St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 26TH APRIL 2017
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	April		
09:35	2.	Apologies for Absence			Richard Fraser
	3.	Declaration of Interests			
	4.	Minutes of the previous Meeting held on 29th March 2017		Attached	
		4.1	Correct record & Matters Arising		
		4.2	Action list	Attached	
Performance Reports					
09:45	5.	Integrated Performance Report		NHST(17) 035	Nik Khashu
		5.1	Quality Indicators		Sue Redfern
		5.2	Operational indicators		Rob Cooper
		5.3	Financial indicators		Nik Khashu
		5.4	Workforce indicators		Anne-Marie Stretch
10:00	6.	~~Agency staffing self-certificate checklist~~ ***No longer an agenda item.***		~~NHST(17) 036~~	

10:05	7.	Corporate Risk Register	NHST(17) 037	Sue Redfern
10:10	8.	Board Assurance Framework	NHST(17) 038	
Committee Assurance Reports				
10:15	9.	Committee report – Executive	NHST(17) 039	Ann Marr
10:20	10.	Committee Report – Quality	NHST(17) 040	David Graham
10:25	11.	Committee Report – Finance & Performance	NHST(17) 041	Denis Mahony
10:30	12.	Committee Report - Audit	NHST(17) 042	Su Rai
Other Board Reports				
10:35	13.	Revalidation update	NHST(17) 043	Sue Redfern
10:45	14.	Purdah during the 2017 government general election	NHST(17) 044	Peter Williams
Closing Business				
10:50	14.	Effectiveness of meeting		Richard Fraser
	15.	Any other business		
	16.	Date of next Public Board meeting – Wednesday 31st May 2017		
BREAK				

TRUST PUBLIC BOARD ACTION LOG – 26TH APRIL 2017

No	Minute	Action	Lead	Date Due
1.	30.11.16 (6.4.2)	Appraisals. Ann Marr asked for an audit to be carried out to ensure that information regarding complaints is captured on medical staff appraisals.	AMS	31 May 17
2.	25.01.17 (8.8)	~~Complaints, Claims & Incidents: Sue Redfern will provide an analysis of claims trends to Sarah O'Brien.~~ ~~22.02.17: Sue Redfern has provided the analysis and is awaiting feedback from Sarah O'Brien.~~		Action closed
3.	25.01.17 (11.5)	HR Indicators: A trend line is required in the next report for Bank, Agency and Overtime usage.	AMS	26 Jul 17
4.	22.02.17 (9.3)	~~Occupancy figures: Ann Marr requested that a deep dive takes place regarding the figures.~~		Action closed
5.	22.02.17 (11.3)	~~Charitable Funds: Ann Marr requested that Anne-Marie Stretch speak to the Media office about raising awareness of the fund.~~		Action closed
6.	22.02.17 (12.6)	~~5 Year Forward View Memorandum of Understanding: Ann Marr asked Nik Khashu to provide a SWOT analysis and recommendations for the Board.~~		Action closed

Paper No: NHST(17)035
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

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

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

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

Patient Safety, Patient Experience and Clinical Effectiveness

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

There were no never events in March 2017. The year to date total is 2.

There were no cases of MRSA bacteraemia in March 2017. Year to date there have been a total of 3 MRSA incidents and 1 contaminant.

There were 4 C.Difficile (CDI) positive cases in March. Year to date there have been 23 confirmed positive cases.
The annual tolerance for 2016-17 is 41 cases.

There were no grade 3 pressure ulcers in March. Year to date there has been a total of 1. There have been no grade 4 pressure ulcers.

There were 3 falls that resulted in severe harm during February. Year to date there have been a total of 20.

Performance for VTE assessment for February was slightly below the required 95% target at 94.28%.

YTD HSMR is 102.0 up to December 2016.

The overall nurse/midwife Safer Staffing fill rate for February was 94.1%

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 16/17 financial outturn will have implications for the finances of the Trust
Stakeholders: Trust Board, Finance Committee , Commissioners, CQC, TDA, patients.
Recommendation: To note performance for assurance
Presenting Officer: N Khashu
Date of Meeting: 26th April 2017

Operational Performance

A&E performance was 80.1% (type 1) and 87.4% (type 1 & 3) in month. Whilst not yet at the required performance, the improvement is recognised. The key actions identified for continued recovery of this position are being driven forward by the senior leaders across the organisation, focusing on both the Emergency Department and the Inpatient wards

Emergency Department key actions:
1. Immediate improvement to ED processes through the Urgent and Emergency Care Transformation Plan
2. Appropriate deployment of clinical resources to meet demand.
3. Improved use of IT to enable real time tracking of patients within 4 hours.

Inpatient areas:
1. Clinically led board rounds on inpatient wards, identifying early morning discharges to support flow.
2. Senior daily review and escalation for patients who no longer need care in an acute bed, supported by weekly system wide Multi Agency Discharge Events (MADE)
3. Expected number of discharges by ward

The additional actions identified within the Trusts recovery plan will continue with support and focus being provided by ECIP in order to sustainably deliver the 95% target.

RTT incomplete performance was achieved in month (93.49%). Specialty level actions to address this continue, including targeted backlog clearance and collaborative working with the CCG to improve the quality and effectiveness of patient referral pathways. Additional activity funded by NHSE to reduce RTT backlog completed with an additional 18 T&O patients and 1208 dermatology patients cleared from the backlog.

Financial Performance

Provisional results for the financial year 2016/17 is expected to show a surplus of £3.3m after technical adjustments which is in line with agreed plans and control totals. This includes the expected full achievement of £10.1m income of STF funding. (Depending upon individual Trust performance and the national financial position, some organisations may receive additional income and cash once the draft accounts have been submitted, as a result of the distribution of any remaining STF funding from NHSI).

The Trust has provisionally delivered £15.2m of CIPs which is in line with the Annual plan.

The Trust's cash balance at the end of March was £1.8m, in line with the Trust's External Finance Limit and represents 2 days of operating expenses.

The Trust fully utilised its capital resources in the year of £3.5m.

Human Resources

The 2016 staff satisfaction score has again increased and the Trust remains in the top 20% of acute Trusts nationally. A full report was presented at the Trust Board in March 2017 and a summary presentation to staff will take place on the 3rd May 2017.

Mandatory Training compliance exceeds the target by 6.6%. Appraisal compliance has continued to improve and has ended the year 2.39% above target following significant effort from managers and L&OD team to meet the 85% target.

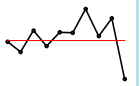
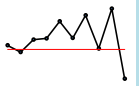
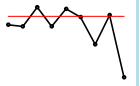
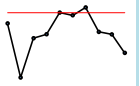
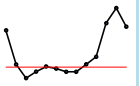
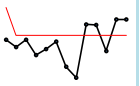
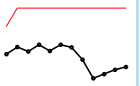
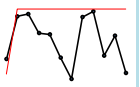
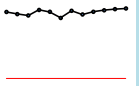
Absence has decreased in March to 4.2% which is a 0.48% improvement on the Q4 target. At year end sickness absence is a 0.1% improvement on last years outturn at month 12.

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

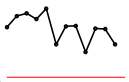
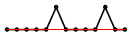
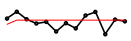
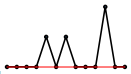
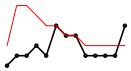
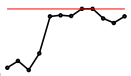
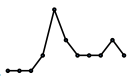
Mar-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 30-34)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Mar-17	2.2%	2.5%	No Target	2.5%		Overall SHMI and HSMR within control limits. Mortality fluctuates month-to-month, but is stable medium-term. Weekend mortality - has fallen again after 'Winter' increase (noisy metric).	Patient Safety and Clinical Effectiveness	Trust is exploring an electronic solution to improve capture of comorbidities and their coding. Focus on addressing R codes use by examining and improving the coding pathway. Palliative care lead aiming to deliver ED and Assessment Unit in-reach to allow input earlier in the patient pathway to improve care and HSMR. Major initiatives to improve management of AKI and Sepsis are well underway to improve care and reduce mortality.	KH
Mortality: SHMI (Information Centre)	Q	▲	Sep-16	1.05		1.00						
Mortality: HSMR (HED)	Q	▲	Dec-16	77.0	102.0	100.0	99.7					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Dec-16	69.8	112.2	100.0	112.9					
Readmissions: 30 day Relative Risk Score (HED)	Q	T	Nov-16	87.4	97.6	100.0	96.4		Continues to improve.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	Action underway to address babies returning electively but documented as emergency admissions.	KH
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Dec-16	88.5	93.2	100.0	92.2		Sustained reductions in NEL LOS are assurance that medical redesign practices continue to successfully embed.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Dec-16	85.3	92.6	100.0	97.7					
% Medical Outliers	F&P	T	Mar-17	3.7%	1.7%	1.0%	2.2%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in LoS, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Mar-17	61.2%	48.3%	52.5%	50.9%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. Critical care rep now attending all bed meetings to agree plan and to highlight patients who will require transfer over the coming 24 hours. In month achieved target. Now utilising 4E medical which will support step down of appropriate patients	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients)	Q	▲	Feb-17	73.9%	76.2%	90.0%	79.9%		eDischarge performance poor. Historic backlog now quantified and being addressed in staged way agreed with CCGs.		Pending ePR, ongoing drive to improve realtime completion on ward rounds, but trainee doctor numbers is an issue. Medium-term plan to supplement trainee doctor numbers with advanced nurses. Action plan to address unsent eDischarges has been agreed with commissioners.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients)	Q	▲	Feb-17	85.2%	90.5%	95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E)	Q	▲	Feb-17	99.3%	99.1%	95.0%	98.5%					

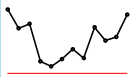
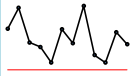
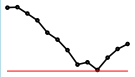
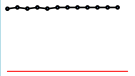
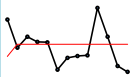
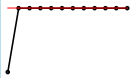
Mar-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

