St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 26th JULY 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
		1.2	July		
09:35	2.	Patient story			Sue Redfern
10:00	3.	Public Health Annual Report – Knowsley CCG		Presentation	Matt Ashton
10:30	4.	Apologies for Absence			Richard Fraser
	5.	Declaration of Interests			
	6.	Minutes of the previous Meeting held on 28th June 2017		Attached	
		6.1	Correct record & Matters Arising		
		6.2	Action list	Attached	
Performance Reports					
10:40	7.	Integrated Performance Report		NHST(17) 068	Nik Khashu
		7.1	Quality Indicators		Sue Redfern
		7.2	Operational indicators		Rob Cooper
		7.3	Financial indicators		Nik Khashu
		7.4	Workforce indicators		Anne-Marie Stretch
BREAK					
Committee Assurance Reports					
11:05	8.	Committee report – Executive		NHST(17) 069	Ann Marr
		8.1	Board Assurance Framework	NHST(17) 070	Sue Redfern

		8.2	Corporate Risk Register	NHST(17) 071	Sue Redfern
11:15	9.	Committee Report – Quality		NHST(17) 072	David Graham
11:20	10.	Committee Report – Finance & Performance		NHST(17) 073	Denis Mahony
Other Board Reports					
11:25	11.	Strategic update report		NHST(17) 074	Nik Khashu
11.30	12.	HR indicators		NHST(17) 075	Anne-Marie Stretch
11:40	13.	Infection Control report		NHST(17) 076	Sue Redfern
Closing Business					
11:50	14.	Effectiveness of meeting			Richard Fraser
	15.	Any other business			
	16.	Date of next Public Board meeting – Wednesday 27th September 2017			
LUNCH					

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 26th July 2017

No	Minute	Action	Lead	Date Due
1.	25.01.17 (11.5)	HR Indicators: A trend line is required in the next report for Bank, Agency and Overtime usage. Agenda item.	AMS	26 Jul 17
2.	~~31.05.17 (2.4.1)~~	~~Patient story: from feedback received on menu variety for long-stay patients with specific eating difficulties, an IT report will be generated to identify such patients. This has been completed~~		Action closed
3.	31.05.17 (7.2.1)	Complaints, Claims and Incidents: A report on SIRI outcomes is required. Agenda item	SR	26 Jul 17
4.	31.05.17 (7.6)	Complaints, Claims and Incidents: More context and data analysis of report is required.	SR	27 Sep 17
5.	31.05.17 (7.8.2)	Availability of staff to discuss patient care plans with relatives to be considered; wards to be encouraged to be more proactive. Executive Committee report back to Board.	SR	27 Sep17
6.	~~31.05.17 (9.8)~~	~~Overdue policies: extent to be explored at future Executive Committee meeting. Now a twice yearly report at Quality Committee.~~		Action closed
7.	31.05.17 (12)	Learning from deaths in the NHS – update back to Board.	KH	27 Sep 17
8.	28.06.17 (7.8)	Board Development agenda – AMS will ensure that CQC guidance is included	AMS	tbc

St Helens and Knowsley Teaching Hospitals NHS Trust

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

Summary

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

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

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

Patient Safety, Patient Experience and Clinical Effectiveness

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

There were no never events in June 2017 and zero cases year to date.

There were no cases of MRSA bacteraemia in June 2017 and zero cases year to date.

There was 1 C.Difficile (CDI) positive cases in June 2017. The total number of C diff positive cases year to date is 8. RCAs are in progress. 2 cases have be identified for appeal.

There were no grade 3 or 4 pressure ulcers in June 2017 and zero cases year to date.

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for June 2017 was 94.5%

During the month of May 2017 there were no falls causing serious harm. Year to date there have been 4 falls causing serious harm .

Performance for VTE assessment for May 2017 was 91.92%.

YTD HSMR was 103.3 up to February 2017.

