St Helens and Knowsley Teaching Hospitals NHS Trust

Trust PublicBoard Meeting

TO BE HELD ON WEDNESDAY 22ND FEBRUARY 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	January		
		1.1	February		
09:40	2.	Apologies for Absence			
	3.	Declaration of Interests			
	4.	Minutes of the previous Meeting held on 25th January 2017		Attached	
		4.1	Correct record & Matters Arising		
		4.2	Action list	Attached	
Performance Reports					
09:50	5.	Integrated Performance Report		NHST(17) 012	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

10:05	6.	Safer Staffing report	NHST(17) 013	Sue Redfern
Committee Assurance Reports				
10:15	7.	Committee report – Executive	NHST(17) 014	Ann Marr
10:20	8.	Committee Report – Quality	NHST(17) 015	George Marcall
10:25	9.	Committee Report – Finance & Performance	NHST(17) 016	Denis Mahony
10:30	10.	Committee Report – Audit	NHST(17) 017	Su Rai
10:35	11.	Committee Report – Charitable Funds	NHST(17) 018	Denis Mahony
Other Board Reports				
10:40	12.	FT programme update report	NHST(17) 019	Nik Khashu
10:50	14.	Loan conversion paper	NHST(17) 021	Nik Khashu
Closing Business				
11:00	15.	Effectiveness of meeting		Richard Fraser
	16.	Any other business		
	17.	Date of next Public Board meeting – Wednesday 29th March 2017		
CLOSE				

St Helens and Knowsley Teaching Hospitals NHS Trust

Minutes of the St Helens and Knowsley Hospitals NHS Trust Board meeting held on Wednesday, 25th January 2017 in the Boardroom, Whiston Hospital

PUBLIC BOARD

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

BH welcomed RC to the Board following his successful interview for the substantive Director of Operations and Performance post.

1. Employee of the Month

The award for Employee of the Month for December 2016 was presented to Janette McNally, Assistant Financial Accountant.

2. Patient Story

2.1. ARW presented the patient story to Board.

2.2. A young gentleman was due treatment at St Helens Hospital. He suffers from autism and has a learning disability, and it was recognised that his appointment would require a lot of pre-planning. The matron arranged for mum and the community matron to have a tour of St Helens Hospital grounds and walk through to the day ward. They were allowed to take photographs to familiarise the patient with the surroundings before the actual day of his appointment; a measure which greatly decreased the possibility of agitation or anxiety for him.

2.3. The plan for the day of his attendance involved many different departments in the Trust and with external partners, to ensure the smooth running of the

patient's management at home, prior to his arrival at the hospital, and the positioning of the patient's vehicle on arrival, to provide safe passage for him from the car park through the hospital building to reach Sanderson Suite and the theatre area.

2.4. The episode of care for this gentleman could not have gone smoother. The gentleman's mum sent in an email expressing her gratitude.

2.5. This pathway is available to all patients accessing the Trust who may have additional needs and require reasonable adjustments to ensure equitable access to care.

3. Apologies for Absence

3.1. Apologies as recorded above were noted.

4. Declaration of Interests

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

5. Minutes of the previous meeting held on 26th October 2016

5.1. Correct Record and Matters Arising

5.1.1. The minutes were approved as a correct record.

5.2. Matters Arising

5.2.1. AM discussed the patient story from the November Board meeting, including the manner in which the complaint had been handled and the pathway. The doctor's name was incorrect in the complaint letter and it was suggested that some Trust staff were defensive and insensitive.

5.2.2. AM confirmed that the Trust has reflected on what happened and have examined the Stroke/TIA pathway and are implementing solutions to overcome the issues raised.

5.2.3. AM has written to the family.

5.3. Action List

5.3.3. Minute 10.2 (26.10.16): Complaints standards. This was discussed under Matters Arising. Action closed.

6. IPR – NHST(17)001

6.1. Quality Indicators

6.1.1. SRe provided a brief update on Quality Indicators.

6.1.2. There was 1 case of CDI in December. Year to date there have been 18 confirmed cases; the annual tolerance for 2016-17 is 41 cases. 3 cases have been successfully appealed and 3 cases will be heard in February.

6.1.3. Year to date there have been 2 cases of MRSA bacteraemia and SRe informed the Board that there has been a skin contaminant case on 8th January which is being investigated.

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

6.1.5. There were 2 falls that resulted in severe harm during November.

6.1.6. VTE performance for November was 95.02%, achieving the required target.

6.1.7. The 2015-16 HSMR is 103.2%.

6.2. Operational Indicators

6.2.1. RC provided an update on the Operational Performance. A&E performance was 74.0% (type 1) and 83.9% (type 1 and 3).

6.2.2. A seasonal increase in non-elective admissions and complexity of patients is continuing to impact upon performance. The key actions identified for recovery of this position are being driven forward by the senior leaders across the organisation, focusing on 3 areas in both the Emergency Department and the inpatient wards.

6.2.3. ED key actions: immediate improvement to ED processes; appropriate deployment of clinical resources to meet demand and improved use of IT to enable real time tracking of patients within four hours.

6.2.4. Inpatient area key actions: Clinical led board rounds on inpatient wards; senior daily review and escalation for patients who no longer need care in an acute bed and expected number of discharges by ward to be re-set using expected LOS.

6.2.5. The Board discussed in detail bed numbers, discharge lounge and embedding charge in ED.

6.3. Financial Indicators

6.3.1. NK provided an update of the Trust's financial position. The Trust is reporting against an annual plan of £3.328m surplus, as approved by the Trust Board and confirmed with NHSI.

6.3.2. As at month 9, the Trust is reporting an overall income and expenditure surplus of £2.435m after technical adjustments, which is slightly above the agreed plan. Trust income is ahead of plan by

£4.307m, while expenditure is overspent by £4.231m, through delivering this additional activity. Expenditure on agency stands at £8.446m for the year against a target for the full year of £7.256m.

6.3.3. To date the Trust has delivered £10.783m of CIPs which is now just ahead of the year to date plan. The CIP programme is formally reviewed both at a Trust and specialty level on a monthly basis.

6.3.4. Capital expenditure to date is £2.695m out of a revised year forecast total of £4.582m. Cash balance at the end of December 2016 is £1.573 which equates to 2 operating days.

6.3.5. NK advised the Board that CQUIN assumptions and STF funding assumptions were risks.

6.3.6. The Board discussed agency spend and the implications to STF funding.

6.4. Workforce Indicators

6.4.1. AMS provided an overview of the Workforce Indicators.

6.4.2. Mandatory training compliance remains 6.8% above target at 91.8%. Appraisal compliance for December is 79%, and the situation is being managed to recover to the compliance rate of 85%.

6.4.3. Sickness absence has increased in December to 5.4% (compared to 5.72% in December 2015). The year to date sickness if 4.8% which is 0.3% above year-end target.

6.4.4. The Trust exceeded the CQUIN flu vaccination target of 75% and is currently at 81% vaccination rate of frontline staff.

7. Safer Staffing report – NHST(17)002

7.1. SRe presented the Safer Staffing Report to provide an overview of nursing and midwifery staffing levels in inpatient areas during November and December 2016.

7.2. The overall headcount fill rate for November was 94.44% for RNs on days; 97.53% for RNs on nights; 106.42% for HCAs on days and 107.59% for HCAs on nights.

7.3. The overall headcount fill rate for December was 94.26% for RNs on days; 98.34% for RNs on nights; 103.01% for HCAs on days and 106.9% for HCAs on nights.

7.4. In November, 7 wards had fill rates below 90%; 4 wards for RNs, 2 for HCAs and 1 ward for both.

7.5. In December, 9 wards had fill rates below 90%; 7 wards for RNs and 2 for HCAs.

7.6. SRe advised the Board that 2 nurses from India had commenced at the Trust and have undergone an intensive period of training for the NMC OSCI, which they sat on 17th January. Unfortunately, one nurse only partially passed and will have to repeat the exam. 8 nurses are due to arrive at the beginning of February subject to their visas being issued.

7.7. The Board discussed international recruitment and agreed that the success and conversion rate from India is not what was expected. AMS said that it was a nationally recognised problem.

7.8. SRe will work with nursing colleagues regarding development programmes.

7.9. SR enquired as to whether there were any financial or reputational repercussions regarding the number of falls at the Trust. SRe replied that the Trust has invested significantly in equipment and has carried out in-depth enquiries to mitigate implications.

8. Complaints, Claims and Incidents – NHST(17)003

8.1. SRe provided an update on complaints, claims and incidents.

8.2. The number of incidents raised for this quarter was 3366 compared to 3254 in the same quarter last year, demonstrating an increase of 112. This is possibly associated with the supportive culture of learning and openness and an increase in activity. The top two categories of reported incidents were:

8.2.1. Accident that may result in personal injury
8.2.2. Implementation of care or ongoing monitoring/review.

8.3. The number of StEIS incidents reported this quarter was 16. This is above the normal quarter reporting level of 10 to 12, and is partly due to the new reporting criteria for Obstetric incidents that have the potential for harm. The Trust's reporting to the National Reporting and Learning System (NRLS) remains excellent with the mean number of days to report being 13 days against a national average of 30 days.

8.4. 69 1st stage complaints were opening during Q2. The top complaint themes during the period were:

8.4.1. Clinical treatment.
8.4.2. Communication
8.4.3. Values and behaviours

8.5. There were 539 PALS contacts/enquiries during Q2, compared to 486 in Q1, reflecting an increase of 11%. This may partially account for the decrease in complaints.

8.6. There were 398 active clinical negligence claims ongoing, compared to 416 in the last quarter. 17 new claims (all clinical negligence) were received in Q2. The top themes for new claims were:

8.6.1. Failure to diagnose/treat.
8.6.2. Performance of surgical procedure.
8.6.3. Delays in treatment.

8.7. Lessons learned are shared within the Claims Governance group, which meets monthly.

8.8. SOB asked if there were any trends regarding the claims and the amounts paid. SRe agreed to provide an analysis. NK informed the Board that £7m was paid for NHSLA insurance due to the amount of claims.

8.9. SR asked whether the staffing within the Complaints team is still appropriate given the increase in activity. SRe informed the Board that the new Head of Complaints is now in post and is looking at the structure.

8.10. The number of third party requests was queried as it seemed high (620). SRe said that this was solicitors requesting access to records but she would investigate.

8.11. KH asked for the year on year figures to be included in future reports.

9. Risk Register Report – NHST(17)004

9.1. SRe provided an update for the Board.

9.2. There are 679 risks on the Trust risk register. There are 14 high risks that have been escalated to the corporate risk register; 7 in Corporate Services, 3 in Medical Care Group, 2 in Surgical Care Group and 2 in Clinical Support. Two risks have been added since the last report regarding SIRI processes and communication equipment for use in major incidents.

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

9.3.1. The proportion of risks with an overdue review date has deteriorated.
9.3.2. 4 risks on the CRR have no recorded action plan on Datix.
9.3.3. The compliance with sign-off of CIPs still requires improvement.
9.3.4. The descriptor of risks in the CRR requires further refinement to ensure it succinctly captures the real risk to the organisation.

9.4. SR asked if the cyber-attack had been recorded on Datix. CW replied that there is an action plan in place but this is yet to be uploaded to the Datix system.

10. Board Assurance Framework – NHST(17)004a

10.1. SRe provided an update for the Board. There have been no changes to scores since the last review. The Board went through the risks and made some slight amendments/updates to the text.

10.1.1. Risk 1: No changes to be made.
10.1.2. Risk 2: Refer to Five Year Forward view.

10.1.3. Risk 3: Change Exec Lead to Rob Cooper.
10.1.4. Risk 4: AMS informed the Board that the new internet has been launched but the intranet is taking longer. Departments have been asked to refresh their pages and a February launch is scheduled.
10.1.5. Risk 5: Communication strategy needs to be under constant review.
10.1.6. Risk 6: Strategies are in place but it is difficult to enact them all. Specialist nursing has been discussed by the Executive Committee and e-rostering is in all departments.
10.1.7. Risk 7: This needs to be updated and PW is liaising with Wayne Longshaw.
10.1.8. Risk 8: CW said that a lot of work has been carried out regarding IT security and the Trust is making significant progress with resilience.

11. HR Indicators – NHST(17)005

11.1. AMS summarised the report for the Board.

11.2. In April 2017, an Apprenticeship Levy will be introduced for all large UK employers with over 250 employees to fund future apprenticeships. This means a financial pressure to the Trust of approximately £800k. The Trust is working with other organisations to develop an Apprenticeship Strategy.

11.3. Organisational development work: Each department is working on an OD plan and a number of cultural surveys are being carried out.

11.4. The Trust's Payroll Department is now processing over 30,000 payslips per months with a client base of 21, increasing to 22 from February 2017.

11.5. SR queried the overtime figure of 2,000 hours for December and whether this was anticipated. AMS agreed to provide a trend line for the next report.

12. Committee Report - Executive – NHST(17)006

12.1. AM reported that there were no issues to be raised with the Board, but was happy to answer any questions.

12.2. Decisions taken by the Committee included a review of the Home of Choice Policy, continuing arrangements for Interventional Radiology, and measures to increase student nursing training.

12.3. Assurances regarding respiratory 7-day working, sepsis management, improving agency controls, 2 year operating plans, CQC action plan close out, the referral management systems, and the EPR business case were obtained.

12.4. No significant investment decisions were made, however agreement to seek tenders for creating additional escalation beds was given, and the Contract for the Risk Management System was agreed.

12.5. PW will be a facilitating a meeting on 8th February to discuss the "house style" of reports.

13. Committee report – Quality Committee – NHST(17)007

13.1. GM presented the Quality Committee Assurance Report.

13.2. Key items discussed at the meeting were:

13.2.1. Complaints.

13.2.2. A&E

13.2.3. Infection control

13.2.4. Safeguarding training: limited assurance because of poor performance at Level 3 training. SR assured the Board that a number of sessions will take place to raise the number of staff being trained.

13.2.5. Clinical and Quality Strategy: NK asked if community services could be included.

13.2.6. IPR: SR asked about the safety thermometer update. This will an agenda item for Quality Committee and an overview presented to the Board.

14. Committee report – Finance & Performance – NHST(17)008

14.1. DM presented the Finance & Performance Committee Report.

14.2. Items discussed and actions agreed included:

14.2.1. A&E performance update. The Committee were reassured by the update but require additional assurance around the delivery of the action plan and the expected impact on A&E performance.

14.2.2. MRSA: Actions from the RCA to be presented to the Committee.

14.2.3. Assurances received that the Trust will achieve the CIPs but there is an ongoing issue with non-recurrent savings.

14.3. The Board discussed at length A&E handover plans and diagnostics, RAT and board rounds and whilst the Executive Team lead on this, the Board requested improved assurances regarding milestones and timescales.

15. FT programme update report – NHST(17)009

15.1. NK updated the Board regarding the FT Programme.

15.2. The final two year operational plans were submitted on 23rd December 2016 in accordance with the national planning timetable. NHSI formal feedback on the plans is expected by 31st January.

15.3. NHSI and the CQC have published a consultation document on the proposed use of resources and well-led assessments. The Trust will respond to the consultation and undertake a further well-led self-assessment.

15.4. The Trust, with support from 5 Boroughs Partnership and St Helens Rota, has been awarded the contract to deliver the St Helens CCG adult community services.

15.5. The Board discussed whether the title of this report should be changed. GM requested that NK formally ask NHSI, on behalf of the Board, for an update regarding FT applications and the FT pipeline.

16. Research Capability Statement – NHST(17)010

16.1. KH summarised the statement, for which there is a requirement for Board approval.

16.2. The statement provides an operational framework setting out how the Trust plans to meet its research related responsibilities/requirements as stated in the Research Governance Framework and other relevant guidance and regulations.

16.3. Southport & Ormskirk's R&D processes were discussed, given the current links, and KH has prepared a statement to be presented at their Board meeting.

16.4. The Board also discussed whether Brexit will pose a risk to R&D work, but it was felt that the wider picture is a massive concern as most researchers are EU nationals.

16.5. Following discussion approval for the statement was given.

17. Safeguarding report (Adults and Children) – NHST(17)011

17.1. SRe presented the annual report to the Board providing information and assurance that the Trust is effectively discharging its safeguarding adults responsibilities.

17.2. Key issues covered by the report are:

17.2.1. Referrals.
17.2.2. Work plan progress.
17.2.3. Safeguarding Boards.
17.2.4. KPIs.
17.2.5. Increase in contacts.
17.2.6. Review of training needs analysis
17.2.7. There have been no domestic homicide reviews
17.2.8. Work is ongoing regarding review of Savile action plans.

