harder for people to care for older relatives.

Long term conditions currently account for 70% of overall health and social care spend with a projected increase related to lifestyle and age profile demographics. The average annual cost to health services of a person with one long term condition is £1,000 and this rises to £8,000 for a person with three or more long term conditions. The system needs an approach to change, that embraces the knowledge and skills of clinicians and practitioners to re-focus where resources are required and improve the impact of them.

Primary Care

Demand has increased significantly in primary care, however related funding has reduced in proportion to total NHS spend. The scale of the challenge faced by general practice is:

- GPs provide 90% of NHS contacts with only 9% of the budget
- Consultations in general practice have increased by 75% between 1995 and 2009
- Growth in new technologies, providing patients with improved access to information and enabling greater involvement in their care
- Innovation in treatments enabling care closer to home
- Increasing patient expectations
- Increasing pressure for general practice to resume responsibility for out-of-hours care
- Staffing pressures, such as ageing workforce, insufficient trainees to meet future need and demands on GP time to support clinical commissioning

Social Care

Social care responds to a wide range of need and touches the lives of almost a fifth of the adult population. There has been good progress in developing different models of care, using the principles of personalisation and control that enable people to live as independently as possible utilising innovative local approaches aimed at earlier intervention and prevention. Investment, however, has inevitably suffered due to the scale of the financial challenge to the health and care economy over a number of years.

However, where there is agreement for whole system investment, there remains considerable scope to achieve better outcomes for people through the further development of services along with the right mix of housing-based support, telecare and other technologies. The responsibility for provision of information and advice to the whole population, which is a key element of the Care Act, will become more important in supporting individuals to manage their own health and care needs and access the right help.

The mainstream use of personal budgets is improving the choice and control individuals have over their care and support, and their lives. Extending these arrangements so that people can access a combined budget covering health as well as social care needs ('Integrated Personal Commissioning') creates the potential for integrated care to be driven as much by individuals as by organisations.

Financial position

The need to improve outcomes and the experience of care is a fundamental part of why we are pursuing this transformation programme. The local health and social care system also knows that it must change to address the scale of the financial pressures that it is facing.

The scale of savings required over the next four years is a step change even from the demanding saving requirements of recent times. Across the Merseyside and Cheshire STP footprint, there is a £5.8b budget to deliver healthcare with a predicted £1b gap by 2021, if services continue to be provided in the same way against significant demand and financial challenges. In this context, The Trust cannot maintain the quality of services currently provided to local people if it continues to deliver them in the same way. In order to continue and improve the quality of services, the entire health and social care economy must radically transform the system in which they are delivered.

Service variability

Outcomes across the boroughs for local people are variable. This is being experienced in primary care, community care and in the hospital. This can manifest itself in a variety of ways, including differing referral rates for cancer, high admission rates to hospitals, variances in hospital length of stay and clinical outcomes.

Similarly patient experience and quality of service delivery across the boroughs can vary significantly. Such variations have to be tackled. The Trust will work to a future where services are delivered consistently to the highest standards in a fair, sustainable and equitable manner.

The Ambition

What can the population and patients expect for the future?

The NHS Five Year Forward View sets out the NHS plan for the coming five years alongside a number of potential models of care. Preventable illnesses are widespread; health inequalities are deep rooted and exacerbated by changing population needs; new treatment options are emerging; there are particular challenges such as mental health, cancer and support for frail older people; service pressures are building and a different model of local health and social care services is required.

The ambition to respond to the challenges is for integrated care. Care which is not impeded by organisational boundaries, poor communication flows, or resource rules which act against the patient's best interest. In future The Trust wants patients to experience care that is more personalised, built around their individual needs and which consistently delivers high quality and seamless experience.

