St Helens and Knowsley Teaching Hospitals NHS Trust

Trust PublicBoard Meeting

TO BE HELD ON WEDNESDAY 25TH JANUARY 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	December		
		1.1	January		
09:40	2.	Patient Story			Sue Redfern
10:00	3.	Apologies for Absence			Richard Fraser
	4.	Declaration of Interests			
	5.	Minutes of the previous Meeting held on 30th November 2016		Attached	
		5.1	Correct record & Matters Arising		
		5.2	Action list	Attached	
Performance Reports					
10:10	6.	Integrated Performance Report		NHST(17) 001	Nik Khashu
		6.1	Quality Indicators		Sue Redfern
		6.2	Operational indicators		Rob Cooper
		6.3	Financial indicators		Nik Khashu

		6.4	Workforce indicators		Anne-Marie Stretch
10:25	7.	Safer Staffing report		NHST(17) 002	Sue Redfern
10:35	8.	Complaints, Claims & Incidents		NHST(17) 003	Sue Redfern
10:45	9.	Risk Report including Board Assurance Framework		NHST(17) 004	Sue Redfern
10:55	10.	HR Indicators		NHST(17) 005	Anne-Marie Stretch
BREAK					
Committee Assurance Reports					
11:15	11.	Committee report – Executive		NHST(17) 006	Ann Marr
11:20	12.	Committee Report – Quality		NHST(17) 007	David Graham
11:25	13.	Committee Report – Finance & Performance		NHST(17) 008	Denis Mahony
Other Board Reports					
11:30	14.	FT programme update report		NHST(17) 009	Nik Khashu
11:40	15.	Research Capability statement		NHST(17) 010	Kevin Hardy
11:45	16.	Safeguarding report (Adults/Children)		NHST(17) 011	Sue Redfern
Closing Business					
11:55	17.	Effectiveness of meeting			Richard Fraser
	18.	Any other business			
	19.	Date of next Public Board meeting – Wednesday 22nd February 2017			
LUNCH					

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 25th JANUARY 2017

No	Minute	Action	Lead	Date Due
1.	26.10.16 (5.3.1)	Paper to be presented by Anne-Marie Stretch at November Board regarding agency usage/spend. **Agenda item.**	AMS	Action closed
2.	26.10.16 (10.2)	Sue Redfern to report back to the Board regarding complaint responses and standards.	SR	25 Jan 17
3.	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
4.	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.	SR	22 Feb 17
5.	30.11.16 (9.6)	Endoscope decontamination incident: Sue Redfern will present the investigation report once completed.	SR	22 Feb 17

Paper No: b l {¢ómtúллм
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

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

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

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

Patient Safety, Patient Experience and Clinical Effectiveness

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

There has been 1 never event during 16/17 (August).

YTD there has been two cases of MRSA bacteraemia.

There was 1 C.Difficile (CDI) positive cases in December. Year to date there have been 18 confirmed positive cases. The annual tolerance for 2016-17 is 41 cases.

YTD there have been no hospital acquired grade 3 / 4 pressure ulcers.

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

Performance for VTE assessment for November was 95.02% achieving the required target.

The YTD HSMR is 103.2.

The overall nurse/midwife Safer Staffing fill rate for November was 95.4%

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: нpúK Wl-yđzl-Wè нлмт

Operational Performance

A&E performance was 74.0% (type 1) and 83.9% (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 3 areas in both the Emergency Department and the Inpatient wards

Emergency Department key actions:
1. Immediate improvement to ED processes.
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.
2. Senior daily review and escalation for patients who no longer need care in an acute bed.
3. Expected number of discharges by ward to be re-set using expected LOS rather than historic performance

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 (92.1%) but remains a challenge.
Specialty level actions to address this continue, including ongoing data quality of referrals , targeted backlog clearance and collaborative working with the CCG to improve the quality and effectiveness of patient referral pathways.
The number of reportable cancelled operations increased significantly in month (1.4%) due to an incident on the St Helens site which led to 33 cases being cancelled in one day. The cause has been rectified and the patients relisted.
All other key national access targets were achieved in month.

Financial Performance

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

Income & Expenditure

As at the month of December 2016 (Month 9) the Trust is reporting an overall Income & 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. 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 £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 and is also part of the Operational Transformation Group agenda.
Capital - Capital expenditure to date is £2.695m out of a revised year forecast total of £4.582m.
Cash - Cash balance at the end of December 2016 is £1.573m which equates to 2 operating days.

Human Resources

Mandatory training compliance remains 6.8 % above target at 91.8%. Appraisal compliance for December is 79%. The situation is being managed to recover to 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

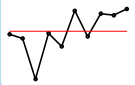
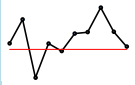
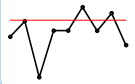
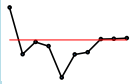
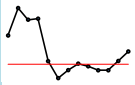
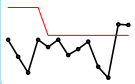
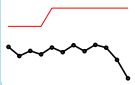
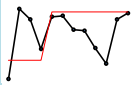
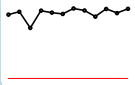
The Trust exceeded the CQUIN flu vaccination target of 75% and is currently at 81% vaccination rate of frontline staff.

The following key applies to the Integrated Performance Report:

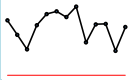
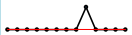
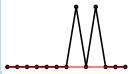
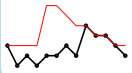
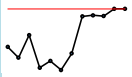
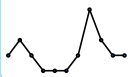
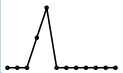
▲ = 2016-17 Contract Indicator
▲£ = 2016-17 Contract Indicator with financial penalty
● = 2016-17 CQUIN indicator
T = Trust internal target

Dec-16

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

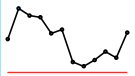
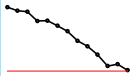
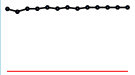
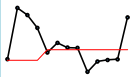
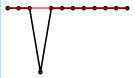
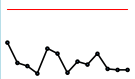
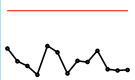
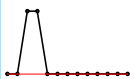
	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 30-34)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Dec-16	2.7%	2.5%	No Target	2.5%		Overall SHMI and HSMR within control 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	▲	Sep-16	108.2	103.2	100.0	99.7					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Sep-16	101.9	111.1	100.0	112.9					
Readmissions: 30 day Relative Risk Score (HED)	Q	T	Aug-16	95.8	99.2	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	Sep-16	94.1	94.5	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	Sep-16	101.1	93.8	100.0	97.7					
% Medical Outliers	F&P	T	Dec-16	1.7%	0.9%	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	Dec-16	58.1%	45.7%	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	▲	Nov-16	70.9%	77.5%	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	▲	Nov-16	94.8%	91.3%	95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E)	Q	▲	Nov-16	99.2%	99.0%	95.0%	98.5%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

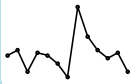
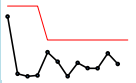
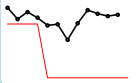
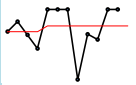
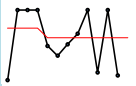
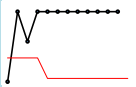
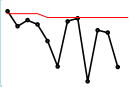
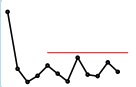
	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Dec-16	93.5%	94.2%	83.0%	92.0%		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	▲£	Dec-16	0	1	0	0		The National safety standards for invasive procedures will provide further mitigation against future never events.	Quality and patient safety	The RCA has been submitted and lessons learnt cascaded. Actions implemented include central line insertion check list	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Nov-16	99.2%	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	Dec-16	0	0	0	0		The trust continues to have no prescribing errors which cause serious harm. Trust has moved from being a low reporter of prescribing errors to a higher reporter - which is good.	Quality and patient safety	Intensive work on-going to reduce medication errors and maintain no serious harm. ePrescribing will be introduced, starting Spring 2017.	KH
Number of hospital acquired MRSA	Q F&P	▲£	Dec-16	0	2	0	0		There were no cases of MRSA bacteraemia and 1 C.Difficile (CDI) cases in December. YTD there have been 21 CDI cases, of which 3 cases have been successfully appealed. This gives 18 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	▲£	Dec-16	1	18	41	26					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Dec-16	0	14	No Target	28					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Nov-16	0	0	No Contract target	1		Pressure ulcer performance continues to improve. There have been no grade 3 or 4 ulcers reported YTD.	Quality and patient safety	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	▲	Nov-16	2	13	No Contract target	21		STHK harm from falls YTD is 0.142 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	▲£	Nov-16	95.02%	92.88%	95.0%	93.31%		VTE performance exceeded target this month.	Quality and patient safety	VTE solutions for all patients in all areas re-examined in November 2016. Work on targeting individual solutions to individual areas commenced November 2016. ePrescribing solution will resolve issue in 2017. Solutions to software interface issue being explored and manual work arounds in place.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Oct-16	2	16	No Target	38					
To achieve and maintain CQC registration	Q		Dec-16	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Nov-16	95.4%	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 January 2017	Quality and patient safety	Daily staffing huddles supported by escalation flow chart are in place. The Trust has an escalation protocol in place which includes Executive authorisation for requesting agency staff.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Nov-16	0	2	No Target	1					

Dec-16

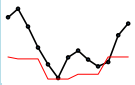
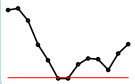
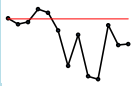
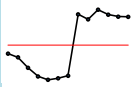
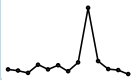
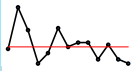
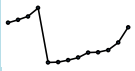
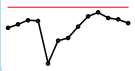
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 41-48)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Nov-16	96.0%	94.7%	93.0%	95.1%		Key access targets achieved	Quality and patient experience	A Programme approach is being utilised to monitor and improve the timeliness of the patients journey along the Cancer pathways.	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Nov-16	98.1%	98.0%	96.0%	97.8%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Nov-16	86.8%	88.6%	85.0%	88.6%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Dec-16	92.1%	92.1%	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 found but further required to decrease backlog and improve RTT position. GPSI not managing demand so referrals back to primary care for gynae, derm and ENT	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	▲	Dec-16	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Dec-16	1.4%	0.8%	0.8%	0.9%		Target underperformed in December due to a chemical incident in St Helens Hospital resulting in the cancellation of 33 patients on the day. 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	▲ £	Nov-16	100.0%	100.0%	100.0%	99.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Dec-16	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Dec-16	74.0%	76.5%	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	Immediate actions for recovery have been presented to the trust board which will focus on 3 key areas in both the Emergency Department and the Inpatient wards. Emergency Department key actions: 1. Immediate improvement to ED processes. 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. 2. Senior daily review and escalation for patients who no longer need care in an acute bed. 3. Expected number of discharges by ward to be re-set using expected LOS rather than historic performance. Continue work with system partners to achieve and maintain reduction in medically optimised patients.	RC
A&E: Total time in A&E: % < 4 hours (All Types)	F&P	▲	Dec-16	83.9%	85.4%	95.0%	89.4%					
A&E: 12 hour trolley waits	F&P	▲	Dec-16	0	0	0	2					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Nov-16	0	0	0	0		Increased demand for IP capacity has a direct bearing on the ability to maintain this quality indicator.	Patient Experience	Maintained focus and awareness of this issue across 24/7.	RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Dec-16	22	234	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	Dec-16	18	226	No Target	372					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Dec-16	61.1%	61.9%	No Target	42.7%					
Friends and Family Test: % recommended - A&E	Q	▲	Nov-16	86.5%	86.6%	90.0%	91.5%		For November the recommendation rates are 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 will be monitored via the Patient Experience Council monthly.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Nov-16	95.9%	95.3%	90.0%	96.4%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Nov-16	100.0%	98.1%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Nov-16	95.5%	97.7%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Nov-16	100.0%	100.0%	95.1%	95.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Nov-16	87.0%	91.9%	98.6%	98.6%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Nov-16	94.3%	94.3%	95.0%	94.7%					

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	▲	Dec-16	5.4%	4.8%	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	Dec-16	6.4%	5.8%	5.3%	6.0%					
Staffing: % Staff received appraisals	Q F&P	T	Dec-16	79.3%	79.3%	85.0%	87.2%		Mandatory Training compliance has remained consistent in month and continues to exceed the target by 6.8%. The fall in appraisal compliance has been halted and remains static in month at 5.7% behind target.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The L&OD team continue to work with managers to ensure that all non compliant staff receive an appraisal and are recorded on ESR . Appraisal data down to department level will be reviewed at the Executive Committee as a monthly standing item on the agenda to ensure an increased focus and oversight on the timely completion of appraisals. Managers of non compliant teams are being contacted in line with the Pay progression policy.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Dec-16	91.8%	91.8%	85.0%	77.6%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2	90.2%		No Contract Target			The Trusts Staff friends and family test results in Q2 focussed on the Surgical Care Group and remain positive. A significant number of staff continue to recommend the Trust as a place to receive care. There has however, been a reduction in the number of staff recommending the Trust as a place to work. The response rate was low but comparable to acute trusts nationally	Staff engagement, recruitment and retention.	Interrogation of the data to understand reasons for the reduction in staff recommending the Trust as a place to work has been completed, with actions forming the basis of a targeted action/ 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	Dec-16	0.6%		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	Dec-16	3.0	3.0	3.0			The Trust's year to date performance is slightly ahead of plan. The Trust has significant contractual agreements with other NHS organisations which may impact on our ability to achieve Better Payment compliance.	Financial	Adherence against the submitted plan and delivery of CIP. Maintaining control on Trust expenditure. Agreeing with Commissioners and NHSE a more advantageous profile for receipt of planned income.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Dec-16	10,783	10,783	15,248	13,043					
Reported surplus/(deficit) to plan (000's)	F&P	T	Dec-16	2,435	2,435	3,328	(9,551)					
Cash balances - Number of days to cover operating expenses	F&P	T	Dec-16	2	2	2	2					
Capital spend £ YTD (000's)	F&P	T	Dec-16	2,695	2,695	4,582	4,169					
Financial forecast outturn & performance against plan	F&P	T	Dec-16	3,328	3,328	3,328	(9,551)					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Dec-16	94.1%	94.1%	95.0%	94.2%					

APPENDIX A

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

			Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	2016-17 YTD	2016-17 Target	FOT	2015-16	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	100.0%	94.1%	95.8%	100.0%	100.0%	100.0%	87.5%	93.1%	89.3%	100.0%	100.0%	100.0%	100.0%	95.4%	85.0%		99.2%		
	Total > 62 days		0.0	0.5	0.5	0.0	0.0	0.0	1.5	1.0	1.5	0.0	0.0	0.0	0.0	4.0			1.0		
Lower GI	% Within 62 days	▲ £	100.0%	100.0%	89.5%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	93.3%	81.8%	71.4%	58.3%	86.8%	85.0%		94.5%		
	Total > 62 days		0.0	0.0	1.0	0.0	0.0	0.0	2.0	0.0	0.0	0.5	1.0	1.0	2.5	7.0			3.0		
Upper GI	% Within 62 days	▲ £	83.3%	100.0%	100.0%	100.0%	81.8%	75.0%	90.9%	0.0%	100.0%	100.0%	0.0%	85.7%	88.9%	85.2%	85.0%		88.9%		
	Total > 62 days		0.5	0.0	0.0	0.0	1.0	0.5	0.5	0.5	0.0	0.0	1.5	1.0	0.5	4.5			5.0		
Urological	% Within 62 days	▲ £	84.0%	79.2%	83.3%	83.3%	84.0%	85.7%	84.6%	81.3%	75.0%	79.3%	76.9%	96.2%	82.6%	82.3%	85.0%		80.8%		
	Total > 62 days		2.0	2.5	2.0	2.0	2.0	2.0	3.0	3.0	4.0	3.0	4.5	0.5	4.0	24.0			28.0		
Head & Neck	% Within 62 days	▲ £	100.0%	50.0%	57.1%	60.0%	50.0%	50.0%	100.0%	37.5%	71.4%	66.7%	100.0%	83.3%	50.0%	65.7%	85.0%		71.1%		
	Total > 62 days		0.0	1.0	1.5	1.0	0.5	0.5	0.0	2.5	1.0	0.5	0.0	0.5	1.0	6.0			6.5		
Sarcoma	% Within 62 days	▲ £			100.0%		100.0%		85.7%			100.0%			100.0%	88.9%	85.0%		87.5%		
	Total > 62 days				0.0		0.0		0.5			0.0			0.0	0.5			0.5		
Gynaecological	% Within 62 days	▲ £	54.5%	50.0%	60.0%	66.7%	71.4%	66.7%	81.8%	100.0%	85.7%	92.3%	33.3%	100.0%	91.7%	87.9%	85.0%		76.4%		
	Total > 62 days		2.5	1.5	1.0	0.5	1.0	0.5	1.0	0.0	0.5	0.5	1.0	0.0	0.5	4.0			8.5		
Lung	% Within 62 days	▲ £	80.0%	100.0%	90.5%	100.0%	88.2%	66.7%	81.5%	90.0%	91.7%	82.6%	100.0%	80.0%	87.5%	84.2%	85.0%		86.5%		
	Total > 62 days		1.0	0.0	1.0	0.0	1.0	1.0	2.5	0.5	0.5	2.0	0.0	1.0	0.5	8.0			10.5		RC
Haematological	% Within 62 days	▲ £	80.0%	66.7%	83.3%	50.0%	86.7%	100.0%	100.0%	0.0%	50.0%	50.0%	100.0%	100.0%		73.5%	85.0%		70.5%		
	Total > 62 days		1.0	1.0	1.0	2.0	1.0	0.0	0.0	2.5	3.0	1.0	0.0	0.0		6.5			13.0		
Skin	% Within 62 days	▲ £	95.9%	95.3%	94.4%	92.5%	96.7%	97.5%	96.0%	100.0%	97.3%	93.7%	95.7%	92.6%	97.4%	96.0%	85.0%		94.5%		
	Total > 62 days		1.0	1.0	0.5	1.5	0.5	0.5	1.0	0.0	0.5	2.0	1.0	2.0	0.5	7.5			13.0		
Unknown	% Within 62 days	▲ £	100.0%	33.3%	100.0%		50.0%		100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	85.0%		83.3%		
	Total > 62 days		0.0	1.0	0.0		0.5		0.0	0.0	0.0	0.0	0.0			0.0			1.5		
All Tumour Sites	% Within 62 days	▲ £	89.3%	86.9%	87.9%	90.1%	89.5%	91.8%	88.0%	87.5%	85.8%	89.4%	87.9%	92.1%	86.8%	88.6%	85.0%		88.6%		
	Total > 62 days		8.0	8.5	8.5	7.0	7.5	5.0	12.0	10.0	11.0	9.5	9.0	6.0	9.5	72.0			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%							100.0%	85.0%		100.0%		
	Total > 31 days		0.0	0.0					0.0							0.0			0.0		
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				

TRUST BOARD PAPER

Paper No: NHST(17)002
Title of paper: Safer Staffing Report for November and December 2016
Purpose: To provide an overview of nursing and midwifery staffing levels (headcount only) in inpatient areas during November and December 2016 to provide assurance that every effort was made to address any shortages. Safer Staffing levels are one indication of the Trust's ability to provide safe, effective inpatient care.
Summary: • The Trust's mandated monthly submission of staffing headcount levels to NHS Choices was : **November 2016** – 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. **December 2016** - 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. • **Wards with Fill Rates below 90%** **November** saw 7 wards with a fill rate below 90%; 4 wards for RNs and 2 for HCAs and 1 ward for both RNs and HCAs. **December** saw 9 wards with a fill rate below 90%; 7 wards for RNs and 2 for HCAs and no ward had a fill rate below 90% for both RNs and HCAs. • **Care Staff Fill Rates** The overall headcount fill rate for care staff is higher than the ward establishment. This relates to the need for 'specials' (i.e. 1 patient to 1 staff member) who are employed to protect vulnerable patients and employing a member of care staff when there is a trained staff shortfall in spite of efforts to back fill with a bank or agency RN. • In **November** 2 patients and in **December** 1 patient experienced severe harm following an inpatient fall.
Corporate objectives met or risks addressed: Care, Safety
Financial implications: None directly from report.
Stakeholders: Patients, public, staff, commissioners, Trust Board
Recommendation(s): I am assuring the Board that the Trust has consistently met the national standards set for staffing levels.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 25th January 2017

Trust Safer Staffing Report for November and December 2016

Aim of Report

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

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

Staffing levels is the head count on each shift and is only one indication of the Trust's ability to provide safe, high quality care across all wards. Safer staffing does not analyse skill mix, the impact of temporary staff on a shift by shift basis or being short of a member of staff on a 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.

1. **Overall Fill Rates (appendix 1)**
   The **November 2016** submission indicates an overall fill rate of 94.44% for RNs on days, 97.52% for RNs on nights, 106.42% for HCAs on days and 107.59% for HCAs on nights. The **December 2016** submission indicates an overall fill rate of 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. 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 maintaining the shift's headcount by employing an HCA when there is a trained staff shortfall on a shift which has remained unfilled in spite of trying to backfill with a bank and/or agency RN or the permanent RNs being offered extra time or overtime. E-rostering does not currently have the functionality to separate out staff employed for specials from the actual shift requirements. This is widely recognised constraint on the E roster system and is reported by other trusts. The e-roster system also does not capture staff moves to other wards which are provided 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 48.12wte RN and 7.11wte HCA vacancies as of the end of November 2016 on the inpatient wards. Staffing remains on the Corporate Risk Register (CRR) which is reviewed monthly. Stabilising and retaining the nursing and midwifery workforce in clinical areas continues to be an area of increased focus:-

2.1. International nurse recruitment update:

- Indian Nurse Recruitment Campaign Update:
  - Initially offered: 122
  - 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. Preparation to support them through the required NMC OSCE has been on-going. OSCE is on 17th January 2017, if successful, NMC PIN provided 5 days later.
- 8 are due to arrive at the beginning of February 2017, subject to their visas being issued;
- 3 are in the process of uploading their documents onto the NMC portal;
- 5 are undergoing CBT training.

The remaining 32 nurses are in the process of studying English and rebooking the IELTS, having failed the test at least once.

- One international nurse has been appointed to St Helens theatres, whilst the other 3 (1 for St Helens Theatres and 2 for Whiston theatres) have been interviewed. 1 nurse was interviewed for Respiratory but was unsuccessful. 1 international nurse is having their details reviewed ICU to assess suitability to progress to interview.

2.2. **The Recruitment of Bank HCAs Update.** Recruitment is on-going, advertising on 1st of every month to recruit HCAs to the nurse bank. 149 shortlisted at the beginning of January 2017 who are being interviewed in the next 2 weeks.

2.3. **Student Nurse Recruitment Update.** HR Recruitment and the Trust's Student Nurse Practice Education Facilitators have met and arranged optimum Recruitment Open Day dates for 2017 to link with the stage in students training when they are job seeking. The dates for 2017 are 25th February and 3rd June.

2.4. **Recruitment Events Update for Stroke and Maternity**. Two events were held on 6th (1 – 4pm) and 8th (5-8pm) December 2016 targeting Stroke but turnout was very low. Open events were held on 4th and 5th November 2016 to recruit midwives. 14 qualified midwives have now been invited to interview following these events.

3. **Care Hours Per Patient Per Day (CHPPD) (Appendix 4)** CHPPD for RNs and Care staff is consistent on the medical wards and surgical wards throughout the year. It is higher for 3alpha in December due to a lower occupancy and it closed 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. Information are reviewing 4D's CHHPD increase during September and October 2016, initial findings suggest this is due to occupancy rates, the work is on-going. SCBU's and Seddon's CHPPD fluctuated due to occupancy. In December, Seddon had many patients on home leave and a much lower occupancy which is very unusual. 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 meaningful comparisons with other Trusts with like for like specialities to ascertain in RN CHPPD rates at this Trust are similar to other Trusts. 5 pilot sites

nationally are presently looking at CHPPD in detail using the Allocate SaferCare module as part of the Carter Model hospital work to be shared in early 2017.

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

5. **Fill rates below 90% (Appendix 2)**
   In November 2016 there were 7 wards, 4 for RNs, 2 for HCAs and 1 for both RNs and care staff. In **December 2016** 9 wards, 7 for RNs, 2 for HCAs and no wards for both RNs and care staff. Of the 7 wards with a fill rate of less than 90% for RNs, 6 of them had fill rates above 100% for care staff to maintain the headcount numbers on a shift, fully appreciating skill mix is compromised.

   At the end of December, there were 6 wards with fill rates of less than 90% consistently for the last 3 months.

6. **Wards where patients have experienced severe harm from an inpatient fall**
   November 2016 - Two patients experienced a fall resulting in severe harm on wards (3C and 3D). Both wards had an overall monthly fill rate of less than 90% in month. This is the first month a fall resulting in serious harm has correlated with a fill rate of less than 90% and needs close monitoring going forward. However, on further review, the patient on ward 3C fell on the early shift when the staffing numbers were correct for both RNs and HCAs and there were 3 extra HCAs on duty specialing vulnerable patients. The patient on ward 3D fell on an early shift when there were the correct numbers of HCAs on duty but the trained staff numbers were decreased by 1 RN.

   December 2016 - One patient experienced a fall resulting in severe harm on ward 1A. The ward was correctly staffed at the time with 3 RNS and 3 care staff on duty on the night shift.

   Level 2 serious incident review investigations are on-going into these incidents when a detailed review of staffing skill mix on the shift when the harm occurred will be undertaken as part of the review.

7. **Staffing Related Reported Incidents**

   A total of 24 incidents were reported in November and 22 in December directly relating to staffing shortages on the wards included in the Safer Staffing submission, of which none are reported as resulting in patient harm. Staff are requested to complete an incident form for shifts where there are skill mix issues or the actual headcount on shift is less than the planned.

8. **Future Developments.**
   8.1. Allocate E-Roster System – 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.