17.3. SRe was asked about modern slavery; SRe said that whilst there had not been an incident at this Trust, there has within the Knowsley area, but actions are in place through the Safeguarding Board.

17.4. The Board also discussed the increase in referrals and DOLs applications.

18. Effectiveness of meeting

18.1. The importance of the Board spending the appropriate amount of time on agenda items was discussed, and it was agreed to have been fitting. Also there was agreed to have been good constructive challenge from the NEDs, and overall an effective meeting.

19. AOB

19.1. DM asked that when the IT systems have gone down, could the NEDs receive the information in a different format i.e. telephone call. CW will take this forward.

20. Date of next meeting

20.1. The next meeting is scheduled for Wednesday, 22nd February 2017 in the Boardroom, Whiston Hospital, commencing at 9.30 am.

Chairman: ……..

Date: ……

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 22ND FEBRUARY 2017

No	Minute	Action	Lead	Date Due
1.	~~26.10.16 (10.2)~~	~~Sue Redfern to report back to the Board regarding complaint responses and standards. 25.01.17: Discussed under Matters Arising in the minutes~~		Action closed
2.	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	30 Mar 17
3.	30.11.16 (6.4.4)	Accountability framework/lessons learned: Sue Redfern to feed back to Board regarding lessons learned and how this is co-ordinated.	SRe	22 Feb 17
4.	30.11.16 (9.6)	Decontamination incident: Sue Redfern will present the investigation report once completed. **Agenda item**.	SRe	22 Feb 17
5.	25.01.17 (8.8)	Complaints, Claims & Incidents: Sue Redfern will provide an analysis of claims trends to Sarah O'Brien.	SRe	22 Feb 17
6.	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
7.	25.01.17 (15.5)	FT Programme Update: Nik Khashu will liaise with NHSI regarding the FT pipeline	NK	22 Feb 17
8.	25.01.17 (19.1)	IT downtime: Denis Mahony asked that if the IT systems have gone down, could the NEDs receive the information in a different format i.e. telephone call. Christine Walters will take this forward.	CW	22 Feb 17

Paper No: NHST(17)012
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 was 1 never event reported in January 2017, taking the year to date total to 2.

There were two cases of MRSA bacteraemia in January 2017 taking the year to date total to 3 MRSA incidents and 1 contaminant.

There was 1 C.Difficile (CDI) positive case in January. Year to date there have been 19 confirmed positive cases.
The annual tolerance for 2016-17 is 41 cases.

There was 1 grade 3 pressure ulcer in January, taking the YTD total to 2, with no grade 4s.

There were 2 falls that resulted in severe harm during December, year to date total 15.

Performance for VTE assessment for December was 94.08% slightly below the required target.

The YTD HSMR is 102.8 up to October 2016.

The overall nurse/midwife Safer Staffing fill rate for December was 95.6%

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: 22nd February 2017

Operational Performance

A&E performance was 69.6% (type 1) and 81.2% (type 1 & 3) in month .
A seasonal increase in non elective admissions and complexity of patients is impacting upon performance.
The key actions identified for 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 (92. 8%) but remains a challenge.
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 NHSE funding to reduce RTT backlog agreed late January 2017.

Financial Performance

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

Income & Expenditure

As at the month of January 2017 (Month 10) the Trust is reporting an overall Income & Expenditure surplus of £2.537m after technical adjustments which is slightly above the agreed plan. Trust income is ahead of plan by £2.577m, while expenditure is overspent by £2.434m, through delivering this additional activity. Expenditure on Agency stands at £9.159m for the year against a target for the full year of £7.256m. The Trust Executive team continues to meet with Specialties on a weekly basis to review the action plans in place to reduce agency expenditure in 2016/17.
The Trust's forecast outturn is to achieve its Annual plan of £3.328m surplus.

CIP - To date the Trust has delivered £12.445m of CIPs which is now just ahead of the year to date plan. The CIP Programme is formally reviewed both at a Trust and Specialty level on a monthly basis and is also part of the Operational Transformation Group agenda.

Capital - Capital expenditure to date is £2.862m out of a revised year forecast total of £4.088m.
Cash - Cash balance at the end of January 2017 is £4.154m which equates to 2 operating days.

Human Resources

Mandatory training compliance has increased in month and is 7.9% above target at 92.9%. Appraisal compliance for January has also improved and is just 4.8% behind target at 80.2%, with work ongoing to recover the compliance rate to 85%.

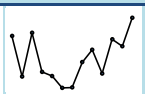
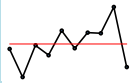
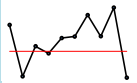
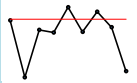
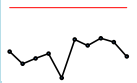
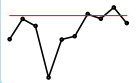
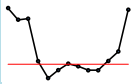
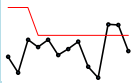
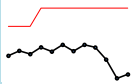
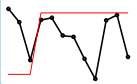
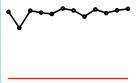
Sickness absence has increased in December to 5.4% (compared to 5.72% in December 2015). The Year to date sickness is 4.8% which is 0.3% above year end target.

The Trust exceeded the CQUIN flu vaccination target of 75% and is currently at 82% vaccination rate of frontline staff.

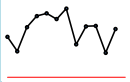
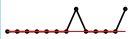
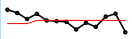
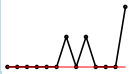
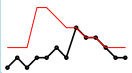
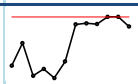
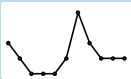
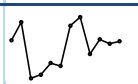
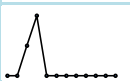
The following key applies to the Integrated Performance Report:

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

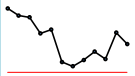
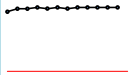
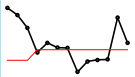
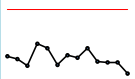
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 30-34)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Jan-17	3.1%	2.5%	No Target	2.5%		Overall SHMI and HSMR within control limits. Crude mortality typically rises at this time of year - this and HSMR trend line being investigated. SHMI improved slightly. Weekend mortality - small numbers cause substantial month to month variation.	Patient Safety and Clinical Effectiveness	Trust is exploring an electronic solution to improve capture of comorbidities and their coding. Focus on missing notes (which is improving) to reduce R codes use (and improve HSMR). Measures to increase palliative care input are in train A drive in ED and MAU to reduce excessive use of symptom-diagnoses, as this impacts on HSMR. Major initiatives to improve management of AKI and Sepsis.	KH
Mortality: SHMI (Information Centre)	Q	▲	Jun-16	1.02		1.00						
Mortality: HSMR (HED)	Q	▲	Oct-16	87.9	102.8	100.0	99.7					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Oct-16	78.0	112.2	100.0	112.9					
Readmissions: 30 day Relative Risk Score (HED)	Q	T	Sep-16	91.4	98.2	100.0	96.4		Much improved over last 12 months.	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	Oct-16	93.6	94.4	100.0	92.2		Sustained reductions in NEL LOS are assurance that medical redesign practices continue to successfully embed. The elective performance is a result of the shifting casemix to daycase, leaving an increasing volume of the more complex patients as inpatients.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Oct-16	97.1	94.4	100.0	97.7					
% Medical Outliers	F&P	T	Jan-17	3.9%	1.2%	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	Jan-17	43.9%	45.5%	52.5%	50.9%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. 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	▲	Dec-16	71.9%	76.9%	90.0%	79.9%		eDischarge performance poor. Historic backlog now quantified.		Pending ePR, ongoing drive to improve realtime completion on ward rounds, but trainee doctor numbers is an issue. Medium-term plan to supplement trainee doctor numbers with advanced nurses. Action plan to address unsent eDischarges has been agreed with commissioners.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients)	Q	▲	Dec-16	87.8%	91.0%	95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E)	Q	▲	Dec-16	99.2%	99.0%	95.0%	98.5%					

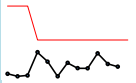
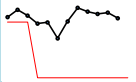
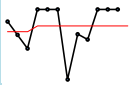
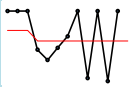
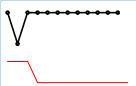
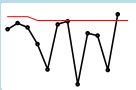
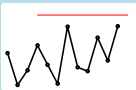
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Dec-16	93.5%	94.2%	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	▲£	Jan-17	1	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	Jan-17	97.8%	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	Jan-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	▲£	Jan-17	2	4	0	0		There were 2 cases of MRSA bacteraemia and 1 C.Difficile (CDI) cases in January YTD there have been 22 CDI cases, of which 3 cases have been successfully appealed. This gives 19 confirmed avoidable cases against an annual tolerance of 41 cases.	Quality and patient safety	Both cases of hospital acquired MRSA bacteraemia have been investigated and Trust-wide action plans are in place to reduce the risk of any further cases. The Infection Control Team continue to support staff to maintain high standards and practices. Monitor and undertake RCA for any hospital acquired BSI and CDI. CDI and Antibiotic wards rounds continue to be undertaken on appropriate wards.	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲£	Jan-17	1	19	41	26					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Jan-17	0	14	No Target	28					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Jan-17	1	2	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	▲	Dec-16	2	15	No Contract target	21		STHK moderate, severe and death harm from falls YTD is 0.139 per thousand bed days(YTD) against a 0.19 national bench mark and a 0.15 internal target	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	▲£	Dec-16	94.08%	93.01%	95.0%	93.31%		VTE performance fell slightly below target this month.	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	Dec-16	3	21	No Target	38					
To achieve and maintain CQC registration	Q		Jan-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	Dec-16	95.6%	95.2%	No Target	96.8%		Shelford Patient Acuity has been completed in October 2016, the results are currently being collated and will be reported in March 2017 as several areas had their audit repeated in January 2017 to ensure continuity of assessment of patient acuity levels by matrons and ward managers.	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	Dec-16	0	2	No Target	1					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

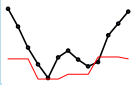
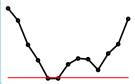
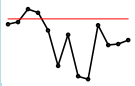
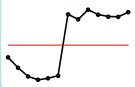
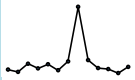
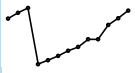
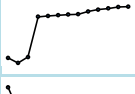
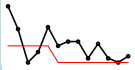
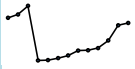
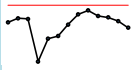
	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 41-48)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Dec-16	95.1%	94.8%	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	▲ £	Dec-16	96.3%	97.8%	96.0%	97.8%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Dec-16	85.8%	88.3%	85.0%	88.6%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Jan-17	92.8%	92.8%	92.0%	95.5%		At specialty level T&O, Plastic Surgery, ENT, General Surgery and Dermatology are failing the incomplete target. Dermatology performance significantly impacting on the Trust overall RTT incomplete position. The impact of the RMS scheme introduced in July by St Helens CCG, Knowsley CCG in November and Halton CCG in January is also impacting on RTT performance due to new referral drop. dermatology undated backlog reduced from 1220 Nov to 940 January	There is a risk due to the current medical bed pressures and the increase in 2ww referrals and activity that the elective programme will be compromised. Dermatology's position worsens the overall incomplete position	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. A backlog management plan is in place and alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand. Dermatology to commence some intensive support and collaborative working with CCG to manage pathways and activity levels. additional dermatology capacity identified but further required to decrease backlog and improve RTT position.	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Dec-16	100.0%	99.996%	99.0%	99.99%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Jan-17	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Jan-17	0.9%	0.8%	0.8%	0.9%		Performance against the target improved in January and remains on track to achieve the national KPI by the end of March. 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	▲ £	Dec-16	100.0%	100.0%	100.0%	99.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Jan-17	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Jan-17	69.6%	75.8%	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	▲	Jan-17	81.2%	85.0%	95.0%	89.4%					
A&E: 12 hour trolley waits	F&P	▲	Jan-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	▲ £	Jan-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	Jan-17	41	275	No Target	291		A delay in responding to patient complaints leads to a poor patient experience. The 2015 - 16 resolution rate of 42.7% includes all stage 1 complaints resolved in 15-16 regardless of when the complaint was received. For stage 1 complaints both received and resolved in 15-16 the resolution rate was 61.4%	Patient experience	A revised structure to support performance has been implemented, but will require time to embed.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Jan-17	14	240	No Target	372					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Jan-17	21.4%	59.6%	No Target	42.7%					
Friends and Family Test: % recommended - A&E	Q	▲	Dec-16	86.1%	86.5%	90.0%	91.5%		The 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.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Dec-16	95.4%	95.3%	90.0%	96.4%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Dec-16	100.0%	98.3%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Dec-16	100.0%	97.8%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Dec-16	100.0%	100.0%	95.1%	95.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Dec-16	100.0%	92.1%	98.6%	98.6%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Dec-16	94.8%	94.4%	95.0%	94.7%					

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 51-55)												
Sickness: All Staff Sickness Rate	Q F&P	▲	Jan-17	5.7%	4.9%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.9%		Absence has increased in December to 5.4%, 0.68% higher than Q3 target of 4.72%. Seasonal virus, flu and colds most common reasons for absence. Nursing sickness including HCAs was 1.1% above target. Staff advised not to attend work with infections that could be spread to patients/other staff.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	Targeted HCA action plan in place to be accelerated during January & February 2017. Audit on time to carry out Return to Work interviews/stages/levels more quickly & to log on ESR in timely way. The HR Absence Support Team have recommended all managers complete mandated refresher training on the attendance management policy. Referrals to HWWB have also increased. An analysis of reason/trends is taking place during January to inform February actions plan.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P	T	Jan-17	7.2%	5.9%	5.3%	6.0%					
Staffing: % Staff received appraisals	Q F&P	T	Jan-17	80.2%	80.2%	85.0%	87.2%		Mandatory Training compliance has increased slightly in month and continues to exceed the target by 7.9%. Appraisal compliance continues to improve and is now 4.8% behind target.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The L&OD team will continue to work with managers to ensure the continued improvement and that all non compliant staff receive an appraisal and are recorded on ESR .	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Jan-17	92.9%	92.9%	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	Jan-17	0.7%		No Target	8.9%		Staff turnover remains stable and well below the national average of 14%.		Turnover is monitored across all departments as part of the Trusts Recruitment & Retention Strategy with action plans to address areas where turnover is higher than the trust average. Further action is required by Ward Managers to provide more support to newly qualified nurses.	AMS
FINANCE & EFFICIENCY (appendices pages 58-62)												
UoRR - Overall Rating	F&P	T	Jan-17	3.0	3.0	3.0			The Trust's year to date performance is slightly ahead of plan. The Trust has significant contractual agreements with other NHS organisations which may impact on our ability to achieve Better Payment compliance.	Financial	Adherence against the submitted plan and delivery of CIP. Maintaining control on Trust expenditure. Agreeing with Commissioners and NHSE a more advantageous profile for receipt of planned income. Reducing agency expenditure in line with NHSI annual cap.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Jan-17	12,445	12,445	15,248	13,043					
Reported surplus/(deficit) to plan (000's)	F&P	T	Jan-17	2,537	2,537	3,328	(9,551)					
Cash balances - Number of days to cover operating expenses	F&P	T	Jan-17	5	5	2	2					
Capital spend £ YTD (000's)	F&P	T	Jan-17	2,862	2,862	4,088	4,169					
Financial forecast outturn & performance against plan	F&P	T	Jan-17	3,328	3,328	3,328	(9,551)					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Jan-17	93.7%	93.7%	95.0%	94.2%					