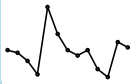
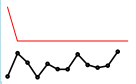
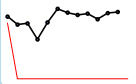
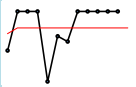
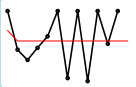
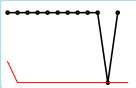
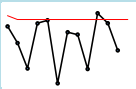
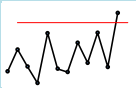
	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Feb-17	90.2%	93.8%	83.0%	92.0%		Target is being achieved	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Continued focus on delivery of this KPI to ensure our patients continue to receive the best possible care	RC
PATIENT SAFETY (appendices pages 37-39)												
Number of never events	Q	▲£	Mar-17	0	2	0	0		The National safety standards for invasive procedures will provide further mitigation against future never events.	Quality and patient safety	The RCA for the first never event has been submitted and lessons learnt cascaded. Actions implemented include central line insertion check list . The January 2017 never event is being made subject of a Serious Incident Investigation.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Mar-17	98.8%	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	Mar-17	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. ePrescribing will be introduced, starting Spring 2017.	KH
Number of hospital acquired MRSA	Q F&P	▲£	Mar-17	0	4	0	0		There were 0 cases of MRSA bacteraemia and 4 C.Difficile (CDI) cases in March. YTD there have been 27 CDI cases, of which 4 cases have been successfully appealed. This gives 23 confirmed avoidable cases against an annual tolerance of 41 cases.	Quality and patient safety	Both January cases of hospital acquired MRSA bacteraemia have been investigated and Trust-wide action plans are in place to reduce the risk of any further cases. The Infection Control Team continue to support staff to maintain high standards and practices. They also 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	▲£	Mar-17	4	23	41	26					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Mar-17	0	17	No Target	28					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Mar-17	0	1	No Contract target	1		A root cause analysis investigation is being undertaken to establish cause and learn lessons accordingly	Quality and patient safety	The Trust remains compliant with tissue viability training for all nursing staff including bank staff	SR
Number of falls resulting in severe harm or death	Q	▲	Feb-17	3	20	No Contract target	21		STHK moderate, severe and death harm from falls YTD is 0.156 per thousand bed days(YTD) against a 0.19 national benchmark.	Quality and patient safety	The RCAs have been completed and lessons learnt cascaded.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲£	Feb-17	94.28%	93.18%	95.0%	93.31%		VTE performance like eDischarge is compromised by trainee doctor numbers pending e-solutions.	Quality and patient safety	E -Prescribing solution will resolve achieving target in 2017. Solutions to software interface issue being explored and manual work arounds in place.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Jan-17	2	23	No Target	38					
To achieve and maintain CQC registration	Q		Mar-17	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	Feb-17	94.1%	95.1%	No Target	96.8%		Shelford Patient Acuity has been completed and will be reported to Trust Board in April 2017.	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	Feb-17	0	2	No Target	1					

Mar-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 41-48)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Feb-17	96.8%	95.0%	93.0%	95.1%		Key access targets achieved	Quality and patient experience	A Programme approach is being utilised to monitor and improve the timeliness of the patients journey along the Cancer pathways.	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Feb-17	97.5%	97.9%	96.0%	97.8%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Feb-17	87.8%	88.3%	85.0%	88.6%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Mar-17	93.5%	93.5%	92.0%	95.5%		At specialty level T&O, Plastic Surgery, ENT, General Surgery are failing the incomplete target. the dermatology backlog clearance plan has significantly improved its and the Trust RTT position. The impact of the RMS scheme introduced in July by St Helens CCG, Knowsley CCG in November and Halton CCG pushed back to April is also impacting on RTT performance due to new referral drop.	There is a risk due to the current medical bed pressures and the increase in 2ww referrals and activity that the elective programme will be compromised.	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. A backlog management plan is in place and alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand. NHSE backlog clearance commenced beginning of February and completed by end of March clearing 18 T&O and 1208 dermatology patients.	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Feb-17	100.0%	99.997%	99.0%	99.99%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Mar-17	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Mar-17	0.3%	0.7%	0.8%	0.9%		Performance against the target improved again in March and achieved below the national KPI. 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	▲ £	Feb-17	100.0%	100.0%	100.0%	99.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Mar-17	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Mar-17	80.1%	76.1%	95.0%	85.0%		Failure to ensure patients are managed within 4 hours in the Emergency Department All Type activity includes the Trusts contribution to the local urgent care centres.	Patient experience, quality and patient safety	The urgent and emergency care transformation plan has several interconnected workstreams designed to improve overall ED performance. **Emergency Department Enablers:** 1. Navigation and streaming at the front door - this allows patients to be assessed and directed to the appropriate pathway with the result of reducing overall time in ED. 2. Rapid assessment ant treatment - this enables senior medical staff to either discharge or redirect ambulance attenders to lower acuity areas and for those who need emergency treatment, instigate the appropriate clinical investigations/treatments within 15 mins of booking in which in turn, allows faster referral to specialty services and faster transfer out of ED. 3. Role of the Clinical shift lead - standardisation of the role to ensure effective management of flow through the department. **Medical Care Group Enablers:** 1. Implementation if the SAFER Care Bundle to increase hospital discharges before midday to 30% of all discharges and ensure that all patients receive a review of their care by a senior clinical decision maker daily. 2. The Medical Care Group is standardising ward level Board Rounds so that these are consistently delivered across the Care group, they will incorporate full attendance by all members of the MDT including doctors, to establish a clear plan for the day against the priorities of value added care and safe and effective admissions and discharges (flow). Specific attention will be focused on achieving a safe and effective discharge of at least one (golden) patient by 10.00 every morning. 3. Multi-Agency Discharge Events (MADE) are now taking place weekly within the Trust . These involve a structured board round on each ward in the presence of cross economy representatives, clinical leads and managers. the main aim is to remove barriers and blocks that prevent patients with complex needs being discharged safely from hospital.	RC
A&E: Total time in A&E: % < 4 hours (All Types)	F&P	▲	Mar-17	87.4%	85.1%	95.0%	89.4%					
A&E: 12 hour trolley waits	F&P	▲	Mar-17	0	0	0	2					

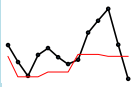
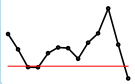
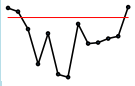
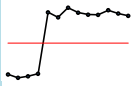
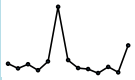
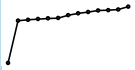
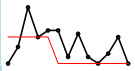
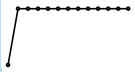
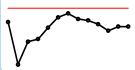
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	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	▲ £	Mar-17	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	Mar-17	35	338	No Target	291		A delay in responding to patient complaints leads to a poor patient experience. The 2015 - 16 resolution rate of 42.7% includes all stage 1 complaints resolved in 15-16 regardless of when the complaint was received. For stage 1 complaints both received and resolved in 15-16 the resolution rate was 61.4%	Patient experience	The department is currently reviewing the potential to identify, when complaints are triaged, less complex complaints, which could be resolved at an early stage by contacting the complainant, taking immediate action and offering appropriate assurances in a closure letter. In addition, the process for obtaining statements is being reviewed with a view to making it as clear and simple as possible for the statement writer to provide the right information, supported by relevant actions being taken to prevent any reoccurrence.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Mar-17	26	293	No Target	372					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Mar-17	50.0%	58.0%	No Target	42.7%					
Friends and Family Test: % recommended - A&E	Q	▲	Feb-17	88.4%	86.7%	90.0%	91.5%		The YTD recommendation rates remain slightly below target for A&E, maternity (birth), maternity (postnatal community) and outpatients, but are above target for in-patients and other maternity services.	Patient experience & reputation	Feedback from the FFT responses are fed back to individual areas to enable actions to be taken to address negative feedback, as well as using positive feedback. The Patient Experience Manager is working with individual services, including the Emergency Department, to look at key areas of concern and the actions that need to be taken to address these. This is monitored via the Patient Experience Council monthly. Training sessions have been provided to ward staff to raise awareness of the importance of responding to feedback to patients and to share the actions taken as a result of this feedback on the patient experience notice boards in public areas.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Feb-17	96.0%	95.4%	90.0%	96.4%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Feb-17	100.0%	98.4%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Feb-17	100.0%	97.9%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Feb-17	100.0%	99.1%	95.1%	95.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Feb-17	91.3%	92.6%	98.6%	98.6%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Feb-17	95.2%	94.4%	95.0%	94.7%					

Mar-17

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 51-55)												
Sickness: All Staff Sickness Rate	Q F&P	▲	Mar-17	4.2%	4.8%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.9%		Absence has decreased in March to 4.2%, which is 0.48% ahead of the Q4 target. YTD this is a 0.1% improvement on last years outturn. Nursing sickness including HCAs was 0.6% below YTD target but 0.1% better than 2015/16 outturn.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	Targeted HCA action plan in place continue to be accelerated during April 2017 along with audit on timely Return to Work interviews/stages/levels & recording onto ESR in timely way. There are departments where managers are not strictly complying with the Attendance Management policy, this is being addressed. Referrals to HWWB have also increased.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P	T	Mar-17	4.9%	5.9%	5.3%	6.0%					
Staffing: % Staff received appraisals	Q F&P	T	Mar-17	87.4%	87.4%	85.0%	87.2%		Mandatory Training compliance exceeds the target by 6.6%. Appraisal compliance has continued to improve and has ended the year 2.39% above target.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The L&OD team continue to work with managers of non compliant staff to ensure continued improvement.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Mar-17	91.6%	91.6%	85.0%	77.6%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2	90.2%		No Contract Target			In Q2 a significant number of staff continued to recommend the Trust as a place to receive care. There has however, been a reduction in the number of staff recommending the Trust as a place to work. The response rate was low but comparable to Acute Trusts nationally	Staff engagement, recruitment and retention.	Actions identified to address the reduced number of staff recommending the Trust as a place to work are included in the OD plan monitored through Workforce Council.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2	69.0%		No Contract Target						
Staffing: Turnover rate	Q F&P	T	Mar-17	1.1%	9.8%	No Target	8.9%		Staff turnover remains stable and well below the national average of 14%.		Turnover is monitored across all departments as part of the Trusts Recruitment & Retention Strategy with action plans to address areas where turnover is higher than the trust average. Further action is required by Ward Managers to provide more support to newly qualified nurses.	AMS
FINANCE & EFFICIENCY (appendices pages 58-62)												
UoRR - Overall Rating	F&P	T	Mar-17	3.0	3.0	3.0			The Trust's indicative year end performance is in line with 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. Reducing agency expenditure in line with NHSI annual cap.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Mar-17	15,248	15,248	15,248	13,043					
Reported surplus/(deficit) to plan (000's)	F&P	T	Mar-17	3,328	3,328	3,328	(9,551)					
Cash balances - Number of days to cover operating expenses	F&P	T	Mar-17	2	2	2	2					
Capital spend £ YTD (000's)	F&P	T	Mar-17	3,508	3,508	4,088	4,169					
Financial forecast outturn & performance against plan	F&P	T	Mar-17	3,328	3,328	3,328	(9,551)					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Mar-17	93.9%	93.9%	95.0%	94.2%					