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

Summary

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

Appendix 1 – Trust's NHS Choices Safer Staffing Submission

November 2016

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	2,100	1,991	95%	2,211	2,230	101%	900	770	86%	900	1,300	144%	860	3.2	4.1	7.3
1B	General Medicine	3,494	3,414	98%	1,558	1,812	116%	1,010	963	95%	600	644	107%	711	6.2	3.5	9.6
1C	General Medicine	2,719	2,691	99%	1,756	2,019	115%	1,660	1,639	99%	600	670	112%	816	5.3	3.3	8.6
1D	Cardiology	1,997	1,710	86%	1,573	1,710	109%	900	781	87%	600	620	103%	879	2.8	2.7	5.5
1E	Cardiology	2,214	2,263	102%	827	819	99%	1,200	1,200	100%	130	130	100%	448	7.7	2.1	9.8
2A	Gen. Medicine / Haematology	1,878	1,798	96%	848	884	104%	600	600	100%	320	350	109%	494	4.9	2.5	7.4
2B	Gen. Medicine / Respiratory	2,118	1,937	91%	1,486	1,496	101%	900	814	90%	600	778	130%	751	3.7	3.0	6.7
2C	Gen. Medicine / Respiratory	2,143	1,995	93%	1,499	1,465	98%	900	860	96%	600	600	100%	839	3.4	2.5	5.9
2D	General Medicine	1,434	1,236	86%	1,087	1,191	110%	600	690	115%	600	610	102%	630	3.1	2.9	5.9
2E	Obstetrics	2,813	2,621	93%	1,920	1,830	95%	1,200	1,200	100%	600	639	106%	739	5.2	3.3	8.5
3A	Plastic Surgery	1,876	1,863	99%	1,201	1,177	98%	750	740	99%	610	598	98%	478	5.4	3.7	9.2
3Alpha	Trauma & Orthopaedics	1,489	1,466	98%	918	1,216	132%	600	621	104%	300	310	103%	368	5.7	4.1	9.8
3B	Trauma & Orthopaedics	1,484	1,327	89%	1,809	1,966	109%	889	869	98%	620	590	95%	539	4.1	4.7	8.8
3C	Trauma & Orthopaedics	1,929	1,597	83%	1,549	1,962	127%	900	910	101%	900	1,031	115%	740	3.4	4.0	7.4
3D	Gen. Medicine / Gastro.	2,025	1,665	82%	1,350	1,538	114%	900	840	93%	600	680	113%	779	3.2	2.8	6.1
3E	Gynaecology	1,491	1,368	92%	825	802	97%	630	580	92%	300	240	80%	584	3.3	1.8	5.1
3F	Paediatrics	2,164	2,156	100%	431	410	95%	1,200	1,205	100%	300	274	91%	550	6.1	1.2	7.4
4A	101 - UROLOGY	2,011	1,859	92%	1,327	1,338	101%	900	900	100%	900	880	98%	813	3.4	2.7	6.1
4B	General Surgery / Urology	2,504	2,367	95%	1,850	1,794	97%	1,080	1,051	97%	470	450	96%	428	8.0	5.2	13.2
4C	General Surgery	2,209	2,064	93%	1,322	1,296	98%	900	900	100%	900	900	100%	807	3.7	2.7	6.4
4D	Plastic Surgery	1,824	1,804	99%	547	525	96%	640	640	100%	300	300	100%	141	17.3	5.9	23.2
4E	Critical Care	5,662	5,382	95%	1,053	1,045	99%	3,600	3,420	95%	540	540	100%	336	26.2	4.7	30.9
4F	Paediatrics	2,046	1,976	97%	557	543	97%	745	745	100%	350	330	94%	320	8.5	2.7	11.2
5A	Gen. Medicine / Geriatric	1,577	1,483	94%	2,214	2,595	117%	900	810	90%	890	1,180	133%	772	3.0	4.9	7.9
5B	Geriatric Medicine	1,681	1,645	98%	2,182	2,073	95%	900	840	93%	890	898	101%	647	3.8	4.6	8.4
5C	Geriatric Medicine	2,365	2,188	93%	1,724	2,186	127%	1,320	1,320	100%	1,200	1,191	99%	762	4.6	4.4	9.0
5D	Gen. Medicine / Geriatric	1,424	1,299	91%	1,295	1,569	121%	600	679	113%	600	749	125%	463	4.3	5.0	9.3
Duffy	Gen. Medicine / Geriatric	1,455	1,316	90%	1,537	1,576	103%	600	600	100%	600	620	103%	564	3.4	3.9	7.3
SCBU	Paediatrics	1,639	1,603	98%	425	410	97%	931	934	100%	300	282	94%	276	9.2	2.5	11.7
Delivery	Obstetrics	3,617	3,583	99%	972	957	98%	2,160	2,109	98%	610	590	97%	280	20.3	5.5	25.9
Seddon	Rehabilitation	1,732	1,718	99%	1,581	1,658	105%	600	600	100%	600	750	125%	491	4.7	4.9	9.6

December 2016

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	1,926	1,685	88%	2,120	2,069	98%	900	840	93%	880	870	99%	826	3.1	3.6	6.6
1B	General Medicine	3,488	3,418	98%	1,491	1,756	118%	960	938	98%	600	571	95%	736	5.9	3.2	9.1
1C	General Medicine	2,936	2,835	97%	1,645	1,944	118%	1,500	1,689	113%	600	639	107%	793	5.7	3.3	9.0
1D	Cardiology	1,980	1,714	87%	1,561	1,578	101%	900	800	89%	600	610	102%	832	3.0	2.6	5.7
1E	Cardiology	2,168	2,045	94%	842	807	96%	1,200	1,140	95%	140	140	100%	441	7.2	2.1	9.4
2A	Gen. Medicine / Haematology	1,847	1,839	100%	812	809	100%	600	632	105%	300	270	90%	435	5.7	2.5	8.2
2B	Gen. Medicine / Respiratory	2,023	1,856	92%	1,492	1,515	102%	900	800	89%	600	809	135%	848	3.1	2.7	5.9
2C	Gen. Medicine / Respiratory	1,970	1,844	94%	1,557	1,387	89%	900	822	91%	600	620	103%	910	2.9	2.2	5.1
2D	General Medicine	1,295	1,044	81%	1,088	1,291	119%	600	690	115%	600	640	107%	603	2.9	3.2	6.1
2E	Obstetrics	3,098	2,920	94%	1,800	1,793	100%	1,335	1,315	99%	900	810	90%	762	5.6	3.4	9.0
3A	Plastic Surgery	1,800	1,783	99%	1,115	1,099	99%	670	670	100%	579	539	93%	440	5.6	3.7	9.3
3Alpha	Trauma & Orthopaedics	1,353	1,293	96%	1,131	1,072	95%	502	503	100%	270	271	100%	282	6.4	4.8	11.1
3B	Trauma & Orthopaedics	1,375	1,347	98%	2,084	1,939	93%	900	840	93%	620	610	98%	572	3.8	4.5	8.3
3C	Trauma & Orthopaedics	2,025	1,780	88%	1,551	1,830	118%	900	860	96%	900	1,113	124%	757	3.5	3.9	7.4
3D	Gen. Medicine / Gastro.	2,067	1,797	87%	1,226	1,148	94%	900	761	85%	600	760	127%	855	3.0	2.2	5.2
3E	Gynaecology	1,338	1,310	98%	696	658	94%	610	610	100%	240	200	83%	569	3.4	1.5	4.9
3F	Paediatrics	2,158	2,115	98%	442	434	98%	1,200	1,209	101%	290	270	93%	412	8.1	1.7	9.8
4A	101 - UROLOGY	1,970	1,791	91%	1,319	1,277	97%	900	890	99%	900	859	95%	827	3.2	2.6	5.8
4B	General Surgery / Urology	2,334	2,149	92%	1,638	1,665	102%	990	979	99%	440	450	102%	382	8.2	5.5	13.7
4C	General Surgery	2,118	1,958	92%	1,327	1,274	96%	890	868	98%	900	890	99%	836	3.4	2.6	6.0
4D	Plastic Surgery	1,850	1,790	97%	455	440	97%	630	630	100%	300	280	93%	143	16.9	5.0	22.0
4E	Critical Care	5,411	5,120	95%	970	1,025	106%	3,600	3,367	94%	600	570	95%	368	23.1	4.3	27.4
4F	Paediatrics	2,104	2,001	95%	526	506	96%	702	701	100%	310	310	100%	238	11.4	3.4	14.8
5A	Gen. Medicine / Geriatric	1,545	1,450	94%	2,220	2,615	118%	900	816	91%	900	1,262	140%	711	3.2	5.5	8.6
5B	Geriatric Medicine	1,739	1,627	94%	2,187	1,996	91%	900	850	94%	900	900	100%	804	3.1	3.6	6.7
5C	Geriatric Medicine	2,482	2,309	93%	1,722	1,966	114%	1,200	1,310	109%	900	1,073	119%	763	4.7	4.0	8.7
5D	Gen. Medicine / Geriatric	1,454	1,303	90%	1,256	1,534	122%	600	670	112%	600	740	123%	588	3.4	3.9	7.2
Duffy	Gen. Medicine / Geriatric	1,346	1,235	92%	1,543	1,551	101%	601	600	100%	600	627	105%	632	2.9	3.4	6.3
SCBU	Paediatrics	1,520	1,463	96%	467	454	97%	970	917	95%	240	228	95%	156	15.3	4.4	19.6
Delivery	Obstetrics	3,465	3,378	97%	814	754	93%	2,143	2,230	104%	580	546	94%	282	19.9	4.6	24.5
Seddon	Rehabilitation	1,412	1,638	116%	1,573	1,708	109%	600	640	107%	600	860	143%	90	25.3	28.5	53.8

Appendix 2 – Wards with Fill Rates below 90% for November and December 2016

Table showing the 4 wards with fill rates below 90% for RNs November 2016

Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
2D	86.2%	109.6%	115.0%	101.7%
3B	89.4%	108.7%	97.8%	95.2%
3C	82.8%	126.7%	101.1%	114.5%
3D	82.2%	113.9%	93.3%	113.3%

Table showing the 2 wards with a fill rate less than 90% for care staff November 2016

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	94.8%	100.9%	85.6%	144.4%
3E	91.7%	97.3%	92.1%	80.0%

The ward with a fill rate below 90% for both RNs and HCAs during November 2016

Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
1D	85.6%	108.7%	86.8%	103.3%

December 2016

Table showing the 7 wards with fill rates below 90% for RNs during December 2016

	Dec 2016 Days		Dec 2016 Nights	
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	87.5%	97.6%	93.4%	98.9%
1D	86.6%	101.1%	88.9%	101.7%
2B	91.7%	101.5%	88.9%	134.8%
2D	80.6%	118.7%	114.9%	106.7%
3C	87.9%	118.0%	95.6%	123.7%
3D	86.9%	93.6%	84.6%	126.7%
5D	89.6%	122.1%	111.7%	123.3%

Table showing the 2 wards with fill rates below 90% for care staff during December 2016

	Dec Days		Dec Nights	
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
2C	93.6%	89.1%	91.4%	103.3%
3E	97.9%	94.5%	100.0%	83.1%

No wards had a fill rate below 90% for both RNs and care staff during December 2016

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

	Oct Days		Oct Night		Nov days		Nov nights		Dec Days		Dec Nights	
Ward	RNs (%)	Care staff (%)	RNs (%)	Care staff (%)	RNs (%)	Care staff (%)	RNs (%)	Care staff (%)	RNs (%)	Care staff (%)	RNs (%)	care staff (%)
1A	98.5%	102.6%	82.9%	118.3%	94.8%	100.9%	85.6%	144.4%	87.5%	97.6%	93.4%	98.9%
1D	86.0%	137.2%	90.3%	127.4%	85.6%	108.7%	86.8%	103.3%	86.6%	101.1%	88.9%	101.7%
2D	79.6%	128.9%	118.0%	99.9%	86.2%	109.6%	115.0%	101.7%	80.6%	118.7%	114.9%	106.7%
3C	76.0%	131.6%	100.0%	122.6%	82.8%	126.7%	101.1%	114.5%	87.9%	118.0%	95.6%	123.7%
3D	86.8%	102.4%	101.1%	122.6%	82.2%	113.9%	93.3%	113.3%	86.9%	93.6%	84.6%	126.7%
3E	84.1%	92.3%	96.5%	90.3%	91.7%	97.3%	92.1%	80.0%	97.9%	94.5%	100.0%	83.1%

Appendix 3 Table 1 CHPPD for the registered workforce. Table 2 for care staff.

Care Hours Per Patient Day (CHPPD) Registered midwives/nurses									
Ward Name	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
1A		2.6	2.8	2.6	2.9	2.9	3.4	3.2	3.1
1B		5.9	5.7	4.6	6.2	5.8	5.6	6.2	5.9
1C		5.8	5.6	5.4	5.4	5.7	5.9	5.3	5.7
1D		2.8	2.8	3.0	2.9	3.1	3.3	2.8	3.0
1E		7.6	7.0	6.8	7.2	7.6	8.1	7.7	7.2
2A		3.6	3.7	3.9	4.8	4.6	4.8	4.9	5.7
2B		2.8	3.0	2.9	2.7	3.0	3.2	3.7	3.1
2C		2.7	2.8	2.8	2.8	3.4	3.6	3.4	2.9
2D		2.9	2.8	3.1	3.4	3.5	3.7	3.1	2.9
2E		4.9	4.6	5.1	5.6	4.4	5.0	5.2	5.6
3A		5.1	4.3	4.6	4.6	5.3	5.7	5.4	5.6
3Alpha		4.8	4.2	4.9	5.2	5.7	5.6	5.7	6.4
3B		3.6	3.3	3.5	3.2	3.9	4.1	4.1	3.8
3C		3.4	2.9	3.2	3.6	3.5	3.4	3.4	3.5
3D		2.8	2.8	3.1	3.0	2.9	3.2	3.2	3.0
3E		3.4	3.4	3.1	3.4	3.8	3.6	3.3	3.4
3F		7.4	9.1	7.1	10.7	8.5	8.4	6.1	8.1
4A		3.3	3.2	3.2	3.1	3.2	3.4	3.4	3.2
4B		7.6	7.0	7.6	8.6	8.8	8.9	8.0	8.2
4C		3.2	3.1	3.2	3.0	3.2	3.5	3.7	3.4
4D		12.6	16.9	15.5	16.5	33.2	40.5	17.3	16.9
4E		27.7	25.2	26.0	26.1	27.9	30.0	26.2	23.1
4F		7.9	10.0	11.5	16.7	15.4	15.7	8.5	11.4
5A		3.5	3.6	2.7	3.0	2.8	3.0	3.0	3.2
5B		2.6	3.8	3.4	3.3	3.4	3.5	3.8	3.1
5C		4.8	4.7	2.0	2.1	5.3	5.1	4.6	4.7
5D		3.7	3.4	4.4	5.2	2.5	3.0	4.3	3.4
Duffy Ward		2.7	2.7	2.5	2.5	2.8	3.3	3.4	2.9
SCBU		7.5	8.1	12.6	15.3	10.7	10.8	9.2	15.3
Delivery Suite		17.0	15.8	18.6	18.2	16.1	18.7	20.3	19.9
Seddon		5.2	5.5	5.5	4.6	5.3	5.4	4.7	25.3

Care Hours Per Patient Day (CHPPD) Registered Care staff									
Ward Name	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**
1A		3.8	3.8	3.5	3.8	3.9	4.1	4.1	3.6
1B		2.8	3.3	4.0	3.7	3.3	3.5	3.5	3.2
1C		3.3	3.0	3.0	3.1	3.7	3.6	3.3	3.3
1D		3.0	2.6	2.8	2.9	3.5	3.4	2.7	2.6
1E		2.3	1.9	1.7	1.7	1.9	2.1	2.1	2.1
2A		2.1	2.1	2.1	2.2	2.3	2.5	2.5	2.5
2B		2.5	2.6	3.3	2.8	2.9	3.2	3.0	2.7
2C		2.8	2.4	2.5	3.1	3.6	4.1	2.5	2.2
2D		2.9	3.5	4.2	4.6	3.5	4.2	2.9	3.2
2E		2.3	2.3	2.2	2.2	2.1	2.3	3.3	3.4
3A		3.5	3.0	3.3	4.0	4.0	4.1	3.7	3.7
3Alpha		3.2	2.9	3.6	3.6	4.1	4.1	4.1	4.8
3B		4.8	4.5	4.6	4.4	5.1	4.7	4.7	4.5
3C		3.4	3.2	3.2	4.3	4.2	4.5	4.0	3.9
3D		2.6	2.6	2.3	2.8	2.6	2.6	2.8	2.2
3E		1.8	2.0	2.0	1.9	2.1	2.2	1.8	1.5
3F		1.4	1.9	1.5	1.9	1.8	1.9	1.2	1.7
4A		2.4	2.9	2.9	3.1	3.1	2.9	2.7	2.6
4B		5.4	4.9	4.9	5.7	5.3	5.7	5.2	5.5
4C		2.8	2.5	2.7	2.5	2.5	2.6	2.7	2.6
4D		3.5	7.2	5.3	4.6	13.0	11.8	5.9	5.0
4E		4.8	4.8	4.0	4.5	4.7	4.8	4.7	4.3
4F		3.4	4.4	2.9	6.1	5.2	4.8	2.7	3.4
5A		4.5	4.2	4.6	5.4	4.5	4.8	4.9	5.5
5B		3.8	5.9	5.0	4.7	4.6	4.4	4.6	3.6
5C		3.8	3.4	2.0	2.3	5.4	4.9	4.4	4.0
5D		3.8	3.7	4.2	5.7	2.6	3.4	5.0	3.9
Duffy Ward		4.3	3.5	3.8	4.3	4.5	4.1	3.9	3.4
SCBU		1.9	2.1	2.4	3.5	2.9	3.2	2.5	4.4
Delivery Suite		4.3	4.2	5.0	4.5	4.2	5.1	5.5	4.6
Seddon		4.7	5.1	5.7	5.5	5.5	5.2	4.9	28.5

TRUST BOARD PAPER

Paper No: NHST(17)003

Title of paper:
Aggregated Incidents, Complaints and Claims Report Q2 2016-17

Purpose:
To highlight trends and learning obtained from the aggregation and analysis of complaints, claims, internal incident reporting and PALS contacts received by the Trust in the period 1st July – 30th September 2016 (Quarter 2).

Summary:

Activity
To set the context, there has been increase in activity compared to Q2 2015-16:
- 5% increase in spells
- 0.4% increase in Emergency Department attendances
- 4% increase in outpatient attendances

Slight increases/decreases in activity compared to Q1 2016-17
- 1% increase in spells (28,430 compared to 28,107)
- 0.3% decrease in Emergency Department attendances (26,045 compared to 26,118)
- 1.2% decrease in outpatient activity (112,168 compared to 113,500)

Incidents
1. The number of incidents raised for this quarter was 3366 compared to 3254 in the same quarter last year demonstrating an increase of 112 (3.4%). This is associated with the supportive culture of learning and openness and an increase in activity.
2. The level of harm for incidents of moderate harm and above has increased during Q2
3. The top two categories of reported incidents were:
    i. Accident that may result in personal injury
    ii. Implementation of care or on-going monitoring/review
4. The number of Strategic Executive Information System (StEIS) incidents reported this quarter was 16. This is above the normal reporting level of 10 to 12 reported each quarter. The increase is partly due to the new reporting criteria for Obstetric incidents that have the potential for harm such as post-partum haemorrhage (PPH). These type of incidents accounted for 3 additional StEIS reports in Q2.
5. National Reporting and Learning System (NRLS) reporting for the latest published data 1st October – 31st March 2016 shows the organisation's reporting level at 39.27 per 1000 bed-days against a national average of 39.31. The Trust's reporting to the NRLS remains excellent with the mean number of days to report being 13 days against a national average of 30 days.

Complaints and Patient Advice Liaison Service (PALS)
6. 69 1st stage complaints were opened during Q2 1st July to 30th September 2016:
    i. A decrease of 10.4% in comparison to Q2 2015-16, when there were 77
    ii. A decrease of 24.7% compared to Q1 2016-17, when there were 93.
7. The top complaints themes during the period were:
    i. 56.5% - clinical treatment
    ii. 13.0% - communication
    iii. 11.6% - values and behaviours (Staff)

8. There were 539 PALS contacts/enquiries during Q2, compared to 486 in Q1 2016-17, reflecting an increase of 11%. This may partially account for the decrease in complaints.
9. The most common PALS issues raised being:
    i. 23% - communication
    ii. 16% - admissions and discharges (excl. delayed discharge re care package)
    iii. 12% - clinical treatment
10. During the quarter, there were 20 complaints linked to 39 Incidents; there were 25 complaints linked to previous PALS contacts/enquiries, and 5 complaints linked to 5 claims. There were 13 claims linked to 13 incidents.

Claims

11. There are 398 active clinical negligence claims on-going, compared to 416 in the last quarter.
12. 17 new claims (all clinical negligence) were received in Q2 compared to:
    i. 33 new claims received in Q1, showing a 48.5% reduction
    ii. 28 new claims received in Q2 2015-16, showing a 39.3% reduction
13. Two of the top themes for new claims were the same as Q1 and were failure to diagnose/treat (6) and performance of surgical procedure (3). Four claims were received relating to delays in treatment.

Information correct at the time of report (end November 2016)

Corporate objectives met or risks addressed:
Safety – We will embed a learning culture that reduces harm, achieves good outcomes and enhances the patient experience.

Financial implications:
There are no direct financial implications arising from this report

Stakeholders:
Patients, carers, commissioners, CQC and Trust staff.

Recommendation(s)/issues to escalate:
Members are asked to consider and note the report.

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

Date of meeting: 25th January 2017

1. Introduction

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

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

The data included in this report covers 1st July to 30th September 2016 (Q2).

2. Quantitative analysis

Table 1: Number of incidents, complaints, PALS and new claims

Q2 2016-17	Incidents	StEIS	1st stage complaints	PALS	New claims
Total number reported	**3366**	**16**	**69**	**539**	**17**
Accident & Emergency	339		18	75	4
Anaesthetics	2		0	1	
Burns	10		0	1	
Cancer Services	30		2	1	
Cardio Respiratory	24		0	2	
Cardiology	88		0	20	
Critical Care	45	1	0	1	
Dermatology	22		1	6	1
Diabetes	20		0	5	1
Ear, Nose & Throat (ENT)	17	1	0	10	
Facilities	136		0	8	
Finance	0		0	0	
Gastroenterology	89	1	3	24	
General Medicine	458	1	3	50	
General Surgery	142		8	82	3
Genito-urinary Medicine	0		0	0	
Gynaecology	33		3	30	2
Haematology	48		0	2	
Human Resources	2		0	1	
Informatics	5		0	0	
Information Governance	1		0	0	
Medicine for Older People	444	3	3	20	1
Neurophysiology	0		0	0	
Nursing	0		0	0	1
Obstetrics	153	2	5	9	1
Operational	12		0	3	

Q2 2016-17	Incidents	StEIS	1st stage complaints	PALS	New claims
Ophthalmology	22		1	6	
Orthodontics & Oral Surgery	5		0	2	
Orthopaedic	142		5	54	1
Paediatrics	260	1	0	5	
Pain Services	2		0	3	
Palliative Care	1		0	0	
Pathology	276		3	3	
Pharmacy	22		0	2	
Plastics	44	1	6	16	1
Psychology	0		0	0	
Quality & Risk	16		0	28	
Radiology	89		0	5	1
Rehabilitation	26		0	0	
Respiratory	141	4	5	17	
Resuscitation	0		0	0	
Rheumatology	8		1	1	
Sexual Health	13		0	0	
Theatres	149		0	1	
Therapy Services	9		1	4	
Unknown	0		0	0	
Urology	21	1	0	7	
Other	0		1	62	

2.1. Top ten themes

Table 2: top ten themes from incidents, complaints, PALS and clinical negligence claims

Incidents		Complaints		PALS		New clinical negligence claims	
Accident that may result in personal injury	821	Clinical Treatment	39	Communications	124	Failure to diagnose/ treat	6
Implementation of care or on-going monitoring/review	488	Communications	9	Admissions and Discharges (excl. delayed discharge re care package)	88	Delay	4
Access, Appointment, Admission, Transfer, Discharge	311	Values and Behaviours (Staff)	8	Clinical Treatment	67	Performance of medical procedure	1
Medication	308	Patient Care/ Nursing Care	4	Appointments	61	Performance of surgical procedure	3
Clinical assessment (investigations, images and lab tests)	277	Admissions and Discharges (excl. delayed discharge re care package)	3	Patient Care/ Nursing Care	52	Nursing care	1
Abusive, violent, disruptive or self-harming behaviour	255	Prescribing	2	Access to Treatment or Drugs	32	Not enough detail	2

Incidents		Complaints		PALS		New clinical negligence claims	
Treatment, procedure	196	Access to Treatment or Drugs	1	Other (e.g. abuse/ behaviour/Theft/ Benefits)	28		
Patient Information (records, documents, test results, scans)	168	Appointments	1	Values and Behaviours (Staff)	25		
Infrastructure or resources (staffing, facilities, environment)	138	Mortuary	1	Facilities	11		
Consent, Confidentiality or Communication	115	Waiting Times	1	Waiting Times	7		

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

Table 3: Colour key for top ten themes

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

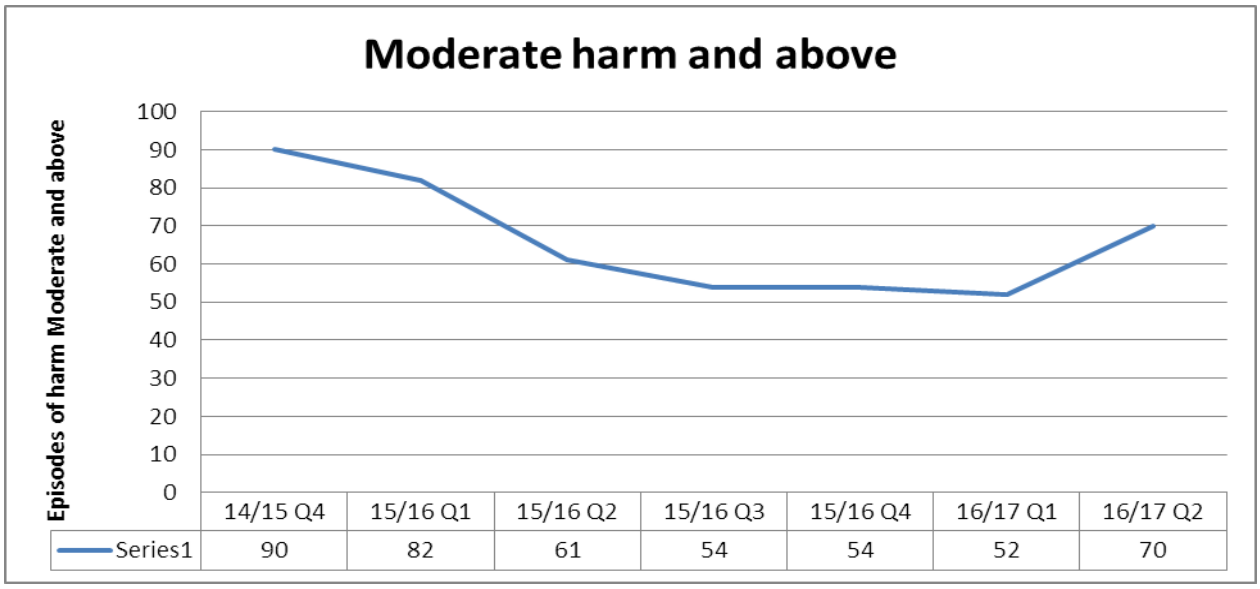
3. Incident data

The latest data published by the NRLS in September 2016 relates to incident data from 1st October 2015 – 31st March 2016.