APPENDIX A

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

			Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	2016-17 YTD	2016-17 Target	FOT	2015-16	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲£	94.1%	95.8%	100.0%	100.0%	100.0%	87.5%	93.1%	89.3%	100.0%	100.0%	100.0%	100.0%	87.5%	94.7%	85.0%		99.2%		
	Total > 62 days		0.5	0.5	0.0	0.0	0.0	1.5	1.0	1.5	0.0	0.0	0.0	0.0	1.0	5.0			1.0		
Lower GI	% Within 62 days	▲£	100.0%	89.5%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	93.3%	81.8%	71.4%	58.3%	100.0%	87.6%	85.0%		94.5%		
	Total > 62 days		0.0	1.0	0.0	0.0	0.0	2.0	0.0	0.0	0.5	1.0	1.0	2.5	0.0	7.0			3.0		
Upper GI	% Within 62 days	▲£	100.0%	100.0%	100.0%	81.8%	75.0%	90.9%	0.0%	100.0%	100.0%	0.0%	85.7%	88.9%	100.0%	86.6%	85.0%		88.9%		
	Total > 62 days		0.0	0.0	0.0	1.0	0.5	0.5	0.5	0.0	0.0	1.5	1.0	0.5	0.0	4.5			5.0		
Urological	% Within 62 days	▲£	79.2%	83.3%	83.3%	84.0%	85.7%	84.6%	81.3%	75.0%	79.3%	76.9%	96.2%	82.6%	70.0%	80.7%	85.0%		80.8%		
	Total > 62 days		2.5	2.0	2.0	2.0	2.0	3.0	3.0	4.0	3.0	4.5	0.5	4.0	6.0	30.0			28.0		
Head & Neck	% Within 62 days	▲£	50.0%	57.1%	60.0%	50.0%	50.0%	100.0%	37.5%	71.4%	66.7%	100.0%	80.0%	33.3%	33.3%	61.1%	85.0%		71.1%		
	Total > 62 days		1.0	1.5	1.0	0.5	0.5	0.0	2.5	1.0	0.5	0.0	0.5	1.0	1.0	7.0			6.5		
Sarcoma	% Within 62 days	▲£		100.0%		100.0%		85.7%			100.0%			100.0%	100.0%	91.7%	85.0%		87.5%		
	Total > 62 days			0.0		0.0		0.5			0.0			0.0	0.0	0.5			0.5		
Gynaecological	% Within 62 days	▲£	50.0%	60.0%	66.7%	71.4%	66.7%	81.8%	100.0%	85.7%	92.3%	33.3%	100.0%	90.9%	92.3%	88.5%	85.0%		76.4%		
	Total > 62 days		1.5	1.0	0.5	1.0	0.5	1.0	0.0	0.5	0.5	1.0	0.0	0.5	0.5	4.5			8.5		
Lung	% Within 62 days	▲£	100.0%	90.5%	100.0%	88.2%	66.7%	81.5%	90.0%	91.7%	82.6%	100.0%	80.0%	87.5%	91.7%	85.0%	85.0%		86.5%		
	Total > 62 days		0.0	1.0	0.0	1.0	1.0	2.5	0.5	0.5	2.0	0.0	1.0	0.5	0.5	8.5			10.5		RC
Haematological	% Within 62 days	▲£	66.7%	83.3%	50.0%	86.7%	100.0%	100.0%	0.0%	50.0%	50.0%	100.0%	100.0%		66.7%	72.7%	85.0%		70.5%		
	Total > 62 days		1.0	1.0	2.0	1.0	0.0	0.0	2.5	3.0	1.0	0.0	0.0		1.0	7.5			13.0		
Skin	% Within 62 days	▲£	95.3%	94.4%	92.5%	96.7%	97.5%	96.0%	100.0%	97.3%	93.7%	95.7%	92.6%	97.4%	95.7%	96.0%	85.0%		94.5%		
	Total > 62 days		1.0	0.5	1.5	0.5	0.5	1.0	0.0	0.5	2.0	1.0	2.0	0.5	1.0	8.5			13.0		
Unknown	% Within 62 days	▲£	33.3%	100.0%		50.0%		100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	85.0%		83.3%		
	Total > 62 days		1.0	0.0		0.5		0.0	0.0	0.0	0.0	0.0			0.0	0.0			1.5		
All Tumour Sites	% Within 62 days	▲£	86.9%	87.9%	90.1%	89.5%	91.8%	88.0%	87.5%	85.8%	89.4%	87.9%	92.0%	86.6%	85.8%	88.3%	85.0%		88.6%		
	Total > 62 days		8.5	8.5	7.0	7.5	5.0	12.0	10.0	11.0	9.5	9.0	6.0	9.5	11.0	83.0			90.5		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲£			100.0%	100.0%					100.0%		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%								100.0%	85.0%		100.0%		
	Total > 31 days		0.0					0.0								0.0			0.0		
Children's	% Within 31 days	▲£															85.0%				
	Total > 31 days																				

TRUST BOARD PAPER

Paper No: NHST(17)013
Title of paper: Safer Staffing Levels Report for January 2017
Purpose: To inform the Trust Board of the nursing and midwifery staffing levels (headcount only) in the Trust's inpatient areas during January 2017 in accordance with mandatory reporting requirements. Safer Staffing levels are one indication of the Trust's ability to provide safe, effective inpatient care.
Summary: • The Trust's mandated monthly submission of staffing (headcount) levels to NHS Choices presented the following overall % fill rates of planned inpatient staffing levels against actual staffing levels for the month of January 2017 as: ➢ RNs on days 94.49% ➢ RNs on nights 96.33% ➢ Care staff on days 105.68% ➢ Care staff on nights 113.07%. • 10 wards experienced a monthly staffing headcount fill rate of below the accepted level of 90%; 8 wards for RNs and 2 wards for care staff • Care Staff monthly fill rates is higher than the funded ward establishment in many inpatient areas because of extra staff employed to either provide 1 to 1 care to vulnerable patients or to compensate for a shortfall in RN headcount levels when efforts to backfill RN gaps have proven unsuccessful. • In January 2017, two patients experienced severe harm or above following inpatient falls. Staffing levels were at the expected levels at the time of both incidents.
Corporate objectives met or risks addressed: Care, Safety
Financial implications: None directly from report.
Stakeholders: Patients, public, staff, commissioners, Trust Board
Recommendation(s): Members are asked to receive the report
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 22nd February 2017

Trust Safer Staffing Levels Report for January 2017

Aims of Report

1. To inform the Board of the Trust's inpatient areas' nursing and midwifery workforce staffing levels during January 2017.
2. The paper reviews for information whether there is a correlation between the monthly staffing levels and one area of harm that patients are at risk of experiencing, i.e. an inpatient fall resulting in severe or catastrophic harm. (Such incidents are STEiS reported and made subject to a robust Serious Incident Review Investigation which investigates all possible root causes including staffing levels as this harm may occur when staffing levels are correct. A review of all inpatient falls is also taken to the Patient Safety Council monthly and monitored through the Trust's Integrated Performance report.)
3. To update the Board on recruitment activity in order to minimise the number of vacancies in the Nursing and Midwifery workforce in order to optimise staffing levels.

Background

It is a national requirement of all Trusts to publish their monthly nursing and midwifery staffing levels to the NHS Choices website. Safer staffing levels are the total planned number of hours worked by registered and care staff measured against the total number of actual hours worked to produce a monthly fill rate as a % for nights and days on each ward. A monthly ward fill rate of 90% and over is considered acceptable nationally. Agency, bank, overtime, extra time hours, discharge coordinators and ward managers supernumerary management days worked are included in the monthly actual hours worked totals in accordance with guidance. (appendix 1 January 2017 Trust Submission)

Staffing levels are the head count on each shift and is only one indication of the Trust's ability to provide safe, high quality care across all wards. Safer staffing does not analyse skill mix, the impact of temporary staff on a shift by shift basis or being short of a member of staff on a particular shift if it has been unsuccessfully backfilled, e.g. only two trained staff on a night shift instead of 3 which for that shift is a fill rate of 66%. This may not be reflected in the ward's overall monthly average which may still be over 100%.

1. Overall Fill Rates (appendix 1)

The January 2017 submission indicates an overall fill rate of 94.94% (94.26% in December 2016) for RNs on days, 98.34% (96.33 % previous month) for RNs on nights, 103.01% (105.86% December) for HCAs on days and 106.9% (113.07% previous month) for HCAs on nights. The overall fill rates for care staff are higher than 100% because the figures are raised by both the employment of additional 'specials' (i.e. 1 patient to 1 care staff member) to protect vulnerable patients and the wards compensating for a shortfall in the registered nurse headcount on a shift by employing an HCA when efforts to backfill with a bank and/or agency RN or the permanent RNs being offered extra time or overtime have proved unsuccessful.

E-rostering does not currently have the functionality to separate out staff employed for specials from the actual shift requirements. This is widely recognised constraint on the E roster system experienced by other trusts. The e-roster system also does not capture staff moves to other wards which are provided each month by the matrons.

2. **Recruitment and Retention** of nursing and midwifery staff remains a priority for the Trust and is an on-going challenge nationally. Trust workforce data shows there were 53.22wte RN and 7.17wte HCA vacancies at the end of December 2016 on the inpatient wards. Staffing remains on the Corporate Risk Register (CRR) which is reviewed monthly. Recruiting and retaining the nursing and midwifery workforce continues to be an area of increased focus:-

2.1. Indian Nurse Recruitment Update:

- Initially offered: 122 posts
- Withdrawn: 9
- Offers retracted due to no communication from nurse: 63
- Remaining: 50

Out the 50 remaining nurses, only 18 of them have passed the IELTS and their progress is as follows:

- 2 commenced in the Trust on 5th December 2016 and have now successfully passed their NMC OSCEs. They are still awaiting their NMC PINs to register and will require an on-going period of supernumerary status and preceptoship before they can be counted in the registered workforce staffing levels.
- 5 more arrived at the beginning of February 2017 and have commenced the 6 week NMC OSCE preparation Trust programme. The pass rate for the OSCEs is very low, with only 2 attempts allowed, therefore the Trust's preparation programme to date has been highly successful.
- Several more recruits are in the process of uploading their documents onto the NMC portal and some are undergoing CBT training. The remainder are in the process of studying English and rebooking the IELTS, having failed the test at least once.

2.2. The Recruitment of Bank staff. Recruitment of bank HCAs is on-going, advertising on 1st of every month to recruit HCAs to the nurse bank and is proving very successful. In the next two weeks, several RNs are also being interviewed to join the Trust's nurse bank.

2.3. Student Nurse Recruitment Update. HR Recruitment and the Trust's Student Nurse Practice Education Facilitators have met and arranged optimum Recruitment Open Day dates for 2017 to link with the stage in students training when they are job seeking. The dates for 2017 are 25th February and 3rd June. Preparations are well underway for 25th February 2017 event and all areas with shortages are attending on the day.

Recruitment of newly qualified staff has also been streamlined for this next intake to have a single point of employment access to the adult inpatient wards, accommodating requests but avoiding the situation where students apply and are interviewed for several staff nurse posts within the Trust. This is a far more coordinated approach and prevents duplication of the process for the interviewers and the HR Recruitment staff.

The Trust is also attending a recruitment event at John Moores University on 23rd February 2017 to attract 3rd year student nurses to the Trust once qualified, at which the Deputy Director of Nursing and Quality is making a key note speech to students about career opportunities at the Trust and support available to transition successfully to a staff nurse role from student.

2.4. On-going Recruitment of Qualified Staff

All areas including specialist areas have on-going local recruitment as required to attract qualified staff to the Trust with the support of HR.

3. Care Hours Per Patient Per Day (CHPPD) (Appendix 2)

CHPPD for RNs and Care staff is reasonably consistent on the medical wards and surgical wards throughout the year. It was higher for 3alpha in December 2016 due to a lower occupancy and it closing over Christmas and the New Year. It is higher on the Assessment Units, 1B, 1C and 4B, Coronary Care 1E, 2A, Haematology, the Burns Unit (4D) and Critical Care (4E) for RNs as there is a higher patient to RN ratio in these areas. Ward 4D's CHPPD has been corrected for submissions last year by Information and fluctuations are due to fluctuations in occupancy. Seddon had many patients on home leave and a much lower occupancy which is very unusual in December 2016. There was a dramatic decrease in referrals to Seddon and an increase in discharges. Activity in Paediatrics peaked in November 2016 on 4F when more beds were opened to accommodate this.

Work is on-going with Information and the Corporate Nursing team in an attempt to make the information more meaningful, however updates from the Carter pilot sites are still awaited. Cost per CHPPD is to be incorporated in future.

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

5. January 2017 Wards with staffing fill rates below 90% (Appendix 3)

There were 10 ward with a fill rate of less than 90%, eight for RNs and two for care staff. Of the eight wards with a fill rate of less than 90% for RNs, seven of them had fill rates above 100% for care staff to maintain the headcount numbers on a shift, fully appreciating skill mix is compromised. Four wards have experienced fill rates for RNs of less than 90% for the last 3 months, none for care staff. These four wards are attending the Recruitment Open Day in February 2017.

6. Inpatients experiencing severe harm or above following a fall in January 2017

Two patients experienced a fall resulting in severe harm or above. Initially both falls were categorised as causing moderate harm to the patient, but later one fall was upgraded to severe after a patient fell in a cubicle whilst attending for an MRI scan. The patient was accompanied by a care assistant from the ward therefore was staffing levels were not relevant at the time of this patient fall.

The other fall was later upgraded to a severity of catastrophic as a patient on ward 2C subsequently died following the fall. The staffing on the ward at the time of the fall were correct with 3 trained staff and 2 care staff on duty on the night shift in question. Investigations are on-going to establish root causes.

7. Staffing Related Reported Incidents

A total of 17 incident forms were completed during January 2017 (22 completed in December 2016) regarding staffing shortages on shifts on the wards included in the Safer Staffing submission. Staff are requested to complete an incident form for shifts where there are skill mix issues or the actual headcount on shift is less than the planned.

8. Future Developments.

8.1. Allocate E-Roster System – The tender is up for renewal of the Allocate system in May 2017. This process will include a bid to purchase the Allocate E-Roster SaferCare module piloted in 5 Trusts nationally at present to address some of the Carter Recommendations. This system allows real time entry by shift leaders of staffing levels, skill mix, the number of specials employed, staff moves to other wards and has the facility to allow the inputting of patient acuity which provides a summary meaningful view of Care Hours Per Patient available on each ward. The successful implementation of this system will require a senior clinical project lead and is not an overnight implementation as a culture change is required across the wards. Once successfully implemented, the system provides efficient and effective use of staff across all wards as a Trust-wide picture of current staffing levels and skill mix on each shift together with patient numbers and acuity is available. The SaferCare module then creates a summary to allow matrons at the daily mandated Staffing levels review meeting to employ their professional judgement to this information to deploy staff accordingly to provide safe care.

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

8.3. NHS Improvement Safer Staffing Guidance for emergency departments, maternity, paediatrics and adult inpatients is presently being developed and due to be published early 2017.

Summary

The report has presented information on staffing headcount fill rates on inpatient wards for the month of January 2017 and provided an update regarding on-going nursing and midwifery workforce recruitment activities to address vacancies. The two inpatient falls resulting in severe harm and above have not correlated with ward staffing levels on the actual shift when the harm occurred.