This would mean:

- Better access to advice and support via electronic, phone and face to face consultation with the appropriate professional available 7 days a week
- Easier access to a joined up integrated system which supports self-management and ensures the appropriate level of care and relevant professionals to meet their needs
- An integrated health and care record, accessible to patients
- People feeling informed by having access to information and resources which will allow them to take responsibility and control for maintaining and improving their own health and well-being; appropriately using self-care and knowing when to seek help and from where
- Better support with long term conditions management including care co-ordination, bespoke care plans and responsive services when needed
- Better support for carers from the voluntary and statutory services
- Improved integration of mental health services across health and social care provision
- People co-designing future care provision, pathways and models
- Outcomes taking priority over output or process targets and measures
- Frequent service users encouraged to make better choices and contribute to their communities through the development of services designed to encourage and facilitate responsible behaviour
- Multi-agency provision of services, across sectors, becoming the norm. Service silos and duplication eliminated
- Technology transforming the ability to predict need, provide advice and deliver service

The Trust believes that this ambition to make the people's lives better is achievable. It recognises that to meet these challenges there is a need to develop new ways of working that span traditional service and organisational boundaries – including working more closely with other hospitals through alliance and partnership models, as well as strengthening relationships with mental health, community, primary and social care. By working together The Trust can improve the way in which care is delivered, not just hospital care, but care in GP practices, mental health services and social care. The ambition is therefore to become more outward facing, supporting the local health system rather than just the organisation.

Including the voluntary sector

The boroughs have many voluntary, community and social enterprise partners. The Trust recognises that its ambitions for improving the health and wellbeing of local people are more likely to succeed if the models of health, care and support services reflect all aspects of health and wellbeing and operate as a strong and integrated part of our health and care system.

Many voluntary organisations have a detailed understanding of specific local needs, high levels of trust and engagement with local communities and the ability to work across multiple services to provide care for individuals. They often have access to people who fail to engage with statutory services. For example, the Voluntary Sector has a crucial role

to play in addressing social isolation, supporting families with difficulties who fail to engage with vaccination, breast feeding and healthy eating, as well as harnessing the power of the local community.

Empowering local people

It is clear that significant opportunities exist to improve health outcomes through empowering patients to be in control in decision-making about themselves and their loved ones' care. In this way The Trust can improve outcomes by addressing the whole person, rather than focusing on single facets of their health and social care needs.

Too many people report negative or unsatisfactory experiences and for too many people there are barriers to accessing the right care. Putting a people first approach, will therefore underpin the plan to achieving a healthier population.

Impact of proposed integrated care model

System modelling from a range of integrated providers working across the country including vanguards shows potential impacts on hospital admissions, length of stay and readmissions as well as improved care co-ordination and patient outcomes. Data based on a collective combination of improved models of disease management across the system as well as admission prevention schemes indicates (The Kings Fund, 2014) potential for this health system delivering;

A reduction in Medicine non-elective admissions

A reduction in Surgical non-elective admissions

A reduction in extended stays (DTOC), including bed days avoided by reductions in admissions

Elective patients staying more than 6 days could be cared for in alternative settings

A range of daily reduction of hospital in-patients

This would mean that existing acute capacity could either be reduced or utilised differently.

Transforming Care

What is happening

TThe multiple demands on our NHS and social care system mean that in planning for the future The Trust will have to manage competing priorities and make decisions that will give the best chance to achieve the ambitious improvements in health and social care outcomes for the people.

The Trust is working with others across the Merseyside and Cheshire sustainability and transformation (STP) footprint to redesign care that is affordable and delivers better outcomes. The Trust is part of a local delivery system (LDS) called the Alliance, within this wider footprint. The LDS has prioritised four key areas to deliver this scale of transformation:

- Demand management and prevention at scale - Out of hospital care, Primary prevention and public health
- Reducing variation by hospital reconfiguration - Secondary care transformation
- Middle and back office collective productivity - back office collaboration
- Changing how we work together- Alliance LDS working together

The Trust believes that its plans to focus on out of hospital resilience, secondary care service transformation and re design and "well-being, self-care and prevention" will give the best opportunity to meet the sustainability challenge.

Demand Management and prevention at scale – Out of hospital new models of care.

The enhancement of primary care as the centre of community locality models is critical to the delivery of new models of care. This includes the improvement of infra-structure (primary care estates, IT etc.) and the opportunities for practices to work together in localities/hubs/clusters to provide 7 day primary care services.

Other community and hospital services aim to deliver planned care alongside the primary care localities as an integrated local health and social care team to bring care closer to patients own homes. The integrated care teams will consist of nurses, therapists, social workers, mental health and home care staff working together with medical leadership from GPs and / or consultants. These teams will pro-actively manage those patients with the most complex of needs in the community and provide a rapid response when a patient's condition deteriorates. They will ensure timely specialist advice for both planned and urgent care via local clinics and home visits as well as cost-effective diagnostics close to home.