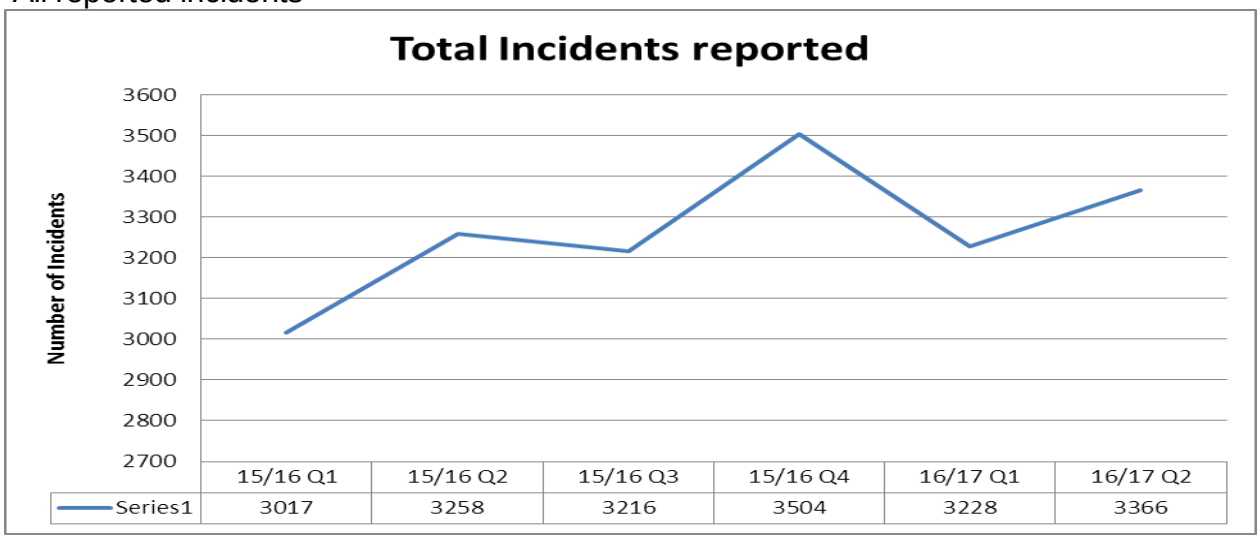
The Trust has increased its reporting of patient incidents with a no or low harm over the last three years, which demonstrates an improved culture of reporting. The Trust reported 39.27 incidents per 1,000 bed days for the period October 2015 – March 2016, which is comparable to local Trusts and the national rate of 39.31 per 1,000 bed days. Our mean number of days for reporting incidents to the NRLS is 13, which is substantially under the expected 30 days.

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

Moderate, severe and death harms reported



All reported incidents



3.1. Lessons learnt from incidents

The following lessons learnt where extracted from serious incidents that took place and were investigated within Q2 2016-17

Fractured neck of femur

- Emergency Department to ensure that patients are appropriately assessed for the risk of falling using the falls risk assessment tool (FRAT) as per policy.
- Referral for Multi-Disciplinary Team review at earliest opportunity.
- Trust care plans for falls must be adhered to by all staff across inpatient areas.

Failure to rescue deteriorating patient:

- The critical importance of thoroughly reviewing a patient's history to ensure all aspects of management is considered particularly when they have a known co-morbidity that

will potentially impact on any additional treatment and the outcome from that treatment.

- Staff must implement the sepsis pathway in line with best practice guidance and seek support and guidance from the Trust sepsis multidisciplinary specialist team as required.
- The importance of nurses following the Modified Early Warning System (MEWS) Policy.
- Review of the outlying policy to include review of criteria for selection of medical patients and the escalation process in the event of concerns of worsening condition of an outlying patient.
- Review of peripherally inserted central catheter (PICC) line process including responsibilities, communication pathway for non-urgent, urgent and critical referrals and associated timeliness of actions.
- Development of a protocol/reminder to raise awareness with medical staff of the relationship between Ciclosporin and creatinine levels and the associated negative impact on kidney function.
- Improve compliance with the completion of the Trust transfer documentation to ensure timely referral to social services.

4. Complaints and PALS

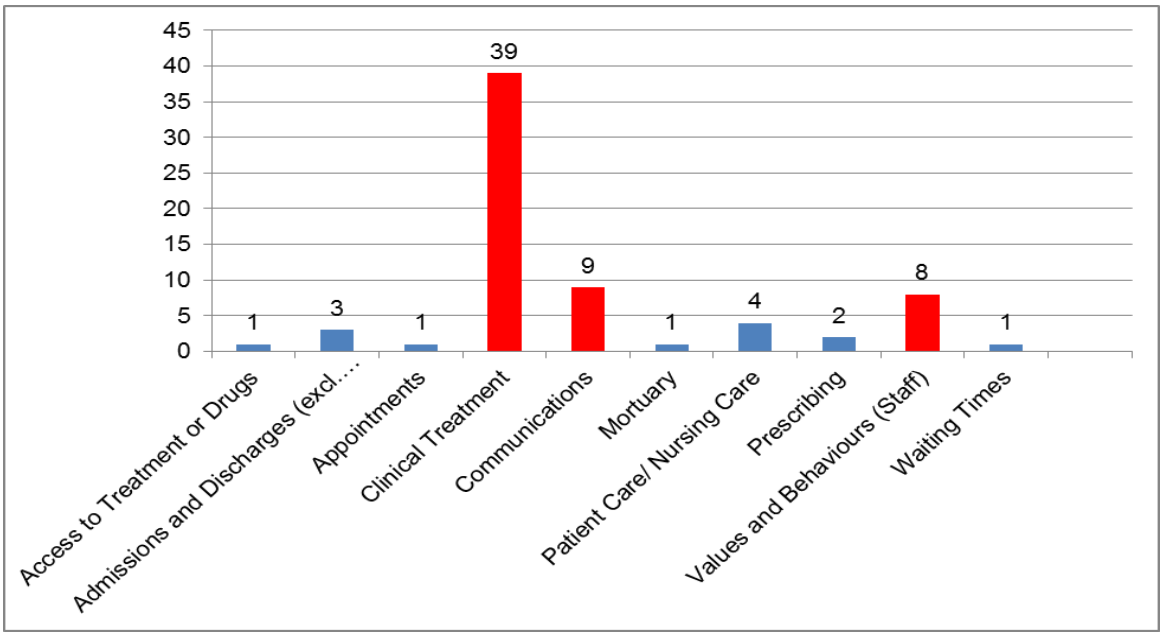
The following data is based on figures that are generated via DatixWeb. The table below shows the cumulative monthly totals of 1st stage complaints that were received by the Central Complaints team during Q2 2016-17 and investigated.

Table 4: Cumulative total of 1st Stage complaints received during 2016-17

	Jul 2016	Aug 2016	Sep 2016	Total
Medical Care Group	9	15	10	34
Surgical Care Group	8	11	10	29
Clinical Support Group/ Services	2	2	2	6
Total	19	28	22	69

Chart 3 below shows the main subject of complaints received during Q2 2016-17. This shows the top themes were clinical treatment (39), Communications (9) values and behaviours (Staff) (8) and are highlighted in red.

Chart 3: Main subject of complaints



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

There were two complaints that were escalated as SIRIs and closed as complaints during Q2. There were two further complaints escalated as SIRIs, one was investigated alongside the complaints process and one is currently awaiting further details from the complainant as shown below:

Table 5: Complaints escalated as serious incidents in Q2 2016-17

Status	First received	Date closed	Description	Care Group/ directorate	Subject (KO41(A))
Closed as complaint	12/07/16	23/08/16	Potential delay in treatment and delay in ordering tests.	Medical Care Group	Clinical Treatment
Opened	18/07/16	09/09/16	Potential missed diagnosis, lack of communication and lack of treatment.	Clinical Support Group	Clinical Treatment
Closed as complaint	25/07/16		Potential failure to order a head CT scan.	Medical Care Group	Clinical Treatment
Awaiting further information	27/07/16		The complainant remains unhappy after receiving the SIRI report and would like to reopen a complaint.	Surgical Care Group	Clinical Treatment

4.2. Actions/lessons learnt

There were 97 1st stage complaints cases closed during Q2, an increase of 59% in closure rate in comparison to Q1 where 61 1st stage complaints were closed. This reflects the improvements made to the complaints management system. The following table shows what actions were taken following the completion of investigations for the Medical Care Group which uses the DatixWeb module to record these.

Table 6: Complaints by action taken codes and first received (Month and year)

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Total

	2016	2016	2016	2016	2016	2016	2016	2016	
Ward meetings	0	0	3	4	9	6	1	1	24
Reflective practice	0	0	2	4	7	11	3	0	27
Training related	1	0	0	0	2	0	0	0	3
Training (Undertaken)	0	0	0	1	0	0	0	1	2
Governance meetings	1	0	2	0	2	3	1	0	9
Audit	0	0	1	1	4	0	1	0	7
Policy	0	0	0	1	1	0	1	0	3
Documentation	1	0	1	0	3	3	0	0	8
No action required/ proposed	0	0	1	0	2	3	4	0	10
Other	0	0	1	3	2	1	0	0	7
Total	3	0	11	14	32	27	11	2	100

The table below shows lessons learnt codes for the 97 1st stage complaints cases that were closed during Q2 2016-17. Each complaint may have several lessons learned codes; the lessons learned codes in the table below are for the Medical Care Group only which fully uses the DatixWeb Investigations section in the complaints module to record these.

Table 7: Complaints by lessons code and first received (month and year)

	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Total
Discharge (unsafe)	0	0	0	0	0	1	0	0	1
Clinical Practice	1	0	1	0	3	3	1	1	10
Communication	1	0	4	3	7	10	3	1	29
Delivery of care	1	0	0	1	5	2	1	0	10
Patient /staff engagement involvement	0	0	0	0	1	0	0	0	1
Staff education/knowledge/ training	0	0	0	0	2	1	0	1	4
Attitude (staff)	0	0	2	3	4	2	0	0	11
Falls	0	0	2	0	0	0	0	0	2
Privacy and dignity	0	0	1	0	2	0	0	0	3
Documentation	1	0	2	5	2	6	2	0	18
Transfer information	0	0	0	1	1	1	0	0	3
Medication errors	0	0	0	1	0	0	0	0	1
Infection control	0	0	0	1	0	0	0	0	1
Other	0	0	1	3	0	4	2	0	10
Total	4	0	13	18	27	30	9	3	104

The table below shows the decisions taken in the 97 1st stage complaints closed during Q2, with 31 not upheld locally, 40 partially upheld and 25 upheld.

Table 8: Decisions outcome cases closed during Q2

	Medical Care Group	Surgical Care Group	Clinical Support Group	Total
Not Upheld Locally	21	9	2	32
Partially Upheld Locally	26	14	0	40
Upheld Locally	14	8	3	25
Total	61	31	5	97

5. PALS data

There were 539 PALS contacts/enquiries during Q2 2016/17. This is an increase of 11% from Q1 2016/17 of 486 PALS contacts/enquiries.

The table below gives an illustration of the PALS contacts/enquiries by Care Groups, noting not all PALS contacts are related to a specific care group.

Table 9: PALS by Care Group/Directorate and first received (month and year)

	Jul 2016	Aug 2016	Sep 2016	Total
Medical Care Group	59	98	72	229
Surgical Care Group	64	83	77	224
Clinical Support Group/ Services	2	4	7	13
Facilities (Medirest/TWFM)	2	2	4	8
Nursing, Governance, Quality & Risk	3	13	13	29
Operational	2	2	2	6
Human Resource	0	0	1	1
Total	132	202	176	510

The top ten specialty areas that received the highest number of PALS contacts are shown in the table below:

Table 10: Top ten PALS activity by speciality

	Jul 2016	Aug 2016	Sep 2016	Total
General Surgery	27	27	28	82
Accident & Emergency	23	29	23	75
Orthopaedic	17	23	14	54
General Medicine	14	15	21	50
Gynaecology	6	10	14	30
Quality & Risk	3	13	13	29
Gastroenterology	7	12	5	24
Medicine for Older People	6	10	4	20
Cardiology	3	7	10	20
Respiratory	2	9	6	17
Total	108	155	138	401

The main KO41(a) subjects that were raised within these PALS enquiries during Q2 2016-17 are given in the table below. It can be noted that highest PALS subject area was communications with 124 contacts/enquiries.

Table 11: PALS by subject (KO41(A)) and first received (month and year)

	Total
Access to Treatment or Drugs	32
Admissions and Discharges (excl. delayed discharge re care package)	88
Appointments	61
Clinical Treatment	67
Communications	124
End of Life Care	5
Facilities	11
Integrated Care (incl. delayed discharge re care package)	2
Patient Care/ Nursing Care	52
Prescribing	2
Privacy and Dignity	3
Transport (Ambulances)	2
Trust Admin/ Policies/Procedures (Inc. Patient Record Management)	1
Values and Behaviours (Staff)	25
Waiting Times	7
Other (e.g. abuse/behaviour/theft/benefits)	28
Total	510

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

6. Legal Services Department Activity

6.1. Claims

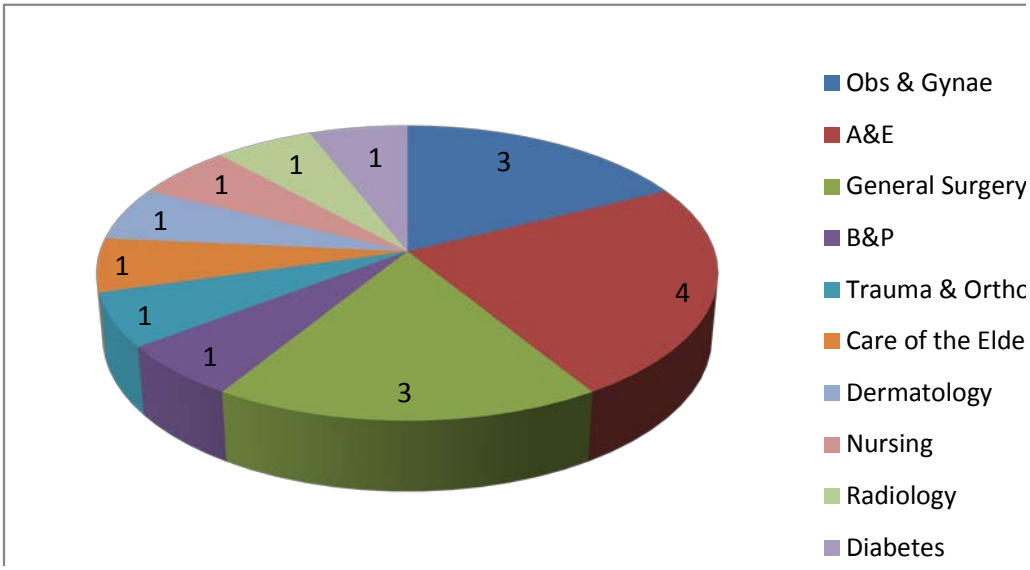
The Trust currently has 398 active clinical negligence claims on-going. This includes those in the pre-action stage through to those which are in the final stages of settlement. The Trust continues to deal with approximately 70% of claims “in house” in order to ensure continuity and cost reduction.

Activity during Q2 includes:

- 17 new claims received compared to 28 new claims received in the same period last year. This represents a 39.3% decrease.
    - Surgical Care Group - 8 claims, compared to 24 in the last quarter
    - Medical Care Group - 8 claims, compared to 8 in the last quarter
    - Clinical Support - 1 claim, compared to 1 in the last quarter
- 36 claims were closed

The chart below shows the breakdown of the 17 new clinical negligence claims by specialty.

Chart 4: Breakdown of claims by speciality



6.1.1. Reasons for clinical negligence claims received

As in the previous quarter, failure to diagnose/treat and performance of surgery remain high litigation areas. Four claims have been received relating to delays. However, it must be noted that these figures relate to the time when the claim was received rather that the index event which could have been some time earlier. Consent issues, although not necessarily the lead reason for a claim are featuring more frequently in particulars of claim.

Table 11: Reasons for clinical negligence claims received

Reason for claim	Number of claims
Failure to diagnose/treat	6 claims
Delay	4 claims
Performance of surgical procedure	3 claims
Performance of medical procedure	1 claim
Nursing care	1 claim
Not enough details	2 claims

6.1.2. Clinical negligence claims closed in the period

A total of 36 claims were closed in Q2, with 22 claims closed with payment of damages which is a 73% increase in comparison to last quarter. The total amount paid in damages on behalf of the Trust was £715,018.27, compared to £131,500.00 in the last quarter. This represents a 544% increase.

14 claims were closed without payment of damages. These claims were either withdrawn, successfully defended or closed after file review:

- Closed after file review 12 claims
- Defended 1 claim
- Withdrawn 1 claim

6.1.3. Lesson Learning

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

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

Training sessions continue to be provided for clinician staff to facilitate statement writing and development of understanding of the claims process. Two presentations on claims were delivered by Hill Dickinson for the Board Development Day and for clinical staff in October. This included information on why we advise settlement and what makes the difference for those that can be defended successfully, as well as reminders for staff on record keeping and consent.

The Claims Governance Group consisting of senior managers and clinicians, review all new claims received in the preceding month and advise on claim defendability.

6.2. Insurance Claims

The Trust currently has 52 open Insurance claims:

- Employers Liability 44 claims
- Public Liability 8 claims

Table 12: Number of claims by reasons

Reason for claim	Number of claims
Slip/trip/fall	25
Manual Handling	5
Assault by patient	4
Needle stick	5
Work related stress	1
Hearing loss	1
Other	11
Total	52

6.2.1. Insurance claims closed in the period

8 insurance claims were closed in Q2, 4 claims were closed with payment of damages and 4 without.

6.2.2. Damages paid

The total paid in damages in this quarter was £17,475.00.

6.3. Inquests

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

Currently there are 8 open inquests that fall within the above criteria

6.4. Police

New requests in this period = 67
Re-opened in this period = 12
Outstanding in this period = 48
Closed in this period = 86

6.5. Access to Health Records including Subject Access

New request within this period = 129
Closed out in this period= 67
Targets breached in this period = 2

6.6. Third Party

New requests within this period= 620
Closed out in this period= 585
Targets breached in this period= 30

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St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(17)004

Title of paper: Risk Register Report – January 2017.

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

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

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

This report is based on Datix information as at 3rd January 2017 and shows that the total number of risks on the risk register is 679. There are 14 high risks that have been escalated to the CRR: 7 in Corporate Services, 3 in Medical and 2 in Surgical Care Groups, and 2 in Clinical Support. The risk categories are: 7 re patient care, 3 re money, 2 re governance and 1 each re activity and staffing. Two risks have been added since the last report regarding SIRI processes and communication equipment for use in major incidents.

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

1. The proportion of risks with an overdue review date has deteriorated
2. 4 risks on the CRR have no recorded action plan on Datix
3. The compliance with sign-off of CIPs still requires improvement
4. The descriptor of the risk included in the CRR requires further refinement to ensure it succinctly captures the real risk to the organisation.

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

Financial implications: None directly from this report.

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

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

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

Date of meeting: 25th January 2017.

CORPORATE RISK REGISTER REPORT – JANUARY 2017

1. Purpose

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

2. Risk Register Summary for the Reporting Period

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

RISK REGISTER	Current Reporting Period 03.01.17	Previous Reporting Period 01.12.16	Previous Reporting Period 01.11.16
Number of new risks reported	28	26	40
Number of risks closed or removed	19	12	17
Number of increased risk scores	5	7	2
Number of decreased risk scores	5	9	5
Number of risks overdue for review	169	91	96
Total Number of Datix risks	**679***	**670**	**657**

**Includes 1 risk recorded but not scored at the time of reporting*

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

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
51	36	29	87	10	156	53	108	36	98	7	6	1	0
116 = 17.1%			253 = 37.3%			295 = 43.5%				14 = 2.1%			

3.1 Surgical Care Group - 235 risks reported 34.7% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
9	13	10	37	2	55	19	44	14	30	1	1	0	0
32 = 13.6%			94 = 4%			107 = 45.5%				2 = 0.9%			

3.2 Medical Care Group - 132 risks reported 19.5% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
7	3	8	12	2	21	13	22	16	25	2	0	1	0
18 = 13.6%			35 = 26.5%			76 = 57.6%				3 = 2.3%			

3.3 Clinical Support Care Group - 53 risks reported 7.8% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
12	2	1	9	0	10	3	8	1	5	2	0	0	0
15 = 28.3%			19 = 35.9%			17 = 32.1%				2 = 3.8%			

3.4 Corporate – 258 risks reported 38.1% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
23	13	15	29	6	70	18	34	5	38	2	5	0	0
51 = 19.8%			105 = 40.7%			95 = 36.8%				7 = 2.7%			

Department	Very Low	Low	Moderate	High	Total
Health Informatics/ Health Records	1	4	15	1	**21**
Facilities (Medirest/TWFM)	6	15	4	0	**25**
Nursing, Governance, Quality & Risk	5	10	23	2	**40**
Finance	24	22	5	1	**52**
Operational	14	38	18	0	**70**
Human Resource	1	16	30	3	**50**
Information Governance	0	1	0	1	**1**
Total	**51**	**106**	**95**	**7**	**259**

4. The Trusts Highest Scoring Risks

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

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

Datix Ref	Risk Title	Current Risk Score	Comments
N/a			

5. Points of escalation

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

b) Four risks on the CRR have no recorded action plan on Datix.