APPENDIX A

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

			Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	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%	87.5%	93.1%	89.3%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	96.2%	95.3%	85.0%		99.2%		
	Total > 62 days		0.0	0.0	0.0	1.5	1.0	1.5	0.0	0.0	0.0	0.0	1.0	0.0	0.5	5.5			1.0		
Lower GI	% Within 62 days	▲ £	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	93.3%	81.8%	71.4%	58.3%	100.0%	91.7%	93.3%	88.6%	85.0%		94.5%		
	Total > 62 days		0.0	0.0	0.0	2.0	0.0	0.0	0.5	1.0	1.0	2.5	0.0	0.5	0.5	8.0			3.0		
Upper GI	% Within 62 days	▲ £	100.0%	81.8%	75.0%	90.9%	0.0%	100.0%	100.0%	0.0%	85.7%	88.9%	100.0%	81.8%	0.0%	77.9%	85.0%		88.9%		
	Total > 62 days		0.0	1.0	0.5	0.5	0.5	0.0	0.0	1.5	1.0	0.5	0.0	1.0	4.0	9.5			5.0		
Urological	% Within 62 days	▲ £	83.3%	84.0%	85.7%	84.6%	81.3%	75.0%	79.3%	76.9%	96.2%	82.6%	70.0%	95.7%	100.0%	82.8%	85.0%		80.8%		
	Total > 62 days		2.0	2.0	2.0	3.0	3.0	4.0	3.0	4.5	0.5	4.0	6.0	0.5	0.0	30.5			28.0		
Head & Neck	% Within 62 days	▲ £	60.0%	50.0%	50.0%	100.0%	37.5%	71.4%	66.7%	100.0%	80.0%	33.3%	33.3%	100.0%	80.0%	64.3%	85.0%		71.1%		
	Total > 62 days		1.0	0.5	0.5	0.0	2.5	1.0	0.5	0.0	0.5	1.0	1.0	0.0	0.5	7.5			6.5		
Sarcoma	% Within 62 days	▲ £		100.0%		85.7%			100.0%			100.0%	100.0%			91.7%	85.0%		87.5%		
	Total > 62 days			0.0		0.5			0.0			0.0	0.0			0.5			0.5		
Gynaecological	% Within 62 days	▲ £	66.7%	71.4%	66.7%	81.8%	100.0%	85.7%	92.3%	33.3%	100.0%	90.9%	92.3%	100.0%	88.9%	89.0%	85.0%		76.4%		
	Total > 62 days		0.5	1.0	0.5	1.0	0.0	0.5	0.5	1.0	0.0	0.5	0.5	0.0	0.5	5.0			8.5		
Lung	% Within 62 days	▲ £	100.0%	88.2%	66.7%	81.5%	90.0%	91.7%	82.6%	100.0%	80.0%	87.5%	91.7%	68.2%	77.8%	81.9%	85.0%		86.5%		
	Total > 62 days		0.0	1.0	1.0	2.5	0.5	0.5	2.0	0.0	1.0	0.5	0.5	3.5	1.0	13.0			10.5		RC
Haematological	% Within 62 days	▲ £	50.0%	86.7%	100.0%	100.0%	0.0%	50.0%	50.0%	100.0%	100.0%		66.7%	66.7%	100.0%	75.7%	85.0%		70.5%		
	Total > 62 days		2.0	1.0	0.0	0.0	2.5	3.0	1.0	0.0	0.0		1.0	1.0	0.0	8.5			13.0		
Skin	% Within 62 days	▲ £	92.5%	96.7%	97.5%	96.0%	100.0%	97.3%	93.7%	95.7%	92.6%	97.4%	95.7%	95.8%	100.0%	96.1%	85.0%		94.5%		
	Total > 62 days		1.5	0.5	0.5	1.0	0.0	0.5	2.0	1.0	2.0	0.5	1.0	1.0	0.0	9.5			13.0		
Unknown	% Within 62 days	▲ £		50.0%		100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	66.7%	0.0%	89.5%	85.0%		83.3%		
	Total > 62 days		0.0	0.5		0.0	0.0	0.0	0.0	0.0			0.0	0.5	0.5	1.0			1.5		
All Tumour Sites	% Within 62 days	▲ £	90.1%	89.5%	91.8%	88.0%	87.5%	85.8%	89.4%	87.9%	92.0%	86.6%	85.8%	89.1%	87.8%	88.3%	85.0%		88.6%		
	Total > 62 days		7.0	7.5	5.0	12.0	10.0	11.0	9.5	9.0	6.0	9.5	11.0	8.0	7.5	98.5			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%		50.0%					66.7%	85.0%		100.0%		
	Total > 31 days		0.0	0.0					0.0		1.0					1.0			0.0		
Acute Leukaemia	% Within 31 days	▲ £				100.0%										100.0%	85.0%		100.0%		
	Total > 31 days					0.0										0.0			0.0		
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)037

Title of paper: Risk Register Report – April 2017.

Purpose: For the Trust Board to review the Trust's Risk Register to ensure it is accurate and reflective of the risks faced by the Trust.

Summary: The following report from the Executive Committee seeks to assure the Trust Board that risks are appropriately managed within the Trust and that all risks:

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

This report is based on Datix information as at 3rd April 2017 and shows that the total number of risks on the risk register is 686. There are 15 high risks on the CRR: 6 in Corporate Services, and 3 in each of the Clinical Support, Medical and Surgical Care Groups. The risk categories are: 10 re patient care; 2 re money and governance; and 1 re staffing.

Issues requiring highlighting, but where remedial actions have been agreed are::

1. The proportion of risks with an overdue review date has deteriorated from 13% to 44%. This is due to year-end review dates which should be better phased.
2. CIP sign-off compliance has significantly improved to 96.9%.
3. The Executive Committee have agreed that 3 CRR risks should be removed; 1152 re 16/17 agency expenditure; 1555 re apprenticeship levy; and 1797 re air blenders for resuscitaires.

Corporate objectives met or risks addressed: The Trust has in place effective systems and processes to identify manage and escalate risks to the delivery of high quality patient care.

Financial implications: None directly from this report.

Stakeholders: Staff, Patients, Executive Committee, Trust Board, Commissioners.

Recommendation(s): The Trust Board are asked to note the risks that have been escalated to the CRR and the mitigating actions and target risk scores.

Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance.

Date of meeting: 26th April 2017.

CORPORATE RISK REGISTER REPORT – APRIL 2017

1. Purpose

The purpose of this report is to provide an overview of the changes to the Trust's risks, and to focus on those risks which score 15 or above which are included on the Corporate Risk Register (CRR) and are escalated to the Executive Committee. This report is based on DATIX data extracted on 3rd April 2017, and covers the changes to the risk register reported in March.

2. Risk Register Summary for the Reporting Period

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

RISK REGISTER	Current Reporting Period 03.04.17	Previous Reporting Period 01.03.17	Previous Reporting Period 01.02.17
Number of new risks reported	25	35	28
Number of risks closed or removed	53	13	17
Number of increased risk scores	1	0	8
Number of decreased risk scores	5	9	18
Number of risks overdue for review	**303**	94	124
Total Number of Datix risks	**686***	**713***	**692***

3. Trust Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
49	**45**	**27**	**81**	**13**	**167**	**55**	**102**	**37**	**92**	**7**	**7**	**0**	**1**
121 = 17.72%			**261 = 38.21%**			**286 = 41.87%**				**15 = 2.20%**			

3.1 Surgical Care Group - 247 risks reported 36.16% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
10	**20**	**11**	**37**	**2**	**56**	**22**	**43**	**15**	**28**	**1**	**2**	**0**	**0**
41 = 16.60%			**95 = 38.46%**			**108 = 43.72%**				**3 = 1.21%**			

3.2 Medical Care Group - 150 risks reported 21.96% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
14	**10**	**3**	**13**	**2**	**25**	**15**	**21**	**15**	**29**	**2**	**0**	**0**	**1**
27 = 18%			**40 = 26.67%**			**80 = 53.33%**				**3 = 2%**			

3.3 Clinical Support Care Group - 30 risks reported 4.39% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
0	**0**	**0**	**4**	**0**	**6**	**4**	**8**	**1**	**4**	**3**	**0**	**0**	**0**
0			**10 = 33.33%**			**17 = 56.67%**				**3 = 10%**			

3.4 Corporate - 256 risks reported 37.48% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
25	**15**	**13**	**27**	**9**	**80**	**14**	**30**	**6**	**31**	**1**	**5**	**0**	**0**
53 = 20.70%			**116 = 45.31%**			**81 = 31.64%**				**6 = 2.34%**			

The highest proportion of the Trusts risks continue to be identified in the Corporate Care Groups, and of these 29% relate to Pharmacy, 21% to Finance and 20% to Human Resources.

4. The Trusts Highest Scoring Risks – Corporate Risk Register

Risks of 15 or above are added to the CRR. New risks reported in the month are formally reviewed and consistency checked by the Risk Management Council, prior to escalation to the Executive Committee (Appendix1).

The Risk Management Council recommendation, approved by the Executive Committee was for the downgrading of three risks from the CRR:

- 1552 relating to 2016/17 agency expenditure
- 1155 relating to the apprenticeship levy now covered in budgets, and
- 1797 relating to resuscitaires now purchased.