Appendix 1 – Trust's NHS Choices Safer Staffing Submission

Ward	Specialty	Monthly Hours - Days						Monthly Hours - Nights						Care Hours Per Patient Day (CHPPD)			
		Qualified staff			HCA's			Qualified staff			HCA's			Monthly Pat's	Qual. staff	HCAs	Total
		Plan	Actual	Rate	Plan	Actual	Rate	Plan	Actual	Rate	Plan	Actual	Rate				
1A	Geriatric Medicine	1,995	1,853	93%	1,995	1,853	93%	900	762	85%	900	1,059	118%	836	3.1	3.8	6.9
1B	General Medicine	3,728	3,355	90%	3,728	3,355	90%	1,111	1,071	96%	600	561	93%	823	5.4	3.1	8.4
1C	General Medicine	3,177	3,144	99%	3,177	3,144	99%	1,700	1,699	100%	600	650	108%	867	5.6	2.8	8.4
1D	Cardiology	2,134	1,949	91%	2,134	1,949	91%	900	742	82%	600	823	137%	913	2.9	2.8	5.7
1E	Cardiology	2,277	2,222	98%	2,277	2,222	98%	1,200	1,130	94%	220	210	95%	468	7.2	2.1	9.3
2A	Gen. Medicine / Haematology	1,586	1,578	100%	1,586	1,578	100%	610	610	100%	290	290	100%	510	4.3	2.2	6.5
2B	Gen. Medicine / Respiratory	2,077	1,810	87%	2,077	1,810	87%	900	810	90%	600	830	138%	893	2.9	2.6	5.5
2C	Gen. Medicine / Respiratory	2,106	1,940	92%	2,106	1,940	92%	900	860	96%	600	610	102%	848	3.3	2.4	5.7
2D	General Medicine	1,395	1,259	90%	1,395	1,259	90%	700	700	100%	600	810	135%	507	3.9	4.6	8.5
2E	Obstetrics	2,983	2,954	99%	2,983	2,954	99%	1,230	1,230	100%	600	850	142%	808	5.2	3.2	8.4
3A	Plastic Surgery	1,728	1,709	99%	1,728	1,709	99%	910	900	99%	580	580	100%	594	4.4	3.1	7.5
3Alpha	Trauma & Orthopaedics	1,259	1,256	100%	1,259	1,256	100%	600	589	98%	280	270	96%	412	4.5	3.3	7.8
3B	Trauma & Orthopaedics	1,343	1,328	99%	1,343	1,328	99%	900	893	99%	600	730	122%	600	3.7	4.5	8.2
3C	Trauma & Orthopaedics	1,915	1,623	85%	1,915	1,623	85%	900	880	98%	890	1,190	134%	687	3.6	4.5	8.2
3D	Gen. Medicine / Gastro.	1,996	1,824	91%	1,996	1,824	91%	900	701	78%	600	839	140%	889	2.8	2.5	5.3
3E	Gynaecology	1,491	1,445	97%	1,491	1,445	97%	630	600	95%	300	310	103%	673	3.0	1.6	4.6
3F	Paediatrics	2,217	2,175	98%	2,217	2,175	98%	1,200	1,200	100%	300	370	123%	411	8.2	2.3	10.6
4A	101 - UROLOGY	2,112	2,014	95%	2,112	2,014	95%	900	890	99%	900	930	103%	891	3.3	2.5	5.7
4B	General Surgery / Urology	2,230	2,139	96%	2,230	2,139	96%	1,110	1,080	97%	440	429	98%	371	8.7	6.0	14.6
4C	General Surgery	2,144	1,898	89%	2,144	1,898	89%	900	884	98%	900	960	107%	914	3.0	2.5	5.6
4D	Plastic Surgery	1,655	1,654	100%	1,655	1,654	100%	660	660	100%	250	250	100%	206	11.2	4.0	15.2
4E	Critical Care	5,350	5,090	95%	5,350	5,090	95%	3,600	3,360	93%	600	470	78%	448	18.9	2.8	21.7
4F	Paediatrics	2,125	2,001	94%	2,125	2,001	94%	600	592	99%	360	330	92%	226	11.5	3.6	15.1
5A	Gen. Medicine / Geriatric	1,570	1,441	92%	1,570	1,441	92%	900	860	96%	900	1,110	123%	646	3.6	5.7	9.3
5B	Geriatric Medicine	1,763	1,748	99%	1,763	1,748	99%	900	900	100%	900	870	97%	698	3.8	4.2	8.0
5C	Geriatric Medicine	2,433	2,171	89%	2,433	2,171	89%	1,300	1,290	99%	900	1,030	114%	790	4.4	3.8	8.1
5D	Gen. Medicine / Geriatric	1,531	1,292	84%	1,531	1,292	84%	700	700	100%	600	740	123%	583	3.4	4.0	7.4
Duffy	Gen. Medicine / Geriatric	1,383	1,339	97%	1,383	1,339	97%	600	600	100%	600	630	105%	585	3.3	4.1	7.4
SCBU	Paediatrics	1,608	1,595	99%	1,608	1,595	99%	960	960	100%	280	272	97%	234	10.9	3.5	14.4
Delivery	Obstetrics	3,152	3,025	96%	3,152	3,025	96%	2,300	2,287	99%	600	470	78%	254	20.9	5.0	25.9
Seddon	Rehabilitation	1,743	1,728	99%	1,743	1,728	99%	600	600	100%	600	870	145%	237	9.8	9.9	19.8

Appendix 2: CHPPDs - Table 1 CHPPD for the registered workforce.

Ward Name	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
1A		2.6	2.8	2.6	2.9	2.9	3.0	3.2	3.1	3.1		
1B		5.9	5.7	4.6	6.2	5.8	5.5	6.2	5.9	5.4		
1C		5.8	5.6	5.4	5.4	5.7	5.7	5.3	5.7	5.6		
1D		2.8	2.8	3.0	2.9	3.1	3.0	2.8	3.0	2.9		
1E		7.6	7.0	6.8	7.2	7.6	7.7	7.7	7.2	7.2		
2A		3.6	3.7	3.9	4.8	4.6	4.5	4.9	5.7	4.3		
2B		2.8	3.0	2.9	2.7	3.0	3.0	3.7	3.1	2.9		
2C		2.7	2.8	2.8	2.8	3.4	3.1	3.4	2.9	3.3		
2D		2.9	2.8	3.1	3.4	3.5	3.3	3.1	2.9	3.9		
2E		4.9	4.6	5.1	5.6	4.4	4.9	5.2	5.6	5.2		
3A		5.1	4.3	4.6	4.6	5.3	4.7	5.4	5.6	4.4		
3Alpha		4.8	4.2	4.9	5.2	5.7	4.7	5.7	6.4	4.5		
3B		3.6	3.3	3.5	3.2	3.9	3.6	4.1	3.8	3.7		
3C		3.4	2.9	3.2	3.6	3.5	3.1	3.4	3.5	3.6		
3D		2.8	2.8	3.1	3.0	2.9	3.1	3.2	3.0	2.8		
3E		3.4	3.4	3.1	3.4	3.8	3.2	3.3	3.4	3.0		
3F		7.4	9.1	7.1	10.7	8.5	7.3	6.1	8.1	8.2		
4A		3.3	3.2	3.2	3.1	3.2	3.2	3.4	3.2	3.3		
4B		7.6	7.0	7.6	8.6	8.8	8.9	8.0	8.2	8.7		
4C		3.2	3.1	3.2	3.0	3.2	3.6	3.7	3.4	3.0		
4D		12.6	16.9	15.5	16.5	33.2	13.0	17.3	16.9	11.2		
4E		27.7	25.2	26.0	26.1	27.9	26.2	26.2	23.1	18.9		
4F		7.9	10.0	11.5	16.7	15.4	13.6	8.5	11.4	11.5		
5A		3.5	3.6	2.7	3.0	2.8	3.4	3.0	3.2	3.6		
5B		2.6	3.8	3.4	3.3	3.4	3.3	3.8	3.1	3.8		
5C		4.8	4.7	2.0	2.1	5.3	4.7	4.6	4.7	4.4		
5D		3.7	3.4	4.4	5.2	2.5	3.9	4.3	3.4	3.4		
Duffy Ward		2.7	2.7	2.5	2.5	2.8	3.0	3.4	2.9	3.3		
SCBU		7.5	8.1	12.6	15.3	10.7	8.8	9.2	15.3	10.9		
Delivery Suite		17.0	15.8	18.6	18.2	16.1	18.2	20.3	19.9	20.9		
Seddon		5.2	5.5	5.5	4.6	5.3	5.9	4.7	25.3	9.8		

Table 2 . Care Hours Per Patient Day (CHPPD) Care staff												
Ward Name	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
1A		3.8	3.8	3.5	3.8	3.9	3.6	4.1	3.6	3.8		
1B		2.8	3.3	4.0	3.7	3.3	3.4	3.5	3.2	3.1		
1C		3.3	3.0	3.0	3.1	3.7	3.5	3.3	3.3	2.8		
1D		3.0	2.6	2.8	2.9	3.5	3.1	2.7	2.6	2.8		
1E		2.3	1.9	1.7	1.7	1.9	2.0	2.1	2.1	2.1		
2A		2.1	2.1	2.1	2.2	2.3	2.4	2.5	2.5	2.2		
2B		2.5	2.6	3.3	2.8	2.9	3.0	3.0	2.7	2.6		
2C		2.8	2.4	2.5	3.1	3.6	3.5	2.5	2.2	2.4		
2D		2.9	3.5	4.2	4.6	3.5	3.7	2.9	3.2	4.6		
2E		2.3	2.3	2.2	2.2	2.1	2.2	3.3	3.4	3.2		
3A		3.5	3.0	3.3	4.0	4.0	3.4	3.7	3.7	3.1		
3Alpha		3.2	2.9	3.6	3.6	4.1	3.5	4.1	4.8	3.3		
3B		4.8	4.5	4.6	4.4	5.1	4.1	4.7	4.5	4.5		
3C		3.4	3.2	3.2	4.3	4.2	4.0	4.0	3.9	4.5		
3D		2.6	2.6	2.3	2.8	2.6	2.5	2.8	2.2	2.5		
3E		1.8	2.0	2.0	1.9	2.1	2.0	1.8	1.5	1.6		
3F		1.4	1.9	1.5	1.9	1.8	1.6	1.2	1.7	2.3		
4A		2.4	2.9	2.9	3.1	3.1	2.7	2.7	2.6	2.5		
4B		5.4	4.9	4.9	5.7	5.3	5.7	5.2	5.5	6.0		
4C		2.8	2.5	2.7	2.5	2.5	2.6	2.7	2.6	2.5		
4D		3.5	7.2	5.3	4.6	13.0	3.8	5.9	5.0	4.0		
4E		4.8	4.8	4.0	4.5	4.7	4.2	4.7	4.3	2.8		
4F		3.4	4.4	2.9	6.1	5.2	4.1	2.7	3.4	3.6		
5A		4.5	4.2	4.6	5.4	4.5	5.6	4.9	5.5	5.7		
5B		3.8	5.9	5.0	4.7	4.6	4.2	4.6	3.6	4.2		
5C		3.8	3.4	2.0	2.3	5.4	4.5	4.4	4.0	3.8		
5D		3.8	3.7	4.2	5.7	2.6	4.4	5.0	3.9	4.0		
Duffy Ward		4.3	3.5	3.8	4.3	4.5	3.7	3.9	3.4	4.1		
SCBU		1.9	2.1	2.4	3.5	2.9	2.6	2.5	4.4	3.5		
Delivery Suite		4.3	4.2	5.0	4.5	4.2	5.0	5.5	4.6	5.0		
Seddon		4.7	5.1	5.7	5.5	5.5	5.6	4.9	28.5	9.9		

Table 3. Care Hours Per Patient Day (CHPPD) Overall												
Ward Name	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
1A		6.4	6.6	6.1	6.7	6.8	6.6	7.3	6.6	6.9		
1B		8.7	9.0	8.6	9.8	9.1	8.9	9.6	9.1	8.4		
1C		9.1	8.6	8.3	8.6	9.4	9.1	8.6	9.0	8.4		
1D		5.8	5.4	5.8	5.9	6.6	6.0	5.5	5.7	5.7		
1E		9.9	8.9	8.4	8.9	9.5	9.7	9.8	9.4	9.3		
2A		5.8	5.8	6.0	7.0	6.9	6.9	7.4	8.2	6.5		
2B		5.3	5.7	6.2	5.5	5.9	6.0	6.7	5.9	5.5		
2C		5.5	5.2	5.4	5.8	7.0	6.5	5.9	5.1	5.7		
2D		5.7	6.3	7.3	8.0	7.1	6.9	5.9	6.1	8.5		
2E		7.2	6.9	7.3	7.8	6.6	7.1	8.5	9.0	8.4		
3A		8.6	7.3	7.9	8.6	9.3	8.1	9.2	9.3	7.5		
3Alpha		8.0	7.1	8.5	8.8	9.8	8.2	9.8	11.1	7.8		
3B		8.4	7.8	8.0	7.6	9.0	7.7	8.8	8.3	8.2		
3C		6.8	6.2	6.4	7.8	7.7	7.1	7.4	7.4	8.2		
3D		5.4	5.4	5.4	5.9	5.5	5.6	6.1	5.2	5.3		
3E		5.1	5.3	5.2	5.3	5.9	5.2	5.1	4.9	4.6		
3F		8.8	11.0	8.6	12.6	10.2	8.9	7.4	9.8	10.6		
4A		5.6	6.1	6.1	6.2	6.3	5.9	6.1	5.8	5.7		
4B		13.0	11.8	12.4	14.3	14.1	14.6	13.2	13.7	14.6		
4C		6.0	5.5	5.8	5.5	5.7	6.2	6.4	6.0	5.6		
4D		16.1	24.0	20.8	21.1	46.2	16.7	23.2	22.0	15.2		
4E		32.5	30.0	30.0	30.6	32.6	30.4	30.9	27.4	21.7		
4F		11.3	14.3	14.3	22.9	20.7	17.7	11.2	14.8	15.1		
5A		8.0	7.8	7.3	8.3	7.2	9.1	7.9	8.6	9.3		
5B		6.4	9.8	8.4	8.0	8.1	7.5	8.4	6.7	8.0		
5C		8.6	8.1	4.0	4.4	10.8	9.2	9.0	8.7	8.1		
5D		7.5	7.1	8.6	10.9	5.0	8.2	9.3	7.2	7.4		
Duffy Ward		7.0	6.2	6.3	6.9	7.4	6.8	7.3	6.3	7.4		
SCBU		9.3	10.2	15.0	18.7	13.6	11.3	11.7	19.6	14.4		
Delivery Suite		21.3	20.0	23.6	22.7	20.3	23.2	25.9	24.5	25.9		
Seddon		9.9	10.7	11.2	10.0	10.8	11.5	9.6	53.8	19.8		

Appendix 3 – 10 Wards with Fill Rates below 90% for January 2017

Table: 8 wards with fill rates below 90% for RNs January 2017

	Jan-17			
Ward name	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
1A	92.9%	100.6%	**84.6%**	117.7%
1D	91.3%	110.1%	**82.4%**	137.2%
2B	**87.1%**	99.4%	90.0%	138.3%
3C	**84.8%**	122.9%	97.8%	133.7%
3D	**91.3%**	102.1%	77.9%	139.8%
4C	**88.5%**	102.3%	98.2%	106.7%
5C	**89.2%**	112.5%	99.2%	114.4%
5D	**84.4%**	123.7%	100.0%	123.3%

Table: 2 wards with a fill rate less than 90% for care staff January 2017

	Jan-17			
Ward name	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
4E	95.2%	**89.4%**	93.3%	**78.3%**
Delivery Suite	96.0%	95.7%	99.4%	**78.3%**

Table: The 4 wards with total fill rates less than 90% for the last 3 months

	Nov-16				Dec-16				Jan-17			
	Day		Night		Day		Night		Day		Night	
Ward name	**RNs**	**care staff**	**RNs**	**Care staff**	**RNs**	**Care staff**	**RNs**	**Care staff**	**RNs**	**Care staff**	**RNs**	**Care staff**
1A	94.8%	100.9%	**85.6%**	144.4%	**87.5%**	97.6%	93.4%	98.9%	92.9%	100.6%	**84.6%**	117.7%
1D	**85.6%**	108.7%	**86.8%**	103.3%	**86.6%**	101.1%	**88.9%**	101.7%	91.3%	110.1%	**82.4%**	137.2%
3C	**82.8%**	126.7%	101.1%	114.5%	**87.9%**	118.0%	95.6%	123.7%	**84.8%**	122.9%	97.8%	133.7%
3D	**82.2%**	113.9%	93.3%	113.3%	**86.9%**	93.6%	**84.6%**	126.7%	91.3%	102.1%	**77.9%**	139.8%

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(17)014
Title of paper: Executive Committee Assurance Report.
Purpose: To feedback to members key issues arising from the Executive Committee meetings.
Summary: 1. Between the 13th January and 9th February 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 continued overseas recruitment, further review of the ward dashboard, actions for orthopaedic improvements, and tendering for payroll services. 3. Assurances regarding the management of risks, agency usage, safer staffing, smoke-free progress, AKI management, and progress with the accommodation review, were obtained. 4. The business case to appoint a Gastroenterologist and a Frailty consultant was approved, and proposed expenditure of the £250k allocated to address RTT was confirmed. 5. There are no specific items requiring escalation to the Board.
Corporate objective met or risk addressed: Contributes to the Trust's Governance arrangements, and its short and longer-term plans.
Financial implications: None directly from this report.
Stakeholders: The Trust, its staff and all stakeholders.
Recommendation(s): The Board are asked to note the contents of the report.
Presenting officer: Ann Marr, Chief Executive.
Date of meeting: 22nd February 2017.

EXECUTIVE COMMITTEE REPORT (13th January to 9th February 2017)

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

19th January

1. Mandatory training and appraisals

    1.1. AMS updated the Committee on the December status of the mandatory training and appraisals. Directors defined their contingency plans for improvements.

2. International recruitment

    2.1. Pauline Jones (PJ) updated the Committee on all international recruitment activity. It was noted that 22 doctors had been appointed via this route including working with the British Association of Physicians of Indian Origin (BAPIO), one European university, and a number of overseas recruitment agencies.

    2.2. Due to difficulties with passing the International English Language Testing System (IELTS) delays in the arrival of Indian nurses offered places have been encountered. Two nurses have now commenced employment and six will join in February. A further 21 are at various stages of pre-employment.

    2.3. It was acknowledged that international recruitment has achieved some positive outcomes for the Trust and should continue.