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

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Appendix 1 - Summary of current CRR

Proposed Risk Category	Datix Ref	Risk	Description	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Review dates	Target Risk Score I x L	Action plan in place with target completion date	Risk /Issue
Money	209	Risk of failure to deliver the annual financial plan 2016/17	If the Trust does not deliver its CIP, activity and income plans, it will fail to achieve the control total outturn agreed with NHSI.	5 x 4 = 20	4 x 4 = 16	08/07/15 - NK	Next 01/02/17	4 x 3 = 12	Action plan in place	Risk
Patient Care	512	Risk to patient safety in ED caring for patients waiting for a bed	The ED provides care for up to 30+ patients waiting for a speciality bed on almost a daily basis	4 x 5 = 20	4 x 5 = 20	20/11/16 SR	Next 19/01/17	4 x 2 = 8	Action plan in place	Issue
Workforce	762	Potential risk of the Trust not being able to provide adequate levels of staffing	Unable to recruit with the knowledge, skills and experience required	4 x 4 = 16	4 x 4 = 16	08/07/15 - AMS	Next 09/01/17	4 x 2 = 8	Not on Datix. Reported to QC and Board	Risk
Patient Care	913	Patient safety risk due to staffing levels below establishment on DMOP	There are insufficient staff leading to an increased risk of patients not receiving the quality of care expected.	3 x 5 = 15	3 x 5 = 15	12/04/16 - SR	Next 06/12/16	2 x 2 = 4	Action plan in place	Issue
Patient Care	1285	Insufficient staffing levels on the frailty unit (1A) affecting patient safety and operational effectiveness	Insufficient staff to meet the establishment staffing levels leading to an increased risk of patients not receiving the quality of care expected.	4 x 4 = 16	3 x 5 = 15	12/04/16 - SR	Next 06/12/16	3 x 3 = 6	Action plan in place	Issue
Money	1152	Potential impact on quality of care, contract delivery and finance due to increased use of bank and agency	Reliance on bank and agency staff risks continuity of care; ability to deliver activity; breaching the agency cap; failure to meet agency spend controls	4 x 4 = 16	4 x 4 = 16	08/07/15 - AMS	Next 09/01/17	4 x 3 = 12	Not on Datix. Escalation process in place	Issue
Patient Care	1205	B & P Prosthetic service – staffing situation, service delivery pressures	Vulnerabilities to existing staff - coping with extra demands and pressures in a service that is currently understaffed.	4 x 4 = 16	4 x 4 = 16	16/08/16 AMS	Next 01/12/16	4 x 2 = 8	Action plan in place	Issue
Governance	1259	Serious Incidents Requiring Investigation (SIRI)	Failure to meet the prescribed deadlines in the management of SIRI's could lead to failure to learn lessons	4 x 4 = 16	4 x 4 = 16	22/12/16 SR	Next 31/01/17	3 x 2 = 6	Action plan in place	Issue
Patient Care	1523	Risk to patient outcomes due to the inability to consistently fill all 3 blood science rotas	Insufficient BMS staff to cover 24hr rota that may result in reduced or no service. This applies to services at Southport and Ormskirk Hospitals.	3 x 4 = 12	3 x 5 = 15	04/01/16 - AMS	Next 15/12/16	3 x 3 = 9	Action plan in place	Issue
Money	1555	Failure to achieve financial plan in 2017/18 due to cost pressure from the introduction of an apprenticeship levy	From April 2017 a new apprenticeship levy is being introduced. This is likely to be a cost pressure of £1m per annum for the Trust.	3 x 5 = 15	3 x 5 = 15	01/04/16 - AMS	Next 09/01/17	3 x 4 = 12	Not on Datix. Capture in financial plan	Issue
Patient Care	1569	Consultant Recruitment within Clinical Support Services	Difficulty recruiting Histopathologists and Radiologists to manage increasing workload	2 x 5 = 10	3 x 5 = 15	17/11/16 AMS	Next 30/12/16	3 x 4 = 12	Action plan in place	Issue

Activity	1700	CCG Referral management system and referral deferral schemes	St Helens CCG have introduced a Referral Management System in July 2016 with an expected reduction in referrals to the Trust.	3 x 4 = 12	3 x 5 = 15	05/08/16 - RC	Next 09/01/17	3 x 2 = 6	Action plan in place	Risk
Governance	1772	Risk of Malicious Cyber Attack	NHS organisations have been targeted by malicious software which could cripple the HIS Network.	3 x 4 = 12	4 x 4 = 16	09/11/16 CW	Next 30/01/17	Not recorded	Not on Datix	Risk
Patient Care	1848	Contingency communication during a major incident	The Trust is currently not adequately prepared for emergency communication in the event of a major incident	5 x 4 = 20	5 x 3 = 15	20/12/16 SR	Next 23/01/17	5 x 2 = 10	Action plan in place	Issue

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

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TRUST BOARD PAPER

Paper No: NHST(17)004a
Title of paper: Review of the Board Assurance Framework (BAF) – January 2017
Purpose: For the Trust Board to review the BAF and agree proposed changes.
Summary: The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its strategic plans and key long term objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in October 2016. **Key to Changes:** ~~Score through~~ = proposed deletions Blue Text = proposed additions Red = overdue actions There are no proposed changes to the scoring of any of the risks (either to increase or to decrease the scores), since the last review.
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to ensure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSI, CQC, Commissioners.
Recommendation(s): The Trust Board are asked to note and approve the strategic risks captured on the Board Assurance Framework.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance.
Date of meeting: 25th January 2017.

Strategic Risks - Summary Matrix

Vision: 5 Star Patient Care

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

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

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

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

Risk Scoring Matrix

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

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

Risk 1 - Systemic failures in the quality of care	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause: • Failure to deliver the Clinical and Quality Strategy • Failure to deliver CQUIN element of contracts • Patient experience indicators decline • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting Effects: • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage Impact: • Harm to patients • Loss of reputation • Loss of contracts/market share	5x4= 20	• Quality metrics and clinical outcomes data • Safety thermometer • Quality Board Rounds • Complaints and claims • Incident reporting • IPR monitoring • Quality Governance structure • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with lead CCG • NHSI Accountability Framework • Appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC Action Plan • Medicines Optimisation Strategy	To Board; • IPR • Patient Stories • Quality Board Round reports • Quality Committee and its Councils • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Staff Survey • Friends and Family scores • Nursing Strategy • Mortality Review Reports • Quality Account • Internal audit • Clinical and Quality Strategy • National Inpatient Survey • Sign up to safety Indicators Other; • National clinical audit programme • External inspections and reviews • PLACE Inspections • Reports • CQC CIH Inspection Report • Learning Lessons League • IG Toolkit results	5 x2 = 10		Consistent achievement of the 95% VTE screening target Achievement of the national targets for AKI and Sepsis Introduction of the midwifery led care pathway for women having low risk births	~~Development of a new Complaints Management system and performance monitoring - October 2015~~ Achievement of complaints response times targets for 2016/17 – March 2017 Delivery of all actions on the CQC Action Plan (March 2017) Plans for implementing the four key 7-day service standards - March 2017 Stroke Service integration with WHH -March 2017 Weekend mortality improvement plan - September 2016 Improve F&F response rates (March 2017)	5 x 1 = 5	KH/ SR

Risk 2 - Failure to agree a sustainable financial plan with commissioners	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to delivery LTFM, including growth and CIP • Failure to control costs • Failure to implement transformational change at sufficient pace • Failure to meet the TDA 4 tests and secure national PFI support • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions Effects; • Failure to meet statutory duties • TDA Escalation status increases • Failure to progress FT application Impact; • Unable to deliver viable services • Loss of market share • External intervention	5 x 5 = 25	• IBP/LTFM • Business Planning • Budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 5 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review) • Contract monitoring and reporting • Contract review Board and CQPG • Activity planning and profiling • IPR • NHSI monthly monitoring submissions • Creation of a PMO to support delivery of CIP and service transformation • Signed Contracts with all Commissioners • Application of agency caps • Internal audit programme	To Board; • Finance and Performance Committee • Annual financial plan • Finance report • IPR • Statement of Internal Control • Annual Accounts • Audit Committee • Grant Thornton CIP Review and Report • SLM Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports • Annual audit programme Other; • NHSI monthly reporting • Contract Monitoring Board	5 x 4 =20	Agree a shared health economy financial and sustainability strategy Develop 2016 - 19 detailed CIP plans	Commissioner engagement in joint long term financial modelling and planning	PMO impact assessment and ROI -March 2017 ~~Agree two year contracts with Commissioners – December 2016~~ Develop a detailed STP implementation plan with Alliance LDS partners - October 2016 Secure maximum SFT funding available – March 2017 for 2016/17 and then equivalent for 2017/8 and 2018/19.	4 x3 = 12	NK

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

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

Risk 5 – Failure to work effectively with stakeholders	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Different priorities and strategic agendas of multiple commissioners • Unable to create or sustain partnerships • Competition amongst providers • Complex health economy • Poor staff engagement • Poor community engagement • Poor patient and public involvement Effect; • Lack of whole system strategic planning • Inability to secure support for IBP/LTFM • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff Impact; • Unable to reach agreement on collaborations to secure sustainable services • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff • Failure to win new contracts • Increase in complaints and claims	4 x 4 = 16	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCC/ Workforce Council • Patient and Public Engagement and Involvement Strategy • CCG CEO Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • CCG Board to Board Meetings • CCG Representative attending StHK Board meetings • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Merseyside and Cheshire Sustainability and Transformation Planning governance structure • Acute Alliance LDS Exec to Exec working • StHK Hospitals Charity annual objectives	To Board; • Quality Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports • Francis Action Plan • TDA IDM's • Review of digital media trends and trust mentions • Monitoring of and responses to NHS Choices comments and ratings • Charitable funds committee	4x3 = 12	Annual programme of engagement events with key stakeholders to obtain feedback and inform strategic planning Agreement of the process and governance arrangements to support the STP footprint planning for the ~~June 2016~~ five year plan submission and subsequent implementation	STP performance and accountability framework reports to Board	Re-fresh stakeholder mapping and engagement plans as part of the renewal of the Communications and Engagement Strategy – July 2016 STP and Alliance shared implementation plans and accountability structures – ~~October 2016 –~~ revised date of March 2017 set by NHSE/NHSI	4 x2 = 8	AMS

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

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

Risk 8 - Major and sustained failure of essential IT systems	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage • Lack of effective risk sharing with HIS shared service partners Effect; • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Inability to record activity and duplication due to reliance on back up paper or manual systems. • Loss of data or patient related information Impact; • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4x4=16	• HIS Management Board and Accountability Framework • IM&T Strategy monitoring • Procurement Policy • Information Strategy • HIS performance framework and KPIs • HIS customer satisfaction ratings	To Board; • HIS Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • MITc Other; • Major Incident Plan • Business Continuity Plans	4x2=8	Secure on-going HIS funding from CCGs and other partners		Develop a final business case for the next generation of clinical IT systems - December 2016 Secure NHSI approval for the PAS replacement business case – June 2017	4x2=8	CW

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(17)005
Subject: HR/Workforce Strategy & Workforce Indicators Report
Purpose: To provide assurance to the Board of the Trust's achievement of workforce indicators that supports the achievement of the Trust's Corporate Objectives specifically to developing organisation culture and supporting our workforce.
Summary: The Trust is committed to developing the organisational culture and supporting our workforce. This paper summarises achievements/progress to date.
Corporate Objective met or risk addressed: Developing organisation culture and supporting our workforce
Financial Implications: N/A
Stakeholders: Staff, Managers, Staff Side Colleagues and Patients
Recommendation(s): The Trust Board are requested to accept the report and to note the areas of achievement/progress against corporate objectives.
Presenting Director: Anne-Marie Stretch, Director of Human Resources & Deputy CEO
Board date: 25th January 2017

HR/Workforce Strategy & Workforce Indicators Report

25th January 2017

1. Developing our Workforce Culture

As part of our continuing development as an organisation, the Trust recognises that our staff are central to the provision of excellent services to our patients, their loved ones, commissioners and our local communities. The Trust's HR & Workforce Strategy states that the Trust's vision is to develop a management culture and style that:

> Empowers, builds teams and recognises and nurtures talent through learning and development.
> Is open and honest with staff, provides support throughout organisational change and invests in Health and Wellbeing.
> Promotes standards of behaviour that encourage a culture of caring, kindness and mutual respect.

2. Purpose of the Paper

This paper is presented to provide assurance to the Board that the workforce strategies, objectives and indicators are being achieved to support the Trust's objectives, specifically to develop organisational culture and supporting our workforce.

2.1 National Workforce Changes

Junior Doctors Contract 2016

The Trust has implemented the new 2016 contract of employment following the decision by the Secretary of State on the 6th July 2016 to introduce new conditions of service from the 6th August 2016 on a phased implementation from October 2016. This had and continues to have particular implications for the Trust as Lead Employer to Cheshire and Merseyside, West Midlands and East of England where c. 4,600 junior doctors have now received new contracts of employment in line with the implementation timetable.

The implementation of the new contract has also included the appointment to two new roles in the Trust who must be a minimum of Consultant or GP level and have previous experience in postgraduate education and training. Following a robust recruitment process, Dr Peter Arthur has been appointed as the **Guardian of Safe Working** for GPs employed under the Lead Employer arrangements and Mr Mike Chadwick has been appointed as the **Trust (as a host) and Lead Employer Guardian of Safe Working**. The responsibilities of the Guardians will include:

- Champion of safe working hours
- Overseeing safety related exceptions reports and monitoring compliance
- Escalation of issues for action where not addressed locally
- Ensuring that work schedule reviews are undertaken where necessary
- Intervention to mitigate safety risks or when issues are not being satisfactorily resolved
- Distributing monies received as a result of fines for safety breaches

- Quarterly reporting to the Trust Board from April 2017

In addition, the role of **Guardian of Flexible Working** will be undertaken by Dr John McLindon, Director of Post Graduate Medical Education

3.0 Developing our Workforce

Following the approval of the Education Strategy and appointment of a new Head of Leadership and Organisational Development in July 2016, a review of all programmes has taken place to identify those that require revision and those which remain fit for purpose aligned to the new strategy. This review has also been used to inform the development of an updated Talent Management Strategy to ensure the provision of future programmes meet the development needs of the Trust.

3.1 Trust Mandatory & Risk Management Training

Mandatory Training activity continues to remain a high priority across the Trust to ensure we achieve and maintain performance targets of 85% (100% of available staff) and staff are appropriately trained to meet regulatory requirements. Detailed statistics are included in the Integrated Performance Report presented to the Finance and Performance Committee. Where areas of underperformance are identified, these are followed up directly with appropriate Services Leads to ensure remedial actions are put in place. Currently the Trust is compliant with the 85% target.

3.2 Appraisals

Appraisal activity continues to remain a high priority across the Trust to meet the performance target of 85% (100% of available staff). Detailed statistics are included in the Integrated Performance Report presented to the Finance and Performance Committee. The pilot programme introduced to enhance the quality of appraisal meetings for both Appraisers and Appraisees has completed and has now gone live for all areas. This includes revised appraisal paperwork which has been developed in conjunction with appraisers and appraisees. Any areas of underperformance are followed up directly with Service Leads to put in place remedial actions. Currently the Trust is slightly under the 85% target.

3.3 Apprenticeships

The Trust currently has 75 Learners who are successfully progressing with apprenticeships across the Trust. In Q2, 12 members of staff completed apprenticeships.

In April 2017 an Apprenticeship Levy will be introduced for all large UK employers with over 250 employees and a pay bill in excess of £3 million, to fund future apprenticeships. The rate for the levy will be set at 0.5% of an employer's paybill and will be collected via PAYE by HMRC. This means a levy of approximately £800k to the Trust which has been identified as a financial pressure in the 2017/18 budget. The Trust is working with other Trusts across the LDS and STP to develop an Apprenticeship Strategy which will support Trusts to be able to draw down their allocation of the levy by accessing apprenticeship educational programmes. This will involve the regional commissioning and delivery of education and training across clinical and non-clinical roles up to post graduate level roles. It is important that opportunities presented by the Levy are used to address workforce challenges.

3.4 Maternity Development Centres

As part of the Maternity Department's Organisational Development (OD) plan, development centres have been successfully delivered to 32 Band 7 members of staff in Maternity. This is part of the talent management and succession planning process to ensure the Trust's clinical workforce are equipped with the leadership skills required to lead a clinical service. The information from the development centres was collated to provide feedback at a managers' meeting at the end November 2016. One to one feedback has been completed to support individuals with career development and Continuing Professional Development (CPD). Key development themes have been identified which will inform a Core Management Development Programme/Team and Personal Development Plans. The framework for the Development Centres will support future Talent Management Programmes in other departments.

3.5 Cultural Surveys

The development and implementation of Cultural Surveys continues to support organisational development plans across operational services. Staff at all levels are invited to participate in surveys to baseline the current climate. The rich data from the surveys is crucial to ensuring staff views are listened to and actions identified and agreed to shape and inform future plans. In addition, the annual staff satisfaction survey was completed in November 2016 and the results will be published in February with a report to the March 2017 Trust Board detailing findings and the 2017/18 action plan.

3.6 Core Management Development

The core management development programme is in the early stages of being implemented. The overall aim of the programme is to build capability and competence across management teams within the Trust to ensure management practice demonstrates the organisation's vision and values in practice. The recently published NHSI Leadership Model will inform the content of future management development programmes.

3.7 Talent Development

A revised Talent Management Strategy 2016-20 has been developed and was ratified at the Trust's Workforce Council in November 2016. Following a successful bid for funding to the NW Leadership Academy, the Trust is working in partnership with a software developer and colleagues from Southport and Ormskirk Hospital Trust, Warrington and Halton Hospitals FT and Countess of Chester to develop an e-Talent tool to support this process. A number of new development programmes require setting up and putting in place to "grow our own" staff in roles that are either difficult to recruit into, or where new/different roles are required to meet service delivery requirements.

3.8 Leadership Coaching

The Trust is committed to developing a coaching culture and there is active coaching activity within the Trust. A coaching strategy will be developed throughout February to set clear direction for maximising coaching resources and ensure there is an appropriate

infrastructure in place to monitor and manage an in-house coaching programme within the organisation.

3.9 Leadership Development

The Ward Managers Leadership Development Programme has been replaced by the recently introduced Core Management Development Programme to achieve a minimum level of management practice across all management teams and extend the offer across all management roles. The introduction of the Apprenticeship Levy in April 2017 will provide additional opportunities to offer leadership and management development qualifications at level 3, 5 and 7. Information to promote the development for the NHS Leadership Academy -' Stepping Up programme' aimed at BME (Black and Minority Ethnic) leaders and aspiring ones working in bands 5 to 7 has been circulated to over 200 staff.

4.0 Recruitment & Retention

The Francis Report published in 2013 highlighted that the shortage of doctors and nurses that were a contributing factor to the issues within Mid Staffordshire NHS Trust. The Trust regularly reviews its Workforce & HR Strategies to ensure that they remain aligned to the Francis Report recommendations and our Recruitment Strategy includes the utilisation of international recruitment and other methods to address the on-going national shortage of doctors and nurses.

Building on our successes to date the Trust will continue to explore international recruitment opportunities. Having gained an insight into international labour markets, our targeted advertising campaigns have improved and we will carry out a number of activities to facilitate a more strategic approach to our advertising strategy. Many agencies recruit medics via European career fairs and a business case will be submitted for the Trust to be represented at these events. We will introduce a rolling programme of international medical and nursing recruitment, working closely with selected international agencies and extend the use of Skype to improve time to hire in line with the Carter Report.

The on-going national shortage of doctors and nurses together with gaps in Deanery training posts and difficulty in recruiting to some Consultant posts continues to challenge the Trust. The Workforce & HR Strategies remain aligned with the Francis Report recommendations and our Recruitment and Retention strategy includes the utilisation of international recruitment.

4.1 Recruitment Challenges

The national shortage of doctors and nurses together with on-going gaps in Deanery training posts continues to challenge the Trust. As at December 2016 the Trust is recruiting to 12 consultant vacancies (a number of which are covered by temporary staff) and there are 55 ward based Registered Nurse (RN) vacancies. Key shortage areas (nationally as well as locally) include Dermatology, Histopathology, Stroke, Care of Elderly and Emergency Medicine.

During 2016, 22 doctors were appointed via various international recruitment activities including the implementation of the Medical Training Initiative Scheme, working in

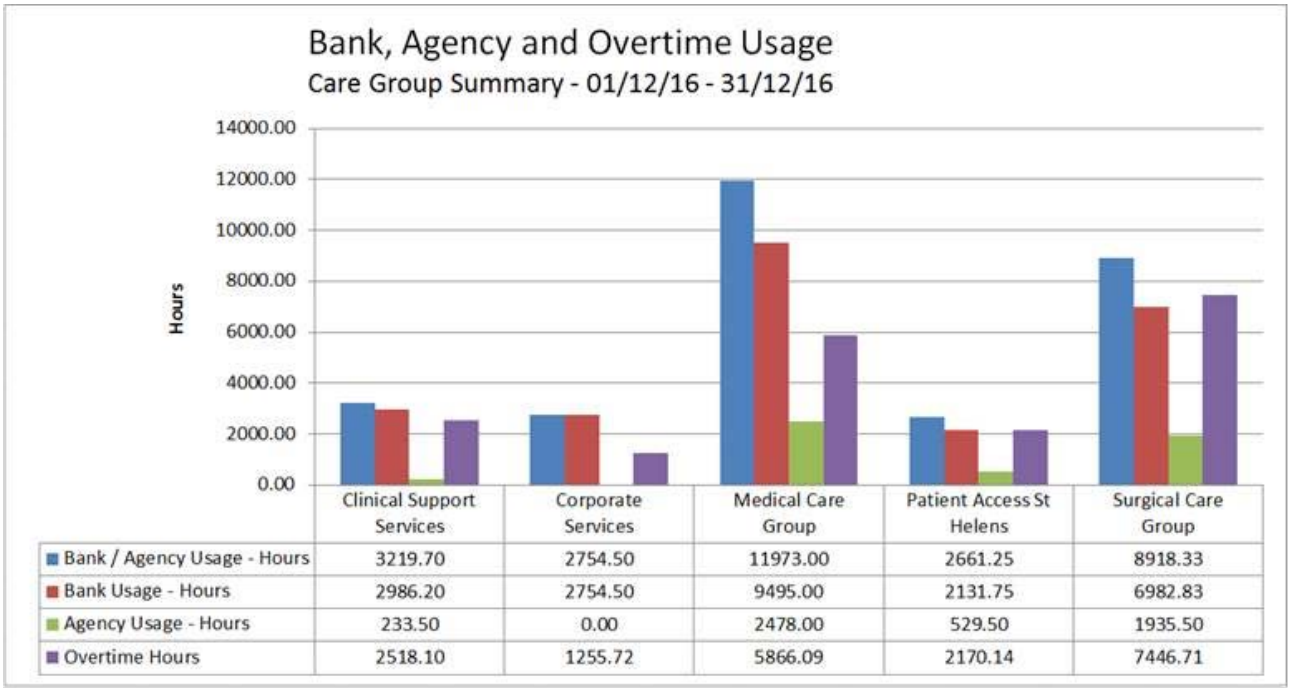
partnership with the British Association of Physicians of Indian Origin (BAPIO), one European university, and a number of overseas recruitment agencies.

100 offers of employment were made to nurses during the recruitment campaign held in India. Due to difficulties in the nurses passing the International English Language Testing System (IELTS) this has delayed them joining the Trust. Two nurses have now commenced employment and six will start in February 2017. A further 21 have now passed the International English Language Testing system (IELTS) and are at various stages of pre-employment requirements such as cognitive behavioural therapy (CBT) training, application to the NMC etc. The overseas recruitment agency expects that a further 6 nurses should arrive in late January/early February 2017 and another 10 by April 2017. It is projected that the Trust will have an additional 29 nurses from this campaign however this may increase over time if the remaining nurses pass the English language test.

The Trust is continuing to raise its profile on the international stage, attending conferences such as the Radiology International Conference in Vienna in April 2016. The Trust is to have its own stand at a further conference in Vienna in 2017. So far the Radiology Department has appointed one overseas doctor. The Trust was represented at the International Stroke conference in Liverpool in November 2016 and we had an advert placed in the programme for the Indian Association of Pathologists conference held in Jaipur, India, in December 2016.

4.2 Temporary Staffing

As a consequence of the on-going workforce challenge there is the continuing need to fill posts on a temporary basis by using bank, agency and/or locum workers. Whilst vacancies are not the only reason for this usage, they are the principle reason and as such there is a premium financial cost. The Trust's agency expenditure is detailed in the Integrated Performance Report and reported regularly to several key Trust Committees and Trust Board. The Trust continues, as per NHSI rules, to report agency spend and framework compliance to the NHSI on a weekly basis. A summary of care group bank and agency usage below illustrates that the majority of additional shifts are filled by a combination of the internal bank and overtime.



	Clinical Support Services	Corporate Services	Medical Care Group	Patient Access St Helens	Surgical Care Group
Bank / Agency Usage - Hours	3219.70	2754.50	11973.00	2661.25	8918.33
Bank Usage - Hours	2986.20	2754.50	9495.00	2131.75	6982.83
Agency Usage - Hours	233.50	0.00	2478.00	529.50	1935.50
Overtime Hours	2518.10	1255.72	5866.09	2170.14	7446.71

The majority of agency spend is on medical staff with the Trust's top 20 highest spend areas all being medical staff.

4.3 NHSI – Agency Spend Reduction

The Trust continues to execute actions to reduce reliance on agency workers and reduce spend against the target including ensuring the Trust Board has the right level of oversight on spend. The Trust is working with partners to reduce agency pay and commission rates which includes encouraging the movement of workers from agency to the Trust Medical Workforce Bank and running monthly recruitment campaigns for HCAs and qualified nurses to join the Trust Clinical Nurse Bank. Options are also being explored across the LDS and STP to create regional banks with the support of systems providers.

4.4 Off Payroll Working in the Public Sector

On the 5th December 2016 the government commenced a consultation on its proposal to move the responsibility for determining whether the off-payroll rules apply to a contract, and deducting and paying associated tax liability to the public sector body or the agency engaging the worker though their personal services company, (PSC). The new HMRC regulations and guidance is expected to be published by March 2017.

The Trust engages temporary workers on PSC both directly through the Trust and also via agencies. A internal project to scope the process of calculating tax liability and the resource implications of the administration of collecting via PAYE from April 2017 is underway.

5.0 Health, Work & Wellbeing (HWWB) - Supporting our Workforce

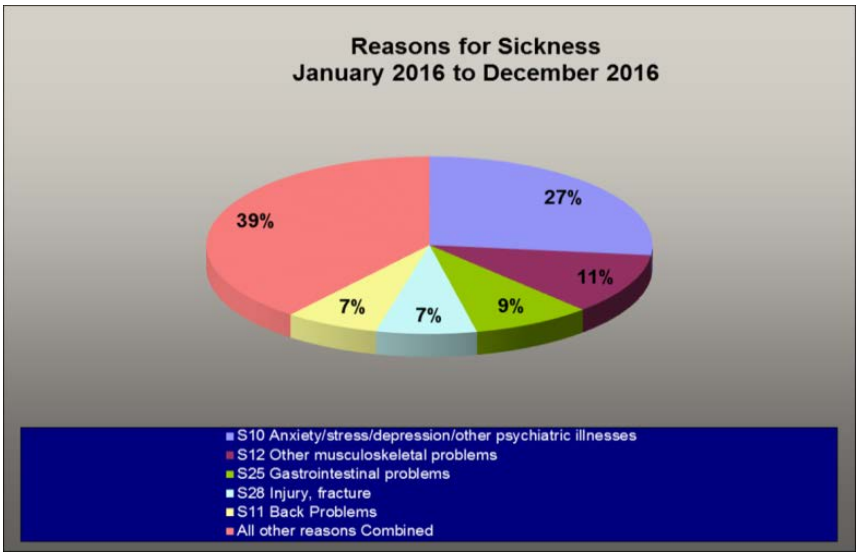
The Health Work and Well Being Service have been re-accredited with Safe, Effective Quality Occupational Health Service, (SEQOHS) in December 2016. This demonstrates ongoing compliance with the nationally required standard for Health, Work & Wellbeing Services in NHS Trusts. The Trust continues to provide HWWB support to external organisations e.g. local CCGs and as the Lead Employer c.3,400 junior doctors in training on behalf of Health Education North West. This service now also includes an additional c.1,200 GP junior doctors in training from HEE West Midlands with effect from August 2016 and a further c1,100 from the East of England from the 1st February 2017. The Trust's Lead Employer Service has also been commissioned to host the new Physicians Associate trainee role on behalf of HEE NW to be deployed in Trusts across the North West. The HWWB Department have carried out employment checks and vaccinations for 160 Physicians Associates who commenced employment on the two year training scheme on the 1st February 2016.