Appendix 1 - Summary of the Corporate Risk Register – March 2017

KEY	Medicine		Surgical		Clinical Support		Corporate	

New Risk Category	Datix Ref	Risk	Description	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Next Review Due	Target Risk Score I x L	Action plan in place with target completion date	Risk /Issue
Governance	1772	Risk of Malicious Cyber Attack	The HIS and neighbouring organisations have been targeted by malicious software via email links/attachments which if successfully bypassed our security controls could cripple the HIS Network.	3 x 4 = 12	4 x 4 = 16	09/11/2016 Christine Walters	20/04/2017	4 x 3 = 12	Action plan in place	Issue
Governance	1259	Serious Incidents Requiring Investigation (SIRI)	Failure to meet the prescribed deadlines in the management of SIRI's could lead to failure to learn lessons, implement changes and reduce risks, as well as, damage the Trust's reputation and reduce commissioner confidence	4 x 4 = 16	4 x 4 = 16	22/12/2016 Sue Redfern	31/05/2017	3 x 2 = 6	Action plan in place	Issue
Money	1555	Failure to achieve financial plan in 2017/18 due to cost pressure from the introduction of an Apprenticeship Levy	From April 2017, a new apprenticeship levy is being introduced by the government that will impact large organisations with a pay bill in excess of £3m. This is likely to be an unfunded cost pressure of £1m	3 x 5 = 15	3 x 5 = 15	01/04/2016 Anne-Marie Stretch	**02/03/2017**	3 x 4 = 12	Action plan not recorded in Datix	Issue that has been included in the draft financial plan as a cost pressure in 2017/18
Money	1152	Potential impact for the Trust on quality of care, contract delivery and finance due to increased use of bank and agency	Increase of bank and agency affects 1) continuity of care 2) ability to deliver against planned activity 3) breaching the agency cap 4) Failure to meet agency spend control target 2016/17	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	**06/03/2017**	4 x 3 = 12	**Action plan not recorded in Datix**	Issue and risk to the Trusts future clinical and financial sustainability
Patient Care	913	Patient safety risk due to staffing levels below establishment on DMOP	Patient safety is potentially compromised and the ability to deliver a good quality standard of care due to increase number of Registered Nurse vacancies. The latest snapshot of DMOP vacancies as of 31st October are 7.4wte (excluding frailty 9.56 WTE & stroke 7 WTE)	3 x 5 = 15	3 x 5 =15	12/04/2016 Sue Redfern	**08/04/2016**	2 x 2 = 4	Action plan in place	Issue
Patient Care	1921	Consent and marking form errors	There are multiple reports of multiple errors relating to consent forms and marking forms. The errors are not being detected on the ward	4 x 5 = 20	4 x 4 = 16	24/03/2017 Sue Redfern	**09/03/2017**	4 x 2 = 8	Action plan in place	Issue

			during pre-operative checks and patients are arriving in theatre with no consent, no marking form, or the wrong site identified on one or both. Patients have been sent with incomplete consent forms, incorrect consent forms (e.g. Consent from 1 when consent form 3 was appropriate) or no consent form at all. There are 10 incidents from 2017 listed in linked records. The risk resulting from this are the wrong operation being undertaken and consent not being satisfactorily obtained.							
Patient Care	1285	Insufficient staffing levels on Frailty Unit affecting patient safety and operational effectiveness	Patient safety is potentially compromised and the ability to deliver a good quality standard of care due to staff vacancies. of medicines. Latest Band 5 vacancy snapshot as of 7th November 2016, 10.56 WTE.	4 x 4 = 16	3 x 5 = 15	12/04/2016 Sue Redfern	07/04/2017	3 x 3 = 6	Action plan in place	Issue
Patient Care	1523	Risk to patient outcomes due to inability to consistently fill all three Blood Science rotas	Insufficient numbers of BMS staff to cover 24hr rota that may result in reduced or no service on site. This applies to Clinical Biochemistry and Haematology/Transfusion at Whiston and Blood Science (biochemistry /haematology/ transfusion) at Southport and Ormskirk Hospitals. Staff are not interchangeable and recruitment of experienced staff and retention of existing staff has proved difficult over the past few years culminating in the current situation despite a number of measures to reverse the situation. (NB. Risk has been expanded beyond just Biochemistry to all Blood Science)	4 x 3 = 12	3 x 5 = 15	04/01/2016 Anne-Marie Stretch	30/06/2017	3 x 3 = 9	Action plan in place	Issue
Patient Care	1569	Consultant Recruitment within Clinical Support Services	Difficulty recruiting Histopathologists and Radiologists to manage increasing workload in line with business and operational requirements	2 x 5 = 10	3 x 5 = 15	17/11/2016 Anne-Marie Stretch	**31/03/2017**	3 x 4 = 12	Action plan in place	Issue
Patient Care	1920	Reduction in AMU Medical staff cover due to locum consultants contract terminations	Full time locum consultant leaving the Trust on 17 March 2017. Full time Locum consultants x2 potentially leaving the Trust on 31 March 2017. Substantive full time medical consultant on	5 x 5 = 25	5 x 5 = 25	07/03/2017 Kevin Hardy	03/04/2017	2 x 2 = 4	**Action plan not recorded in Datix**	Issue

			maternity leave since 14 February 2017. (Expected to return February 2018). No cover in place currently. Therefore potentially (17 Locum sessions) + (8 substantive sessions) = 25 session reduction in medical staff cover. AMU Risks: patient safety, clinical effectiveness, patient experience. In addition, potential serious negative impact on other services due to interlinked dependencies e.g. 'Seven day working' and associated impacts on potential reduction of this service, including patient discharges, increased surgical cancellations due to requirement for increased bed base, short/long terms income							
Patient Care	1797	Air blenders for neonatal resuscitaires	Risk of a baby suffering brain damage because we cannot provide best practice resuscitation for neonates at birth because no neonatal resuscitaires on Delivery Suite have air/oxygen blenders. Air/oxygen blenders enable resuscitation to commence in air as per the National Resuscitation Council National Newborn Life Support guidelines (2010)who state 'In term infants air should be used for resuscitation at birth' (page 119). The international Liaison Committee on Resuscitation (ILCOR) states ' in term infants receiving resuscitation at birth with positive pressure ventilation, it is best to begin with air rather than 100% oxygen' they continue 'It is clear that hyperoxia (excess supply of oxygen)is damaging to tissue, including the cells of the developing brain, and particularly so after a period of asphyxia'.	5 x 3 = 15	5 x 3 = 15	27/02/2017 Sue Redfern	**31 /03/2017**	5 x 1 = 5	**Action plan not recorded in Datix**	Issue
Patient Care	1820	Pathology Computer Hardware Refresh	The pathology computer system hardware was purchased in 2007, and has a 7 year refresh recommendation. We are in the process of identifying the best option to refresh the existing hardware, update	5 x 2 = 10	5 x 3 = 15	03/01/2017 Christine Walters	31/05/2017	5 x 1 = 5	Action plan in place	Risk

			the operating software or replace the Laboratory Information System							
Patient Care	1205	B&P Prosthetic Service - staffing situation, service delivery pressures	This risk is 3 fold. There are currently 3 qualified Prosthetists for a team that should be made up of 7. There is also 1 funded maxillofacial technician who is currently off sick. The Prosthetic Department delivers its services from 2 different hospital sites and receives referrals from Burns, Plastic Surgery, Dermatology, Neurology, ENT, Maxillofacial Surgery and GP's from across Merseyside, Cheshire, North Wales and IOM. Until recently the service also carried out burn prosthetic work for South Manchester however we have had to withdraw from this due to capacity constraints here.	4 x 4 = 16	4 x 4 = 16	16/08/2016 Anne-Marie Stretch	**20/03/2017**	4 x 2 = 8	Action plan in place	Issue
Patient Care	1931	Off-Payroll working in the public sector; reform of the intermediaries legislation	From 6.4.17 the government will move responsibility for operating tax rules that apply to off-payroll engagements to the Trust. For those who fall under the scope of IR35 the Trust will be liable to calculate and pay income tax and national insurance to HMRC via RTI. In addition the Trust will be liable for NI contributions and the apprenticeship levy and this is estimated to cost £1.02 million. It is expected that extra admin support will be required, external agencies are preparing to renegotiate even higher rates of pay for PSC medical locum. The Trust has already received a small number of resignations, a risk assessment is underway	4 x 4 = 16	4 x 4 = 16	14/03/2017 Anne-Marie Stretch	**21/03/2017**		Action plan in place	Issue
Staff	762	Potential risk of the Trust not being able to provide safe levels of staffing	Unable to recruit staff with the knowledge, skills and experience required.	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	**06/03/2017**	4 x 2 = 8	Action plan not recorded in Datix	Risk

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

ENDS

TRUST BOARD

Paper No: NHST(17)038
Title of paper: Review of the Board Assurance Framework (BAF) – March 2017
Purpose: For the Committee to review the BAF and agree proposed changes.
Summary: The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its strategic plans and key long term objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in January 2017. The Executive Committee have reviewed the BAF in advance of its presentation to the Trust Board and proposed changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the proposed actions and additional controls are sufficient to mitigate the risks being managed by the Trust, in accordance with the level of risk appetite acceptable to the Board. **Key to Changes:** ~~Score through~~ = proposed deletions Blue Text = proposed additions Red = overdue actions It is proposed that the risk score for Risk 2 be changed to a score of 16, from 20, to reflect the achievement of the 2016/17 financial plan. The BAF will be aligned to the agreed Trust Objectives for 2017/18 and this will be reported in the next scheduled Board report in July 2017.
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to assure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSI, CQC, Commissioners.
Recommendation(s): To review and approve the proposed changes to the BAF.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance.
Date of meeting: 26th April 2017

Strategic Risks - Summary Matrix

Vision: 5 Star Patient Care

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

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

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

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

Risk Scoring Matrix

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

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

Risk 1 - Systemic failures in the quality of care	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause: • Failure to deliver the Clinical and Quality Strategy • Failure to deliver CQUIN element of contracts • Patient experience indicators decline • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting Effects: • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage Impact: • Harm to patients • Loss of reputation • Loss of contracts/market share	5x4= 20	• Quality metrics and clinical outcomes data • Safety thermometer • Quality Board Rounds • Complaints and claims • Incident reporting • IPR monitoring • Quality Governance structure • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with lead CCG • NHSI Accountability Framework • Appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC Action Plan • Medicines Optimisation Strategy	To Board; • IPR • Patient Stories • Quality Board Round reports • Quality Committee and its Councils • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Staff Survey • Friends and Family scores • Nursing Strategy • Mortality Review Reports • Quality Account • Internal audit • Clinical and Quality Strategy • National Inpatient Survey • Sign up to safety Indicators Other; • National clinical audit programme • External inspections and reviews • PLACE Inspections • Reports • CQC CIH Inspection Report • Learning Lessons League • IG Toolkit results	5 x2 = 10		Consistent achievement of the 95% VTE screening target Achievement of the national targets for AKI and Sepsis Introduction of the midwifery led care pathway for women having low risk births	Achievement of complaints response times targets for 2016/17 – March 2017 Delivery of final actions on the CQC Action Plan (March 2017) Plans for implementing the four key 7-day service standards Implementation of Stroke Service integration with WHH – phase 2 planned completion in 2017/18 ~~Weekend mortality improvement plan - September 2016~~ Improve F&F response rates (March 2017)	5 x 1 = 5	KH/ SR