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 17/18 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: нсύK Wdzfê нлмт

Operational Performance

The 62 day standard was unexpectedly not met in month for the first time. Fewer numbers of overall patients in month and an increase in patients with complex pathways resulted in failure to meet the standard.
RCA review of patients whose pathways breeched the standard identified opportunities to refocus management effort on pathway monitoring particularly of patients attending multiple MDT's and whose care is provided by other tertiary providers.

A&E performance was 78.7% (type 1) and 86.6% (type 1 & 3) in month. The key actions identified for continued recovery of this position are being driven forward by the senior leaders across the organisation, focusing on both the Emergency Department and the Inpatient wards

Emergency Department key actions:
1. In the final phase of the Urgent and Emergency Care Transformation Plan 30-60-90 Improvement with Standard Operating Procedures following PDSA cycles to be finalised.
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. KPI of expected number of discharges per ward of which 33% to be achieved by midday
3. Senior daily review and escalation for patients who no longer need care in an acute bed, supported by weekly system wide Multi Agency Discharge Events (MADE).

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

RTT incomplete performance was achieved in month (93.2%). Specialty level actions to address this continue, including targeted backlog clearance and collaborative working with the CCG to improve the quality and effectiveness of patient referral pathways.

Financial Performance

Surplus/Deficit - For the month of June 2017 (Month 3) the Trust is reporting an overall Income & Expenditure surplus of £1.377m which is slightly better the YTD profiled plan.
Clinical Income was £0.2m behind plan, which means that we have caught up the shortfall in clinical income after the impact of reduced activity from the additional bank holidays and weekend in April 2017. This has been offset by additional expenditure within variable costs, such as agency and other premium costs and offset by released slippage in reserves. This will be recovered from productivity opportunities agreed with divisions around theatre utilisation and productivity. The Trust is planning to deliver its FOT surplus of £8.536m, which equates to (£0.581)m deficit excluding STF.

The Trust has delivered £2.99m of CIPs which is behind the YTD plan by £65k.

The Trust's cash balance at the end of June was £11.432m, in line with the Trust's External Finance Limit and represents 12 days of operating expenses.

The Trust has incurred £821k of capital expenditure in the three months to June.

Human Resources

Absence in June was again lower than the Q1 target of 4.25% at 4.1%, which is 0.15% ahead of the Q1 target. Nursing sickness including HCAs has increased to 5.45% which is 0.5% better than the 2016/17 outturn but 0.1% worse than the 2017/18 target.

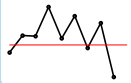
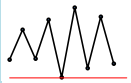
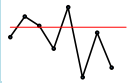
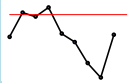
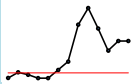
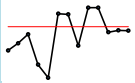
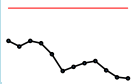
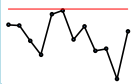
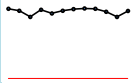
Mandatory Training compliance has reduced in month but continues to exceed the target by 5.0% at 90% compliant. Appraisal remains 4.6% behind target.

The following key applies to the Integrated Performance Report:

▲ = 2017-18 Contract Indicator
▲£ = 2017-18 Contract Indicator with financial penalty
● = 2017-18 CQUIN indicator
T = Trust internal target