3. Risk Register report and Board Assurance Framework (BAF)

    3.1. SR summarised the report, which shows that the total number of risks on the risk register at 679 with 14 high risks that have been escalated to the Corporate Risk Register. The risk categories are: 7 re patient care; 3 re money; 2 re governance; and 1 each re activity and staffing. It was agreed that the descriptors require further refinement to ensure they succinctly capture the real risk to the organisation.

    3.2. The 8 strategic risks on the BAF were discussed and amendments agreed.

4. Well-Led Framework

    4.1. The CQC consultation on the Well Led Framework including Trust self-assessment was noted; a Trust response is being prepared and an initial self-assessment being carried out.

5. Safer Staffing / Vacancy Dashboard

    5.1. SR summarised the monthly submission, and ward fill-rates and patient harms were discussed. The need to ensure that the paper includes the appropriate assurances was discussed and it was noted that this is will be included in the review of report writing with senior managers.

6. Clinical Nurse Specialist Review

    6.1. NK circulated an update paper reconciling the 21 additional specialist nurse posts recruited over recent years.

7. Five Year Forward View feedback

    7.1. KH reported that, in partnership with St Helens CCG, the Trust has applied for transformation funding for Diabetes, and AMS reported that Simon Banks has applied for Learning Disability funding. PW reported on the Halton Health and Wellbeing Board, where positive feed-back was given by ECIP, however, it was noted that over Christmas and New Year, there were a large number of extra GP slots provided which were unused.

8. OFSTED Inspection

8.1. SR reported that Knowsley have an OFSTED Inspection (January or February), and safeguarding information will have to be provided from the Trust.

9. Smoke free

9.1. SR updated on the Trust's "Smoke Free Site" launch on 1st April, and confirmed that policing and communications has been agreed with HR colleagues.

26th January

10. Acute Kidney Injury

10.1. Ragit Varia and Joy Woosey presented on the success to date with the initiatives to improve the management of AKI within the Trust.

11. Clinical Quality Performance Group (CQPG)

11.1. SR provided feedback including the Provider monitoring tool, Warrington's Paediatric Utilisation, Equality & Diversity, and the Patient Access Policy.

12. Ward dashboard

12.1. SR presented the latest iteration of the ward dashboard. Following discussion it was concluded that it still contains a vast range of figures, but remains difficult to reach conclusions regarding the greatest risks and priorities for action. It was agreed that other Trust's dashboards should be reviewed.

13. IT issues

13.1. CW provided an update on both E-prescribing roll out and measures to address the recent cyber security issue.

14. Quality Account timeline

14.1. Anne Rosbotham –Williams provided an update on the timetable and proposed process for drafting the 2016/17 Quality Account, including sign-off.

2nd February

15. Get It Right First Time (GIRFT) report & National Hip Fracture database

15.1. Phil Nee and John Foo provided an update on the actions planned to address the recommendations in advance of the proposed re-visit in May. Whilst there was some improvement there is need for further progress with Patient Recorded Outcome Measures, DNAs, Length of Stay, and procedure costs.

16. Payroll services tender

16.1. Jennie Dwerryhouse briefed members on the proposal given its value and the financial penalties, and received approval to submit a bid against the tender.

17. Accommodation review

17.1. Nicola Bunce (NB), Geoff Hunter and Diane Stafford (DS) provided an update. Whilst only a proportion of the 28 beds are open, plans are being progressed on the remainder. Actions in the interim to deal with bed-pressures were agreed.

17.2. Proposals on plastic surgery moves were discussed with agreement to seek clarity, and the revised use of Ward 3E gynae day-case beds was discussed.

18. Trust Board Agenda

18.1. The draft Board agenda for February was approved. It was agreed that the Strategy Board agenda would consist of discussion on the strategic landscape.

19. Gastroenterology Business Case

    19.1. DS presented a case for investment in 2 consultants to support the growth in activity, which has accountant approval. The proposal was approved, subject to explicit job-plans delivering the aims of the business case.

20. EPR

    20.1. CW reported on progress confirming that the case will shortly be submitted to NHSI for approval to proceed. Further work is being undertaken with the preferred bidder to clarify any remaining uncertainties with their proposal.

21. RTT backlog by specialty

    21.1. RC circulated graphs by specialty. Areas of concern are ENT and Dermatology, however £250k funding from NHSE to reduce the backlog has been received which is expected to enable a significant improvement by March.

9th February

22. Integrated Performance Report (IPR)

    22.1. Key issues on latest performance were discussed in advance of the final version being made available for Committees and Board.

23. Well-led Framework consultation & self-assessment

    23.1. PW advised that comments were submitted on the proposed Framework, and an initial self-assessment had been undertaken on 1st February with BH and NB to test the draft framework which was largely positive.

24. Agency usage

    24.1. PJ and Sue Hill presented 3 separate reports. The 1st covered the monthly reporting that showed a continuing reduction in expenditure, but at too slow pace. Further measures to increase the rate of reduction were discussed.

    24.2. The 2nd was in response to a specific question regarding the “unfilled” requests for HCA bank staff, to provide assurance that this had not impacted upon adequate staffing levels.

    24.3. The 3rd described the systems in place to govern premium payments for additional activity. Whilst the report showed that electronic systems were now in place for recording hours worked and appropriate payments a number of scenarios were explored that suggested more safeguards were desirable, and these were agreed.

25. Proposals for Trust Offices at Alexandra Business Park

    25.1. PW presented an update on progress to identify what clinical services could be used to back-fill vacated accommodation, and generate income. Whilst progress has been made in consolidating the vacated accommodation into useable areas, further work was required to reach a definitive outcome.

26. EPR update

    26.1. CW briefed members on the continuing work being undertaken with the preferred bidder to clarify any remaining uncertainties with their proposal.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(17)015
Title of paper: Quality Committee Assurance Report.
Purpose: The purpose of this paper is to summarise the Quality Committee meeting held on 14th February 2017 and escalate issues of concern.
Summary: Key items discussed were: 1. Complaints 2. IPR 3. Lord Carter review update 4. Francis action plan update 5. MRSA action plan update 6. Quality priorities for 2017/18 7. Pharmacy audit update
Corporate objectives met or risks addressed: Five star patient care and operational performance.
Financial implications: None directly from this report.
Stakeholders: Patients, the public, staff and commissioners.
Recommendation(s): It is recommended that the Board note this report.
Presenting officer: George Marcall, Non-Executive Director
Date of meeting: 22nd February 2017

QUALITY COMMITTEE ASSURANCE REPORT

Summary of the discussions and outcomes from the Quality Committee meeting held on 14th February 2017.

Action Log

1. All actions on the log were reviewed.

Complaints Report

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

   2.1. 41 1st stage complaints were received and opened in January 2017; an increase of 18 (78%) in comparison to January 2016 and an increase of 8 (24%) compared to December 2016.

   2.2. At the end of January 2017, there were 66 open 1st stage complaints, including 10 overdue.

   2.3. The Trust responded to 21.4% of 1st stage complaints within agreed time frames during January, leading to a year to date response rate of 60%.

   2.4. The top complaint themes during January 2017 were:

   2.4.1. Clinical treatment.

   2.4.2. Admissions and discharges

   2.5. There were 141 PALS contact/enquiries during January 2017; an increase of 10 in comparison to December 2016 and an increase of 5 compared to January 2016.

   2.6. The majority (93%) of PALS contacts were concerns or complaints resolved locally, as opposed to signposting or dealing with enquiries (7%).

   2.7. The Committee discussed complaints in great detail and the fact that response rates had deteriorated slightly in January and this was due, in part, to operational pressures and long term sickness within the team. Due to the high cost of agency staff, a member of staff from Legal Department has been seconded in to a case management role.

   2.8. Following further discussion, assurance was not gained, but the Committee were confident of improvement in the coming months.

Safer Staffing report

3. This report was deferred due to the timing of Quality Committee.

IPR

4. Nik Khashu (NK) summarised the report.

   4.1. There was 1 never event report in January 2017, taking the year to date total to 2.

   4.2. Sue Redfern (SR) informed the Committee that the never event involved a surgical patient. A drain was inserted and the cap at the end of the drain was retained. The patient was readmitted to the hospital and the cap removed. SR is working with Surgical Care Group regarding an action plan and an investigation is underway. Once the incident had been detected, a formal count of drain caps is now on the WHO checklist. John Clayton has started

discussions with the manufacturer regarding the colour/design of the cap on the product used.

4.3. There were two MRSA cases in January 2017, taking the year to date total to 4. SR explained that one case was an infection and the other was a contaminant. The PIR has taken place and there are some recurrent themes Julie Hendry (JH) informed the Committee that following CD Forum, she had asked a number of staff on the wards if they were aware of the operational change in the policy regarding suppression therapy and it became apparent that nursing staff and consultants alike were not aware.

4.4. Anne-Marie Stretch (AMS) asked SR to have key messages delivered to staff today through enhanced communications.

4.5. There was 1 C.Diff case in January. Year to date there have been 19 confirmed positive cases. The annual tolerance for 2016/17 is 41 cases.

4.6. There was 1 grade 3 pressure ulcer in January, taking the year to date total to 2.

4.7. There were 2 falls that resulted in severe harm, including a death, during December. SR said that she has now instigated a 72 hour rapid review. Monthly audits are carried out and SR will bring a formal report to Quality Committee regarding falls. The death was not directly related to the fall.

4.8. VTE assessment for December was 94.08%, slightly below the required target. The YTD HSMR is 102.8 up to October 2016.

4.9. A&E performance was 69.6% (type 1) and 81.2% (type 1 and 3) in month. The key actions identified for recovery of this position are being driven forwards by senior leaders across the organisation, focusing on both the Emergency Department and the inpatient wards.

4.10. GM said that A&E performance will be looked at in greater detail at the Finance & Performance meeting on 16th February. An update will be given at the next Quality Committee.

4.11. NK reported that the Trust is reporting against an annual plan of £3.328m surplus, as approved by the Trust Board and confirmed with the NHSI. This does include the STF allocation of £10.1m

4.12. As at month 10, the Trust is reporting an overall income and expenditure surplus of £2.537m and technical adjustments which is slightly above the agreed plan. Trust income is ahead of plan by £2.577m, while expenditure is overspent by £2.434m, through delivering additional activity. Expenditure on agency stands at £9.159m for the year against a target for the full year of £7.256m.

4.13. To date the Trust has delivered £12.445m of CIPs, which is now just ahead of the year to date plan.

4.14. Capital expenditure to date is £2.862m out of a revised year forecast total of £4.088m. Cash balance at the end of January is £4.154m which equates to 2 operating days.

4.15. Mandatory training compliance has increased in month and is 7.9% above target at 92.9%. Appraisal compliance for January has also improved and is just 4.8% behind target at 80.2%, with work ongoing to recover the compliance rate to 85%. AMS urged everyone to ensure that mandatory training and appraisals are up to date, as the Trust did not want to fail these targets.

4.16. Sickness absence has increased in December to 5.4% (compared to 5.72% in December 2015). The year to date sickness is 4.8% which is 0.3% above year end target.

4.17. The Trust exceeded the CQUIN flu vaccination target of 75% and is currently 82% vaccination rate of frontline staff.

4.18. Patient Safety – Appendix 5

4.18.1. All patient safety aspects had been discussed earlier in the meeting.

5. Lord Carter review update

5.1. AMS provided a summary for the Committee.

5.2. The paper provides assurance to the Trust Board of the actions taken by St Helens & Knowsley Hositals NHS Trust in response to the recommendations detailed in the Trust Response to the independent report for the Department of Health published by Lord Carter.

5.3. There are 3 amber actions within the action plan:

5.3.1. Appraisals (the Alliance footprint is looking at e-forms).
5.3.2. Specialing policy/approach.
5.3.3. Agency spend/rules.

6. Francis action plan update

6.1. AMS provided an update.

6.2. The Francis action plan provides assurance on the Trust's progress to meet the recommendations following the publication of the Francis Report in February 2015.

6.3. AMS advised that the action plan has been completed, but does need to be continually refreshed and to look at the different ways the key messages can be disseminated to all staff.

6.4. The new Assistant Director of Safety, Rajesh Karimbath is also the Trust's new Guardian and he will commence in post on 1st March 2017.

MRSA action plan update

7. Ali Kennan (AK) and Cathy Umbers (CU) provided an update

    7.1. MCG and SCG has amalgamated their plans. There are no red actions but there are 7 amber. AK and CU said that they were going to revisit the newsletter and see if this would be best suited to disseminate information to staff. AMS asked that three top things are identified from the action plan and then communicated to staff; the Board will be looking for assurance regarding MRSA.

    7.2. NK expressed some concerns that papers presented at the meeting were asking the committee to receive or note the contents; NK felt that assurance was not being given. Peter Williams (PW) informed the Committee that he had held a meeting last week with some of the lead report writers and recommendations have been made that will address NK's concerns.

Quality priorities for 2017/18

8. ARW provided an update:

    8.1. Following Clinical Senate, clinical priorities for 2017/18 were decided.

    8.2. For patient safety they will be Sign up to Safety, embed lessons learned and ensuring patients are safe.

    8.3. For patient experience it will be e-discharge.

    8.4. For clinical effectiveness it will be BiPAP and non invasive ventilation on the ward rather than on ICU.

Pharmacy audit update

9. Simon Gelder (SG) provided an update.

    9.1. The report summarises overall performance against the Trust's standards for medicines storage and security.

    9.2. Overall Trust performance has improved from 87% to 96%. 89% locations rated GREEN (vs 60% in November 2016 audit). 9% locations rated AMBER (vs 20% in last audit and 2% locations rated RED (vs 20% in last audit).

    9.3. A&E continues to struggle to comply with the Trust standards although marked improvement in completion of daily checklists and temperature logs is noted.

    9.4. SR and GM expressed concern regarding A&E percentages, especially Paediatrics. SR will meet with Tricia Beech and visit the A&E to see what is happening. Tricia Beech is looking at Theatres in St Helens and SR will also visit Ward 3E.

Feedback from Patient Safety Council

10. ARW provided an update on the VHP pilot report – The council supported the decision to roll out the health vessel preservation framework after the successful pilot on ward 1D which saw a reduction of vascular related MSSA bacteraemia.

Feedback from Patient Experience Council

11. ARW provided an update on the Spiritual Care 2016 report. There have been 2600 patient interactions but most activity is general support, less than 25% is religious referral. Awareness raising discussed and will review with Media and Comms.

Feedback from Clinical Effectiveness Council

12. ARW reported on the Red Cell transfusions 2 week audit. Audit findings showed an unsatisfactory high number of transfusions being required out of working hours. A robust action plan will be put in place.

Feedback from CQPG Meeting

13. ARW informed the Committee that SIRI reporting is on the risk register due to breaches. The process will be streamlined and there will be a rota of people to assist in writing the reports. The 72 hour review will assist in asking the correct questions.

14. CQUINS: NHS England are looking to increase telephone helplines for GPs and there may be potential difficulties in achieving this national CQUIN. The issues include the lack of an IT solution, time commitment required to deliver and historic poor utilisation when it has been trialled previously.

15. GM enquired about smoking cessation. ARW informed the Committee that the launch date would be 8th March and the Trust would become a non smoking site on 1st April. ARW will report back to the Quality Committee in April.

Feedback from Executive Committee

16. SR had nothing to escalate to the Committee.

17. GM asked about the extra beds and the timeframe. AMS replied that this would be mainly at the end of February/beginning of March. PW will pass the information to GM on Thursday, 16th February.

Feedback from Workforce Council

18. AMS said there were no issues to be escalated.

Effectiveness of meeting

19. GM said that there were a couple of areas giving cause for concern, but we had clarified the level of assurance.

20. Tom Skerritt commented that everything was taken seriously in the meeting, with good discussion, especially around MRSA. He said he had learned a lot in the last two days shadowing NK.

AOB

21. None noted.

Date of next meeting

22. Tuesday, 21st March 2017.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(17)016

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the activities of the Finance and Performance Committee held in February 2017

Summary: Agenda Items

For Information

- Mandatory Training Update
- Cost Transformation Programme Pilot
- Procurement efficiencies: Drugs & Clinical Supplies
- Q2 SLR Surgery, including ENT & T&O reviews
- CIP Programme 2017/18
- DoH Loan Conversion

For Assurance

- Agency update on Expenditure and Compliance; good progress with nursing
- HCA Sickness update
- 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 10 2016/17 – concern around MRSA, Pressure ulcers and never event incidents
- Month 10 2016/17 Finance Report – still forecasting to achieve £3.328m surplus
- Governance Committee Briefing Papers:
    - CIP Council

Actions Agreed

- HCA sickness – deep dive into St Helens Hospital
- Procurement efficiencies – Cheshire & Merseyside 5YFV project
- Agency update – present a paper on IR35 changes to the Committee in April
- A&E performance update – suite of metrics to highlight progress against action plan

Corporate objectives met or risks addressed: Finance and Performance duties

Financial implications: 2016/17 Annual Plan forecasting a £3.3m surplus, based on receipt of £10.1m Sustainability and Transformation Funding

Stakeholders: Trust Board Members

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

Presenting officer: Denis Mahony Non-Executive Director

Date of meeting: 22nd February 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(17)017

Title of paper: Audit Committee Assurance Report.