Patient pathways of care will be redesigned to ensure there is smooth referral between professionals, services and organisations. This change in the system will reduce variation and improve quality particularly for vascular, cancer, maternity, mental health, stroke and care of older people in the first instance.

In a similar way a whole system approach will be taken to redesigning urgent and emergency care pathways that are simpler, responsive and clear to all. In order to deliver the right care at the right time in the right place first time, large scale change is required that will include co-location of services and changes to the payment system. Integrated services particularly for the elderly will support out of hospital, hospital stays and discharge, as well as improved care home support by multi-disciplinary care teams.

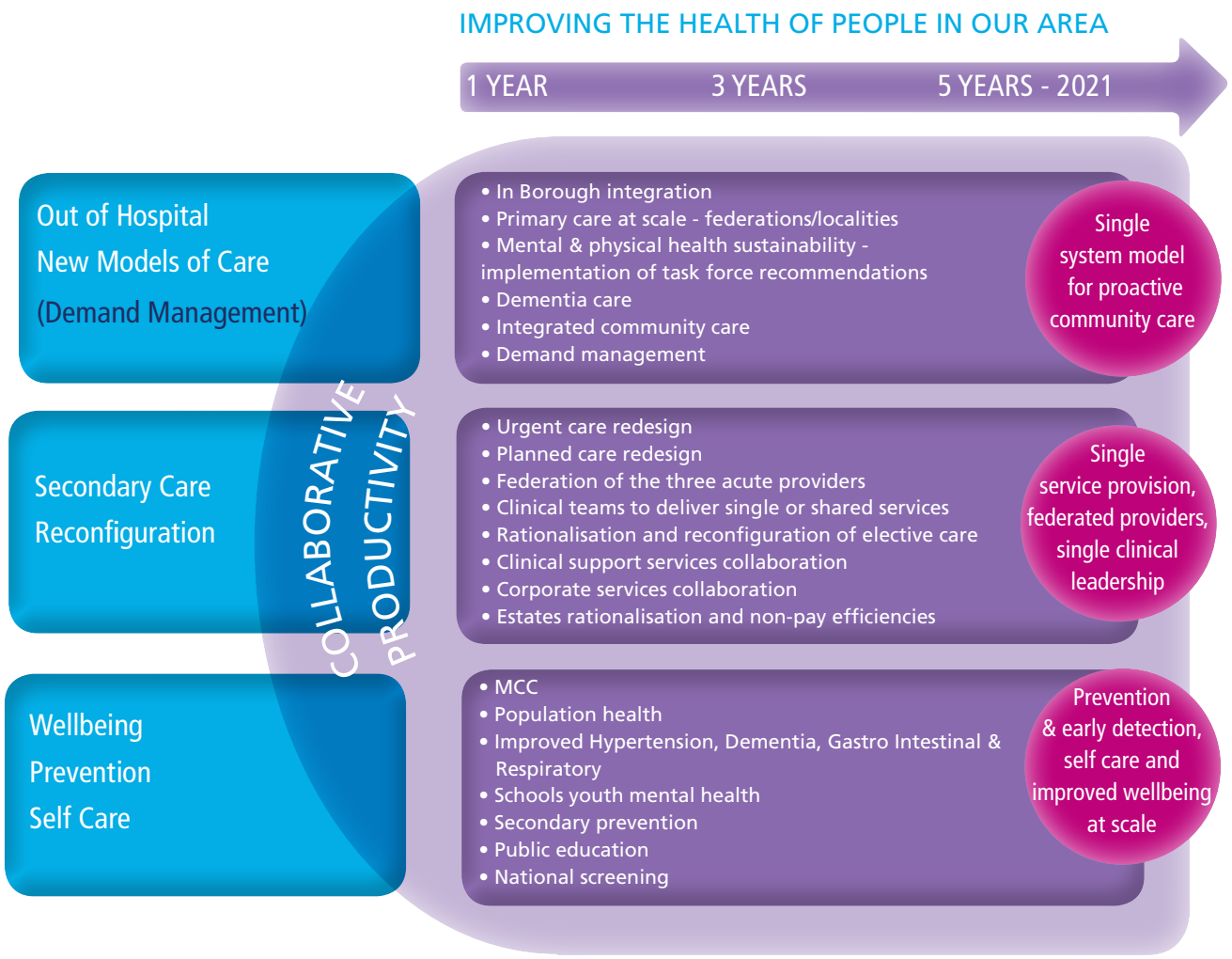
Preventing demand is essential and requires radical up scaling of prevention, early detection and self-management of conditions in the community, primary and acute sectors. Close working with the local authorities, schools, housing, leisure providers and the voluntary sector to mobilise communities to adopt preventative initiatives to avert obesity, reduce alcohol consumption and improve the overall health and well-being of the population is necessary. Investment in health check programmes, early identification and proactive case finding will be rolled out as well as living-well programmes to enable people to manage their own health and long term conditions.