Jun-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

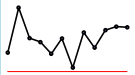
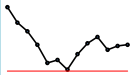
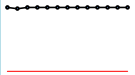
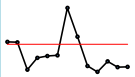
	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 30-34)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Jun-17	2.3%	2.2%	No Target	2.5%		Overall SHMI and HSMR within control limits. Mortality fluctuates month-to-month, but is stable medium-term. Weekend mortality - has fallen again after 'Winter' increase (noisy metric).	Patient Safety and Clinical Effectiveness	Trust is exploring an electronic solution to improve capture of comorbidities and their coding. Specific diagnostic groups with raised mortality are subject to intensive investigation (e.g. COPD). Increasing FCEs per spell is contributing to mortality performance adversely (because diagnosis and risk information are gleaned from 1st FCE (nationally). We are exploring options to reduce FCEs per spell. Major initiatives to improve management of AKI and Sepsis are well underway to improve care and reduce mortality.	KH
Mortality: SHMI (Information Centre)	Q	▲	Dec-16	1.03		1.00						
Mortality: HSMR (HED)	Q	▲	Feb-17	84.4		100.0	103.3					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Feb-17	108.3		100.0	117.1					
Readmissions: 30 day Relative Risk Score (HED)	Q	T	Jan-17	93.9		100.0	98.6		Continues to improve.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	Action ongoing to address babies returning electively but documented as emergency admissions.	KH
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Feb-17	91.9		100.0	93.3		Sustained reductions in NEL LOS are assurance that medical redesign practices continue to successfully embed.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Feb-17	93.4		100.0	91.7					
% Medical Outliers	F&P	T	Jun-17	2.9%	2.8%	1.0%	1.7%		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. Made events are held on a weekly basis, in partner with local authority and all CGG's, to reduce the number of patients medically fit which will in turn have a positive impact on bed availability and reduce the need to outlie patients.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Jun-17	50.7%	50.5%	52.5%	48.3%		Failure to step down patients within 4 hours who no longer require ITU level care. Compliance has improved this year compared with last year by 0.9%. June 17 - 50.7%. June 16 - 41.7%.	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.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	May-17	68.5%	68.7%	90.0%	75.7%		eDischarge performance poor - there is insufficient trainee doctor resource to hit this target with existing paper-based systems.		Pending ePR, we are exploring a revised, automated eDischarge solution to address the problem that there are too few trainees to reliably hit the 95% target. Medium-term plan to supplement trainee doctor numbers with advanced nurses is ongoing.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	May-17	89.7%	84.9%	95.0%	90.0%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	May-17	99.1%	98.9%	95.0%	99.0%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

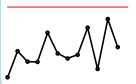
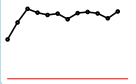
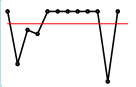
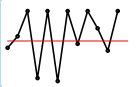
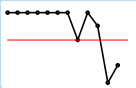
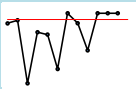
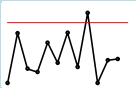
	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Jun-17	92.6%	91.9%	83.0%	94.0%		Target is being achieved. With effect from April 2017, STHK is also treating patients from the Warrington Area. 6 Warrington Patients have been treated by STHK in total the first 2 months of the financial year.	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	There is 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	▲£	Jun-17	0	0	0	2		The National safety standards for invasive procedures will provide further mitigation against future never events.	Quality and patient safety	The RCA for the first never event has been submitted and lessons learnt cascaded. Actions implemented include central line insertion check list . The January 2017 never event is being made subject of a Serious Incident Investigation.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Jun-17	98.2%	98.7%	98.9%	98.8%		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	Jun-17	0	0	0	0		The trust continues to have no prescribing errors which cause serious harm. Trust has moved from being a low reporter of prescribing errors to a higher reporter - which is good.	Quality and patient safety	Intensive work on-going to reduce medication errors and maintain no serious harm. ePrescribing is being rolled out.	KH
Number of hospital acquired MRSA	Q F&P	▲£	Jun-17	0	0	0	4		There were no cases of MRSA bacteraemia and 1 C.Difficile (CDI) case in June 2017.	Quality and patient safety	The Infection Control Team continue to support staff to maintain high standards and practices. They also monitor and undertake RCA for any hospital acquired BSI and CDI. CDI and Antibiotic wards rounds continue to be undertaken on appropriate wards.	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲£	Jun-17	1	8	41	22					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Jun-17	0	2	No Target	17					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Jun-17	0	0	No Contract target	1		No grade 3 or 4 pressure ulcers in month	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	▲	May-17	0	4	No Contract target	22		STHK moderate, severe and death harm from falls YTD is 0.156 per thousand bed days(YTD) against a 0.19 national benchmark.	Quality and patient safety	The RCAs have been completed and lessons learnt cascaded.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲£	May-17	91.92%	92.74%	95.0%	93.36%		VTE performance lower than expected as data cleansing was affected by staff sickness and lower update by junior doctors for additional sessions. Pending e solution when implemented expected to resolve issues	Quality and patient safety	E -Prescribing solution will resolve achieving target in 2017. E-prescribing roll out now underway.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Mar-17	3		No Target	28					
To achieve and maintain CQC registration	Q		Jun-17	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Jun-17	94.5%	94.3%	No Target	94.9%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	Next shelford acuity is commencing 17th July	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Jun-17	0	0	No Target	2					