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

Summary: The Audit Committee met on 15th February 2017. The following matters were discussed and reviewed:

External Audit (Grant Thornton):

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

Internal Audit (Mersey Internal Audit Agency – MIAA):

- The Committee were apprised of recent final audit reviews, including follow-ups of previous reports.
- MIAA provided two further reports for the Audit Committee to note:
  - External quality assessment of MIAA undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA).
  - Notes of events and briefing notes that may be of interest to the Audit Committee.

Anti-Fraud Services (MIAA):

- The Committee received an update on progress being made against the 2016/17 anti-fraud plan.
- A draft anti-fraud work plan for 2017/18 was also presented for acceptance by the Audit Committee.

Trust Governance and Assurance:

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

Standing Items:

- The audit log (report on current status of audit recommendations) (ADoF)
- The losses, compensation and write-offs report for the quarter ending December 2016 (ADoF).
- Aged debt analysis as at end of December 2016 (ADoF).
- Tender and quotation waivers (ADoF).
- External reviews – The Committee was informed of a recent cost assurance review of the Trust's reference costs by Ernst and Young which has yet to be finalised (DoF).

Other Business:

- An annual update was given on use of the Trust seal (DoCS).
- A report was presented on the Trust's 2015/16 Reference Costs score (HoCF).

Key: DoF = Director of Finance DoN = Director of Nursing, Midwifery & Governance or representative DoCS = Director of Corporate Services ADoF = Assistant Director of Finance (Financial Services) HoCF = Head of Corporate Finance 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 directly from this report
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: 22nd February 2017

TRUST BOARD PAPER

Paper No: NHST(17)018

Title of paper: Committee Report – Charitable Funds Committee

Purpose: To brief the Board on the main issues discussed and decisions made at the Committee meeting on 16th February 2017.

Summary:

1. Approval of Expenditure:
   Mr Mark Rowson, Simulation Lead, presented a funding request for 2 neonatal simulation manikins to enable the setting up of a new neonatal simulation service within Clinical Education. The Committee agreed to fund the cost of £21,911.00 (exc. vat).

2. Action Log:
   Dormant Funds update – Mrs Elizabeth Titley, Fundraiser, is going to get a plan of action as part of her new role. It was acknowledged that some funds are dwindling as a matter of course and aren't necessarily dormant.
   Investment Manager meeting – Blackrock, the Trusts' present investment company, only have a small team and will teleconference but do not tend to do client site visits. The Committee decided to table investment companies as an item for discussion in 6 months.

3. Mrs J Turner, presented the latest positions on the following items:
   - Investment portfolio – The charitable fund shares are invested in 'Common Investment Funds' (COIFS) and managed on the Trust's behalf by Blackrock Investments who are expert fund managers. (COIFS are very common in the NHS.) Such investments will fluctuate up and down in value over time but hopefully there will be an overall upward gain.
     - At 31st March 2016, the shares were valued at £552.5k, showing an unrealised gain of £89.5k, since the acquisition of the shares in 1998. (In other words, the value has shown an increase since they were purchased originally.)
     - In the months since year-end to the valuation, as at 13th February 2017, presented at the February Charitable Funds Sub-Committee, the share value has increased by £79.7k, and overall the unrealised gain (ie. increase in value since purchase) is £169.2k.

4. Financial position - The Committee reviewed Income and Expenditure since the previous meeting. It was noted that expenditure is higher than the comparable period last year.

- Mr D Mahony asked to find the reason behind a large £30k donation to Ophthalmolgy.
- Mr N Khashu asked for representation at the next meeting to give assurance that expenditure approved by the Committee is being effective.
- A procedure be put in place that enables thank you letters to be signed by Mr D Mahony as Chair of the Committee or Ms A Marr.

5. Fundraising – Mrs E Titley, newly appointed Fundraiser, provided the Committee with her view of the Charity within the Trust and possible areas of improvement.

6. Any other business:

    - Annual Meeting Effectiveness Review – information provided was noted and recommendations approved.

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

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff and all stakeholders.

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

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

Date of meeting: 22nd February 2017

TRUST BOARD PAPER

Paper No: NHST(17)019
Title of paper: Foundation Trust Application and Regulation
Purpose: To provide the Board with assurance that the Trust continues to take into account and comply with governance good practice and regulatory requirements.
Summary: This report includes briefing on; 1. Operational Plans 2017/18 – 2018/19 2. The new Conflict of Interest regulations and how they will be enacted 3. The new Well Led Framework consultation and actions being taken to ensure the Trust will be in a position to meet the requirements 4. An update on the St Helens Community Services contract mobilisation 5. The proposed governance arrangements for the Cheshire and Merseyside Five Year Forward View delivery programmes.
Corporate objectives met or risks addressed: Provide high quality sustainable services
Financial implications: This paper does not include a request for additional funding
Stakeholders: Patients, Staff, Alliance LDS Partners, Commissioners, NHSI
Recommendation(s): The report is intended to inform and assure the Board The Board are requested to consider the Boards response to the C&M FYFV governance framework.
Presenting officer: Nik Khashu, Director of Finance and Information
Date of meeting: 22nd February 2017

Foundation Trust Application and Regulation

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

1.1 No formal feedback on the Trusts submitted plans has been received from NHSI, to date.

1.2 The Cheshire and Merseyside Five Year Forward View (C&M FYFV) financial model submitted with last Sustainability and Transformation Plan in October is being refreshed to take into account the operational plans agreed in December and the 2016/17 actual position as reported at Q3. This work will give a new baseline financial position for the C&M footprint from April 2017.

2. Managing Conflicts of Interest in the NHS

2.1 Due to widespread variation in the practices of managing conflict of interests across the different parts of the NHS a single framework has been issued by NHS England following a consultation exercise in 2016.

2.2 The new rules published on 9th February 2017 are applicable to all organisations commissioning or providing services funded by the NHS, and to their staff whether directly or indirectly employed and come into effect on 1st June.

2.3 There is a single definition of Conflict of Interest;

A conflict of interest can occur when there is the possibility that a person's judgement regarding their primary duty to NHS patients may be influenced by a secondary interest they hold. Conflicts can occur with interests held by the individual or their close family members, friends and associates. Such a conflict may be:

- *Potential – there is the possibility of a conflict in the future*
- *Actual - there is a relevant and material conflict now*
- *Perceived – an observer could reasonably suspect there to be a conflict.*

2.4 The guidance designates the positions in NHS organisations which are covered by the guidance;

- Executive and non-executive directors
- Medical staff
- Budget holders
- Those at Agenda for Change band seven or above
- Those involved in purchasing or formulary decisions
- FT Governors
- NHS contractor professions e.g. pharmacists, dentists, optometrists etc.

2.5 The key requirements for Board members are;

- All staff must declare gifts, hospitality and other interests within 28 days via a positive declaration
- Senior staff should declare interests on appointment and annually
- Interests should be recorded in one or more organisational registers
- The process should be audited on a three yearly basis

- The Audit Committee should oversee the management of Conflicts of Interest
- Boards and Committee members should review and update their interests prior to the start of each meeting and review interests against each agenda item.
- Appendix 1 – Areas requiring declaration of interests

3. Consultation on the use of resources and well-led assessments

3.1. Following the briefing in January the Trust has submitted a response to the consultation on the new Well led framework

3.2. A comparison of the current and proposed frameworks has been undertaken to align the evidence that is already in place.

Comparison of 2015 Version and Proposed Changes

2015 Monitor Version – 10 Key Lines of Enquiry	2017 NHSI/CQC Consultation Proposals – 8 Key Lines of Enquiry
Domain 1 - Strategy and Planning	Is there a clear vision and credible strategy to deliver high quality sustainable care to people who use services and robust plans to deliver?
1. Does the Board have a credible strategy to provide high quality sustainable services to patients and is there a robust plan to deliver?	
2. Is the board sufficiently aware of potential risks to the quality sustainability and delivery of current and future services?	
Domain 2 – Capability and Culture	
3. Does the Board have the skills and capacity to lead the organisation?	Is there the leadership capacity and capability to deliver high quality sustainable care?
4. Does the Board shape an open, transparent and quality focused culture?	Is there a culture of high quality sustainable care?
5. Does the Board support continuous learning and development across the organisation?	Are there robust systems, processes for learning, continuous improvement and innovation?
Domain 3 – Process and Structures	
6. Are there clear roles and accountabilities in relation to Board governance (including quality governance)?	Are there clear responsibilities, roles and systems of accountability to support good governance and management?
7. Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?	Are there clear and effective processes for managing risk, issues and performance?
8. Does the Board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?	Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
Domain 4 - Measurement	Is robust and appropriate information being effectively processed and challenged?
9. Is appropriate information on organisational and operational performance being analysed and challenged?	
10. Is the Board assured of the robustness of information?	

3.3. A small group including the Director of Corporate Services and supported by Bill Hobden (Non- Executive Director) have undertaken an initial desk top review, which will be used as the starting point for the Trusts own self-assessment once the guidance is finalised and published and as the basis for the next development action plan to ensure that the Board continues to meet the regulatory standards for Well led.

4. St Helens CCG Community Services

4.1 The Trust is now working with Five Boroughs partnership NHSFT and St Helens ROTA to mobilise the contract for a go live date of 1st April 2017. There is a mobilisation programme board in place supported by a number of work streams; Clinical & Operational, HR & Communications, IM&T, Finance/Contracting and Performance and Estates & Facilities.

4.2 There are also regular meetings with the Commissioners to ensure the handover of the services and mobilisation of the contract is completed safely. The timescales are challenging but through this collective approach there is a high degree of confidence that the transition will be completed without disruption to services.

5. Cheshire and Merseyside Five Year Forward View Governance Proposals

5.1 The C&M FYFV has asked each member organisation to consult with their Boards/ Governing Bodies about the proposed governance framework for achieving the development and delivery of the five year plans to deliver Better Care, Better Health, Better Value. Appendix 2.

5.2 These proposals recognise the statutory duties and authority of individual member organisations and create a “Joint working group” for the system leaders to come together to provide collective leadership around an agreed scope of transformational activity to achieve clinical and financial sustainability. Ultimate accountability for delivery of their “share” of the plans remains with each individual member organisation, in accordance with the current national NHS regulatory framework.

5.3 All member organisations have been asked to consider the framework and respond with any comments before the C&M FYFV Membership Group meeting on 29th March.

5.4 It is intended that the full governance framework will be in place for 2017/18 to meet the requirements of NHSE for a robust governance framework to deliver the FYFV plans.

5.5 A framework for the Alliance Local delivery System is also being constructed along similar principles.

ENDS

Appendix 1

Summary of areas for declarations

Gifts	Recipient's name and position, date of gift, details of gift	On organisation register
Hospitality	Recipient's name and position, date and details of the hospitality, supplier's name and nature of business	
Outside employment	Name and position, nature of outside employment	
Private practice	Name and position, name of organisation with whom private practice conducted, sessions conducted, brief outline of duties, gross earnings in the previous 12 months	
Shareholdings	Details of shareholdings or other ownership interests held	
Patents	Details of patents held	
Sponsorship general	Date of arrangement, details of sponsorship, sponsors name and nature of business	On organisation register or website
Sponsored events		On website
Sponsored education		
Sponsored research		
Sponsored posts		
Donations	Date of donation, value of donation, donor's name and nature of business	
Loyalty interests	Name and position, nature of interest	On organisation register or website, or meeting minutes

Appendix 2

Cheshire and Merseyside 5YFV Membership Group

Cheshire & Merseyside
Delivering the Five Year Forward View:

‘Better Care, Better Health, Better Value’

Memorandum of Understanding

DRAFT V0.9 12 Jan 2017

Contents

Appendices

1 Introduction

The purpose of the Cheshire & Merseyside (C&M) 'Memorandum of Understanding' (MOU) to deliver the Five Year Forward View (5YFV), is to enable, on behalf of all our communities and staff, the closure of the three gaps defined in the 5 Year Forward View (5YFV)[1] namely: health and wellbeing, quality of care and financial sustainability. This requires a more integrated approach to the use of the existing health and care resources as well as transformational changes in the way in which services are delivered across C&M. Our aspiration is: **Better Care, Better Health, Better Value.**

To facilitate this, the MOU creates a framework for achieving the development and delivery of a five year Plan for C&M. The MOU sets out the process for collaborative working across C&M that will be critical to realising our ambitions. It signposts the programmes of that will deliver the medium and longer term outputs and outcomes anticipated from this process.

The local, statutory architecture for health and care remains, as do the existing accountabilities for Chief Executives of provider organisations and Accountable Officers of CCGs[2]. This is about ensuring that organisations are able to work together at scale and across communities to plan for the needs of their population, and help deliver the Five Year Forward View (5YFV) – improving the quality of care, health, and NHS efficiency by 2020/21. Organisations are still accountable for their individual organisational plans, which should form part of the first year of their footprint's Plan. As such, there is no delegation of powers to the C&M 5YFV framework and any financial commitments will need to be agreed through collaborative agreement and change programme structures.

All parties agree to act in good faith to support the objectives and principles of this MOU for the benefit of all patients/service users/clients and citizens of C&M. To demonstrate this collaborative sprit all parties to the MoU will be asked to sign the Charter at **Appendix A.**

2 Parties

The Parties to the agreement are:

- All Clinical Commissioning Groups in C&M
- All NHS Trusts and NHS Foundation Trusts in C&M
- All local authorities in C&M
- NHS England Regional Specialised Team (North)

While not parties to the agreement the following regulatory organisations will have a close interest in the MoU and a role to play in facilitating the changes:

- NHS England (NHSE)

[1] NHS 5YFV dated 2014
[2] NHSE Website, 5YFV Pages

- NHS Improvement

The parties are described individually at **Appendix B.**

The MoU, in establishing the agreement, sets out:

- Agreement: **how** we will work together
- Context: **why** we are doing this
- Scope: **what** we want to deliver
- Commitment: **aim** to implement the changes

3 How - The Membership Agreement including Governance

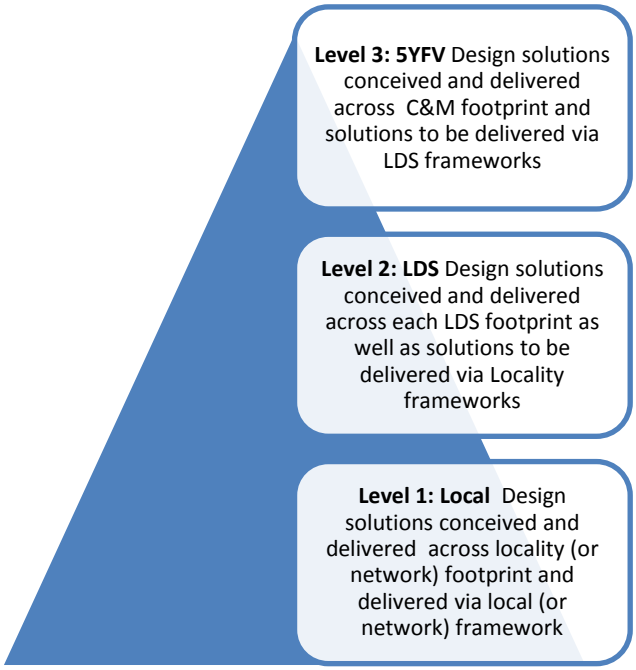
This MoU incorporates the Membership Agreement, **Appendix C**, that describes the approach to governance, decision making, assurance and risk handling. The governance function is also described pictorially at **Appendix D**.

The Cheshire and Merseyside membership recognises that building the relationships and collective leadership needed to make the C&M 5YFV real will take dedicated time, effort and resource. Each footprint will need to set out governance arrangements for agreeing and implementing a plan[3]. The aim should be to produce a 5YFV that is based upon strong analysis and insight rather than a glossy brochure. The process of exposing these issues and having real conversations about the potential benefits for patients is as least as important as the final product itself. A robust process will enable 5YFVs to set out the actions that will make a difference for local people rather than abstract principles or vision statements[4].