Risk 2 - Failure to agree a sustainable financial plan with commissioners	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to delivery LTFM, including growth and CIP • Failure to control costs • Failure to implement transformational change at sufficient pace • Failure to meet the TDA 4 tests and secure national PFI support • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions Effects; • Failure to meet statutory duties • TDA Escalation status increases • Failure to progress FT application Impact; • Unable to deliver viable services • Loss of market share • External intervention	5 x 5 = 25	• IBP/LTFM • Business Planning • Budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 5 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review) • Contract monitoring and reporting • Contract review Board and CQPG • Activity planning and profiling • IPR • NHSI monthly monitoring submissions • Creation of a PMO to support delivery of CIP and service transformation • Signed Contracts with all Commissioners • Application of agency caps • Internal audit programme	To Board; • Finance and Performance Committee • Annual financial plan • Finance report • IPR • Statement of Internal Control • Annual Accounts • Audit Committee • Grant Thornton CIP Review and Report • SLM Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports • Annual audit programme Other; • NHSI monthly reporting • Contract Monitoring Board	4 x 4 =16	Agree a shared health economy financial and sustainability strategy Develop 2017 - 19 detailed CIP plans	Commissioner engagement in joint long term financial modelling and planning	PMO impact assessment and ROI -March 2017 Develop a detailed STP implementation plan with Alliance LDS and C&M partners in line with the priorities outlined in the Next Steps FYFV plan Secure maximum SFT funding available for 2016/17 and then equivalent for 2017/8 and 2018/19.	4 x3 = 12	NK

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

Risk 4 - Failure to protect the reputation of the Trust	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff engagement and involvement • Failure to maintain CQC registration/Good Rating • Failure to report correct or timely information Effect; • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit & retain skilled staff • Increased external scrutiny/review • Trust unable to pursue long term aims within the health system /partners Impact; • Reduced financial viability and sustainability • Reduced service safety and sustainability • Reduced operational performance • Increased intervention	4 x 4 = 16	• Communication and Engagement Strategy • Communications and Engagement Action Plan • HR & Workforce Strategy • Recruitment & Retention Strategy • Publicity and marketing activity • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board Development Programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement programme • Trust internet and social media monitoring and usage reports	To Board; • Quality Committee • Audit Committee • Workforce Council • Communications and Engagement Strategy • IPR • Staff Survey • Complaints reports • Friends and Family • Staff F&F Test • PLACE Survey • National Cancer Survey • Francis action plan • Referral Analysis Reports • Market Share Reports • CQC national patient surveys • CQC Inspection ratings • Annual assessment of compliance against the CQC fundamental standards Other; • Health Watch • CQC • TDA Escalation Rating	4 x 3 = 12		Communication and Engagement Strategy quarterly update to Workforce Council	Communication and Engagement Strategy refresh to approved at Workforce Council May 2017	4 x 2 = 8	AMS

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

Risk 6 - Failure to attract and retain staff with the skills required to deliver high quality services	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment Effect; • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff Impact; • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	5x4 = 20	• Team Brief • Staff Newsletter • Mandatory training • Staff benefits package • HWWB Provision • Staff Survey action plan • JNCC/Workforce Council • Francis Report Action Plan • Education, Training & Development Plan • HR Policies • Exit interviews • Staff Engagement – Listening events • Involvement in Academic Research Networks • HR & Workforce Strategy Implementation Plan • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews • Workforce KPIs • Recruitment and Retention Strategy action plan • Nurse development programmes • Agency caps and usage reporting • LWAB membership • ACE Behavioural standards	To Board; • Quality Committee • Finance and Performance Committee • Workforce Council • IPR - HR Indicators • Staff Survey • Monthly Nurse safer staffing reports • Workforce plans aligned to strategic plan • Monitoring of bank, agency and locum spending • Monthly monitoring of vacancy rates and staff turnover • Recruitment & Retention Strategy action plan • Staff F&FT snapshots • OD actions plans • International Recruitment Strategy & action plan • Communication Sub groups meetings • HEG feedback Other • Annual workforce plans • HR benchmarking • Nurse staffing benchmarking • Speak out Safely updates	5x4= 20	Apprenticeship levy for 2017 execution of action plan monitored via Workforce Council and Trust Executive Committee	Junior Medical Cover following reduction in Deanery allocations Implementation plan to mitigate risks of Apprenticeship levy for 2017	Complete E-Rostering roll out to all Medical Staff Specialist nurses to dedicate time to research and training -April 2017 Departmental Development and Succession Plans - May 2017	4 x 2 = 8	AMS

Risk 7 - Major and sustained failure of essential assets or infrastructure	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire Effect; • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective or • Increase in complaints Impact; • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 4 = 16	• New Hospitals / Vinci Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • Capital programme • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy	To Board; • Finance and Performance Committee • Finance Report • Capital Programme • Audit Committee • I.P.R. Other; • Major Incident Plan • Business Continuity Plans • ERIC Returns • PLACE Audits • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee, to capture: ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance	4 x 2 = 8	The estates strategy will need to be continually refreshed as the configuration of clinical, clinical support and back-office functions across a wider footprint develops. At this stage it is not envisaged that major changes to the Trust estate are anticipated but maximising the use of the high-quality accommodation for clinical services will be pursued.	To dovetail into the 5-year forward view programme.	Membership of the St Helens Strategic Estates Group Membership of the Alliance LDS Estates Enabling Group and Corporate Services programme Board	4 x 2 = 8	PW

Risk 8 - Major and sustained failure of essential IT systems	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage • Lack of effective risk sharing with HIS shared service partners Effect; • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Inability to record activity and duplication due to reliance on back up paper or manual systems. • Loss of data or patient related information Impact; • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4x4=16	• HIS Management Board and Accountability Framework • IM&T Strategy monitoring • Procurement Policy • Information Strategy • HIS performance framework and KPIs • HIS customer satisfaction ratings	To Board; • HIS Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • MITc Other; • Major Incident Plan • Business Continuity Plans	4x2=8	Secure on-going HIS funding from CCGs and other partners		PAS:- • ~~Replacement Business Case approval – March 2017~~ • Signed Contract in place with System C – June 2017 • Replacement PAS implemented by April 2018 Hospital IT Strategy approval by July 2017 HIS Cost Model and SLAs agreed by June 2017.	4x2=8	CW

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)039
Title of paper: Executive Committee Assurance Report.
Purpose: To feedback to members key quality issues arising from the Executive Committee meetings.
Summary: 1. Between the 17th March and 13th April four meetings of the Executive Committee have been held. The attached paper summarises the issues discussed at the meetings. 2. Decisions taken by the Committee included managing the IR 35 Task rule implementation, benchmarking of A&E staffing, and deferral of the pathology IT system replacement. 3. Assurances regarding safer staffing, lung care services, cardiovascular treatment, CQUIN performance, theatre staff relations, management of agency expenditure, and risk management were obtained. 4. The business cases to replace the EPR, and renew the soft FM service contract were agreed for recommendation to the Board. Proposals for radiology equipment refresh, and skin preparation products (c£100k) were approved. 5. There are no other specific items requiring escalation to the Board.
Corporate objective met or risk addressed: Contributes to the Trust's Governance arrangements, and its short and longer-term plans.
Financial implications: None directly from this report.
Stakeholders: The Trust, its staff and all stakeholders.
Recommendation(s): The Board are asked to note the contents of the report.
Presenting officer: Ann Marr, Chief Executive.
Date of meeting: 26th April 2017

EXECUTIVE COMMITTEE REPORT (17th March to 13th April 2017)

The following report highlights key issues considered by the Committee.

23rd March

1. Safer Staffing / Vacancy Dashboard

    1.1. SR presented an update on the staffing levels and recruitment. Members asked for details on the number of registered nurses on duty in the wards. The probable introduction of a rotation programme for new nurses was noted, along with the innovative work under way at Lancashire Teaching Hospital.

    1.2. Duplication of the report to Committees and Board was discussed and proposed that it should be reviewed monthly at Quality Committee and quarterly at Executive Committee linked to the vacancy dashboard and Shelford review.

2. IR35 Tax rules

    2.1. Malise Szpakowska and Pauline Jones updated on the new IR35 rules coming into force on 6th April. The system for dealing with each case individually, and the internal communications to be sent were agreed. The potential impact to each service from staff choosing to leave the organisation was discussed.

3. Lung care data

    3.1. Julie Hendry gave a presentation on the national lung cancer data sets. Errors with historical data collection were noted and assurance provided that these have now been addressed. Whilst it was acknowledged that this may account for the Trust's benchmark performance the 2017 data should show that the Trust's relative performance has improved; if not further action will be required.

4. Respiratory 7 day working

    4.1. KH presented the updated data on the use of the additional resources provided on the back of 7-day working initiatives. Following discussion it was agreed that further benefits realisation from sessions on weekdays was required.

5. Electronic Patient Record (IPR) IT system

    5.1. Mark Hogg (MH) attended to present the revised business case for EPR prior to consideration by the Trust Board. The revised timeline and costs, including the interim implementation costs were scrutinised.

6. Telepath System business case

    6.1. CW presented a report which outlined the need to replace the laboratory Telepath IT hardware. Measures to mitigate the risk are in place but this cannot be viewed as a long-term solution. It was agreed that this could not be approved in isolation and would need to be considered against other capital bids.

7. ePrescribing

    7.1. CW reported that the pilot had been delayed due problems with the new software. Whilst the likely rescheduled dates will not impact on the spend profile, the benefits realisation plans agreed with NHSE will require realignment.