Jun-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	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	▲ £	May-17	94.3%	94.7%	93.0%	95.1%		Two week and thirty one day targets achieved. Sixty two day target disappointedly was missed and RCA's undertaken to establish issues for corrective actions.	Quality and patient experience	A Cheshire and Mersey Cancer Alliance PTL is being established as part of the wider strategy to support system wide issues across patient Cancer pathways. Locally the focus is on accelerating pathway redesign and reducing variation in pathway performance by improved clinical engagement . Tumour specific dashboards are being redesigned to assist with visibility of clinical pathway performance. Increased scrutiny at patient level of open pathways and action planning at the weekly Cancer PTL review meeting. Actions arising from the reviews include improvements in booking by day 7, inter service transfers ,review of complex pathways requiring multiple MDT access and improved clinical and managerial accountability.	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	May-17	98.8%	98.8%	96.0%	97.9%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	May-17	81.3%	85.4%	85.0%	88.4%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Jun-17	93.2%	93.2%	92.0%	93.5%		At specialty level T&O, Plastic Surgery, ENT, General Surgery, Gynaecology and Urology are failing the incomplete target. The impact of the RMS scheme introduced in July 2016 by St Helens CCG, Knowsley CCG in November and Halton CCG commenced roll out in April is also impacting on RTT performance due to new referral drop.	There is a risk due to the current medical bed pressures, the increase in 2ww referrals and activity, impact of RMS in unbalancing the numerator / denominator that the elective programme will be compromised risking increases in backlogs and worsening RTT performance.	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. Actions to maintain and improve RTT performance reliant on theatre and bed capacity along with staff availability in collaboration with CCG's in ensuring RMS delivers in a sustainable and manageable way	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Jun-17	100.0%	100.0%	99.0%	100.00%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Jun-17	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Jun-17	0.4%	0.5%	0.8%	0.7%		The target was achieved again in June 2017. 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 including increasing GA capacity on Saturdays. 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	▲ £	May-17	100.0%		100.0%	100.0%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Jun-17	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Jun-17	78.7%	79.0%	95.0%	76.1%		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. June 2017 4 hour performance was 2.7% better than June 2016, this is despite a 4.3% increase in attendances (374 more patients attended in June 17 compared with June 16 - an average of 13 more patients per day.	Patient experience, quality and patient safety	The urgent and emergency care transformation plan has several interconnected work streams designed to improve overall 4 hour access performance. **Emergency Department/Front Door** encompassing a 90 day Improvement Programme. In May PDSA cycles tested a number of processes including 'walk in' streaming, Stretcher Triage streaming and internal departmental efficiencies and exit from ED. In June, a new GP stream will be in place as per NHSE recommendations ahead of Sept deadline. **Flow through the Hospital** 1. Continuation of use of the SAFER Care Bundle to increase hospital discharges before midday to 33%. 2. Standardising ward level Board Rounds so that these are consistently delivered across the Care group. Specific attention will be focused on achieving a safe and effective discharge of at least one (golden) patient by 10.00 every morning. 3. Multi-Agency Discharge Events (MADE) continue weekly within the Trust with system wide representation from Executives monthly. Main aim to remove barriers and blocks that prevent patients with complex needs being discharged safely from hospital. 6A event held with physicians and ED consultants to seek alternatives to admission. 13 patients reviewed, 3 deemed as needing to be in hospital. Suggests physician in-reach would be beneficial - further live PDSA event planned	RC
A&E: Total time in A&E: % < 4 hours (All Types)	F&P	▲	Jun-17	86.6%	86.8%	95.0%	85.1%					
A&E: 12 hour trolley waits	F&P	▲	Jun-17	0	0	0	0					