The Membership Agreement sets out how the Cheshire and Merseyside 5YFV will work in practice; emphasising the primacy of delivering programmes of change on the ground and explaining how the 'function' of delivering that change will lead, with the 'form' of the governance and decision making tailored to support and facilitate that function. The Terms of reference of the C&M 5YFV Membership Group and C&M 5YFV Working Group are at **Appendices E and F** respectively.

Decisions will be made at the appropriate level of the 5YFV framework, Appendix E refers, recognizing that the majority of decisions will be made at Organisational and Local Delivery System (LDS) levels and be based around the content of specific programmes that stakeholders agree to deliver together (or individually). This principle of subsidiarity means that decisions around the delivery of the closure of the three gaps - health & wellbeing, quality of care and financial sustainability – are decisions that will be taken at the lowest possible level or closest to where they will have their effect, for example in a local area rather than for the whole C&M footprint (or an individual organisation rather than a locality) whenever that is most appropriate. It follows that programme decisions at the C&M level will be the exception rather than the rule. The diagram below illustrates the principle:

[3] Letter Stevens et al, Annex A, p1, dated 16 Feb 16
[4] Letter Stevens et al, Annex A, p4, dated 16 Feb 16



NHSE will engage with C&M in developing any further requirements of the 5YFV as the NHS Five Year Forward View evolves. These will be subject to the governance arrangements of the 5YFV and will be under the auspices of further evolution of the MoU by the consent of the parties.

4 Why - Context and Objectives

The NHS Constitution sets out clearly what patients, the public and staff can expect from the NHS. Delivery of the Five Year Forward View, on behalf of all our communities and staff, aims to close the three gaps defined in the 5 Year Forward View (5YFV)[5] namely: health and wellbeing, quality of care and financial sustainability. This requires a more integrated approach to the use of the existing health and care resources as well as transformational changes in the way in which services are delivered across C&M. Our aspiration is: **Better Care, Better Health, Better Value.** The parties to the C&M 5YFV therefore share the following objectives:

- To improve the health and wellbeing of the population of C&M,
- To move from having some of the worst health outcomes to having some of the best;
- To close the health inequalities gap within C&M and between C&M and the rest of the UK faster;
- To create a health system that is able to deliver these outcomes within the financial envelope available.

[5] NHS 5YFV dated October 2014

The parties believe this will be best achieved by:

- having a clear focus on prevention of ill health and the promotion of wellbeing;
- reducing clinical variation across C&M;
- delivering effective integrated health and social care across C&M; and
- redress of the balance of care to move it closer to home where appropriate.

It is recognised that integrating health and social care is vitally important for improving the efficiency of our public services and delivering improved health and wellbeing for our population. A digitally integrated health economy with strong partnerships with research institutions and industry can support C&M's general economic growth.

C&M wants to build upon the rights and pledges of the constitution and provide further opportunities for patients and the public to be involved in the future of their NHS.

The NHS Five Year Forward View articulates why change is urgently needed, what that change might look like and how it can be achieved. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Furthermore, it sets out the development of new organisational models. C&M is keen to be an early implementer and a test bed for new, innovative approaches of delivering new models of integrated health and social care which reflect the needs of local populations.

5 What - Scope

The scope is comprehensive and will involve the whole health and care system:

- Hospital (acute) care (including specialised services);
- Primary care (including management of GP contracts);
- Community services;
- Mental health services(including specialised services);
- Social care;
- Public Health;
- Health and Wellbeing; 1 x CHAMPS representative
- Health Education;
- Research and Development;

The key enablers of transformation will include changes to:

- Governance and regulation;
- Resources and Finance;
- Capital and Estate;
- Workforce;
- Communication and Engagement;

- Information sharing and systems, including the potential for digital integration across C&M.

A road map will be developed which sets out the key changes to be delivered by C&M and its national partners. This will be supported by robust governance arrangements and a clear delivery plan. By working together, NHS England and C&M will be able to fully understand and manage risk together.

A programme of work will be agreed by the parties, see **Appendix G**. This will include, programme by programme, consideration of the governance framework and ensuring the work programme as a whole is fully aligned with the 5YFV.

6 Aim – Designing and Implementing the Changes

In support of implementation, NHSE will actively lead and facilitate the links to other national bodies/ALBs (e.g. DH, NHSI and HEE) to help all key bodies align to achieve the intent of this MoU. In this context, NHSE is committed to working with C&M in pursuit of the aims of the portfolio of programmes.

All programmes should be subject to a gateway process, either as part of their own governance regime or as invoked on behalf of the 5YFV assurance framework. This will allow all stakeholders to understand at exactly which point in the programme cycle each programme has attained and the next steps.

Prior to implementation, all programme design processes will need to show evidence that they have been fully and transparently consulted with all stakeholders – and where necessary publicly consulted – and feedback completed before options are selected and implementation commences.

To this end, all parties acknowledge their various requirements to engage with patients, service users, carers and members of the public at relevant points and will cooperate to do so in a co-ordinated way. The C&M 5YFV Communications and Engagement Strategy will be agreed, and its delivery monitored, by the 5YFV Working Group.

7 Resources and Appointments

The C&M 5YFV requires a minimum level of resource to build the leadership and management capacity to govern, administer, assure and direct the actions required to assure and underpin delivery of the portfolio of programmes. In the first year of operation, with the emerging scope and priorities of 5YFVs being set by NHSE and ALBs, it was necessary to raise modest funds from NHS organisations on an ad-hoc basis. In future years, FY17/18 onwards, the C&M 5YFV (including PMO) budget will be planned and agreed before the commencement of each financial year.

In line with best practice, appointments to all senior positions of the C&M 5YFV/LDS structure will be appointed by the 5YFV Membership Group, 5YFV Lead and LDS memberships. The following positions in the 5YFV and LDS leadership, governance and programme roles will be recruited to under the auspices of the 5YFV Membership Group and 5YFV Lead:

- Membership Group will appoint:
    - Chair of the C&M 5YFV Membership Group
    - 5YFV Lead
- 5YFV Lead (with Working Group colleagues) will appoint:
    - 5YFV Finance Director
    - 5YFV Portfolio Director
    - 5YFV Communications and Engagement Director
- LDS Memberships (Alliance, Cheshire & The Wirral, North Mersey) will appoint:
    - LDS Lead

Appendix H describes these 5YFV budget and recruitment processes.

8 Ratification

C&M partners will be requested to formally ratify this C&M 5YFV MoU through Boards and Councils and consult on its content with stakeholders as appropriate.

Each organisation commits to fully engage in and support the work of the C&M 5YFV, and to effectively manage the balance between the sustainability of their organisation and that of the C&M health economy.

Appendix A: C&M 5YFV Charter

Working DRAFT v0.4 12 Jan 17

Cheshire and Merseyside 5YFV Membership Group

Charter

This charter is entered into by the membership of the Cheshire and Merseyside Five Year Forward View footprint No.8 Northern Region.

The Charter enshrines the following principles, which will support the objective of implementing the 5YFV for C&M, with all members:

1. Acting in good faith to mutually support all transformational efforts across the 5YFV footprint and maintain and promote the potential of the C&M footprint

2. Bringing all issues into the 5YFV forums in an open and transparent way to ensure that all of the collaborative partners have an opportunity to discuss

3. Showing consistency of purpose in enacting all planning agreements both within and outside the 5YFV governance structures

4. Upholding the standards set out in national guidance and those of the NHS Constitution underpinning the delivery of social care and public health services

5. Making timely decisions that are 'programme-led' and focussed on the interests and outcomes for patients and people

6. Communicating and engaging with patients, carers and the public during the different stages of development and implementation

7. Applying the principle of subsidiarity, ensuring that place based decisions are made at the most appropriate level

8. Sharing all data, information and knowledge that will benefit the sponsorship and establishment of new programmes of change

9. Aligning and phasing the portfolio of programmes to underpin delivery of the NHS Five Year Forward View (2014) including a financially sustainable landscape

10. Working expeditiously to access any new or additional health and/or social care funding streams that become available

Appendix B: Parties to the C&M 5YFV MoU

The local, statutory architecture for health and care remains, as do the existing accountabilities for Chief Executives of provider organisations and Accountable Officers of CCGs[6]. Organisations are still accountable for their individual organisational plans, which should form part of the first year of their footprint's Plan. As such, there is no delegation of powers to the (C&M Five Year Forward View) framework and any financial commitments will need to be agreed through collaborative agreement and change programme structures.

Local Authorities

Cheshire East Council
Cheshire West and Chester Council
Halton Borough Council
Knowsley Borough Council
Liverpool City Council
Sefton Council
St Helens Council
Warrington Borough Council
Wirral Council

Clinical Commissioning Groups

NHS Eastern Cheshire CCG
NHS Halton CCG
NHS Knowsley CCG
NHS Liverpool CCG
NHS South Sefton CCG
NHS Southport and Formby CCG
NHS South Cheshire CCG
NHS St Helens CCG
NHS Vale Royal CCG
NHS Warrington CCG
NHS West Cheshire CCG
NHS Wirral CCG

Specialised Commissioning
NHS England Regional Specialised Team (North)

NHS Providers
Aintree University Hospital NHS Foundation Trust
Alder Hey Childrens NHS Foundation Trust
5 Boroughs Partnership NHS Foundation Trust
Bridgewater Community Healthcare NHS Foundation Trust
Cheshire and Wirral Partnership NHS Foundation Trust
The Clatterbridge Cancer Centre NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust
East Cheshire NHS Trust
Liverpool Heart and Chest NHS Foundation Trust
Liverpool Women's NHS Foundation Trust
Mersey Care NHS Foundation Trust
The Mid Cheshire Hospitals NHS Foundation Trust
Royal Liverpool and Broadgreen University Hospitals NHS Trust
St Helens and Knowsley Teaching Hospitals NHS Trust
Southport and Ormskirk Hospital NHS Trust
The Walton Centre NHS Foundation Trust
Warrington and Halton Hospitals NHS Foundation Trust
Wirral Community NHS Foundation Trust
Wirral University Teaching Hospital NHS Foundation Trust

[6] NHSE Website, 5YFV Pages

Appendix C: Membership Agreement

Working DRAFT v0.4 12 Jan 17

Cheshire and Merseyside 5YFV Membership Group

Membership Agreement

Introduction

This agreement is entered into by the membership of the Cheshire and Merseyside Five Year Forward View (5YFV) footprint No.8 Northern Region.

The NHS Shared Planning Guidance asked every health and care system to come together to create their own ambitious local blueprint for **accelerating implementation of the Five Year Forward View (5YFV)**. The 5YFVs will be place-based, multi-year plans built around the needs of local populations[7]. The guidance went on to state that this will require a different type of planning process – one that releases energy and ambition and that focusses the right conversations and decisions. It will require the NHS, at both the local and national level, to work in partnership across organisational boundaries and sectors[8].

The Cheshire and Merseyside membership recognises that building the relationships and collective leadership needed to make 5YFVs real will take dedicated time, effort and resource. Each footprint will need to set out governance arrangements for agreeing and implementing a plan[9]. The aim should be to produce a 5YFV that is based upon strong analysis and insight rather than a glossy brochure. The process of exposing these issues and having real conversations about the potential benefits for patients is as least as important as the final product itself. A robust process will enable 5YFVs to set out the actions that will make a difference for local people rather than abstract principles or vision statements[10].

This document sets out how the Cheshire and Merseyside 5YFV will work in practice; emphasising the primacy of delivering programmes of change on the ground and explaining how the 'function' of delivering that change will lead, with the 'form' of the governance and decision making tailored to support and facilitate that function.

Governance

The footprints do not replace other local NHS governance structures. NHSE is clear on this point: the local, statutory architecture for health and care remains, as do the existing accountabilities for Chief Executives of provider organisations and Accountable Officers of CCGs. This is about ensuring that organisations are able to work together at scale and across communities to plan for the needs of their population, and help deliver the Five Year Forward View – improving the quality of care, health, and NHS efficiency by 2020/21.

[7] Letter Stevens et al, p1, dated 16 Feb 16
[8] Letter Stevens et al, p2, dated 16 Feb 16
[9] Letter Stevens et al, Annex A, p1, dated 16 Feb 16
[10] Letter Stevens et al, Annex A, p4, dated 16 Feb 16

Organisations are still accountable for their individual organisational plans, which should form part of the first year of their footprint's 5YFV[11].

Therefore, the Cheshire and Merseyside 5YFV relies upon the collaborative spirit that the members bring to the joint planning effort, the behaviours that allow new levels of insight and open up new opportunities across the wider footprint. To enable these conversations to be all inclusive, a Membership Group has been established to represents the interests of all NHS bodies through the offices of Chief Executives of provider organisations and Accountable Officers of CCGs, as well as the interests of all Local Authorities as represented by Chief Executives. To streamline the effort and make meeting time more efficient, the smaller Cheshire and Merseyside 5YFV Working Group acts of behalf of the Membership Group to steer the planning process thought the design phase.

In scope: the governance will include the sponsorship of programmes of work in so far as this extends to developing ideas – of strategic value - into designs that can then be 'endorsed' for consideration and implementation by LDSs and/or individual Trusts. It will monitor the decision making processes across LDSs/Trusts with a view to monitoring the progress of the portfolio of programmes through 'gated' checkpoints (while the responsibility for driving the programmes remains with the teams at LDS/Trust level). The governance will also include, as it has from the inception of the 5YFV, interaction with NHSE/NHSI and ALBs in terms of the aggregate reporting of progress and assurance to these highest level sponsors of the 5YFV; this will include management of the overall financial sustainability picture through management of the 5YFV template. Finally, the strategic communications and engagement planning will be overseen at this level of the 5YFV but with the maximum flow-down of communications products to LDS/Trust level for them to engage at locality level.

Out of scope: Simply put, the governance will not make any decisions concerning programme design 'sign-off' nor implementation; these decisions are for the LDS(s) and Trusts who are party to those programmes. Thus, it is 100% of decision making that will be based around the delivery and benefits on a programme by programme basis. This simple logic follows the principle at the heart of the collaboration that the 5YFV is no more than the sum (and strength) of its parts and that it will be led by the 'function' of delivering programmes (place based) to close the 3 gaps that lie at the centre of the 5YFV.

Decision Making

It follows, given the scale of the Cheshire and Merseyside 5YFV footprint, that a large proportion of the programmes of work that comprise the 5YFV will be decided by individual organisations. In these cases the role of the 5YFV is to highlight any further opportunities that those Trusts may consider by making those programmes of work coherent across a wider geography. However, these would be proposals offered by the Working Group for the consideration of the organisations concerned.

At another level there will be a significant number of larger programmes initiated, designed and implemented by groups of organisations within Local Delivery Systems (LDS). Again, the role of the 5YFV will be to highlight any further opportunities that the LDS(s) may wish to consider by making those programmes of work coherent across a wider geography. Again, these would be proposals offered by the Working Group for the consideration of the LDS(s) concerned.

[11] 'Frequently asked questions – 5YFVs' page of the NHS England website visited 14 Nov 16 https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/5YFV/faqs/

Finally, where a programme arises from design work sponsored by the 5YFV Working Group, and where that involves a Cheshire and Merseyside wide solution to be implemented, then there will need to be a decision referred to every organisation (with a clear stake/interest in that programme) for them to agree to the design proposal and the plans for implementation.

At all stages of programmes, and at each of the 3 levels described above, all current policy and protocols regarding best practice engagement and, where appropriate, public consultation will be adhered to by all organisations.

Thus, the decisions making will be 'programme-led' and always default to the single or multi-organisational authority to agree the design and implementation of solutions and lead any consultation.

Assurance

The Cheshire and Merseyside Five Year Forward View, No.8 Northern Region, is being requested to assure the conception and delivery of the entire range of programmes (in 5YFV scope) to close the 3 gaps highlighted in the 5YFV. Therefore, the 5YFV Working Group will agree with NHSE Regional authorities how an 5YFV programme assurance framework can be woven into the existing assurance mechanisms. This will avoid the need for any parallel assurance vehicle and place the assurance authority within the usual regulatory framework.

The framework will be based upon the principles of the recognised public sector programme management standard 'Managing Successful Programmes' and seek evidence to assure the collaboration that each programme has: an effective team; scope clearly defined; benefits defined and measurable; milestone plan tracked; stakeholders mapped and engaged; risks identified and managed; and equality assessments and quality impact assessments completed.