The Trust's HWWB service is taking a lead role in the progression of the Cheshire and Merseyside STP Streamlining Programme of Occupational Health Services throughout the region. This includes the streamlining of blood tests and vaccination tests to remove unwarranted variation and unnecessary costs of duplication as NHS staff move across the region for career progression. Harmonisation of IT systems and regional procurement as part of back office savings is also being explored.

The Health Work and Well Being Service enabled the Trust to achieve the 2016/17 CQUINN target of 75% of frontline staff within the first month for the vaccination programme, going on to achieve an uptake rate of 81% to date. This is against a national average of 54.9%. The Trust's results demonstrate an impressive effort to ensure as many frontline staff as possible are vaccinated in order to protect patients as well as the workforce.

5.1 Health, Work & Wellbeing – Key Performance Indicators

The Trust's HWWB services are aligned to needs identified via analysis of the main reasons for absence whilst also offering services to keep staff healthy and in work.



6.0 Human Resources Advisory Team – Attendance Management

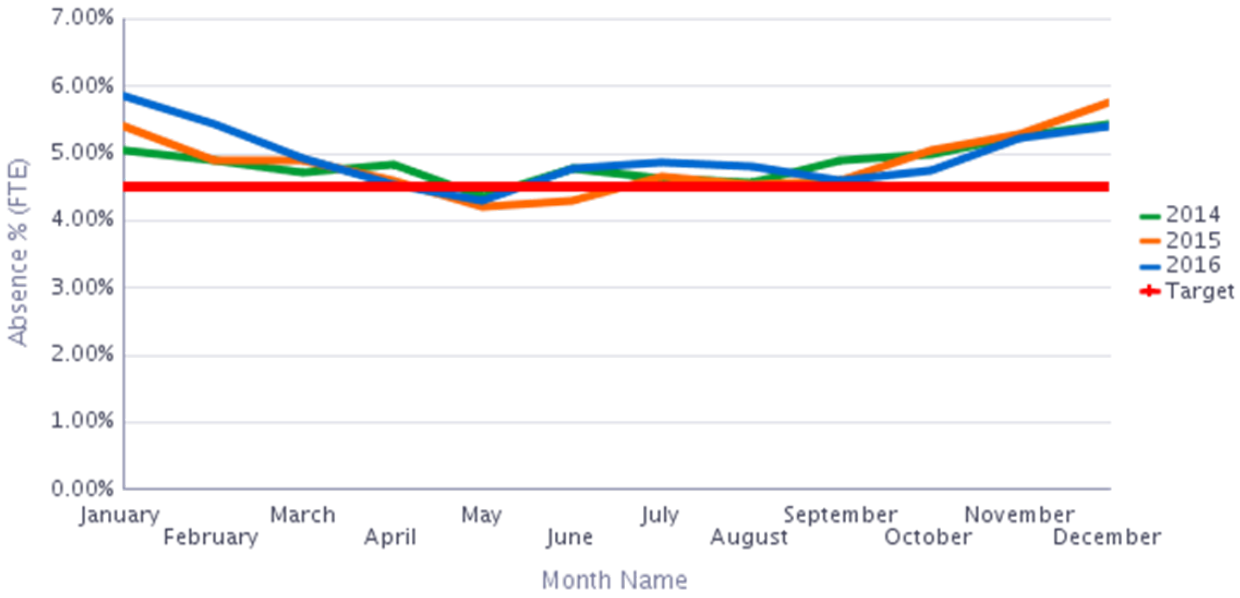
In addition to the support provided to staff and the Trust's management to improve the health and wellbeing of staff by the HWWB service, the Human Resources Advisory Team assist managers in the consistent application of the Trust's Attendance Management policy. The benchmarking data below shows that the Trust's sickness absence for this period compares favourably overall in all Staff Groups. Additional Clinical Services (HCAs) is an area of focus for the Trust with regular monitoring occurring through the Fiinance and Performance Committee.

Benchmarking of Cumulative Absence January 2016 to December 2016			
Staff Group	St Helens and Knowsley	Merseyside Trust A	Merseyside Trust B
Add Prof Scientific and Technic	4.74%	4.01%	4.94%
Additional Clinical Services	7.86%	6.64%	8.83%
Administrative and Clerical	3.77%	4.63%	5.12%
Allied Health Professionals	3.13%	3.03%	3.37%
Estates and Ancillary	6.61%	9.38%	8.50%
Healthcare Scientists	3.56%	2.08%	4.26%
Medical and Dental	1.53%	2.51%	1.09%
Nursing and Midwifery Registered	5.10%	6.12%	5.82%

The last 3 years shows absence levels in 2016 started off higher than previous years but is currently an improved position on last year.

3 Year Absence Trend Analysis

	2014	2015	2016
January	5.06%	5.40%	5.85%
February	4.89%	4.90%	5.45%
March	4.73%	4.89%	4.94%
April	4.84%	4.59%	4.54%
May	4.36%	4.21%	4.31%
June	4.77%	4.30%	4.79%
July	4.63%	4.67%	4.88%
August	4.57%	4.55%	4.80%
September	4.90%	4.59%	4.60%
October	4.98%	5.05%	4.75%
November	5.25%	5.29%	5.21%
December	5.45%	5.77%	5.42%



6.1 Human Resources Advisory Team - Attendance Management Positive Action

The HR Advisory Team continues to work closely with Ward Managers, Matrons and Directorate Managers to address sickness absence, with particular attention being paid to areas with the highest levels of sickness absence. They also continue to work in partnership with the HWWB team to tackle long term sickness absence and support staff back to work.

6.2 Application of the Attendance Management Policy

The following table shows the number of staff per Care Group who are being currently actively managed under the Trust's Attendance Management Policy.

Stages and Levels	MCG	SCG	St Helens	CSSG	Pharmacy	Corp	Non-Clinical	Trust Total
Stage 1	**148**	**140**	**32**	**37**	**6**	**27**	**59**	**449**
Stage 2	**40**	**30**	**4**	**11**	**4**	**4**	**10**	**103**
Stage 3 (Non-Dismissal)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Stage3 Dismissal	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**2**
Stage 4	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Level 1	**62**	**57**	**22**	**25**	**4**	**10**	**29**	**209**
Level 2	**17**	**7**	**2**	**11**	**0**	**2**	**8**	**47**
Level 3 (Non-Dismissal)	**3**	**3**	**0**	**0**	**0**	**0**	**0**	**6**
Level 3 Dismissal	**0**	**0**	**0**	**2**	**0**	**0**	**1**	**3**
Level 4	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**
Total	**270**	**237**	**60**	**88**	**14**	**43**	**108**	**820**

6.3 Attendance Management Policy

Amendments to the policy were approved at the Workforce Council in January 2017 to strengthen the triggers in place for moving staff to stages/levels of the policy as well as ensuring a robust process for managing trends in sickness absence which do not hit a trigger. Changes were also made to clarify reasons for management referrals to HWWB and to improve cancellations and non-attendance at appointments.

Promoting a Culture of Well-Being - Well-being Champions

In order to place a positive emphasis on staff health, the Trust is planning to introduce well-being champions on all wards/depts. The Champions will help to support the following areas of health improvement**:**

- Stress & reliance
- Stopping smoking
- Exercise
- Alcohol
- Weight management

Leadership & Developing our Culture

As part of promoting an overall culture of well-being, there is to be an emphasis on embedding the following leadership behaviours: Being well-being focussed, ensuring staff feel valued, thanking staff for their contribution, managing with kindness and encouraging team building. These will be promoted through leadership training and a re-launch of the NHS leadership standards.

7.0 Equality, Diversity & Inclusion

The Trust has continued to make progress with the Equality Delivery System (EDS2) during 2016/17 and the Workforce Race Equality Standard (WRES) action plan is on trajectory for completion of milestones by 31st March 2017. A new standard from NHS England; the Workforce Disability Equality Standard (WDES), will commence a preparatory year of communication and engagement with Trusts by the NHS Equality and Diversity Council, (EDS) from 2017-18. It is proposed the WDES is mandated from April 2018. The Trust intends to develop an action plan in 2017/18 as part of our preparation for the WDES.

8.0 Enhancing Workforce Systems & Processes

The implementation of e-rostering solutions are aligned to the delivery of the Trust's Carter Workforce action plan and also support the Secretary of States statement on the 30th November 2016 where he asked all NHS providers to adopt a more flexible approach to rostering using e-rostering software where available.

8.1 Health Roster (E-Rostering)

Implementation of the system is on-going and there are now 54 clinical areas live with Health Roster across the Trust. There are a further 7 departments preparing for implementation by April 2017. The Trust is working towards full implementation across Clinical Support Services and Administration and Clerical areas in 2017/18.

8.2 E-Rota / E-Job Planning

As part of the implementation of the 2016 Junior Doctors contract, all junior doctor rotas are now uploaded using E-rota and the system has been utilised to make adjustments to the rotas to ensure that they are compliant to the new terms and conditions of service and avoid significant unexpected costs or safety implications that may arise from non-compliant rotas.

Work is underway to implement a further module, Health Roster for the medical workforce. This will allow for the recording of annual leave, study leave and sickness absence and will enable Divisional Managers and Clinical Directors to have improved oversight of junior doctors' rotas and consultants' job plans (previously all paper based), so they remain dynamic to service priorities and commissioning intentions.

8.3 Roster Perform

Roster Perform is the management information tool available to the Trust to analyse the effectiveness of rostering and assist in identifying where benefits can be realised by rostering differently. This software provides comprehensive data from which the Trust has now developed a suite of Key Performance Indicators and monthly reports are produced detailing performance against five KPIs. Departments are using these reports to further enhance efficient workforce utilisation.

8.4 Employee On line and E-timescales

These 2 new system developments allow registered individuals to book available Bank shifts direct. This system has been fully implemented and has streamlined the bookings procedure enabling shifts to be filled more efficiently.

E-Timesheets have also now been implemented successfully for all nursing, Allied Health Professionals and clerical Bank workers. All bank staff now submit their hours worked by a new e-timesheet which following approval by the authorising line manager, goes directly to payroll reducing double entering and the cost of paper. This was implemented in Q2 and is now fully operational.

9.0 Electronic Staff Records (ESR) & Payroll

ESR Release 33 in December 2016 resulted in a new look and feel of the system. Over the last 12 months a series of workshops for pilot organisations took place. Being a pilot for Release 33 has enabled the Trust to work with the software providers IBM and the NHS Central Team to adapt the functions with the end users in mind. Work is underway to roll-out E Expenses to Trust Corporate Services and staff will use the system from February 2017. The remainder of the Trust will move to e-Expenses by the end of March 2017., the Trust has also benefited from a range of new functions including:

- Access to staff's own records via the internet through the use of MYESR
- Online payslips
- Online P60's
- Total Reward Statements
- Mobile access via smartphones and tablets
- E-learning
- Alerts and newsletters
- Email notifications

The Trust will be introducing the new functions to users to Trust staff from January 2017 onwards.

9.1 Payroll Services

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

Achievements year to date:

- Expanded product portfolio that we offer to clients to include weekly payroll and an E-Expenses locally developed system
- Increased number of clients
- Project plan for implementation of E-Expenses
- Efficiencies from service improvement processes and 'e' functionality
- Significant assurance received from Internal Audit by MIAA
- Extension of all client contracts that expired in 2015/2016
- Supported the Trust through the Pensions Auto Enrolment and Re Enrolment process
- Project plan for implementation of 'e' payslips
- Project plan to streamline the payroll process for managers and employees

The Payroll Department is currently developing a microsite to promote the StHK brand as a national NHS payroll provider. It will contain a service catalogue to support current and potential future clients to understand our product range.

10.0 Workforce Planning – Staff in Post

Since April 2016, the figure for staff in post increased overall by 122.11 wte. Increases in Healthcare Assistants and Administrative and Clerical staff account for the majority of the increase. The Trust has been successful in expanding several shared services. There are currently c.118 staff on maternity leave, with 46 of staff on secondments from their substantive posts and 7 staff on a Career Break.

Staff Group	Apr-16	Sep-16	Dec-16	Difference
Add Prof Scientific and Technic	146.77	156.89	154.09	7.32
Additional Clinical Services	869.98	904.09	911.22	41.24
Administrative and Clerical	935.01	959.14	976.54	41.53
Allied Health Professionals	228.72	232.56	231.71	2.99
Estates and Ancillary	289.74	289.19	287.31	-2.43
Healthcare Scientists	177.98	189.00	191.08	13.10
Medical and Dental	402.25	400.97	407.65	5.40
Nursing and Midwifery Registered	1,346.59	1,344.66	1,359.54	12.95
Grand Total	**4,397.04**	**4,476.50**	**4,519.15**	**122.11**

10.1 Workforce Planning - Staff Turnover Rates

Turnover rate is currently 9.86% for the period January 16 to December 16. The Trust benchmarks lower against local Acute Trusts and national average of c.17%.

Staff Turnover by Staff Group (Period January 2016 to December 2016)			
Staff Group	**Trust**	**Alder Hey**	**Royal Liverpool**
Add Prof Scientific and Technic	9.36%	10.96%	10.61%
Additional Clinical Services	8.74%	12.39%	9.54%
Administrative and Clerical	7.63%	12.33%	8.82%
Allied Health Professionals	16.01%	11.58%	10.40%
Estates and Ancillary	7.50%	3.88%	3.68%
Healthcare Scientists	11.20%	7.07%	14.29%
Medical and Dental	19.02%	20.12%	22.22%
Nursing and Midwifery Registered	10.41%	10.61%	8.95%

10.3 Staff Retirements Due within 12 months

Staff Group	Retirements Due	3 Months	6 Months	9 Months	12 Months
Add Prof Scientific and Technic	1	1	1	1	1
Additional Clinical Services	35	39	45	48	49
Administrative and Clerical	25	27	31	32	36
Allied Health Professionals	3	3	3	3	3
Estates and Ancillary	32	35	38	39	40
Healthcare Scientists	3	4	4	4	4
Medical and Dental	5	7	8	13	13
Nursing and Midwifery Registered	20	23	23	23	24
Grand Total (Aged 65)	**124**	**139**	**153**	**163**	**170**
Nurses Aged 55	**257**	**273**	**287**	**295**	**301**
Nurses Aged 60	**84**	**88**	**96**	**104**	**109**

11.0 Employment & Advisory Services

11.1 Policy Development and Changes

The HR Department continually revise and update policies, procedures and toolkits to ensure they are best practice and aligned to changes in legislation and case law. The Trust continues to discuss issues with Staff Side colleagues on a regular basis, consulting and negotiating policy changes as appropriate.

A revised Raising Concerns Policy has been published to comply with national guidance on whistle-blowing and the requirement for Trusts to appoint a Guardian of Speaking out Safely. This role is carried out by the Assistant Director of Safety and also supports the delivery of the Trust's Francis action plan.

The Trust is continuing to support staff to stop smoking as part of the plan for the Trust to work towards being a smoke free site by April 2017. Staff support in smoking cessation is being promoted as part of the annual Health, Work and Well Being programme and managers will receive guidance as to how the Trust ensures compliance with the Smoke Free Policy as part of a communication and engagement plan over the next few months.

11.2 Organisational Development (OD) Plans

HR Business Partners have continued to support each Specialty to devise targeted Organisational Development plans to help drive improvements in organisational effectiveness. Excellent feedback and progress has already been seen in areas such as Pharmacy, Sexual Health, and Maternity Services as a result of these interventions. Pathology, Theatres, the Emergency Department and IT have also now completed their OD plans and are in the implementation phase. All departments will have commenced the development of their plans along with cultural surveys and OD interventions by the 31st March 2017.

11.3 Case Management

The HR Advisory Team continue to support managers through a range of cases such as disciplinary, grievances and Respect and Dignity at work. The HR Advisory Team introduced a new electronic system to allow the team to track all employee relations casework in a central system. This will also produce management information allowing for analysis of case work for equality and other monitoring purposes.

11.4 Organisational Change Programmes

Many of the organisational changes implemented during 2016/17 to date have been to support the move to 7 day working, extended opening hours and the expansion of on-call arrangements. This has involved consultation and engagement with staff across all Care Groups. Following the Trust's successful bid to deliver St Helens Community Services, c60 staff from Bridgwater Community Health will transfer (TUPE) to the Trust with effect from 1st April 2017. Recent and ongoing consultation programmes, internal to the Trust, include the following services:

- Endoscopy Services -Increased demand for diagnostic service provision has led to implementing 7 day working in Endoscopy services and to allow for working hours to up to 8pm during the weekdays.
- Therapies, Trauma & Orthopaedics - 7 day working
- Informatics – Re-organisation to align the structure and roles to meet the needs of the Trust and partnership organisations.
- Sexual Health – Review of administration roles
- Theatres – Expansion of 7 days working and on call arrangements
- Pharmacy – Extension of opening hours to support 7 day services

12.0 HR Streamlining

The Trust is actively engaging in the NW HR Streamlining Programme which aims to remove un-warranted variation, duplication and improve productivity and efficiency across a range of functions. This will improve recruitment processes, mandatory training, induction, locally determined terms and conditions and occupational health employment checks. The Programme will also act as an enabler for regional procurement of systems where cost improvements can be realised to support the delivery of LDS and STP plans.

13.0 Governance

The Workforce Council provides on-going assurance to the Quality Committee that policies and procedures ratified are legally compliant and in line with national guidance.

14.0 Recommendations

The Trust Board are requested to accept the report, noting the areas of achievement/progress against corporate objectives and governance standards.

Anne-Marie Stretch
Deputy Chief Executive and Director of HR
January 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(17)006
Title of paper: Executive Committee Assurance Report.
Purpose: To feedback to members key issues arising from the Executive Committee meetings.
Summary: 1. Between the 17th November 2016 and 12th January 2017 seven 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 a review of the Home of Choice Policy, continuing arrangements for Interventional Radiology, and measures to increase student nurse training. 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. 4. Agreement to seek tenders for creating additional escalation beds was given, and the Contract for the Risk Management System was agreed but no significant investment decisions were made. 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: 25th January 2017.

EXECUTIVE COMMITTEE REPORT (24th November 2016 to 12th January2017)

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

24th November

1. Stroke

    1.1. KH advised that commitment to a single hyper acute pathway had been received from Warrington and Southport Trusts. For a viable pathway 8 consultants would need to be on the rota and repatriation issues would have to be resolved along with the bed requirements.

2. Respiratory ward seven-day working

    2.1. Simon Twite (ST) provided an overview of 7/7 working noting that consultants working at the weekend see 1/3 of patients in 6 hours. Discharge times were discussed with the related problems of ambulance transport which RC agreed to address. The potential for junior doctors to start work earlier and identify potential patients fit for discharge will be explored.

    2.2. The increase in Consultant PA's was highlighted and the VFM of investment questioned. ST agreed to reconcile the business case figures.

3. CQUIN

    3.1. NK provided an update regarding contracting issues and the incurred penalties.

4. Sepsis

    4.1. Chakri Molugu provided an update since the business case in October 2015 noting that CQUIN has been achieved for the last quarter. Nurse specialists were recruited and commenced in post in January 2016 with positive feedback and Emma Taylor described her role including that of educating other staff. Members discussed mortality, LOS, sepsis pathway and ITU referral. KH asked for audits to be undertaken regarding readmission rates and last diagnosis.

5. VTE update

    5.1. KH reported a significant improvement to just below the 95% target.

6. Clinical Quality Performance Group (CQPG)

    6.1. SR highlighted key items discussed which included patient safety thermometer; mortality and biliary tract disease, and the provider monitoring tool.

7. Sustainability and Transformation Plan (STP) feedback

    7.1. AM reported on the plans published by the STP leadership and advised that delivery of services will have to be carried out in the future with £200m less funding and a range of solutions would need to be seriously considered.

8. Midwifery Local Supervising Authority review

    8.1. SR fed back following the review earlier that day where the overall impression was good. One negative comment regarding induction of labour and the lack of information was being addressed.

1st December

9. Cyber Security Risk

    9.1. CW reported on the recent cyber security threat that took place at North Lincolnshire and Goole FT and provided assurance that the HIS is working on plans to improve resilience locally and a business case is anticipated.

9.2. It was noted that a specific risk, scored at 16, with an action plan has been placed on Datix.

10. STP feedback

10.1. NK reported back from the STP Working Group noting that KMPG have been commissioned to develop a capacity and demand model.

10.2. KH reported that St Helens CCG model is to be called an Accountable Care Management System (ACMS). The final proposal is being produced by PWC, and will be ready in shadow format by April 2017 – completed by April 2018.

10.3. PW highlighted that staff have voiced concerns about the implications of the STP indicating that more communication is needed. AMS advised that 2 staff sessions had taken place, and an in-depth session for senior managers is planned. RC reported that he had set up a forum for Ops Managers and will now extend the invitation to other senior managers.

11. Speak in Confidence

11.1. Neal Jones provided an overview of the effectiveness of the anonymous on-line concerns/ideas system launched in June 2016.

11.2. 85 members of staff have registered and 17 concerns/ideas were raised during the first 4 months, 14 of which have been closed-out following correspondence. AMS will bring this back to Committee when further data is available.

11.3. Members discussed the progress being made to address cultural issues in Theatres which were raised and a date for report to Committee was agreed.

12. Team Brief at St Helens

12.1. PW highlighted feedback from Team Brief at St Helens including the F&FT report, replacement cartridges, and pay arrangements potentially restricting the popularity of working on the staff bank, and actions were agreed.

13. Home of Choice Policy

13.1. Application of the Policy was discussed as it was felt that beds were being unnecessarily taken up by medically optimised “family choice” patients. RC is to summarise the policy and reiterate key points to all staff.

14. Resources redeployment

14.1. KH advised that he will chair a session with CDs and DMs to discuss the redeployment of resources for example the creation and use of ANPs.

15. Accommodation review

15.1. Nicola Bunce (NB), Geoff Hunter (GH) and Diane Stafford (DS) attended to provide an overview, including St Helens hospital office accommodation. Progress with Mohs/ Dermatology and Plastic day case facilities was noted, and options for Dermatology and Orthotics discussed.

15.2. Approval was given to tender for schemes to create additional escalation beds from day room and seminar room conversions.

16. Premium payment expenditure

16.1. RC reported on current vacancies within the Ophthalmology department, and the historical reason for not appointing consultants was revisited.

16.2. The system for coding expenditure for WLI’s was noted and AMS advised that this is being addressed as part of the financial controls and approval process.

17. Stroke

17.1. KH reported that the LDS had met to discuss Stroke and a decision is awaited from Warrington Trust regarding the model produced by Andrew Hill, which if agreed, will require the ring-fencing of additional stroke beds. Following discussion it was agreed that clarity on exact bed numbers is still required.

8th December

18. Opera Project

18.1. CW detailed the actions undertaken since the Trust delayed the project in order to resolve identified issues. GE Healthcare has agreed to update the software, and the Trust has agreed to ensure that appropriate clinicians and operational staff are available to support user workshops to agree modifications.

18.2. CW confirmed that the cost implication for the continued use of the Ormis system is £10k per month.

19. MAXIMS outage

19.1. CW presented a briefing paper on the system outage on 28th November caused by the lack of data storage space. An improved monitoring and alerting system has now been implemented.

20. Telephony outage

20.1. CW presented a briefing paper on the telephony outage on 8th December due to a hardware failure within a Virgin Media cabinet that services Whiston Hospital. Business continuity plans were enacted and a scheme is in place for a new and updated 'platform' for the Trust by the end of February 2017.

21. Option appraisal for the Trust Risk Management System

21.1. Nadine Higgins (NH) and Jane Heaps (JH) attended with an analysis of the different options available for the risk system given the contract for Datix is nearing its end. The options presented were debated. It was noted that 85% of NHS organisations use Datix, and the advantages of remaining with the same system were acknowledged; this being the preferred option. JH confirmed that all procurement procedures had been fulfilled.

21.2. The proposal was approved and JH agreed to set up a user group with neighbouring trusts to share knowledge. It was also noted that additional staff are being trained in administration of the system.

22. Dermatology and RMS

22.1. RC gave verbal feedback following a meeting with the dermatology consultants which focussed on space requirements to meet the increase in referrals and proposals to allow nurse consultants to undertake minor ops. The impact of RMS and out of area referrals was discussed along with the proposals from the Dermatologists to meet demand.

23. STP feedback

23.1. RC fed back on pathology discussions where the pathway model has been drawn up. An option appraisal and decision on 'one site with one hub' or 'dual hub' is required.

23.2. AMS reported on the weekly project leads meeting where Simon Banks was very transparent with information sharing. A paper showing four governance options has been prepared for decision and agreement.

23.3. Louise Shepherd had received feedback from the submitted plan, which asked for more pace, more governance detail, and more aspiration.

23.4. CW fed back from the IM&T group where alignment of IT plans with planning footprints is a key issue for decision by the Alliance Group.

24. Executive Committee Schedule

24.1. The proposed schedule for 2017 meetings was agreed. It was also agreed that PW will facilitate a meeting to discuss the 'house style' of reports.