30th March

8. Cardiovascular Disease Clinical Summit

    8.1. Abdullah Mohammed provided a presentation. The significant variation in timely access to cardiac intervention across the region was highlighted. Additional data was requested to play into strategic discussions.

8.2. The need for closer collaboration between sites was agreed, and the current situation with Warrington and Southport was discussed.

9. CQUIN

9.1. Nicola Broderick presented a summary report which showed that the Trust had performed extremely well. A specific clinical challenge with taking blood samples from paediatric patients was discussed and SR agreed to progress the close-out of the associated draft policy.

10. Managed Equipment Service (MES) update

10.1. David Anwyl and (MH) presented the proposal for radiology refresh in the next two years and the successful negotiations with GE Medical that have resulted in additional MRI and CT equipment within the current PFI financial envelope. It was noted that relocation of lithotripsy and laser work temporarily housed in radiology at Whiston will be required and that plans are in place.

11. CQPG

11.1. SR summarised the February CQPG meeting. A key issue discussed was the reporting and investigation of incidents where improvements are needed.

12. STP Feedback

12.1. Recent issues including the discussions around the footprint, structure and management resource were noted. Confirmed that AM is to become LDS lead.

6th April

13. Theatres development plan

13.1. John Clayton provided an update on the work undertaken in theatres to improve staff satisfaction. A significant amount of changes have been made and it appears that this has resulted in improvement.

14. Sherdley GP Practice Tender update

14.1. MH provided information on the tendering process underway to select a provider for primary care services for the practice based in St Helens Hospital. It was agreed that further strategic discussions will be required prior to any decision to submit a bid.

15. Theatre IT system

15.1. CW provided an update on the revised implementation plan following the pause last December which indicates roll-out in May for completion in July.

16. Contract for Soft FM Services

16.1. PW presented the proposal for the contract which is up for renewal in June 2018. Following discussion a recommendation to the Board was agreed.

13th April

17. NHSI Agency usage

17.1. Malise Szpakowska (MS) updated members on agency expenditure. Early figures indicate an expenditure of £10.7m which shows a 13% reduction from the previous year.

18. IR35

18.1. MS updated on progress with management of the current staff affected by the changing tax rules and the impact on services.

19. Use of Chloraprep

    19.1. John Clayton and Dr Kalani Mortimer presented the business case for surgical skin preparation products. Following discussion it was agreed that Chloraprep should be used for interventions with a higher risk of infection with an alternative product for low-risk surgery. The financial impact will be circa £100k p.a.

20. Escalation of new high risk

    20.1. Andy Ashton talked through the current pressure in A&E from the shortage of middle grade doctors. Whilst mitigation plans are currently in place including the use of temporary staffing it was agreed that he would work with AMS on a robust longer-term employment solution.

    20.2. It was agreed that benchmarking data of A&E services would be reviewed and the potential for a deep-dive with Wirral Trust would be explored.

21. Risk report and CRR

    21.1. PW took members through the latest report. The removal of 3 risks from the CRR was agreed, and improved phasing of review dates was supported.

22. Board Assurance Framework

    22.1. SR took members through the updated framework. Members agreed to feed in any final changes prior to submission to the Board.

23. Orthopaedic sessions gap – reconciliation data and LLP information

    23.1. Phil Nee and John Foo gave an updated capacity planning report. Further information was identified in order to explain clearly the link between referrals, conversion to activity and resulting capacity requirements.

24. IPR

    24.1. NK provided early information from the draft IPR and outstanding actions to be closed-out prior to the document going to Committee were agreed.

25. Agenda for Exec to Exec with St Helens CCG

    25.1. Proposals for the agenda at the joint Exec to Exec meeting on 20th April were agreed.

26. STP feedback

    26.1. Feedback from the recent discussions was provided.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)040
Title of paper: Committee report – Quality Committee
Purpose: To summarise the Quality Committee meeting held on 18th April 2017 and escalate issues of concern.
Summary: Key items discussed were: 1. Complaints 2. Safer Staffing 3. IPR 4. Mortality Review update 5. Lord Carter review update 6. Francis action plan update 7. No smoking site update 8. Gram negative bacteraemia update 9. CAS alert action plan (Nasogastric tube misplacement) 10. Quality Account 11. CQC action plan update 12. Hospital pharmacy transformation programme
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: Kevin Hardy, Medical Director
Date of meeting: 26th April 2017

QUALITY COMMITTEE ASSURANCE REPORT

Summary of the discussions and outcomes from the Quality Committee meeting held on 18th April 2017.

Action Log

1. All actions on the log were reviewed.

Complaints Report

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

   2.1. 338 formal 1st stage complaints were received and opened for investigation from 1st April 2016 to 31st March 2017, which is an increase of 15% from the previous year's total of 293.

   2.2. The Trust responded to 58% of 1st stage complaints within the agreed time frames during 2016-17, a slight decrease from 61.4% during the previous year.

   2.3. There were 42 2nd stage complaints during 2016/17, a decrease of 43% from the previous year's 74.

   2.4. The top complaint themes were:

   2.4.1. Clinical treatment

   2.4.2. Admissions and discharges

   2.4.3. Values and behaviours.

   2.5. There were a total of 2022 PALS contacts in 2016-17, which is a 54% increase over the previous year's 1312 contacts. 86% of the PALS contacts related to managing concerns or complaints and 14% were for signposting. The main subject of PALS contacts related to communication.

   2.6. David Graham (DG) said that although the figures had improved, it was still disappointing that the Trust are still not responding to complaints in a timely fashion; despite the fact that there has been an increase in the number of days for a response. ARW replied that improvement should be seen in Q1.

   2.7. Kevin Hardy (KH) asked that the year on year comparison figures also be provided in rates of complaints as this would give a more realistic picture, given the increase in activity.

   2.8. The Committee discussed an update from Julie Hendry, which outlined the time-frame taken for each stage of a complaint (a selection of three complaints from medicine). The update showed that on occasions, the delay can be waiting for Executive sign off. AM explained that for the majority of complaints that she signs off, further clarification is required and this can take time.

   2.9. Both Sam Pedder (SP) and Sharon Egdell (SE) asked if the correct people are writing the complaint responses. KH advised that from May, a senior consultant was going to work one day per week on complaints.

   2.10. Nik Khashu (NK) asked who decides on the complaint outcomes and how the Trust compares nationally? ARW said that the decision is made by the Executive Team, as to whether the complaint is "upheld", "partially upheld" or

"not upheld". ARW said he could look at the KO41's to look at how we compare nationally.

Safer Staffing report

3. Sue Redfern (SR) provided an update for the Committee.

3.1. The overall % fill rates of planned inpatient staffing levels for the month of March 2017 were:

3.1.1. RNs on days 91.9%

3.1.2. RNs on nights 94.68%

3.1.3. Care staff on days 110.51%

3.1.4. Care staff on nights 117.86%

3.2. 14 wards experienced a monthly staffing headcount fill rate of below the accepted level of 90%; 13 wards for RNs and 1 ward for care staff.

3.3. In March 2017, 4 patients experienced moderate or severe harm following inpatient falls.

3.4. SR discussed overseas recruitment with committee members. 12 Indian nurses have arrived to date and 9 have passed the OSCE. 1 staff member is awaiting the OSCE resit and 2 are in training for the OSCE. The remaining 31 nurses are to re-sit the IELTS.

3.5. SR informed the committee that HEE have recently announced that the applicants will now be allowed 3 attempts at passing the OSCE instead of 2 and are presently lobbying the NMC to reduce the IELTS pass rate of 7 down to 6.5 in line with the GMC.

3.6. Bank staff, student nurses, turnover and preceptorship were also discussed.

3.7. CS informed the committee that the HR department were meeting with another agency that afternoon and the School of Nursing is still under discussion.

3.8. NK asked whether it would be possible to over recruit to certain posts as some wards are difficult to staff. SR said that she was meeting with Rob Cooper and the Directorate Manager on 19th April, to discuss staffing on Ward 1A.

3.9. Ann Marr (AM) wishes to discuss the RN/HCA ratio at the Executive Committee meeting.

IPR

4. NK summarised the report.

4.1. There were no never events reported in March 2017, taking the year to date total to 2.

4.2. There were no cases of MRSA bacteraemia in March 2017. Year to date there have been a total of 3 MRSA incidents and 1 contaminant.

4.3. There were 4 C.Diff positive cases in March. Year to date there have been 23 confirmed positive cases. The annual tolerance for 2016-17 is 41 cases.

4.4. There were no grade 3 pressure ulcers in March. The wording of the IPR was corrected to read "there have been a total of three grade 3 pressure ulcers which were deemed to be avoidable".

4.5. There were 3 falls that resulted in severe harm during February. Year to date there have been a total of 20.

4.6. VTE assessment for February was slightly below the required 95% target at 94.28%.

4.7. HSMR stands at 102 up to December 2016.

4.8. A&E performance was 80.1% (type 1) and 87.4% (type 1 & 3) in month. Whilst not yet at the required performance, the improvement is recognised.

4.9. RTT incomplete performance was achieved in month (93.49%). Specialty level actions to address this continue, including targeted backlog clearance and collaborative working with the CCG to improve the quality and effectiveness of patient referral pathways. Additional activity funded by NHSE to reduce RTT backlog was completed with an additional 18 T&O patients and 1208 dermatology patients cleared from the backlog.

4.10. Provisional results for the financial year 2016/17 are expected to show a surplus of £3.3m after technical adjustments which is in line with agreed plans and control totals. This includes the expected full achievement of £10.1m income of STF funding.

4.11. The Trust has provisionally delivered £15.2m of CIPs which is in line with the annual plan.

4.12. The Trust's cash balance at the end of March was £1.8m, in line with the Trust's external finance limit and represents 2 days of operating expenses.

4.13. The Trust fully utilised its capital resources in the year of £3.5m.

4.14. The 2016 staff satisfaction score has again increased and the Trust remains in the top 20% of acute trusts nationally A full report was presented at the March 2017 Trust Board and a summary presentation to staff will take place on 3rd May 2017.

4.15. Mandatory training compliance exceeds the target by 6.6%. Appraisal compliance has continued to improve and has ended the year 2.39% above target following significant effort from managers and L& OD team to meet the 85% target. It was recognised that there is an ongoing issue with appraisals in A&E which is being addressed.