It is also necessary that resilience is built within communities themselves to enable them to rely less on external support such as creating jobs and suitable housing. Likewise health and social care systems need to take an asset-based approach to drawing on the full resources that communities, families and individuals have to offer.

Reducing variation by hospital reconfiguration - Secondary care transformation

There are three acute trusts (six hospitals) in the Alliance LDS: St Helens and Knowsley Teaching Hospitals, Warrington and Halton FT and Southport and Ormskirk Hospital. Through a federation approach the acute providers have come together to deliver single or shared services which are clinically and financially sustainable across the alliance footprint. The three providers will work together to deliver a single system of secondary care across a range of services.

This will allow appropriate numbers of patients accessing services to ensure the best outcomes as well as ensuring a critical mass of clinicians to maintain appropriate rotas for safe, effective and sustainable care across seven days a week. Standardisation of care pathways will eliminate variation, and drive improvements in quality. Vertical integration with local community services and horizontal integration with other acute providers will underpin the service model. This will require services to be reconfigured so that they are clinically and financially sustainable, based on demand and the appropriate geographic access.



Middle and back office collective productivity - back office collaboration

Clinical support collaboration:
Alongside the development of single clinical services across the Alliance LDS footprint, there will also be shared clinical support services such as pathology, radiology and pharmacy, building on existing relationships. For example there would be a single medicines management strategy, formulary and medicines approval process.

Corporate services collaboration:
Rationalisation of 'back-office' provision such as finance, human resources and IM&T would work to enable a single platform of delivery for all the clinical service transformation.

Estates rationalisation and non-pay efficiencies:
There will be a uniform approach to estates running costs; procurement and discretionary non-pay spend taking a whole system perspective.

Changing how we work together- Alliance LDS working together

Workforce:
In order to deliver the vision the systems workforce needs to change through:

- Making sure all health and care professionals are focused on health promotion, disease prevention, early detection, self-care and proactive management
- Improve the skill mix of teams and create new roles to make sure the right care is delivered, by the right person, in the right care setting
- Develop more community based specialists and more staff with flexible skills who can carry out a range of functions
- Retention and recruitment strategies including rotation of staff across agencies and career development opportunities

Digital

- Enable people to utilise digital technology to manage their own care
- Work towards a single shared record
- Utilise advance technology to further medical interventions

Leadership

- Clinicians leading the development of new models of care and shared clinical standards
- Co-design with the population
- Strong and innovative working relationships with local authorities around prevention and joining up health and social care
- Single system governance for transformation
- Joint strategies to support efficiencies and sustainability
- Collaboration with our system partners across Cheshire and Merseyside

7. Measure of Success

To achieve the ambitious integration outlined above will involve a redesign of a new service delivery model, changes in staff roles, and patient flows across the entire system. It will mean changing what some patients currently perceive as a safety net in order to achieve far more for the wider population in the long term. The Trust will engage patients, communities and staff in long term support for this vision. The measures of success are important and need to be a mix of the long and short term, so that immediate gains can be shown.

The health and social care system will have improved if together there is:

- increased the number of people having a positive experience of care
- reduced health inequalities
- ensured that local people can access care to the highest standards, at the right time and are protected from avoidable harm
- ensured that all individuals will be supported by new, improved integrated, joined-up community services
- increased the proportion of older people living independently at home and who feel supported to manage their condition
- reduced the number of elderly people accessing long term care on a permanent basis
- improved the health related quality of life of people with one or more long term conditions, including mental health conditions

- reduced dependency on hospital care by reducing the number of patients accessing and being admitted and readmitted to hospital

NHS

St Helens and Knowsley
Teaching Hospitals

NHS Trust