25. Pathology Telepath IT System

25.1. CW provided an update on the ongoing risk with Telepath which is being managed and of progress with developing a business case. CW went on to confirm that she is undertaking a review of all stand-alone IT systems.

26. Orthodontics

26.1. AMS reported that the Royal College of Surgeons has been asked to advise on appropriate treatment of patients if the service changes.

27. Board Development

27.1. AMS reported that Prof Sir Mike Aaronson, ex-Chairman of Frimley Park Hospital FT has agreed to talk to the Board following an invitation from RF.

28. NHSE Chief Information Officer visit on 3rd February

28.1. Noted that Will Smart who reports directly to Matthew Swindells, National Director for Commissioning Operations and Information is visiting the Trust.

29. Cardiology Specialist Nurse Quality Ward Round

29.1. Communication improvements specifically around the CQUIN process and support from consultant colleagues, raised at the QWR, were discussed. RC agreed to follow this up along with succession planning given the number of potential retirements.

15th December

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

30.1. Phil Nee, John Foo and Jordi Ballester presented the report. Action plans including timescales were requested for improvements in infection control performance.

30.2. It was noted that the Trust were unable to align the data in the GIRFT Report to Trust data therefore further scrutiny of the figures is required.

31. Interventional Radiology

31.1. Glen Massey and David Anwyl attended to discuss the future of the Interventional Radiology SLA entered into with the Royal Liverpool Hospital in 2013. Following discussion it was agreed that KH would write to the Medical Director at the Royal to reiterate the desired terms of the SLA, with consultants working at both sites and seeing patients out of hours.

32. Agency

32.1. AMS provided an update on the Trust agency position which showed some improvement. A benchmarking report showing medical and nursing cap breaches at local Trusts was discussed and it was agreed that this will be regularly reported.

33. EDMS

33.1. CW provided an update on the roll out of the new version of EDMS where new version testing will be carried out up to January. Updates on E-Prescribing and the upgrade of Internet Explorer were provided.

34. Integrated Performance Report (IPR)

34.1. Changes to the IPR were discussed and agreed.

35. STP feedback

35.1. NK provided an update on the STP Working Group where the main item discussed was Accountable Care Organisations (ACO's).

35.2. AM & AMS attended the Alliance Local Delivery System Leadership Group where stroke, IDS and Digital roadmaps were the key points of discussion.

36. Orthodontics

36.1. KH provided an update on the review being undertaken by the Royal College of Surgeons. It has been recommended to extend the locum contract to the end of July to allow plans to be further developed.

22nd December

37. 2-year Operating Plans

37.1. Sue Hill and Nicola Bunce provided an update of the plan to be submitted on 23rd December. Key points included PFI indexation; impact of CIPS; impact of RMS and RTT; metrics from NSHI. Contract negotiations have concluded. Board members have received copies and their comments have been noted.

37.2. The plan was supported by the Executive Committee for approval by the Board.

38. Orthopaedic Limited Liability Partnership (LLP) briefing paper

38.1. Phil Nee and John Foo provided an update to address issues raised from the November presentation namely: Consultant productivity; Orthopaedic capacity within 'normal working hours'; and contribution from substantive and LLP lists. Case mix, income generation, theatre times and theatre utilisation, category of patients and individual consultant productivity were discussed.

38.2. Further information on the current gap to meet demand and the comparative merit of recruitment, LLP and WLIs was requested.

39. Referral Management Systems (RMS)

39.1. Dave Miles (DM) provided an update on the financial impact since implementation by St Helens CCG in July. There has been a reduction in all referrals by 1.6% however the waiting list will mask the impact until quarter 3. The paper assessed the financial and activity impacts and started to develop plans in mitigation where demand modelling is needed by each specialty.

39.2. DM was asked to refresh the model and bring back to the Committee quarterly.

40. Clinical Nurse Specialists review

40.1. Sally Duce (SD) and Diane Dearden (DD) provided an update of the 194 Nurse Specialist workforce, noting if the posts are banded correctly according to role, responsibilities and current guidance. The report showed that the workforce undertake some roles that would otherwise be undertaken by doctors. The proportion of admin time included in job plans was discussed and some felt this to be excessive and required scrutiny.

40.2. It was agreed that the number of recent additional posts needs to be reconciled to business cases. Also, members discussed the role of the MET team and whether a nurse-led model could be implemented which KH agreed to consider.

40.3. The reallocation of staff when clinics and theatre sessions are cancelled was discussed and it was agreed that Care Groups must be more proactive in ensuring that use of labour is maximised.

40.4. The conclusions and 12 recommendations from the report were noted and further work on productivity at specialty level was requested.

41. Proposals for Trust Offices at Alexandra Business Park

41.1. PW presented a paper which highlighted the growth in personnel on the Trust sites, and the problem of office space for Lead Employer and Payroll services from additional contracts. The proposed solution involved these services moving to vacant accommodation at Alexandra Business Park following the relocation of IT services on that site.

41.2. The efficiency of this proposal was dependent upon usefully backfilling the vacated accommodation, ideally with services that could generate income. Whilst some existing pressures were highlighted that the proposal could address more definitive plans were requested.

42. Flu

42.1. SR reported on a Flu outbreak on Duffy Ward which had led to the closure of 2 bays.

5th January

43. Trust Board agendas

43.1. The agendas for the January meeting were agreed subject to minor changes. The actions required following the Patient Story in November were discussed and SR will ensure they are closed out prior to the Board meeting.

44. Outlier Policy

44.1. RC reported that he and SR are updating the current outlier policy as the appropriate selection of patients out-of-hours requires improvement.

12th January

45. Anaesthetic on-call

45.1. Paul Atherton (PA) and John Clayton (JC) attended to discuss the current Anaesthetic on-call rota and options for providing 2nd on call and discreet obstetric cover. Given the range of options available there was insufficient supporting data to make a decision however it was agreed that AMS, KH and RC would meet with PA and JC to formulate a recommendation.

46. Theatres Organisational Development Plan

46.1. JC, Phil Nee and Claire Scrafton attended to feedback on progress with addressing staffing and cultural issues in Whiston Theatres. Following discussion it was agreed that JC would pull together a small number of quick-win actions from the draft action plan.

47. Agency usage

47.1. AMS presented the month 9 information showing month on month reductions in expenditure with a YE forecast now of circa £10.3m against a target of £7.3m.

47.2. Whilst nursing expenditure has turned a corner, spending on agency medical staff is still excessive and discussions were held on how this can be addressed.

47.3. In addition, RC and SR were asked to confirm that controls on the use of agency were not inadvertently adversely impacting overall staffing levels.

48. School of Nursing Sponsored/ Scholarship Students

48.1. Adam Rudduck attended to discuss the changes in the arrangements for training student nurses from April 2017, including the removal of the cap on numbers in training and the introduction of self-funding.

48.2. The report included the option of the Trust developing its own training facility, however the current indications are that numbers trained through colleges are likely to increase and the attrition rate of qualified nurses may well improve. Therefore it was agreed that the Trust should look to maximise the capacity to provide placements for college trainees, and then to develop initiatives to attract and retain a greater proportion of newly qualified nurses.

49. CQC Action plan

49.1. Anne Rosbotham-Williams reported on the latest position with closing-out actions from the CQC report. Only 5 of the original 57 actions are outstanding, and these relate to 4-hour A&E access targets, appraisals in A&E, the Maternity Strategy, and the 'Amber Care Bundle' for potential end-of-life cases. Measures required to close-out the remaining actions were agreed.

50. Integrated Performance Report (IPR)

50.1. NK took members through the draft January report. Key areas discussed were A&E performance, mortality, RTT, and eDischarge letters.

51. MIAA review of the Electronic Patient Record (EPR) implementation costs

51.1. The independent report from MIAA on the business case for EPR was discussed. The report confirmed the appropriateness of all elements of the case including the specification, costs and assumptions, benefits realisation and the option appraisal process. This supports the decision taken by the Trust Board in November to approve the business case.

52. Community Services

52.1. The recent decision by St Helens CCG to award the contract for services to the Trust was discussed along with the action plan for service transfer in April 2017.

52.2. Progress with developing the job description for the Director of Transformation role was noted.

53. Clinical Nurse Specialist Review: Consultant Job Plan admin time

53.1. KH fed back on his initial review of consultant job plans for allocated administration time and confirmed that in some cases this was excessive and is being addressed by Dr Andrews through the job-planning review process.

54. STP feedback

54.1. Members fed back from the various workstreams including the recent local STP discussions held with Jim Mackey.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(17)007
Title of paper: Quality Committee Assurance Report.
Purpose: The purpose of this paper is to summarise the Quality Committee meeting held on 17th January 2017 and escalate issues of concern.
Summary: Key items discussed were: 1. Complaints 2. Safer Staffing 3. CQC action plan update 4. IPR 5. Clinical & Quality Strategy update 6. Approval of Quality Account timetable 7. Safeguarding training update 8. Mortality Surveillance Review update 9. Infection control update 10. Update on meeting the Smoke-free inpatient KPIs
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: 25th January 2017

QUALITY COMMITTEE ASSURANCE REPORT

Summary of the discussions and outcomes from the Quality Committee meeting held on 17th January 2017.

Action Log

1. All actions on the log were reviewed.

Complaints Report

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

   2.1. 71 1st stage complaints were opened during Q3. This is broadly in line with Q3 2016-16 with 72 and Q2 2016-17 with 68. There were a further 21 opened complaints, including 11 2nd stage complaints. 99% of complaints were acknowledged within 3 working days, in line with policy.

   2.2. The Trust responded to 65% of 1st stage complaints within agreed time frames in Q3, compared to 55% in Q2 and 61% in 2015-16.

   2.3. There were 3 overdue 1st stage complaints at the end of December 2016, with none received prior to September 2016. The top complaint themes during the period were clinical treatment and patient care/nursing care.

   2.4. Two cases were referred to the PHSO during Q3 and four cases remained open with the PHSO. The Committee discussed in depth a complaint upheld PHSO regarding fluid balance charts and documentation. Training and learning is being developed, and input and output is now part of eMews. An audit will be carried out in 3-6 months.

   2.5. PALS activity has risen, being 502 contacts/enquiries during Q3, compared to 462 in Q2, reflecting a 9% increase.

   2.6. ARW reported that there have been a number of delays in January, partially due to hospital pressures, and also one member of the team is on long term sick leave; given the situation, it has been agreed by Anne-Marie Stretch and Nik Khashu to recruit an interim. A person has been identified but is unable to start at the Trust until the end of the month.

   2.7. David Graham (DG) asked if the new timescales for responses have been put into place. Following further discussion, it was agreed that 30 days would be given for noncomplex complaints and 60 days for complex cases and this would be starting immediately.

   2.8. Sue Redfern (SR) informed the Committee that there have been a number of complaints regarding patients fasting before surgery. Ali Kennah and Cathy Umbers will look at the policy.

Safer Staffing report

3. Sally Duce (SD) provided an update.

   3.1. The report covers staffing numbers for November and December 2016.

   3.2. 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.

   3.3. 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.

3.4. In November there were 7 wards with a fill rate below 90%; 4 wards for RNs and 2 for HCAs and 1 ward for both RNs and HCAs.

3.5. In December there were 9 wards with a fill rate below 90%; 7 wards for RNs and 2 for HCAs.

3.6. In November 2 patients experienced severe harm following falls and in December 1 patient experienced severe harm. In the November cases, the fill rate was below 90% in month, however, at the time of the fall the staff numbers were correct.

3.7. Trust workforce data shows there were 48 WTE RN and 7 WTE HCA vacancies as of the end of November 2016 on the inpatient wards.

3.8. SD reported that two of the nurses from the Indian recruitment drive are now in post and have undergone an intensive period of training for the NMC OSCE, which they will sit today (17th). 8 nurses are due to arrive at the beginning of February, subject to their visas being issued. Further international recruitment has taken place as has HCA bank recruitment, which has been very successful.

3.9. SD discussed the Shelford Acuity Audit which was carried out in October 2016. Several wards are to repeat the data collecting during January 2017 to ensure consistency and accurate patient acuity assessment data and the report will be presented at the March Quality Committee.

3.10. SD enquired as to payments at Band 4 for nurses awaiting the NMC PIN. SR will take a paper to the Executive Committee for discussion.

3.11. SD said that she meets with Student Quality Ambassadors every six weeks and it has been decided that certain Trust information i.e. QCAT and Quality Ward Rounds will be uploaded to their intranet site.

3.12. The committee discussed inpatient falls and whether the patients had been medically fit and were awaiting discharge.

CQC action plan update

4. ARW provided an update

4.1. 52 out of 57 actions have been completed.

4.2. 2 actions are in progress but are at risk of failing to achieve the original deadline. These relate to achieving the four hour emergency access targets, for which there is an internal action plan and a formal concordat to underpin the partnership working between the St Helens and Knowsley system and the Emergency Care Improvement Programme (ECIP).

4.3. 3 actions are overdue:

4.3.1. Achievement of appraisal target of 85% within the Emergency Department.

4.3.2. Completion of Maternity strategy

4.3.3. The Amber Care Bundle and how this will be rolled out.

4.4. ARW informed the Committee that MIAA had conducted spot checks on four wards and gave significant assurance on three wards and limited assurance on one ward due to an issue with the keys for the controlled drugs cabinet being located with non-clinical staff. This has now been addressed.

4.5. The CQC is currently undertaking a consultation on their next phase of regulation seeking to ensure a more targeted, responsive and collaborative approach.

IPR

5. Rob Cooper (RC) summarised the report.

5.1. There has been 1 never event during 2016/17, which has been discussed at previous meetings.

5.2. There have been 2 cases of MRSA YTD. SR advised the committee that there has been one positive blood sample notified on 8th January. It was felt to be community acquired but an RCA panel meeting was taking place this afternoon (17th).

5.3. There was 1 C.Diff positive case in December. YTD there have been 18 confirmed cases. The annual tolerance for 2016-17 is 41.

5.4. YTD there have no hospital acquired grade 3/4 pressure ulcers. There were 2 falls in November that resulted in severe harm. Performance for VTE in November was 95.02%, achieving the required target. The YTD HSMR is 103.2.

5.5. A&E performance was 74% (type 1) 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 3 areas in both the Emergency Department and the inpatient wards:

5.5.1. 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.

5.5.2. Inpatient areas: Clinically 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 rather than historic performance.

5.5.3. Cancer performance was 86% for the month.

5.5.4. The number of reportable cancelled operations increased significantly in month due to an incident at St Helens site which led to 33 cases being cancelled in one day. The cause has been rectified and the patients relisted.

5.5.5. DG asked how the Trust measures against neighbouring Trusts with the A&E figures. RC explained that we can only see ourselves compared to Warrington, who are just above STHK this week, but we are ahead of other trusts in the area. The Trust is 66/140 overall for A&E performance.

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

5.5.7. As at the month of December 2016, 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 by 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. The Trust's forecast outturn is to achieve its annual plan of £3.328m surplus.

5.5.8. To date the Trust has delivered £10.783m of CIPs which is now just ahead of the year to date plan.

5.5.9. Capital expenditure to date is £2.695m out of a revised year forecast total of £4.582m.

5.5.10. Cash balance at the end of December 2016 is £1.573m which equates to 2 operating days.

5.5.11. Mandatory training compliance remains 6.8% above target at 9.18%. Appraisal compliance for December is 79%. The situation is being managed to recover to the compliance rate to 85%.

5.5.12. 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.

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

Clinical & Quality Strategy update

6. Kevin Hardy (KH) provided an update

6.1. In the refresh to the Clinical & Quality Strategy, the Board chose to narrow its focus to 10 challenging and difficult goals. There were:

6.1.1. 4 hour performance
6.1.2. Weekend mortality SMR
6.1.3. 62 day cancer
6.1.4. VTE assessment ≤ 24 hours
6.1.5. eDischarge ≤ 24 hours
6.1.6. Serious Harm Falls
6.1.7. Complaints in timeframe
6.1.8. Antibiotics in Sepsis ≤ 4 hours
6.1.9. #NOF to surgery ≤ 48 hours
6.1.10. Critical care SMR

6.2. The Committee discussed at great length eDischarge and the current backlog, which will be very difficult to fix in the short term.

6.3. It was felt by the Committee that this is a particularly important piece of work, given it highlights the main quality issues in the Trust. It was agreed it would be kept under regular review.

Approval of Quality Account timetable

7. ARW provided an update:

    7.1. A timetable has been drafted in order to ensure that all the prescribed content is included in the Quality Account and that all the relevant stakeholders have been engaged in reviewing the draft account and proposed quality priorities, prior to formal Board approval and submission to the Secretary of State b the due deadline of 30th June.

    7.2. ARW advised the Committee that for next year, the Trust will be mandated to investigate and learn from deaths.

Safeguarding training update

8. SD provided an update.

    8.1. Quarter 2 KPIs have been submitted. Feedback was received from the designated nurses (commissioners for safeguarding, St Helens CCG) on 29th November 2016. The main area of concern is poor compliance with training (levels 2 and 3 for both adults and children). A recovery plan has been agreed with the CCG and is now in place.

    8.2. The CQC, via Knowsley Local Safeguarding Board, visited the Trust in November. They visited ED Adults and Children, Paediatrics and Maternity. Feedback was given at the end of the day and a report will be sent to the Trust by the end of January. An action plan has been drafted and different A&E documentation is required 16-18 year olds. The Trust has challenged the request that all ED staff need to be trained to Level 3. Good practice was identified on the Children's Ward, Paediatrics, ED and Maternity.

Mortality Surveillance Review update

9. Francis Andrews (FA) summarised the report.

    9.1. The Mortality Surveillance Group was initiated as the Trust was required to put in place a process to review all deaths in the Trust. All deaths are identified and sent out to Consultants, who have four weeks to complete the review using a specialised proforma.

    9.2. The meeting has been streamlined following October's meeting as it was felt that reviews of cases and discussion of relevant issues were occupying less than half the meeting with much of the rest of the time given over to presentations, which did not have a direct focus on mortality.

    9.3. Issues have been identified, which include negative feedback from consultants regarding the time taken to complete the reviews and a lack of understanding of the requirements, along with some unwillingness to review cases outside their own specialty. The number of reviews completed to date has fallen steadily from 77% in June to 24% for November 2016. Attendance has also been poor.

9.4. A review of the mortality surveillance process has been commissioned by KH, and FA is reviewing the whole process, he has collated evidence internally and externally to provide a report, which has largely been completed and will be presented to the Committee in February. In the meantime, the meetings will continue, cases will be correctly routed and efforts will be made to improve attendance.

9.5. It is recognised locally and nationally that this is an important process which is difficult to manage given there are circa 1500 deaths per annum. The development of the process will be kept under close review.

Infection Control update

10. SR provided an update

10.1. The number of cases for 2016-17 has already been discussed under the IPR

10.2. SR informed the Committee that she was working with Learning and Development regarding junior doctor's workstations and assessments and to ensure that doctors on rotation are captured to ensure they are compliant with ANTT.

10.3. Infection, Prevention and Control will proving a rolling programme of education for blood culture training. The blood culture policy will be reviewed.

10.4. E-Coli remains a challenge across the health economy. KH advised that 86% of e-coli cases are community acquired and 40% of the local population are resistant to the antibiotic Trimethaprim.

10.5. There have been 63 cases of influenza confirmed in December and Duffy Suite was closed for 7 days. Public Health England (PHE) were notified and updated as required. Staff are being encouraged to have the flu vaccine to protect themselves, their patients and families.

10.6. The Trust met with PHE on 20th December to discuss the outbreak of MDRP on the Burns Unit. This case is now closed and learning is ongoing.

Smoke Free inpatient KPIs

11. SD provided an update:

11.1. The three adult inpatient smoke free indicators have a target of 90% for all inpatients during Q4 2016-17 and are as follows:

11.1.1. Smoking status recorded for all adult smokers inpatients (excluding Critical Care).
11.1.2. All smokers to be offered smoking cessation advice (excluding Critical Care).
11.1.3. All smokers to be offered a referral to a Stop Smoking Specialist Community Service (excluding Critical Care).

11.2. The Trust is planning to become a Smoke-free site, including e-cigarettes from 8th March 2017, which is National No Smoking day. More communications will follow including online smoking cessation support. Global emails to be sent as reminders with support available for staff in the two week run up to March 10th. The key issue is whether it will be enforced and by whom!

Feedback from Patient Safety Council

12. SD had nothing to escalate to the Committee – all items already discussed.

Feedback from Patient Experience Council

13. ARW provided an update on key issues:

13.1. ARW said there had been an increased use of interpreters, which has a financial implication.

Feedback from Clinical Effectiveness Council

14. KH reported on key issues:

14.1. There has been a SUSAR (Serious Unsuspected Adverse Reaction) associated with the use of the drug Rithximab in Haematology being used in research. An investigation is ongoing.

Feedback from CQPG Meeting

15. SR said there were no issues to escalate to the Committee.

Feedback from Executive Committee

16. SR said there were no issues to escalate to the Committee.

Feedback from Workforce Council

17. AMS had nothing to escalate to the Committee.

Effectiveness of meeting

18. Peter Williams (PW) said the timing was good and there had been helpful debate between committee members. Out of the 16 papers on the agenda, 15 met the corporate standards and this meeting would be used for the annual effectiveness review.

AOB

19. Sue Mundy (SM) advised the Committee that Maternity Services had securing £63,000 of external funding for the Safety Bid Fund.

Date of next meeting

20. Tuesday, 14th February 2017.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(17)008

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 January 2017

Summary: Agenda Items

For Information

- C-Diff infection report
- PA Consulting report recommendations
- Report on duration of long term sickness absences
- Q2 SLR Trust wide
- Draft Budget Setting 2017 – 2019
- Forecast outturn 2016/17 with risks and values noted: STF funding re A&E and RTT; CQUIN and CIP delivery

For Assurance

- A & E update – detailed consideration of plans to improve performance
- Integrated Performance Report Month 9 2016/17 – RTT performance 92% - good assurance around action plan but note risk as we approach Winter period
- Month 9 2016/17 Finance Report – good performance against year to date plan while noting financial risks
- Governance Committee Briefing Papers:
  - CIP Council
  - Procurement Council

Actions Agreed

- 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
- MRSA performance – Actions from RCA to be presented to the committee
- Trust SLR – T & O improvement over last 5 years to be presented next month
- SLR to SLM recommendation to be presented
- Finance Report – Procurement review on Drugs and Clinical Supplies

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: 25th January 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(17)009
Title of paper: Foundation Trust Application Programme – Update Report
Purpose: To provide the Board with assurance that the final operational plans for 2017/18 and 2018/19 were submitted to NHS Improvement (NHSI) on 23rd December 2016, following agreement of contracts. To brief the Board on the NHSI consultation on the proposed new Well-Led assessment framework and use of resources indicators that will be used by the Care Quality Commission (CQC) and NHSI as part of the Quality assessment of NHS provider organisations. To update the Board on the progress of the St Helens Community Services bid.
Summary: 1. The final two year operational plans were submitted on 23rd December 2016 in accordance with the national planning timetable. 2. The plans reflected the planning assumptions agreed by the Board in November and the briefing that was circulated to Board members in mid-December and approved under delegated authority. 3. NHSI formal feedback on the plans is expected by 31st January. 4. 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 exercise. 5. The Trust, in conjunction with Five Boroughs Partnership NHSFT and St Helens ROTA has been awarded the contract to deliver the St Helens CCG Adult community services.
Corporate objectives met or risks addressed: Provide high quality sustainable services
Financial implications: This paper does not include a request for additional funding
Stakeholders: Patients, Staff, Alliance LDS Partners, Commissioners, NHSI
Recommendation(s): Members are asked to note the content of the report and agree the suggested approach to the use of resources and well-led consultation.
Presenting officer: Nik Khashu, Director of Finance and Information
Date of meeting: 25th January 2017

Foundation Trust Application Programme – November 2016

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

1.1 The Trust was able to finalise and formally sign contracts and submit its final operational plans for 2017/18 and 2018/19 on 23rd December 2016.

1.2 The operational plans covering activity, performance, quality, workforce and finance addressed the feedback from NHSI on the draft plans (submitted in November) and the progress made in contract negotiations.

1.3 NHSI will provide further feedback on the final plans and then the plans must be published. The NHSI feedback will be received by 31st January so it is anticipated that the final plans will be published (via the Board papers) in February.

1.4 The plans highlight a number of risks and caveats to the Trust being able to achieve its financial control total and the national access targets, primarily relating to activity growth remaining within commissioned levels.

1.5 The final two year operational plan has previously been circulated to Board members.

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

2.1. In June 2015 the secretary of state requested that NHSI and the CQC work together to develop and joint assessment of acute Trusts use of resources.

2.2. It had been recognised that the CQC could not undertake its role effectively without considering whether the Trust was efficient and productive and similarly it had also been recognised that NHSI needed to consider the quality of services rather than just its financial performance and achievement of national access targets.

2.3. The CQC and NHSI will retain distinct legal duties, but it has been recognised that they are overseeing “different sides of the same coin” and it therefore makes sense for them to work together to develop a common framework for assessment.

2.4. **Use of resources**

2.5. The following principles have been agreed by the CQC and NHSI;

- trusts must have due regard to both quality and financial objectives in delivering services
- the assessment and rating of trusts’ use of resources must be meaningful for patients and the public, as well as useful for providers, CQC and NHS Improvement
- the assessment and approach to ratings should be simple, robust and transparent
- providers must be able to achieve ‘outstanding’ and ‘good’ ratings and the approach must continue to incentivise improvement

- the assessment must minimise regulatory burden for providers as far as possible.