A commonly held and robust approach to the key tenets of sound programme management is an essential (but not sufficient) component of successful delivery. Holding to the assurance framework will provide the collaborative with leading indicators of the level of confidence in delivery.

Risk

The balance of risk and reward for each programme, as part of the normal benefits planning process, will be calculated and made transparent within the programme documentation. The organisations involved in each programme – whether individual organisation, LDS collaboration or 5YFV wide – will need to sign off on the risk profile which should include any arrangements for specific financial flows that would be related to implementation. As described in the assurance process, the programme will be expected to run a dynamic risk management and mitigation process throughout the lifecycle of the programme.

Resource

The Membership and Working Group will commit such human and financial resources as are required to ensure that the governance, assurance and decision making at the top

level of the C&M 5YFV is fairly and reasonably supported and able to discharge it responsibilities without detriment to any particular Commissioning Group, Local Authority, NHS Trust or individual office.

As previously stated, there is no delegation of powers to the C&M 5YFV framework and any such financial commitments will need to be agreed through collaborative agreement and change programme structures.

Annex E: C&M 5YFV Membership Group ToRs

Cheshire and Merseyside 5YFV Membership Group
Terms of Reference

Constitution: The members of the Cheshire & Merseyside (C&M) Five Year Forward View (5YFV) hereby resolve to establish a committee of the membership to be known as the 5YFV Membership Group.

Purpose: The purpose of the Membership Group is to maintain the overall 5YFV leadership and governance for Cheshire and Merseyside. This will include:

- Enabling the C&M system to manage and resolve key issues relating to the delivery of the Five Year Forward View (5YFV) for the NHS (2014).
- Establishing an effective and joined up approach from the C&M Health and Social Care economy organisations to the co-ordination and delivery of the 5YFV.
- Enhancing the ability of C&M organisations to speak with one voice to national, regional and local bodies.
- Continue and enhance collaboration on areas that are of benefit to the effective and efficient commissioning of health services in C&M.

These Terms of reference should be read in conjunction with the 5YFV Membership Agreement and 5YFV Charter.

Membership: The 5YFV Membership Group shall consist of:

- Chair – Appointed by the Membership Group
- 5YFV Lead
- Chief Executive or Chief Officer or Chair of each of the 40 member organisations.
- 1 x Specialised Commissioner

Members are expected to attend each meeting of the Membership Group; members who cannot attend should ensure that their nominated deputy is in attendance.

Attendance: Each 5YFV Membership Group meeting will require the attendance of:

- NHSE DCO
- NHSI Delivery & Improvement Director
- 1 x CHAMPS representative
- 5YFV Programme Director
- 5YFV Finance Director

- 5YFV Communications Director

Quorate: A quorum shall be 21 members and include at least three from each LDS.

Wider Attendance: Invitees to the 5YFV Membership Group on an 'as required basis' would include, but not be limited to, the following:

- SROs of the 5YFV 'Cross-cutting themes' (including 5YFV representing primary care)
- Leads of the 5YFV 'Enabling Themes'
- Chair of the C&M Clinical Senate
- HEE
- NWLA
- NWAHSN

The Chair of the 5YFV Membership Group reserves the right to invite other colleagues from local government/NHS to attend for particular items.

Frequency: Meetings shall be held every 3 months unless advised otherwise.

Authority and Decision Making: The 'authority' of the 5YFV Membership Group is derived directly from the MoU and 5YFV Membership Agreement, as follows:

In scope: the governance will include delegation to the 5YFV Working Group the authority to sponsor programmes of work in so far as this extends to developing ideas - of strategic value - into designs that can then be 'endorsed' for consideration and implementation by LDSs and/or individual Trusts.

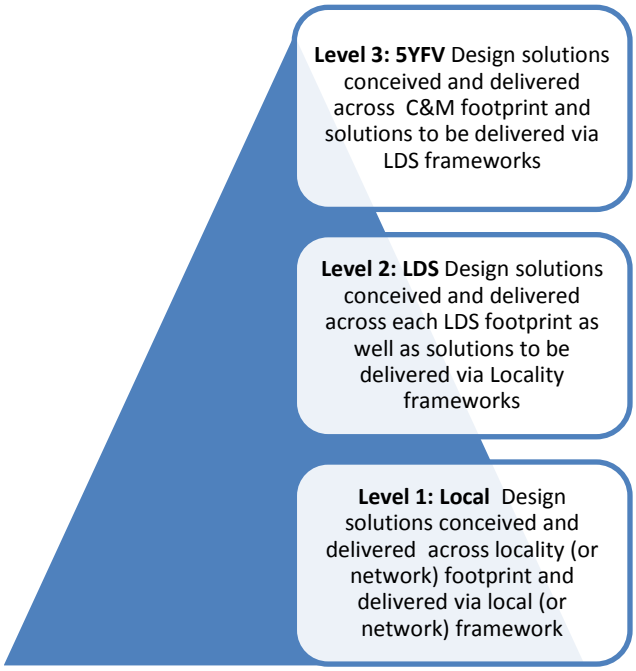
The governance will also include, as it has from the inception of the 5YFV, delegation to the Working Group responsibility for the frequent interaction with NHSE/NHSI and ALBs in terms of the aggregate reporting of progress and assurance to these highest level sponsors of the 5YFV; this will include management of the overall financial sustainability picture through management of the 5YFV template.

Finally, the delegation to the Working Group of the strategic communications and engagement planning with the maximum flow-down of communications products to LDS/Trust level for them to engage at locality level.

Out of scope: Simply put, the governance will not make any decisions concerning programme design 'sign-off' nor implementation; these decisions are for the LDS(s) and Trusts who are party to those programmes. Thus, it is 100% of decision making that will be based around the delivery and benefits on a programme by programme basis. This simple logic follows the principle at the heart of the collaboration that the 5YFV is no more than the sum (and strength) of its parts and that it will be led by the 'function' of delivering programmes (place based) to close the 3 gaps that lie at the centre of the 5YFV.

Decisions will be made at the appropriate level of the '5YFV' framework recognizing that the majority of decisions will be made at Trust and LDS

Levels and be based around the content of specific programmes that stakeholders agree to deliver together (or individually). This principle of subsidiarity means that decisions around the delivery of the closure of the three gaps - health & wellbeing, quality of care and financial sustainability – are decisions that will be taken at the lowest possible level or closest to where they will have their effect, for example in a local area rather than for the whole C&M footprint (or an individual organisation rather than a locality) whenever that is most appropriate. It follows that programme decisions at the C&M level will be the exception rather than the rule. The diagram below illustrates the principle:



In terms of decisions concerning the agreement of, and recruitment to, the 5YFV management & leadership and programme structures – with the exception of the Chair of the Membership Group and 5YFV Lead – all collaborative decisions will be delegated to the 5YFV Working Group/LDSs.

Duty: The duty of the 5YFV Membership Group is to ensure that organisations are able to work together at scale and across communities to plan for the needs of their population, and help deliver the Five Year Forward View – improving the quality of care, health, and NHS efficiency by 2020/21. Organisations are still accountable for their individual organisational plans, which should form part of the first year of their footprint's 5YFV[12].

Reporting: The notes of the 5YFV Membership Group shall be recorded; moreover, specific items for information/action will form part of communications bulletins to the membership.

[12] 'Frequently asked questions – 5YFVs' page of the NHS England website visited 14 Nov 16 https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/5YFV/faqs/

Approved by:	5YFV Membership Group
Version:	Issue 7.0
Date:	January 2017
Review Date:	March 2018

Cheshire and Merseyside 5YFV Working Group
Terms of Reference

Constitution: The Cheshire & Merseyside (C&M) Five Year Forward View (5YFV) Membership Group hereby resolves to establish a representative committee to be known as the 5YFV Working Group.

Purpose: The purpose of the Working Group is to maintain the overall 5YFV documents and financial model for Cheshire and Merseyside. It will initiate and sponsor programmes of design work at the 5YFV level for implementation by the Local Delivery Systems. It will establish the governance (both what is in and out of scope) of the C&M 5YFV construct and be explicit about how the 5YFV works. It will work with NHSE to develop an assurance mechanism to generate confidence in delivery by use of a dashboard showing leading indicators of programme progress. It will work with the membership to secure the resources to maintain the necessary 5YFV level capabilities on behalf of the membership (in a lean model).

These Terms of Reference should be read in conjunction with the 5YFV Membership Agreement and 5YFV Charter.

Membership: The 5YFV Working Group shall consist of:

- Chair – 5YFV Executive Lead for C&M
- Alliance LDS: Senior Responsible Owner, NHS provider rep, NHS commissioner rep, LA rep
- C&W LDS: Senior Responsible Owner, NHS provider rep, NHS commissioner rep, LA rep
- North Mersey LDS: Senior Responsible Owner, NHS provider rep, NHS commissioner rep, LA rep
- 4 x Work Stream Leads for the 5YFV 'Strategic Aims'
- 1 x Specialist Commissioner
- 1 x CHAMPS representative.
- The Chair of the C&M Membership Group

Members are expected to attend each meeting of the Working Group; members who cannot attend should ensure that their nominated deputy is in attendance.

Attendance: Each 5YFV Working Group meeting will require the attendance of:

- NHSE DCO
- NHSI Delivery & Improvement Director
- 5YFV Programme Director
- 5YFV Finance Director

- 5YFV Communications Director
- LDS PMO Leads

Quorate: A quorum shall be 10 members and include at least one from each LDS.

Wider Attendance: Invitees to the 5YFV Working Group on an as required basis would include, but not be limited to, the following:

- SROs of the 5YFV 'Cross-cutting themes' (including 5YFV representing primary care)
- Leads of the 5YFV 'Enabling Themes'
- Chair of the C&M Clinical Senate
- HEE
- NWLA
- NWAHSN

The Chair of the 5YFV Working Group reserves the right to invite other colleagues from local government/NHS to attend for particular items.

Frequency: Meetings shall be held every two weeks unless advised otherwise.

Authority: The 'authority' of the 5YFV Working Group is derived directly from the 5YFV Membership Agreement, as follows:

In scope: the governance will include the sponsorship of programmes of work in so far as this extends to developing ideas – of strategic value - into designs that can then be 'endorsed' for consideration and implementation by LDSs and/or individual Trusts. It will monitor the decision making processes across LDSs/Trusts with a view to monitoring the progress of the portfolio of programmes through 'gated' checkpoints (while the responsibility for driving the programmes remains with the teams at LDS/Trust level). The governance will also include, as it has from the inception of the 5YFV, interaction with NHSE/NHSI and ALBs in terms of the aggregate reporting of progress and assurance to these highest level sponsors of the 5YFV; this will include management of the overall financial sustainability picture through management of the 5YFV template. Finally, the strategic communications and engagement planning will be overseen at this level of the 5YFV but with the maximum flow-down of communications products to LDS/Trust level for them to engage at locality level.

Out of scope: Simply put, the governance will not make any decisions concerning programme design 'sign-off' nor implementation; these decisions are for the LDS(s) and Trusts who are party to those programmes. Thus, it is 100% of decision making that will be based around the delivery and benefits on a programme by programme basis. This simple logic follows the principle at the heart of the collaboration that the 5YFV is no more than the sum (and strength) of its parts and that it will be led by the 'function' of delivering programmes (place based) to close the 3 gaps that lie at the centre of the 5YFV.

Duty: The duty of the 5YFV Working Group is to ensure that organisations are able to work together at scale and across communities to plan for the needs of their population, and help deliver the Five Year Forward View – improving the quality of care, health, and NHS efficiency by 2020/21. Organisations are

still accountable for their individual organisational plans, which should form part of the first year of their footprint's 5YFV[13]

The 5YFV Working Group will from an 'Executive Group' from its members – comprising the 5YFV Lead, 3 LDS Leads, and Chair of the Membership Group, to address such decisions, risks and issues that may need to be addressed outside the Working Group or which the Working Group is unable to resolve in the first instance. Any issues not resolved by the Executive Group will need to be referred to the wider 5YFV Membership for resolution.

Reporting: The notes 5YFV Working Group shall be recorded. The notes would not normally be reported to the 5YFV Membership Group; however, specific items for information/action will form part of communications bulletins to the wider membership.

Approved by: 5YFV Membership Group
Version: Issue 7.0
Date: January 2017
Review Date: April 2018

[13] 'Frequently asked questions – 5YFVs' page of the NHS England website visited 14 Nov 16 https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/5YFV/faqs/

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(17)021

Title of paper: DoH Loan Conversion

Purpose: To report to the Trust Board on the conversion of the Trust loan facility on 15 February 2107

Summary:

The Trust had access to an Interim Working Capital Loan facility (IRWCF) of £7.444m which the Board signed up to in March 2016. The facility bore an interest charge of 3.5% and the Trust could draw down advances as needed to a limit of £7.444m and any loans taken out would have to be repaid in full by 18th February 2021.

At the end of January, the Trust had an outstanding balance of £2.525m, an advance against the Q3 STF income which has to be repaid when the Trust receives it (NHSI has advised Trusts to expect receipt in March although it may be February). The Trust was not guaranteed to be able to access any further longer-term loan advances unless its cash situation considerably deteriorated.

For any Trust currently projecting to achieve its I&E control total in 2016/17, the DH offered to convert the outstanding IRWCF loan to a "revenue support loan facility" (RSLF). This carries the same additional terms and conditions as in the IRWCF loan agreement but has the following key operational changes:

(i) The RSLF loan bears a reduced interest charge of 1.5%

(ii) The final repayment date is 18th January 2020

(iii) The Trust would no longer have to manage its month-end cash balances between a minimum and maximum cash balance (currently £1.489m and £7.444m respectively)

If the Trust required a further loan going forward it would have to apply and justify the need for it and would require a board resolution for each new loan. Converting the balance to an RSLF gives the Trust more control over when it has to pay this back and therefore will help the Trust's cash resilience in the meanwhile. The completed paperwork had to be with the DH by Tuesday 31st January, which consisted of a Board Resolution letter, a signed conversion loan variation letter and a signed conversion loan agreement and was approved through a Chairman's action.

We now need to forward a Board Resolution minute to the DoH, a draft of which is attached as Appendix 1.

Corporate objectives met or risks addressed: Finance and Performance duties

Financial implications: Achievement of Statutory Duties

Stakeholders: Trust Board Members

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

Presenting officer: Denis Mahony Non-Executive Director

Date of meeting: 22nd February 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

Board Resolution

Statement from the Chair and Chief Executive of St Helens and Knowsley Teaching Hospitals NHS Trust regarding the Trust Board approval of the conversion of the Trust's current Single Currency Interim Revolving Working Capital Support Facility (IRWCF), ref: DHPF/ISRWF/RBN/2016-03-04/A, to a Single Currency Interim Revenue Support Facility (RSF), ref: DHPF/ISWBL/RBN/2017-01-12/A and the transfer of its outstanding loan balance of £2,525,000 drawn against its IRWCF to the new RSF.

Due to time constraints a decision was taken under Chairman's Action on behalf of the Board on 31st January 2017, as permitted in the Trust's Standing Financial Instructions, to accept and agree the above loan conversion and transfer and relevant documents were forwarded to the Department of Health on the same day to facilitate this.

A paper was presented to the Finance and Performance Committee on the 16th February 2017 and the Board on the 22nd February 2017 for scrutiny regarding the loan conversion and balance transfer, recommending ratification of the decision taken under Chairman's Action.

We, the Board, confirm that we have ratified the decision made under Chairman's Action on 31st January 2017, thereby approving the conversion of its existing IRWCF to the new RSF and transferring the balance of £2,525,000 (being repayable by 18th January 2020).

In line with Schedule 1 of the conversion loan agreement (henceforth referred to as the Finance Documents), we also:

a) Approve the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;

b) authorise Ms Ann Marr, Chief Executive Officer, to execute the Finance Documents to which it is a party on its behalf; and

c) authorise Mr Nikhil Khashu (Director of Finance), Mrs Sue Hill (Deputy Director of Finance) and Mr David Brimage (Assistant Director of Finance) to sign and/ or dispatch all documents and notices (including Utilisation Requests) in connection with the Finance documents to which it is a party on its behalf.

d) Confirm our undertaking to comply with the Additional Terms and Conditions.

We certify that a paper has been presented to the Finance and Performance Committee and the Trust Board for scrutiny regarding the proposed Finance Documents and that this has been circulated to all Trust Board members.

Mr R Fraser, Chair, St Helens and Knowsley Teaching Hospitals NHS Trust

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Ms A Marr, Chief Executive, St Helens and Knowsley Teaching Hospitals NHS Trust

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Dated: 22nd February 2017