4.16. Absence has decreased in March to 4.2% which is a 0.48% improvement on the Q4 target. At year end, sickness absence is a 0.1% improvement on last years outturn at month 12.

4.17. The Committee discussed infection control at some length. Rani Thind (RT) felt that the MRSA message needs to be reinforced every month. Francis Andrews (FA) commented that Kalani Mortimer sends out a trajectory to all consultants

and this reinforces the issues around infection control. The problem could be the rapidly changing medical staff and junior staff do not have a forum to attend.

4.18. AM also advised that the IPR is discussed at Team Brief, particularly regarding infection control.

Mortality update

5. Francis Andrews (FA) provided a summary for the Committee.

5.1. The mortality review programme has been in place at the Trust for nearly a year. A number of issues have emerged which have resulted in the number of completed mortality reviews being less than that required under the current system, a further issue elates to how learning and actions are monitored.

5.2. Following a recent CQC report on mortality reviews, the National Quality Board has issued national guidance on learning from deaths in March 2017.

5.3. A new Structured Judgement Review will have to be completed and results will be published on a quarterly basis (by Q3 onwards). There could be further implications for the Trust, as we are being asked to review deaths up to 30 days post discharge, however, we would do not have ready access to records in primary care.

5.4. KH will take a paper to Board in May, and FA will report back to the Committee with an update on progress in September.

5.5. NK asked if there was a policy for engagement? FA said that it will have to be developed to encompass the changes.

Lord Carter review update

6. Claire Scrafton (CS) provided an update.

6.1. The report provides an overview of the recommendations following the publication of the Carter report.

6.2. CS asked committee members, given it was a new financial year, if the action plan should be refreshed and new actions added? This was agreed by the Committee.

6.3. AM asked that the wording be altered in recommendation 1E, and the phrase “high rates” of bullying and harassment is altered given it is not applicable to the Trust. CS will rewrite the definition.

Francis action plan update

7. CS provided an update.

7.1. All recommendations have been met. The appointment of Rajesh Karimbath should ensure that raising concerns will be more widely promoted.

No Smoking update

8. SD will provide an update at the July meeting

E.Coli update

9. SR summarised the report.

    9.1. From April 2017, the Department of Health extended the surveillance of bacteraemia caused by gram-negative organisms to include Klebsiella species and Pseudomonas aeruginosa in addition to the existing E.Coli collection with the intention of reducing such infections by 50% by 2021.

    9.2. SR is working with colleagues across the health economy collaborative regarding prescribing UTI's.

    9.3. The committee agreed a target of no more than 55 for the 2017-18 period for gram-negative infections.

    9.4. The committee discussed at length the reasons why Knowsley/St Helens have such a high incidence of E.Coli. It was felt that reasons include high levels of antibiotic prescribing, poor prescribing, custom and practice and a lack of education. AM would like to see benchmarking data.

    9.5. It was agreed that gram negative bacteraemia is now an important issue which should remain high on the agenda.

NPSA Nasogastric Tube – Trust compliance

10. Rajesh Karimbath (RK) provided an update.

    10.1. On 22 July 2016, NHS Improvement cascaded a stage 2 alert in respect of nasogastric tube misplacement. The actions pertaining to this alert were deemed to be relevant to all organisations where nasogastric or orogastric tubes are used for patients receiving NHS funded care. The report provides assurance to the Quality Committee on the progress made so far by the Trust and details further actions required relating to the safety alert.

    10.2. Following the discussion, the Committee could not fully approve the action plan until recommendation 3 has been completed (introduce a system of 'hot reporting' of all x-rays). RK will report back to the Committee in May.

Quality Account

11. ARW presented the Quality Account draft.

12. The Quality Account was received by the Committee and the broad principles accepted. However, after discussion, AM asked to meet with SR and ARW to discuss particular aspects before review by external organisations. This meeting has been arranged for 20th April.

CQC action plan update

13. ARW provided an update to the Committee.

    13.1. Three actions have missed their deadline; A&E, Maternity and End of Life care. The appraisal rate in ED did not quite make the target.

    13.2. Both DG and AM re-iterated the importance for this action plan to be signed off.

Hospital Pharmacy Transformation Programme (HPTP)

14. Simon Gelder (SG) provided an overview for the Committee.

    14.1. The draft plan was reviewed by NHSI in November 2016. The plan was given a "Green" rating. The final HPTP has been produced following incorporation of best practice feedback from NHSI events during December, increased medicines optimisation content in the Model Hospital dashboard, increased tripartite LDS and NW chief pharmacist network collaboration.

    14.2. SG advised that Board approval was required by the end of April. The Committee approved the plan, provided there are regular reports on progress and would advise the Board of the same.

    14.3. SG will provide a quarterly update to the Committee, commencing in July.

Feedback from Patient Safety Council

15. RK provided an update.

    15.1. Safeguarding training: The target to achieve trajectory for Level 2 and Level 3 training remains a challenge due to, staff being unable to complete workbooks whilst working clinically, matters identifying training requirement and ESR capabilities on recording training accurately. A further update is required for the May meeting.

    15.2. ICNET licence renewal and fee. The risk identified is a failure to meet an organisational requirement to gather data and carry out appropriate surveillance. The Patient Safety Council recommended this to be added to the risk register.

    15.3. SR has discussed the renewal and fees with Nik Khashu and Christine Walters. There is likely to be a cost pressure of £48k per year.

Feedback from Patient Experience Council

16. There was nothing to escalate to the Committee.

Feedback from Clinical Effectiveness Council

17. There was nothing to escalate to the Committee.

Feedback from CQPG Meeting

18. There was nothing to escalate to the Committee.

Feedback from Executive Committee

19. There was nothing to escalate to the Committee.

Effectiveness of meeting

20. DG felt that although the meeting overran slightly, there had been several important issues which required appropriate debate and discussion.

21. PW said that it had been a particularly. He also pointed out that it would be valuable to have another Non-Executive Director sitting on the Committee. He agreed to raise this with the Chair.

AOB

22. SP asked about the interim Head of Quality for Surgical Care and when there would be someone in place. CS said that she was looking at CV's today.

Date of next meeting

23. Tuesday, 23rd May 2017.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)041

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance and Performance Committee, 20th April 2017

Summary:

Agenda Items

For Information

- Proposal and Costing for co-location in ED
- DoH Temporary Loan Facility

For Assurance

- St Helens Sickness review
- A & E update - the Committee were assured by the update on the action plan to improve performance and will continue to monitor progress
- Integrated Performance Report Month 12 2016/17
- Provisional 2016/17 Finance Report delivered £3.4m surplus, may improve by circa £0.4m, based on re-allocation of STP funding
- Governance Committee Briefing Papers:
  - CIP Council

For Approval

- Agenda for F & P for 2017/18

AOB

- UoRR finance metric - performance against the RAG rating was discussed

Actions Agreed

- UoRR metric to be presented to the Committee
- A&E performance update
  - Add RAG rating to PDSA summary
  - Present the ED model and risk assessment of financial impact to the Committee
- St Helens sickness – investigate reasons why sickness level is higher and how effective is the Attendance Management policy
- IPR
  - Ward Dashboard - RAG rating to be reviewed by the Executive Committee
  - Present the Keeping Nourished – MUST tool Rag rating to the Committee

Corporate objectives met or risks addressed: Finance and Performance duties

Financial implications: None as a direct consequence of this paper

Stakeholders: Trust Board Members, NHSI

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

Presenting officer: Denis Mahony Non-Executive Director

Date of meeting: 26th April 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)042

Title of paper: Committee Report – Audit

Purpose: To feedback to members key issues arising from the Audit Committee.

Summary: The Audit Committee met on 19th April 2017.

The following matters were discussed and reviewed:

External Audit (Grant Thornton):

- An update on progress being made against the 2016/17 audit plan
- a benchmarking report on the Annual report
- 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):

- Progress report on Internal Audit programme
- MIAA provided three further reports for the Audit Committee to note:
  - Director of Internal Audit Report 2016/17
  - Draft Internal Audit plan was presented and approved
  - Internal Audit Charter was reviewed

Anti-Fraud Services (MIAA):

- The Committee received an update on progress being made against the 2016/17 anti-fraud plan.
- The final anti-fraud work plan for 2017/18 was presented and approved.
- NHS Protect Charter was presented

Trust Governance and Assurance:

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

Standing Items:

- The audit log (report on current status of audit recommendations) (ADoF)
- The losses, compensation and write-offs report for the period 1 April 2016 to 31 March 2017 (ADoF).
- Aged debt analysis as at end of March 2017 (ADoF).
- Tender and quotation waivers (ADoF).

Any Other Business:

- Annual meeting Effectiveness Review was presented, recommendations being to improve the quality of some of the papers and attendance (DoCS)
- Going concern paper was presented (DoF)
- Draft accounting policies for 2016/17 were approved (ADoF)
- Responses to letters from External Audit to those charged with governance (Chair) and Trust management (DoF) were agreed

Key: Chair = Audit Committee Chair

DoF = Director of Finance

DoN = Director of Nursing, Midwifery & Governance

DoCS = Director of Corporate Services

ADoF = Assistant Director of Finance (Financial Services)

NB. There was no meeting required of the Auditor Panel required on this occasion.

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

Financial implications: None as a direct consequence of this paper

Stakeholders: The Trust, its staff and all stakeholders

Recommendation(s): For The Board to be assured on the Trust Audit programme

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

Date of meeting: 26th April 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)043
Title of paper: NMC Revalidation Trust Implementation Update
Purpose: To update Trust Board on the successful implementation of NMC Revalidation of the nursing and midwifery registered workforce since 1st April 2016 to 31st December 2016.
Summary: 1. Background to Revalidation 2. What is NMC Revalidation? 3. Benefits of Revalidation 4. Individual requirements of each registrant every 3 years to be approved by the Confirmer 5. Role of confirmer 6. Roll Out and On-going process to support time Revalidation of Registered NMC Workforce 7. Success of implementation 8. NMC Revalidation Activity During 2016 9. MIA Review of Trust's NMC Revalidation Processes Audit findings, April 2017 10. Summary
Corporate objectives met or risks addressed: Safety, Care
Financial implications: none
Stakeholders: All Trust staff, patients, carers, NMC
Recommendation(s): Members are asked to receive the report for information.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance
Date of meeting: 26th April 2017

NMC Revalidation Trust Implementation Update

1. Background

The NMC Revalidation requirement of all nursing and midwifery registrants commenced in April 2016. The NMC introduced Revalidation to assure the public post Francis Report of each registrant's basic on-going competence to practice and remain on the professional register.