2.6. The proposed use of resources key lines of enquiry and indicative metrics are;

Area of use of resources	Key lines of enquiry (KLOEs)	Indicative metrics
Finance	How effectively is the trust managing its financial resources?	• Capital service capacity • Liquidity (days) • Income and expenditure margin • Distance from financial plan • Agency spend (performance against agency ceiling)
Clinical services	How well is the trust maximising patient benefit, given its resources?	• Pre-procedure non-elective bed days • Emergency readmissions • Cancelled operations • Proportion of beds occupied by those with an average length of stay of over seven days
People	How effectively is the trust using its workforce to maximise patient benefit?	• Vacancy and staff turnover rates • Sickness absence
Operational	How well is the trust maximising its operational productivity?	• Purchase Price Index Benchmark tool top 100 index • Estates cost per square metre • Pharmacy spend – quarter-on-quarter change

2.7. These build on the financial measures collected by NHSI as part of the single oversight framework and look at other key lines of enquiry (KLOEs) which indicate effective resource utilisation.

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

2.9. **Well-led Assessment**

2.10. The consultation proposes that the CQC well led assessments and the Monitor well-led framework for governance reviews are brought together into a common structure for all NHS Provider Trusts to assess the leadership, management and governance of the organisation.

2.11. It is also proposed that there will be a single evidence submission from Trusts to support both the CQC inspection and NHSI oversight roles.

2.12. NHSE England are also assessing their leadership frameworks so that there is a common understanding of "good leadership" across commissioners and providers.

2.13. There are 8 well-led KLOE's being proposed;

2.14. Within the KLOE's a number of leadership capabilities needed to support the health service as it develops, have been identified;

- Compassion, inclusion and effective leadership
- Financial and resource governance
- System leadership

2.15. The consultation document proposes that all NHS Provider Trusts should have an external independent well-led assessment at least every 3 years and should undertake a self-assessment annually.

2.16. The Trust will develop a response to the 13 consultation questions by the deadline of 14th February.

2.17. The Trust is also proposing to undertake a self-assessment based on the proposed well-led KLOE's, to be prepared for the next CQC Provider Information Request.

3. St Helens CCG Community Services

The Trust was notified in December that our bid with Five Boroughs partnership NHSFT and St Helens ROTA was successful, subject to the mandatory "cooling off period". None

of the other bidders have challenged the decision and the Trust has now started to work with St Helens CCG and the incumbent service provider to agree a smooth transfer of the services, and a future development plan to achieve the objectives of the bid.

ENDS

TRUST BOARD PAPER

Paper No: NHST(17)010
Subject: Research & Development Operational Capability Statement (RDOCS)
Purpose: As part of the National Institute for Health Research (NIHR) Research Support Services Programme, each NHS organisation is required to publish a Research and Development Operational Capability Statement (RDOCS). This Statement provides a Board level approved operational framework which sets out how the organisation plans to meet its research related responsibilities/requirements as stated in the Research Governance Framework, Clinical Trials Regulations, Operating Framework for the NHS in England, Handbook to the NHS Constitution and other relevant guidance and regulations.
Summary: The statement provides researchers with an operational overview of resources available to support Research & Development in the organisation and an overview of research collaborations and partnerships with other organisations, including areas of special interest. The statement is a tool to improve effectiveness and collaborations in research activities.
Corporate Objective met or risk addressed: • Non-compliance with DOH directive • Lose potential research partners who want to work with STHK
Financial Implications: None, however the RDOCS is viewed by commercial companies who are looking to invest in research and will use the RDOCS to seek out potential sites.
Stakeholders: • St Helens & Knowsley Teaching Hospital's NHS Trust • North West Coast Clinical Research Network (NWC CRN) • Commercial Partners • External Partners
Recommendation(s): This statement should be on STHK website as we have to provide a link to the NWC CRN and they in turn submit to the DOH.
Presenting Officer: Kevin Hardy, Medical Director
Date of meeting: 25th January 2017

NIHR Guideline B01
RDI Operational Capability Statement

May 2011

Note: This spreadsheet is protected to help avoid inadvertent changes. However there is no password set so that users can unlock the sheet and edit their own content if required.

Version History

Version number	Valid from	Valid to	Date approved	Approved by	Updated by
Statement 001					
Statement 002	01/11/2013	01/11/2014	27/11/2013	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 003	18/11/2014	18/11/2015	18/11/2014	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 004	31/12/2015	31/12/2016	27/01/2016	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 005			12/01/2017	Professor Kevin Hardy	Mrs Jeanette Anders

Contents

Organisation RDI management arrangements

Information on key contacts.

Organisation details	
Name of organisation	St Helens and Knowsley Teaching Hospitals NHS Trust (STHK)
RDI lead / Director (with responsibility for reporting on RDI to the organisation Board)	Professor Kevin Hardy
RDI office details:	
Name:	Research Development and Innovation Department
Address:	Whiston Hospital, Ground Floor , Yellow Zone, Warrington Road, Prescot, Merseyside, L35 5DR
Contact number:	0151 430 2334 / 1218
Contact email:	research@sthk.nhs.uk
Other relevant information:	
Key contact details e.g. Feasibility, confirmation of capacity and capability to conduct reseach at STHK	
Contact 1:	
Role:	Research Development and Innovation Department Manager (RDI)
Name:	Jeanette Anders
Contact number:	0151 430 2334
Contact email:	jeanette.anders@sthk.nhs.uk
Contact 2:	
Role:	Research Development and Innovation Co-ordinator
Name:	Paula Scott
Contact number:	0151 430 1218
Contact email:	paula.scott@sthk.nhs.uk
Contact 3:	
Role:	Research Development and Innovation Administrator
tsp.	David Roberts
Contact number:	0151 430 1424
Contact email:	David .roberts2@sthk.nhs.uk
Contact 3:	
Role:	
Name:	
Contact number:	

Contact email:	

Information on staffing of the RDI office.

RDI team		
RDI office roles (e.g. Governance, contracts, etc.)	Whole time equivalent	Comments indicate if shared/joint/week days in office etc.
Research Development and Innovation Manager	1.0 WTE	
Research Development and Innovation Co-ordinator	1.0 WTE	
Research Development and Innovation Administrator	1.0 WTE	

Information on reporting structure in organisation (include information on any relevant committees, for example, a clinical research board / research committee / steering committee).

Reporting structures		
Trust Board		The Medical Director reports to the Trust Board.
RDI Manager report to the Quality Committee.		The Quality Committee advises the Board on all matters pertaining to Quality of services and subsequent risk to patients and the Trust. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported to the Board for approval before action.
RDI Manager report to the Clinical Effectiveness Council (CEC)		The CEC Council investigates any issue that sits within it terms of reference. Its aim is to seek and receive from any department or service assurance on the maintenance and improvement of clinical effectiveness. The Council is authorised by the Quality Committee to investigate any issue that may pose a risk to Clinical Effectiveness. The Committee shall advise the Board on all matters pertaining to Quality of services and subsequent risk to patients and the Trust. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported to the Board for approval before action.
RDI Manager report to the Research Development & Innovation Group (RDIG)		The RDI Group reports to the Quality Committee to provide assurance about all aspects of RDIG activity within and involving the Trust. The RDI Committee has representation from Academia, Primary Care and Finance. The RDI Group is responsible for: Review and approval of the RDI strategy consistent and compliant with contemporary (inter)national guidance Review and approval of the Annual RDI Report (written by the RDI Manager) Review and approval of the Research Capability and Capacity Statement Review and approval of the Research Standard Operating Procedures Oversee operational delivery of the RDI strategy via updates received from the RDI Manager The RDIG has a a sub-group, The Research Practitioner Group (RPG), who will report to the RDIG quarterly (through the RDI Manager who sits on both groups) Review of research studies deemed high risk or with identified issues/concerns will be referred to RDIG for consideration (by the RDI Manager). Any risk or safety issues relating to research activity will be reported to the RDI Group for discussion and action plan.
The Research Practitioner Group (RPG)		The Research Practitioner Group (RPG) has delegated responsibility from the Research Development & Innovation Group (RDIG) to ensure that the trust has robust processes and systems in place for Research Development & Innovation (RDI). The RPG is responsible for: Review Research Standard Operating Procedures (SOPs) prior to submission to RDIG for approval. Ensure that the Trust is prepared for a Research MHRA (Medicines and Healthcare Products Regulatory Agency) inspection through the review and discussion of regular action plans Report to the RDIG quarterly (through the RDI Manager who sits on both groups) Support the aim to embed a positive research culture throughout the organisation Ensure that lessons are learned from research audits/issues and that effective improvement is implemented Ensure that on a day to day basis RDI activities are conducted according to RDI Standard Operating Procedures (SOPs) Support the training programme for Research Nurses to ensure that they are fully complaint in accordance with nursing/trust requirements.

Information on research networks supporting/working with the organisation.
Information on how the organisation works with the Comprehensive Local Research Network (CLRN), Primary Care Research Network (PCRN), Topic Specific Clinical Research Networks (TCRN).

Research networks	
Research network (name/location)	Role/relationship of the research network e.g. host organisation
Clinical Research Network, North West Coast (CRN NWC)	STHK host 1 x WTE Research Nurse (Cancer) 1 x 0.8WTE Senior Research Nurse (Cancer)
Clinical Research Network, North West Coast (CRN NWC)	STHK host 0.7 x WTE Data Manager (Cancer)
Clinical Research Network, North West Coast (CRN NWC)	STHK host 0.8 x WTE Data Manager (Cancer)
Clinical Research Network, North West Coast (CRN NWC)	STHK host 1 x WTE Senior Research Nurse (Cross divisional)

Clinical Research Network, North West Coast (CRN NWC)	STHK host 4 x WTE Research Nurses (Cross divisional)
Clinical Research Network, North West Coast (CRN NWC)	STHK host 2 x 0.5 WTE Research Nurses (Cross Divisional)
Clinical Research Network, North West Coast (CRN NWC)	STHK host 0.8 x WTE Generic Administrator (Nurse support)
St Helens & Knowlsey Teaching Hospitals NHS Trust	STHK fund 1 x WTE Generic Research Nurse
North West Dementia & Neurodegenerative Disease Research Network	There are no posts funded by this network.

Information on collaborations and partnerships for research activity (e.g. Biomedical Research Centre/Unit, other NHS organisations, higher education institutes, industry).

Current collaborations / partnerships

Organisation name	Details of collaboration / partnership (e.g. university/organisation joint office, external provider of pathology services to organisation, etc., effective dates)	Contact name	Email address	Contact number
Southport and Ormskirk NHS Trust	St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) provide Research Management support to Southport and Ormskirk NHS Trust (SOHT). They support the delivery, performance and oversight of research conducted at SOHT.	Dr P Mansour	paul.mansour@nhs.net	01704 704 685
Liverpool John Moores University (LJMU)	The Trust is involved in a number of research projects with Liverpool John Moores University. LJMU also have representation on the Trust Research Development and Innovation Group.	Dr Dave Harriss, Research Governance Manager	D.harriss@ljmu.ac.uk	0151 904 6236
NIHR Research Design Service -North West	The Research Design Service in the North West is part of the NIHR infrastructure and exists to provide support and advice for people preparing NIHR grant applications.	Dr P Dolby, Communications and information Manager	www.rds-nw.nihr.ac.uk	
2 Bio	STHK have signed an exclusive contract for service delivery with 2 Bio who assist us with healthcare technology, innovation and links with other organisations at a national level.	Charlotte Ward, Senior Business Consultant	charlotte.ward@2bio.co.uk	0151 795 4100
Clatterbridge Centre for Oncology	Oncology Research Clinics are undertaken at St Helens and Knowsley Teaching Hospitals where PIs from Clatterbridge actively consent and recruit patients to research trial.	Dr Maria McGuire	Maria.Maguire@clatterbridgecc.nhs.uk	0151 334 1155 x4917
Academic Health Science Network, North West Coast	The Trust is a partner of the AHSN, we work together to embed innovation as a core part of the business within STHK .	Dr Liz Mear	info@nwcahsn.nhs.uk	01772 520250
Clinical Commissioning Groups	The Trust is involved in a small number of primary care research projects.	For further information contact Jeanette Anders, RDI Manager	jeanette.anders@sthk.nhs.uk	0151 430 2334

Liverpool University	The Trust is involved in a number of research projects with Liverpool University.	For further information contact Jeanette Anders, RDI Manager	jeanette.anders@sthk.nhs.uk	0151 430 2334
St Helens Primary Care Group	The Trust has links to Primary Care through the CCG. These links are vital and offer us the potential to collaborate on joint research projects as well as recruiting from the primary care sector.	Professor Sarah O'Brien Chief Nurse St Helens CCG	Sarah.OBrien@sthelensccg.nhs.uk	01744 621819
Liverpool University	Mr Rowan Pritchard Jones, Consultant Plastic Surgeon at STHK and Honorary Clinical Lecturer at Liverpool University	Mr Rowan Pritchard Jones	rowan.pritchardjones@sthk.nhs.uk	

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
Go to top of document

Organisation study capabilities

Information on the types of studies that can be supported by the organisation to the relevant regulatory standards.

Types of studies organisation has capabilities in (please tick applicable)							
	CTIMPs (indicate phases)	Clinical trial of a medical device	Other clinical studies	Human tissue: Tissue samples studies	Study administering questionnaires	Qualitative study	OTHER
As sponsoring organisation			√	√	√	√	
As participating organisation	√ (Phase, II, III, IV,)	√	√	√	√	√	
As participant identification centre	√ (Phase, II, III, IV,)	√	√	√	√	√	

Information on any licences held by the organisation which may be relevant to research.

Organisation licences			
Licence name Example: Human Tissue Authority licence	Licence details	Licence start date (if applicable)	Licence end date (if applicable)
Human Tissue Act 2004	Licence number 12043	May-08	On-going

For organisations with responsibilities for GPs: Information on the practices which are able to conduct research.

Number/notes on General Practitioner (GP) practices

Organisation services

Information on key clinical services contacts and facilities/equipment which may be used in studies for supporting RDI governance decisions across the organisation.

Clinical service departments					
Service department	Specialist facilities that may be provided (e.g. number/type of scanners)	Contact name within service department	Contact email	Contact number	Details of any internal agreement templates and other comments
Pathology	Minus 20, 30 and 80 freezers	Samantha Bonney	samantha.bonney@sthk.nhs.uk	0151 430 1838	
Pharmacy	Designated Research Pharmacist	Margaret Hargreaves	margaret.hargreaves@sthk.nhs.uk	0151 290 4284	
Pharmacy	Back up Research Pharmacist	Jodie Kirk	jodie.kirk@sthk.nhs.uk	0151 430 1750	
Radiology	Clinical Radiation Expert	Glenn Massey	glenn.massey@sthk.nhs.uk	0151 426 1600	Clinical Director for Radiology
Radiology	Medical Physics Expert	Paul Connolly	paul.connolly@irs-limited.com	0151 709 6296	Paul Connolly from IRS Ltd is the Medical Physics expert for the Trust
Radiology	2x 1.5 GE MRI / 3 X GE 64 slice CT	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Radiology	2x Digital Mammography	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Radiology	2x Digital dental including cephalometry	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Radiology	2x Fluoroscopy	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Radiology	18x Ultrasound including Cardiac /Elastography	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Radiology	6x Digital radiography including tomosynthesis	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Cardio-Respiratory Department	24 hour ambulatory electrocardiography Extended ambulatory electrocardiography Cardiomemo Event Recording Tilt table testing [HUTT] Carotid sinus massage test Ambulatory blood pressure monitoring Electrocardiograms: 12 lead ECGs Transthoracic echocardiography Transoesophageal echocardiography Stress echocardiography Exercise electrocardiography Spirometry Measurement of maximum expiratory and inspiratory flow volume loop Oximetry assessment Carbon monoxide transfer factor test Simple lung function exercise test Measurement of static lung volume Measurement of respiratory muscle strength Measurement of maximum expiratory and inspiratory flow volume loop Bronchial Reactivity Overnight oximetry (Includes: Measurement of oxygen desaturation index)	Gina Rogers	gina.rogers@sthk.nhs.uk	0151 430 2424	
Cardio-Respiratory Department	Assessment for fitness to fly (hypoxic challenge) - flight assessment Pacemakers - single / dual [plus Box Changes] Implantation / Removal of electrocardiography loop recorder inc Pacemakers / Defibrillators / ILR Remote Follow-up ,Coronary Angiography	Gina Rogers	gina.rogers@sthk.nhs.uk	0151 430 2424	

Information on key management contacts for supporting RDI governance decisions across the organisation.

Management Support e.g. Finance, legal services, archiving					
Department	Specialist services that may be provided	Contact name within service department	Contact email	Contact number	Details of any internal agreement templates and other comments
Archiving	Archiving arrangements are part of the Trust approval process and are detailed in the Clinical Trial Agreement for each study. The Trust holds a corporate archiving contract with Cintas.	Jeanette Anders	jeanette.anders@sthk.nhs.uk	0151 430 2334	
Contracts (study related)	Advice and support - See comments	Jeanette Anders	jeanette.anders@sthk.nhs.uk	0151 430 2334	The model agreement for non-commercial research and the model agreement for pharmaceutical and biopharmaceutical industry sponsored research is used by St Helens and Knowsley Teaching Hospitals NHS Trust
Contracts (study related)	Sign off of clinical trial agreements	Professor K Hardy	kevin.hardy@sthk.nhs.uk		The model agreement for non-commercial research and the model agreement for pharmaceutical and biopharmaceutical industry sponsored research is used by St Helens and Knowsley Teaching Hospitals NHS Trust
Finance	Corporate Accountant	Nicola Wood	nicola.wood@sthk.nhs.uk	0151 430 1600	The RDI Department has links with finance and are fully supported in all areas relating to research.
Information Technology	Director of Informatics	Christine Walters	christine.walters@sthk.nhs.uk	0151 430 1134	RDI Department is fully supported by the Director of ICT. IT training, IT system set up, hardware and software configuration set up, firewall configuration and connection to external servers.
Legal	Head of Complaints & Legal Services	John Culshaw	john.culshaw@sthk.nhs.uk	0151 430 1434	Support and advice with the legal aspects of research is provided when necessary.
HR	Research Passports, Honorary Contracts, Letters of Access	Andrea Wisdom	andrea.wisdom@sthk.nhs.uk	0151 426 1600	
Training	Essential In house Standard Operating Procedure Training	Jeanette Anders, Amanda McCairn, Susan Dowlling	research@sthk.nhs.uk	0151 430 2334/ 2315	In house training on essential Standard Operating Procedures is provided for new starters or as updates if required.
Training	Good Clinical Practice (GCP) training. The Trust has 2 NIHR GCP Facilitators.	Jeanette Anders, Susan Dowlling	research@sthk.nhs.uk	0151 430 2334/ 2315	The GCP facilitators are required to facilitate 4 courses per year.
Study Management	EQMS Document Management System	Paula Scott	research@sthk.nhs.uk	0151 430 2334/ 2315	EQMS Document Manager delivers control over critical documentation for research.To be fully implemented in 2017.

Performance Management of studies	Audit and on-going review of studies.	Contact via RDI Department	research@sthk.nhs.uk	0151 430 2334/ 2315	During the RDI approval process, feasibility, capacity and capability checks take place including requirement for nurse support, appropriate resources, equipment & facilities, realistic recruitment target etc. After approval is granted, the RDI Department remain a point of contact, reviewing the progress of each study. A yearly Research Governance Framework (RGF) audit is conducted and when a need is identified ad hoc audits will be completed..

Organisation RDI interests

Information on the research areas of interest to the organisation (provide detailed or summary information as appropriate).

Organisation RDI areas of interest				
Area of interest	Details	Contact name		Contact number
Anaesthetics		Dr P Yoxall	peter.yoxall@thk.nhs.uk	0151 430 1267
Anaesthetics		Dr K Mukhtar	karim.mukhtar@sthk.nhs.uk	0151 430 1268
Burns and Plastics		Mr R Pritchard-Jones	rowan.pritchardjones@sthk.nhs.uk	
Burns and Plastics		Mr P Brackley	philip.brackley@sthk.nhs.uk	0151 430 1664
Burns and Plastics		Mr K Shokrollahi	kayvan.shokrollahi@sthk.nhs.uk	
Cancer		Ms Leena Chagla	leena.chagla@sthk.nhs.uk	
Cancer		Professor R Audisio	riccardo.audiso@sthk.nhs.uk	01744 646672
Cancer		Dr T Nicholson	toby.nicholson@sthk.nhs.uk	0151 430 1825
Cancer		Dr E Hindle	elaine.hindle@sthk.nhs.uk	
Cancer		Dr Z Khan	zahed.khan@clatterbridgecc.nhs.uk	
Cancer		Dr R Lord	rosemary.lord@clatterbridgecc.nhs.uk	
Cancer		Dr H Innes	helen.innes@clatterbridgecc.nhs.uk	
Cancer		Dr E Marshall	ernie.marshall@sthk.nhs.uk	01744 646771
Cardiology		Dr R Katira	Ravish. Katira@sthk.nhs.uk	0151 430 1041
Critical Care		Dr J Wood	julie.wood@sthk.nhs.uk	0151 430 2394
Critical Care / Acute Medical Unit		Francis Andrews	francis.andrews@sthk.n	
Critical Care		Dr K Simms	kevin.simms@sthk.nhs.uk	
Dermatology		Dr J Ellison	judith.ellison@sthk.nhs.uk	01744 646584
Dermatology		Dr E Pang	evelyn.pang@sthk.nhs.uk	01744 646614
Dermatology		Dr M Walsh	Maeve.Walsh@sthk.nhs.uk	
Dermatology		Dr Ngan	Kok.Ngan@sthk.nhs.uk	
Diabetes		Professor K Hardy	kevin.hardy@sthk.nhs.uk	01744 646490
Diabetes		Dr N Furlong	naill.furlong@sthk.nhs.uk	01744 646496
Diabetes		Dr Mahgoub	Yahya.Mahgoub@sthk.nhs.uk	
Emergency Medicine		Dr H Kataria	himanshu.Kataria@sthk.nhs.uk	0151 430 1063
Emergency Medicine		Dr J Matthews	john.matthews@sthk.nhs.uk	
Musculoskeletal		Dr R Abernethy	rikki.abernethy@sthk.nhs.uk	01744 646586
Gastro		Dr A Bassi	ash.bassi@sthk.nhs.uk	
Gastro		Dr R Chandy	rajiv.chandy@sthk.nhs.uk	
Gastro		Dr J McLindon	john.mclindon@sthk.nhs.uk	
Gastro		Dr D McClememts	dave.mcclements@sthk.nhs.uk	
Gastro		Dr S Priestley	Sue.Priestley@sthk.nhs.uk	
Haematology		Dr M Gharib	majed.gharib@sthk.nhs.uk	0151 430 1315
Paediatrics		Dr A Elbadri	abubaker.elbadri@sthk.nhs.uk	.
Paediatrics		Dr M Aziz	maysara.aziz@sthk.nhs.uk	
Paediatrics		Dr L Chilukuri	lakshmi.chilukuri@sthk.nhs.uk	
Paediatrics		Dr Ijaz Ahmad	ijaz.ahmad@sthk.nhs.uk	0151 430 1636
Paediatrics		Dr L Amegavie	laweh.amegavie@sthk.nhs.uk	0151 430 1435
Reproductive and Child Health		Mrs Sandhya Rao	Sandhya Rao@sthk.nhs.uk	0151 430 2289
Reproductive and Child Health		Miss Vicky Cording	vicky.cording@sthk.nhs.uk	0151 430 1495
Reproductive and Child Health		Mrs Nidhi Srivastava	nidhi.srivastava@sthk.nhs.uk	
Reproductive and Child Health		Mrs Susmita	susmita.pankaja@sthk.nhs.uk	
Stroke		Dr V Gowda	vinod.gowda@sthk.nhs.uk	0151 430 1224
Stroke		Dr S Mavinamane	sunandra.mavinamane@sthk.nhs.uk	0151 430 1224
Stroke		Dr S Meenakshisundaram	sanjeevikumar.meeakshisundaram@sthk.nhs.uk	
Stroke		Dr A Hill	andrew.hill@sthk.nhs.uk	
Stroke		Dr T Smith	tom.smith@sthk.nhs.uk	0151 430 1245
Surgery		Mr R Rajaganeshan	raj.rajaganwshan@sthk.nhs.uk	
Urology		Mr J McCabe	john.mccabe@sthk.nhs.uk	
Urology		Mr A Samsudin	azi.samsudin@sthk.nhs.uk	

Information on local / national specialty group membership within the organisation which has been shared with the CLRN.

Specialty group membership (local and national)					
National / local	Specialty group	Specialty area (if only specific areas within group)	Contact name	Contact email	Contact number
North West Coast	Division 6	Injuries and Emergencies	*Dr Himanshu Kataria*	himanshu.kataria@sthk.nhs.uk	*0151 430 1063*

Organisation RDI planning and investments

Planned investment			
Area of investment (e.g. Facilities, training, recruitment, equipment etc.)	Description of planned investment	Value of investment	Indicative dates
Investment including an income distribution plan for commercial trials will be agreed by the board.			
Grant Development	Advice and support in the development of new STHK led grant applications		

Organisation RDI standard operating procedures register

Standard operating procedures				
SOP ref number	SOP title	SOP details	Valid from	Valid to
A suite of SOPs are available upon request				

Information on the processes used for managing research passports.

Indicate what processes are used for managing research passports
Research Passports are accepted at STHK and a letter of access issued via the RDI Department. At present Research Passports are not produced at STHK.

Information on the agreed escalation process to be used when RDI governance issues cannot be resolved through normal processes.

Escalation process
In accordance with RDI management structure: The Research Practitioner Group reports to the Research Development and Innovation Group who reports to the Clinical Effectiveness Council who report to the Quality Committee then to the Trust Board.

Planned and actual studies register

The organisation should maintain or have access to a current list of planned and actual studies which its staff lead or in which they are involved.

Comments
STHK records every research project on the local ReDA database and the NIHR CRN NWC Edge system. These systems are used to register and manage all research projects.