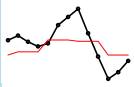
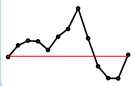
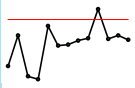
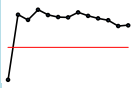
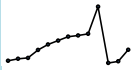
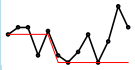
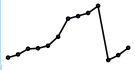
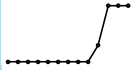
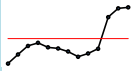
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Jun-17	0	0	0	0		Increased demand for IP capacity has a direct bearing on the ability to maintain this quality indicator.	Patient Experience	Maintained focus and awareness of this issue across 24/7.	RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Jun-17	19	53	No Target	338		A delay in responding to patient complaints leads to a poor patient experience.	Patient experience	The Complaints Team are continuing to work on reducing the small backlog of overdue complaints and to improve the timeliness of responses, which has increased to 74% this month. Complaints training is being provided for staff involved in both investigating complaints and drafting responses in order to ensure comprehensive statements are provided to reduce any delays. Feedback received to date regarding the training has been positive.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Jun-17	31	92	No Target	293					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Jun-17	74.2%	56.5%	No Target	58.0%					
Friends and Family Test: % recommended - A&E	Q	▲	May-17	86.9%	87.9%	90.0%	86.6%		The YTD recommendation rates remain slightly below target for A&E, maternity (antenatal and post-natal ward) and outpatients, but are above target for in-patients and birth and community maternity services.	Patient experience & reputation	Feedback from the FFT responses is 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 continues to contact areas with low response rates to offer support. Reports to the Patient Experience Council will include updates on the number of areas who submit their actions to address the FFT feedback each month.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	May-17	96.1%	95.8%	90.0%	95.5%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		May-17	100.0%	90.0%	98.1%	98.5%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	May-17	100.0%	98.6%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		May-17	90.6%	89.1%	95.1%	98.7%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		May-17	100.0%	100.0%	98.6%	93.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	May-17	94.3%	94.3%	95.0%	94.4%					