2. What is NMC revalidation?

- A process for all registrants every 3 years.
- Promotes good practice and is **not an assessment of fitness to practice** (remains an NMC function).
- Aims to enhance good practice.
- Reflects on new NMC code (March 2015)and requires registrants to evidence this.
- Encourages a culture of development, feedback and sharing and professional discussions about practice.

3. Benefits

- Registrants more aware of the NMC code
- Increases employer confidence
- Help to raise standards for NMC

4. Individual requirements of each registrant every 3 years to be approved by Confirmer

It is the individual registrant's responsibility to ensure successful and timely revalidation every 3 years on the 1st day of the month in which their registration expires (at the end of the month).

1. Evidence of 450 of clinical hours (indirect or direct which benefits patient care).
2. CPD 35 hours of which 20 hours to be participatory learning.
3. Five pieces of practice related feedback every 3 years.
4. Five written reflective accounts on CPD or practice related feedback.
5. Reflective discussion with a Registrant. Date, name, discussion, PIN of registrant discussion held with summary of discussion to be documented. Reflective discussion is of the 5 reflective accounts.
6. Health and character declaration
7. Professional indemnity arrangements to be declared as part of revalidation.

5. Role of confirmer

- Will have to demonstrate that the registrant applying for revalidation has met the revalidation requirements (items 1 to 5 above).
- Should always be line manager who is a registrant if possible, preferably linked to appraisal. If not possible, should be another health professional.

6. Roll Out and On-going process to support time Revalidation of Registered NMC Workforce

- From December 2015 briefing sessions were held for staff, especially targeting those due to revalidate in the first quarter of 2016.

- A Trust NMC Revalidation intranet site was established with details of the process and of how support can be accessed.
- A generic revalidation email inbox was set up for registrants to use to request support or information.
- A letter from the Deputy Director of Nursing is sent out 3 months in advance to each registrant due their 3 yearly revalidation. (Revalidation dates are visible on ESR). The letter sets out the process required, the requirements of revalidation and how and when to access their NMC on-line account to complete in good time. The letter also sets out how to access additional support. (see appendix 1)
- The Professional Standards Policy was amended to include NMC Revalidation requirements during early 2016 and is available on the Trust Intranet.
- All newly qualified staff commencing on the Trust's Preceptorship programme (since April 2016) receive training on NMC Revalidation process and requirements as part of the programme which to date has been very well evaluated.

7. Success of Implementation

Failure to revalidate on time can result in a lengthy re-application process with the NMC which can take several weeks to complete and result in a registrant not being registered or able to practice during this period**.** Special circumstances have been identified by the NMC for not revalidating which are available on the NMC website, which they will take into consideration in very rare situations because registrants have 3 years to be Revalidation Ready. Maternity leave and planned long term sickness are rarely considered a special circumstance as the NMC expectation is that the registrant will have prepared in advance. Special circumstances have to be addressed between the individual registrant and the NMC directly. To date, all staff from April 2016 to 31st December 2016 have revalidated successfully as required.

Any staff experiencing difficulties with NMC Revalidation in future, are to be reviewed at the monthly Trust's Nursing and Midwifery Professional Standards meeting chaired by the Deputy Director of Nursing together with all registrants with on-going NMC involvement.

8. Trust NMC Revalidation Activity During 2016

The numbers who revalidated each month are set out below.

Month/Year	No. who Revalidated
4 2016	75
5 2016	38
6 2016	11
7 2016	20
8 2016	21
9 2016	235
10 2016	34
11 2016	25
12 2016	40
Total	**499**

9. MIA NMC Revalidation Audit Findings April 2017

An in-depth review of the Trust's preparation, implementation and on-going processes to facilitate the successful revalidation of the Nursing and Midwifery registered workforce was undertaken in quarter 4. The audit findings have graded the Trust as providing 'significant assurance' making 4 recommendations for management action. The latter have been actioned

accordingly to ensure an optimum process continues with all registrants revalidating and re-registering successfully and on time.

10. Summary

The roll out has proved very successful to date with all registrants revalidating on time. 499 registrants revalidated with the NMC during the first 3 quarters of 2016 since the 'go-live' date. This is to be monitored and reported on a bi-annual basis going forward (unless the success of the process deteriorates). The 'significant assurance' of the Trust's processes by MIA provides additional evidence that the Trust's processes of reminding, preparing and supporting staff through NMC Revalidation are robust.

Appendix 1

Trust's NMC Revalidation (sent 3 month in advance) preparation template letter to all registrants

Reval template letter appendix 1 on workfc

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

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?? 2017

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Whiston Hospital
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L35 5DR

0151 426 1600

Dear Colleague,

Re: Nursing & Midwifery Revalidation

You are probably aware that the Nursing and Midwifery Council (NMC) have changed the process for nurses and midwives to remain on the NMC register. The new process is called Revalidation and it replaced the old PREP and Fitness to Practice re-registration system from 1st April 2016. Registrants are required to revalidate every three years and there are additional requirements that you must meet to revalidate which are considerably different to PREP. The requirements are closely aligned to the NMC code. As an NMC registrant you will be required to provide evidence that you have met these requirements. This will require important preparation by you in order to revalidate and remain on the NMC register.

Trust records show that your NMC revalidation date is 1st **?? 2017**. The NMC have specified that you must submit your application to the NMC to revalidate **BEFORE 1st ?? 2017.**

The requirements are detailed below:-

- 450 hours practice (900 hours for dual registered nurses & midwives)
- 35 hours Continuous Professional Development (20 hour MUST be participatory)
- 5 pieces of practice related feedback
- 5 pieces of reflective writing
- Have a reflective discussion with your confirmer or another NMC registrant (usually your line manager)
- Declare that you are of good health & character
- Provide evidence of indemnity cover (if applicable)
- Participate in a confirmer meeting (usually with your line manager and completed at the same time as the reflective discussion) so that you can have the confirmation form completed by your confirmer that you have successfully met the Revalidation requirements.

Please be aware that should you fail to submit your application to revalidate before **1st ?? 2017,** you will be financially disadvantaged. The NMC will remove you from the register, you will be unable to practice as a registered nurse/midwife (you will have to take unpaid leave, which may constitute a break in service of approximately 6-8 weeks) and you will be charged an administration fee to be re-entered onto the NMC register (possibly another £120 on top of your annual fee). Gathering this evidence will be time consuming for you and you are advised to commence this as soon as possible.

Revalidation can **only** be done electronically and you are required to create an online account on the NMC website in order to revalidate. You should register at www.nmc.org.uk immediately if you haven't already done so, where step by step guidance is available to

guide you through the process. We are here to offer advice and support regarding the Revalidation process, but ultimately it is your responsibility to ensure you have completed this process by **1st ?? 2017** so that you are able to re-register by **30th ?? 2017**. You can submit the evidence of confirmation at NMC online up to 60 days before registration expiry date, i.e. 30 days before your revalidation date.

For an electronic pack of the NMC template forms, please contact the Quality & Risk Admin Team on Q&RAdmin.Team@sthk.nhs.uk. If you have any queries please do not hesitate to contact the Corporate Nursing Team on 0151 290 4147. In addition, a dedicated email address is available where you can ask questions regarding the Revalidation process at revalidation@sthk.nhs.uk

Yours sincerely

Mrs Sally Duce
Deputy Director of Nursing and Quality/Lead Nurse for Revalidation

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)044
Title of paper: Purdah during the 2017 government general election.
Purpose: To brief members on the requirements to restrict announcements or activities if they could be regarded as influencing the outcome of the general election.
Summary: 1. A Government General Election is planned for 8th June 2017. 2. For six weeks before the election there are restrictions in place on the activity of civil servants and local government officials to minimise influencing the processes or their outcomes. 3. The following paper outlines the practical steps that the Trust must take to comply with this requirement from 3rd May.
Corporate objective met or risk addressed: Contributes to the Trust's Governance arrangements.
Financial implications: None directly from this report.
Stakeholders: The Trust and its staff.
Recommendation(s): The Board are asked to note the contents of the report.
Presenting officer: Peter Williams, Director of Corporate Services.
Date of meeting: 26th April 2017

PURDAH DURING GOVERNMENT GENERAL ELECTION

1. Introduction

1.1. The term “purdah” is used across central and local government to describe the period of time before elections or referendums when specific restrictions on the activity of civil servants and local government officials are in place.

1.2. Purdah prevents announcements from, and activities by, public bodies which could influence or be seen to influence the proceedings.

2. General Elections

2.1. A “period of sensitivity” applies from six weeks prior to elections and in general councils should not publish any material which appears to be designed to effect public support for a political party.

2.2. The NHS is often viewed as being central to government elections, with issues such as NHS performance and waiting times, finance, and NHS workforce being potential subjects.

2.3. The general election in the United Kingdom is due to take place on 8th June 2017 therefore the pre-election period of sensitivity runs from 3rd May when parliament is dissolved.

3. For the NHS, do:

3.1. Confine communication, activities and announcements to those necessary for the safety and quality of patient care.

3.2. Consider whether to allow visits from councillors, political parties or campaign groups and what format it would take. Remember to keep the policy around visits consistent and impartial – invite all or none.

3.3. Keep any communications with such groups to a factual and apolitical basis – apply the same approach to any communications with the media.

3.4. Continue to conduct normal business and adhere to good governance.

4. For the NHS, don’t:

4.1. Undertake activities that could be considered politically influential, or could give rise to criticism that public resources are being misused.

4.2. Allow party political meetings to take place on the Trust’s premises.

4.3. Allow visits which interrupt services or care for patients.

4.4. Launch large-scale PR campaigns.

5. Board meetings

5.1. Where Board meetings are scheduled the agenda should be confined to those matters that need a Board decision or require Board oversight. Matters of future strategy or future deployment of resources, which may be construed as favouring one party over another, should be avoided.

ENDS