Other information

For example, where information can be found about the publications and other outcomes of research which key staff have led or have otherwise contributed.

Other information (relevant to the capability of the organisation)
The Trust's Research Development and Innovation (RDI) Strategy resonates with the Board objectives, vision, values and goals, and ensures that we have robust systems to facilitate high quality research. We are committed to ensuring that our patients are given the opportunity to participate in safe research. Our performance in terms of study setup and recruiting to time and target is excellent. The development and strengthening of partnerships is pivotal to delivering the Trusts Strategic Plan and partnerships with Primary Care are being developed.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARDPAPER

Paper No: NHST(17)011
Title of paper: Trust Board Safeguarding Adults and Managing Adults at Risk Annual Information and Assurance Report 2015/6
Purpose: To provide the Trust Board with information and assurance that it effectively discharged its safeguarding adults responsibilities during 2015/6
Summary: The report provides information and assurance for all aspects of safeguarding adults during the financial year 2015/6
Corporate objectives met or risks addressed: Care, Safety, Communication
Financial implications: None
Stakeholders: Trust Board, Commissioners
Recommendation(s): Members are asked to approve the report
Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance
Date of meeting: 25th January 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Safeguarding Adults and Managing Adults at Risk

Annual Information and Assurance Report

2015-2016

Phil Dearden, Head of Safeguarding and Public Protection

CONTENTS

STHK Trust Board Safeguarding Adults and Managing Adults at Risk Annual Information and Assurance Report 2015-2016

FOREWORD

The purpose of this Annual Report is to provide an overview of safeguarding adult activity across the Trust for the last financial year (April 2015 – March 2016) and to provide assurance to the Trust Board.

This report combines adult safeguarding activity with the Trust's wider remit of the management of adults at risk. The Report details what we have achieved in both areas and lays out our plans for the coming year.

The Care Act 2014 has placed safeguarding adults on a statutory footing. The policy and strategic context guiding safeguarding practice continues to evolve therefore this report outlines how the Trust remains responsive to national evidence and local need. It aims to provide assurance that the trust activity is compliant with the Care Quality Commission (CQC), NHS England and the Clinical Commissioning Groups (CCG) as well as the Local Safeguarding Adults Boards (LSABs).

This report is in two sections; **Section 1** details the work undertaken around the formal safeguarding process which aims to protect patients where allegations have been made.

Section 2 details the work around the wider safeguarding agenda which outlines how the Trust identifies and manages patients with additional needs which may limit their ability to protect themselves from harm, abuse and exploitation.

Together both sections aim to provide a clear overview as to how the Trust safeguards its patients and responds to those who require protection as a result of abuse. The importance of the preventative approach, managing low level concerns, learning from incidents and using intelligence wisely cannot be overestimated in the journey to keeping all patients safe.

SECTION 1 : SAFEGUARDING AND PROTECTING ADULTS

1.1 OVERVIEW

1.1.1 The Director of Nursing, Midwifery and Governance continues to have the Executive lead responsibility for Safeguarding.

1.1.2 The dedicated post of Head of Safeguarding and Public Protection oversees the Trust's safeguarding adults and children agenda and is supported by key staff throughout every part of the organisation. In respect of adults, the Trust has 1.5 Whole Time Equivalent specialist nurses concentrating on Safeguarding Adults supported by two part time administrative staff.

1.1.3 The Trust's Safeguarding Adult Steering Group reporting to the Patient Safety Council, provides the Trust Board with the assurance that it is effectively discharging its adult safeguarding responsibilities and is working to manage all aspects of vulnerability. The Group was established in September 2011 and in the period 2015/16 has met three times due to changes in the Terms of Reference mid-year. The group will meet quarterly in 2016/17 in line with the reporting schedule. The Group has an overarching work plan which ensures that the Trust has a clear grip of the agenda, the work it is undertaking and progress being made. Concerns around attendance and representation have been included within the work plan.

1.1.4 The Care Act 2014 placed adult safeguarding on a statutory setting and the Trust has been working with its local Safeguarding Adult Boards to implement the legislation and work within the Contract Framework with Commissioners for the reporting of Key

Performance Indicators. The Indicators have been further extended to encompass requirements from the Care Act 2014 Guidance and statutory instruments.

1.1.5 The Modern Slavery Act 2015 introduces a National Reporting Mechanism which will need to be integrated within current Trust procedures and will probably involve new policies.

1.1.6 The Annual Safeguarding Audit Tool no longer requires completion but actions required from the previous tool have been included with the Trust Work plan.

1.2. EVIDENCE OF ASSURANCE

1.2.1. Local Safeguarding Adult Boards

1.2.1.1 The Trust is an active partner in three Local Safeguarding Adults Boards (LSABs) in St Helens, Halton and Knowsley. The minutes from each of the Boards are provided to the Trust's Adult Safeguarding Steering Group and through to the Trust Board.

1.2.1.2 The Liverpool Board has a Health Sub-Group to which the Trust contributes.

1.2.2 Feedback from Key Performance Indicators

1.2.2.1 Feedback from its Quarter 1 Submission from the safeguarding commissioners resulted in a judgement of 'significant assurance', the first time that this has been achieved locally by a provider trust. Since then the judgments have been of 'reasonable assurance' which have been maintained through to Quarter 4.

1.2.3 Care Quality Commission Report August 2015

1.2.3.1 In January 2016 the Trust received its final report of the formal inspection undertaken in August 2015. The area of safeguarding was positively commented upon in each area visited by CQC throughout the Trust.

1.3. TRUST SAFEGUARDING ADULTS ACTIVITY

1.3.1 The Trust has been collecting data over the last three years and the two tables below detail this year's activity with a comparison with previous years.

Table 1 below shows comparison of Contacts and Referrals to Adult Social Care in each quarter of 2015/2016

Quarter	Contact	Referral
1-2015	252	79
2-2015	244	55
3-2015	217	35
4-2016	248	72

Table 2 below shows comparison of Contacts and Referrals for 2012-2015/6

	Total Contacts	Total Referrals	Percentage %
April 2012- March 2013	458	206	45
April 2013-March 2014	510	194	38
April 2014–March 2015	798	177	22
April 2015- March 2016	961	241	25

A contact is when a member of staff within the Trust contacts the Trust's Safeguarding Team with a safeguarding related issue. A referral is when the contact generates a formal safeguarding referral to the local authority. The data shows an increasing level of contacts

between areas of the Trust and the Safeguarding Team which is viewed as being very positive with a corresponding increase in the number that are formally referred to the local authority and a slight increase in the proportion referred.

Work is in progress to monitor and review safeguarding outcomes which suggests that the Trust is making appropriate referrals and is using the work on thresholds to guide it.

1.4. SAFEGUARDING ADULTS TRAINING UPDATE

1.4.1 In the period 2015/16 the Trust has continued to experience difficulties in achieving compliance with commissioned training targets. High levels of operational activity throughout the winter months proved very challenging and compliance dropped below the required commissioner targets for Level 2 training. The Trust reports on a quarterly basis to the commissioner led Clinical Quality and Performance Group.

1.4.2 The current Training Needs Analysis is being reviewed following publication of the Intercollegiate Document: Roles and competences of health care staff' for Safeguarding Adults.

1.4.3 The Levels of training are as follows (March 2016):

- Level 1 Mandatory/Induction (face to face)
- Level 2 Focused awareness (face to face and workbook)
- Level 3 Foundation Programme /Full day (face to face)

Current Compliance:	Required Compliance:
Level 1 = 97%	90% Contract
Level 2 = 64%	80% Contract
Level 3 = 71%	80% Contract

1.4.4 **Training Evaluation**

Details of each of the courses and the staff who have attended are recorded on a data base held in Learning and Development Department. Records are also kept on staff who have failed to attend and escalation to senior managers is generated. Evaluation forms are completed after each session and the results used to form a report and improve training delivery

1.4.5 **Training Monitoring**

Training compliance was subject to monthly monitoring through the Patient Safety Council and to the Quality Board

1.5. SERIOUS UNTOWARD INCIDENTS / CASE REVIEW ACTIVITY

1.5.1 There have been no new Domestic Homicide Reviews; the Trust has completed all actions relating to its input to previous reviews.

1.5.2 The Trust is involved in one Serious Case Review which continues to be outstanding but has completed all actions from its local investigation. The case involved the death of an adult by hanging in the ED Department. The action plan was multi-agency due to the patient's complex mental health and social care needs. Closer links to mental health liaison and risk assessment procedures within ED have been implemented.

1.5.3 In all cases the learning specific for the Trust has been acted upon.

1.6 IMPLEMENTATION OF THE PREVENT STRATEGY

1.6.1 The Trust has Executive and Operational Leads for the implementation of the Government's 'Prevent' strategy. Meetings have taken place with Merseyside Police Channel Coordinators and the Trust is represented at the regional meeting for NHS Leads and the Merseyside Prevent Group led by Liverpool City Council.

1.6.2 The Trust has over 20 members of staff who are accredited trainers and from November 2015 began to roll out its HealthWrap Training Plan.

1.6.3 PREVENT is included in Mandatory Training (Level 1) and in more detail in both Levels 2 and 3 Safeguarding Adult Training ensuring that approximately 300 members of staff each month received some briefing and awareness raising in 2014/15.

1.6.4 All staff received a leaflet with their payslips in June 2015 which complied with the need to provide basic awareness training to all staff.

1.6.5 In March 2016 the Trust had reached a compliance of 30% which is less than the required compliance of 40% and must achieve 70% by March 2017.

1.6.6 The Trust made no formal referrals in the reporting period.

1.7 SAVILE AND LAMPARD REPORT RECOMMENDATIONS

1.7.1 The Trust has a Savile Action Plan which covers the main risks which have been identified from the independent investigations into Savile's activities across the country.

1.7.2 The Trust has now taken account of the recommendations of the Lampard Inquiry which brings together the main themes into fourteen recommendations and has compiled an action plan which identifies the Trust's main risks and actions required. This is monitored through the Trust Safeguarding Steering Groups and through the Trust Workforce Council; there are currently none which are RAG rated as RED.

1.8 MAKING SAFEGUARDING PERSONAL AGENDA

1.8.1 The 'Making Safeguarding Personal' agenda places the adult firmly at the heart of the incident/investigation which, on occasion, may mean that no referral is made by complying with the wishes of the person involved. This may result in risks to vulnerable patients continuing. This will be under review during the coming year.

1.9 MANAGING ALLEGATIONS OF ABUSE (ADULTS) ACTIVITY

1.9.1 The Trust has clear processes for the management of allegations of a safeguarding nature made against professionals meeting on a bi-monthly basis to manage what are inevitably complex matters. The withdrawal of national guidance relating to the role of Designated Adult Safeguarding Manager's has been accounted for within the Trust. In the period there have been 23 incidents relating to adults 5 cases which are outstanding. This activity includes Lead Employer activity.

1.10 THE GODDARD ENQUIRY

1.10.1 The Trust has taken into account the requests by the Goddard Enquiry to retain all records in any situation where there are allegations against children both current and historical.

1.10.2 The Trust has received the 'Verita' checklist and will be working through this to ensure that assurance can be provided.

1.11 AREAS FOR DEVELOPMENT 2016/7

- Improving non- specialist attendance and representation at the Safeguarding Adults Trust Steering Group;
- Recover the slippage in compliance with Safeguarding Adults training targets;
- Develop Trust wide awareness of Female Genital Mutilation, Modern Slavery and Honour Based Violence;
- Achieve 70% training compliance in respect of HealthWRAP 3 (Prevent Training);
- Develop a structured Audit and Assurance Framework;
- Develop a single reporting pathway using DATIX for all safeguarding related activity:
- The work on restraint and the management of challenging behaviour has not been progressed and is to be prioritised. A Restraint Focus Group has been set up;

1.12 BUSINESS PLAN

See Business Plan in Appendix 1

SECTION 2

MANANGING ADULTS AT RISK AND KEEPING PATIENTS SAFE

2.1 OVERVIEW

2.1.1 A high number of our patients have additional needs and require support to complete their acute journey and to protect themselves. The way that we identify and support this group of patients is key to achieving positive outcomes for the patients, their carers, families and representatives, avoiding harm and, at the same time, improving Trust performance. The ability to identify patients with additional needs, risk assessing and managing these needs involves making reasonable adjustments. Whilst the implementation of these 'reasonable adjustments' and provision of support for individual patients is a legal obligation, the manner in which the Trust undertakes the process and the confidence it has in all staff complying to this obligation requires monitoring and oversight.

2.1.3 The approach has been to develop an overarching work plan which captures in as comprehensive a manner as possible the range of additional needs ensuring corporate oversight and ownership reflecting the Trust's awareness and discharge of its wider safeguarding responsibility.

2.1.5 The vehicle for this approach is the Trust Safeguarding Adults Steering Group. The Group's terms of reference has been reviewed over the last year, it now meets quarterly and is chaired by the Deputy Director of Nursing, Midwifery and Governance with an appropriate representation from all areas reporting to the Patient Safety Council.

2.2 TRUST SAFEGUARDING ADULTS WORKPLAN

2.2.1 The aim of the work plan is to detail the range of work being undertaken to address particular areas of vulnerability and provide a framework to work within. This then becomes a part of the Trust's assurance around its compliance with CQC standards and its contract responsibilities.

2.2.2 The main areas around vulnerability are reported in greater detail below:

- Mental Capacity
- Deprivation of Liberty Safeguards
- Learning Disability
- Mental Health Liaison
- Interpreter and Translation Services
- Carers Support

2.2.3 The work plan identifies each of the above areas detailing the person responsible the risks and outstanding work and timescale.

3.0 MENTAL CAPACITY ACT

3.1 The management of patient's who may lack mental capacity is a key area of the Trust's ability to manage patients with additional needs and who may be at risk. The Act provides a statutory framework for the management of patients who may lack mental capacity requiring a formal process to be undertaken and recorded.

3.2 The Trust Mental Capacity Act Group has met six times in 2015/16 and includes regular representation from local Supervisory Authorities.

3.3 The Trust Mental Capacity Policy was updated and ratified in July 2015.

3.4 The Trust is required to report the number of referrals made to the local Independent Mental Capacity Advocate Service (IMCA) in a range of situations where patients do not have relatives or friends to support them around changing accommodation and serious medical treatment. The number continues to be relatively low and has reduced over the last 12 months from 6 per quarter to 2 per quarter.

3.5 The Trust has a MCA Training Strategy and Plan which details the competences expected of staff and compliance was monitored through the Key Performance Indicator throughout 2015/16.

3.6 The Care Quality Commission Report included comments on staff's understanding and use of the MCA and with very few exceptions the comments were very favourable. One ward area was highlighted and the Trust was invited to review the guidance to staff relating to under 18 year olds which has been included in the work plan.

4.0 DEPRIVATION OF LIBERTY STANDARDS

4.1 The Deprivation of Liberty Safeguards (DoLS) were introduced as an addendum to the Mental Capacity Act. This process involves the Trust identifying patients who lack capacity and need restrictions to be put into place to ensure their safety. This requires the Trust, as the 'managing authority', to request an authorisation from the patient's supervisory authority, a role which transferred to the local authority in April 2013. A series of assessments of the patient's needs are then undertaken to determine the patient's best interests.

4.2. In March 2014 the Supreme Court handed down its judgements relating to two DoLS cases, one known as Cheshire West, which has effectively lowered the threshold for a deprivations and increasing the likelihood that authorisations will need to be made by the Acute Trust.

4.3. **Table 3** provides a detailed record of the Trust DoLS activity in 2015/16 demonstrating the significant increase in applications and authorisations resulting from the amended definition.

Year	DoLS Applications
2012/13	13
2013/14	12
2014/15	69
2015/16	190

4.4. Whilst the number of applications has increased **Table 4** details the outcome of the applications. A high number of patients subject to an Urgent authorisation are discharged prior to the completion of the assessment which is a concern and is a criticism made of the Trust by its supervisory authorities. This is being addressed in the Trust Mental Capacity Act Meeting.

Table 4 Data 2015/16

	Authorised	Declined	D/C prior to assessment	Awaiting Outcome	Total
St Helens	53	20	10	1	**84**
Knowsley	24	14	19	-	**57**
Halton	12	6	6	-	**24**
Liverpool	8	2	8	-	**18**
Out of Area	-	2	5	-	**7**
Total	**97**	**44**	**48**	**1**	**190**

4.5. The training plan identified in 2.3.1.5 above covers DoLS and the need for additional training to reinforce the implications of the Supreme Court Judgements.

4.6. In November 2015 the Trust provided a submission to the Law Commission Review of the Deprivation of Liberty Safeguards legislation.

5.0 THE ACCESS OF PEOPLE WITH A LEARNING DISABILITY TO ACUTE CARE

5.1. The Trust Learning Disability Pathway Group reviewed its terms of reference and was renamed as the Learning Disability Steering Group meeting quarterly. The group continues to be the Trust's vehicle for improving the access and experience of patients with a learning disability to the Trust.

5.2. The Trust contributed to the local self-assessment process (LDSAF) for 2014/15 led by St Helens Clinical Commissioning Group and was very pleased at the feedback received for St Helens which indicated that those areas which involved acute care were all judged to be GREEN.

5.3. In March 2015 the Trust Executive Team gave its approval to the funding of a 'Changing Places' facility on the Whiston site but due to problems with contractors the start of the work was delayed and only started at the end of March 2016 with a plan to be complete late April 2016 and will require formal registration with the 'Changing Places' Team.

5.4 The Trust's successful bid to North West Education for funding towards establishing an integrated pathway led to the compilation of a pathway brochure which has been showcased in a Regional Event in November. Work will be on-going throughout 2016/17 to embed this in all areas of the Trust. The work was launched with our partners in March 2016 and will be launched in 'Dignity Conference' in June 2016.

5.5. Audits began in 2015 have demonstrated that whilst there is often evidence that the Trust has provided a range of reasonable adjustments to the patient journey these are not always recorded.

Table 5

	Emergency Dept				Inpatient				Outpatient			
	2014/15		2015/16		2014/15		2015/16		2014/15		2015/16	
	Episodes	Patients	Episodes	Patients	Episodes	Patients	Episodes	Patients	Episodes	Patients	Episodes	Patients
St Helens	334	141	301	122	218	152	213	155	689	154	566	123
Knowsley	317	128	212	91	188	123	155	108	373	112	269	74
Halton	115	50	146	46	82	59	95	61	188	51	171	41
Liverpool	54	28	67	33	36	32	53	41	62	21	75	18
Other	5	5	20	9	11	10	35	26	68	15	114	27
Total	825	352	746	301	535	376	551	391	1380	353	1195	283

5.6. Work using the International Classification of Disease codes has led to the Trust being able to identify specific activity around people with a learning disability. Table 5 above shows comparisons over the last two years for patients with a learning disability

attending at the Emergency and Outpatient Departments and inpatients broken down by local authority of residence.

5.7 Whilst this is not ideal it continues to be the best way of understanding activity in the absence of a sharing of GP Registers.

5.8 The Safeguarding Team over the last year has had **138** patients referred to it for support around reasonable adjustments and additional needs. This is a reduction from the **159** of the previous year but this may reflect the increasing confidence of areas to manage the access of people with a learning disability. This will continue to be closely monitored.

6.0. MENTAL HEALTH LIAISON

6.1 The Trust has a fully commissioned Acute Adult Mental Health Liaison Team based in the Emergency Department, working 24/7, undertaking assessments both in the Emergency Department and across all inpatient areas.

6.2 There is a fully commissioned Older Peoples Mental Health Liaison Service working over a seven day period working to extended hours and including the Emergency Department. It is well established and is continuing to make a significant contribution to identifying and managing older patients with mental health needs.

7.0. PATIENTS WITH INTERPRETER AND TRANSLATION NEEDS

7.1. The Trust has two contracts for the provision of interpreter and translation services. The largest is with Prestige Network which is for the Trust's foreign language face to face, telephone interpreter and translation service. The second is for British Sign Language (BSL) interpretation which is with a small local provider St Helens Deafness Resource Centre.

7.2. Activity for Foreign Language Interpretation has shown an increase of 64% over the twelve month period. For BSL interpretation the increase has been 40%. It is felt that a large proportion of this activity relates to greater awareness as well as an increase in the use of local NHS services by those who do not have English as their first language.

Table 6

Interpreter Activity

Period	Foreign Language	British Sign Language
2013/14	**482**	**171**
2014/15	**665**	**203**
2015/16	**1093**	**284**

7.3. Interpreter Activity is reported to the Patient Experience Council on a quarterly basis.

8.0. CARER SUPPORT

8.1. The Trust has a funded Carer Support Team provided by St Helens Carers Centre which is part of Carers Trust. The team is based within the Integrated Discharge Team on site at Whiston Hospital. It is a long established team providing a range of direct services to carers including emotional and practical support, onward signposting and individual case management. Referrals are made direct to the service from patients, relatives and staff at any point in a patient's journey.

8.2. In the period 2015/16 the Carers Team activity included:

- New registrations increased from 1149 to 1165
- Total contact activity increased from 5286 to 5440
- Referrals from NHS staff increased from 370 to 515.

8.3 The Team produced an Annual Report providing case examples of those who have received support. Referrals are made from all areas of the Trust, demonstrating the awareness of Trust staff to carer issues and the work of the team in embedding this agenda in Trust business and activity.

8.4 The Team is now included in the Nurse Preceptorship Programme which enables them to promote the carer agenda in the Corporate Objectives and Five Star Care.

9.0 ACHIEVEMENTS

- The compilation of the Learning Disability Pathway Tool provides a detailed tool for all areas of the Trust;
- The judgements made around the St Helens Learning Disability Self- Assessment Framework demonstrates external assurance of Trust activity and culture;
- The compilation of a Mental Health Annual Report for 2014/15 was a significant collaborative achievement;
- The monthly Mental Health Steering Group is genuinely multi-agency and now includes Local Healthwatch representation;
- The increase in usage in both Foreign Language and British Sign Language Interpretation reflects an increasing awareness of the Trust Interpreter Policy

10.0 FUTURE DEVELOPMENTS

- Work on developing a service level agreement with 5BPFT for the discharge of the Trust's Mental Health Act administrative duties has not progressed and needs prioritising;
- Continue to work with commissioners to develop accessible pathways for people with a learning disability and ways of auditing the process;
- Ensure that the implications for the Acute Trust of recent case law around Mental Capacity and Deprivation of Liberty Safeguards are understood and appreciated.

Please see the Business Plan which is attached as Appendix 1

Appendix 1

St Helens & Knowsley Teaching Hospitals NHS Trust
Safeguarding Adults Business Plan 2013/16

PART 1 - SAFEGUARDING ADULTS PROCESS				
Aim	**Actions**	**Target Date**	**Desired Outcome**	**Lead**
Work with Local Safeguarding Adults Boards to implement requirements of the Care Act	Internally develop work on categories of abuse in Care Act • FGM • Modern Slavery • Honour Based Violence • Self- Neglect	April 2017	The Trust is working with its partners to meet its future statutory responsibilities and has embedded the new categories of abuse detailed in the Care Act	**HSPP**
Ensure that the Trust have a workforce which understands safeguarding adults and the associated policies and procedures	Work to the implementation of the Safeguarding Training recovery plan to meet contractual compliance. Achieve recovery in L2 to become contract compliant	March 2017	The Trust will have a highly skilled and trained workforce able to respond to safeguarding concerns.	**HSPP**
The Trust to report on a regular basis on safeguarding performance activity and service improvement	• Report through the Patient Safety Council on a regular basis • Compile the KPIs for the CCGs on a quarterly basis	March 2017	All safeguarding performance activity is provided through a clear governance process and concerns are escalated to the right level.	**HSPP**
All safeguarding activity and associated issues, eg. 'expressions of concern' are managed through the Care Group governance processes	Formal links are in place with Care Group Governance process. Develop the use of DATIX as he only formal reporting process for all safeguarding and related (eg expressions of concern') activity	March 2017	Individual care groups have information about safeguarding concerns within their area and can take appropriate action.	**HSPP**
All areas have staff skilled in the assessment of risk associated with Domestic Abuse	Implement Domestic Abuse training plan. Ensure that all key areas have staff who have received the appropriate training;	March 2017	Patients experiencing Domestic Abuse are able to speak to and consult with staff who understand the issues and can assess and manage risk.	**DV Lead**

Staff have the required skills to manage patients who challenge and resist	Develop a strategic approach Consult with staff Develop Training Programme Develop Policies and Procedures Training starts early 2015/16	March 2017	Training programme being implemented All staff are able to respond appropriately to patients who challenge and resist their care and treatment	**HSPP** **LSMS**
Work to comply with the NHS Contract in respect of the PREVENT Agenda	Agree and ratify PREVENT Strategy and training Plan and work to achieve training compliance	March 2017	Appropriate staff groups are prioritised for training around identifying and responding to patients and staff members who are at risk of being radicalised towards extremist agenda.	**HSPP**

PART 2 - MANAGING VULNERABILITY

Aim	Actions	Target Date	Desired Outcome	Lead
Ensure that all staff have an appropriate level of training around the Mental Capacity and can apply the legal framework	Implement training plan and update all policies to conform with case law	March 2017	Staff are able to identify and respond to people who may lack the mental capacity to make decisions for themselves in a sensitive and lawful manner.	**HSPP**
Contribute to the revised Local Learning Disability Self Assessment Process	Understand the revised CCG process Identify evidence bases within the Trust Generate CCG specific evidence	September 2016	The Trust is able to evidence the progress it is making in improving the access to acute care of people with a learning disability.	**HSPP**
Provide clear structures to support the Trust's extension of regulated activity to include detained patients	Compile Policy/guidance Compile and implement training plan Develop Service Level Agreement	March 2017	The Trust will be able to identify and manage in a lawful manner patients who are detained under the Mental Health Act and who require acute inpatient care.	**HSPP**