Jun-17

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 51-55)												
Sickness: All Staff Sickness Rate	Q F&P	▲	Jun-17	4.1%	3.8%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.8%		Absence in June was again lower than the Q1 target of 4.25% at 4.1%, which is 0.15% ahead of the Q1 target. Nursing sickness including HCAs has increased to 5.45% which is 0.5% better than the 2016/17 outturn but 0.1% worse than the 2017/18 target.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	Targeted HCA and St Helens action plan in place continues to be accelerated during July 2017 along with audit on timely Return to Work interviews/stages/levels & recording onto ESR in timely way. A Manual handling audit will be carried out in Q2 by HWWB in partnership with Matrons to identify how improvements in training cold improve sickness absence for reasons of MSK issues.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P	T	Jun-17	5.4%	4.8%	5.3%	5.9%					
Staffing: % Staff received appraisals	Q F&P	T	Jun-17	80.4%	80.4%	85.0%	87.4%		Mandatory Training compliance has reduced in month but continues to exceed the target by 5.0%. Appraisal remains 4.6% behind target.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The Education, Training & Development team continue to work with managers of non-compliant staff to ensure continued improvement.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Jun-17	90.0%	90.0%	85.0%	91.6%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q4	91.9%		No Contract Target			Whilst response rates fluctuate we remain in the top 3 acute Trusts in our region for both response and recommendation rates.	Staff engagement, recruitment and retention.	Continue to expand the number of local FFT trainers to scrutinise comments; ensure FFT posters are widely disseminated; and expand the use of "You said, we did" posters.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q4	82.2%		No Contract Target						
Staffing: Turnover rate	Q F&P	T	Jun-17	0.8%		No Target	9.8%		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	Jun-17	3.0	3.0	3.0	3.0		The Trust's forecast for year end performance is in line with plan. The Trust has significant contractual agreements with other NHS organisations which may impact on our ability to achieve Better Payment compliance.	Financial	Adherence against the submitted plan and delivery of CIP. Maintaining control on Trust expenditure. Agreeing with Commissioners and NHSE a more advantageous profile for receipt of planned income. Reducing agency expenditure in line with NHSI annual cap.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Jun-17	2,992	2,992	15,315	15,248					
Reported surplus/(deficit) to plan (000's)	F&P	T	Jun-17	1,377	1,377	8,536	4,861					
Cash balances - Number of days to cover operating expenses	F&P	T	Jun-17	12	12	2	2					
Capital spend £ YTD (000's)	F&P	T	Jun-17	821	821	8,015	3,519					
Financial forecast outturn & performance against plan	F&P	T	Jun-17	8,536	8,536	8,536	4,861					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Jun-17	97.3%	97.3%	95.0%	94.3%					

APPENDIX A

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

			May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	2017-18 YTD	2017-18 Target	FOT	2016-17	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲£	87.5%	93.1%	89.3%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	96.2%	94.4%	100.0%	84.6%	91.7%	85.0%		95.2%		
	Total > 62 days		1.5	1.0	1.5	0.0	0.0	0.0	0.0	1.0	0.0	0.5	0.5	0.0	1.0	1.0			6.0		
Lower GI	% Within 62 days	▲£	83.3%	100.0%	100.0%	93.3%	81.8%	71.4%	58.3%	100.0%	91.7%	93.3%	100.0%	76.9%	100.0%	88.9%	85.0%		89.3%		
	Total > 62 days		2.0	0.0	0.0	0.5	1.0	1.0	2.5	0.0	0.5	0.5	0.0	1.5	0.0	1.5			8.0		
Upper GI	% Within 62 days	▲£	90.9%	0.0%	100.0%	100.0%	0.0%	85.7%	88.9%	100.0%	81.8%	0.0%	87.5%	100.0%	100.0%	100.0%	85.0%		78.7%		
	Total > 62 days		0.5	0.5	0.0	0.0	1.5	1.0	0.5	0.0	1.0	4.0	0.5	0.0	0.0	0.0			10.0		
Urological	% Within 62 days	▲£	84.6%	81.3%	75.0%	79.3%	76.9%	96.2%	82.6%	70.0%	95.7%	100.0%	67.6%	92.7%	56.0%	78.8%	85.0%		81.4%		
	Total > 62 days		3.0	3.0	4.0	3.0	4.5	0.5	4.0	6.0	0.5	0.0	6.0	1.5	5.5	7.0			36.5		
Head & Neck	% Within 62 days	▲£	100.0%	37.5%	71.4%	66.7%	100.0%	80.0%	33.3%	33.3%	100.0%	80.0%	80.0%	66.7%	66.7%	66.7%	85.0%		67.3%		
	Total > 62 days		0.0	2.5	1.0	0.5	0.0	0.5	1.0	1.0	0.0	0.5	0.5	0.5	0.5	1.0			8.0		
Sarcoma	% Within 62 days	▲£	85.7%			100.0%			100.0%	100.0%			100.0%	66.7%		66.7%	85.0%		93.3%		
	Total > 62 days		0.5			0.0			0.0	0.0			0.0	0.5		0.5			0.5		
Gynaecological	% Within 62 days	▲£	81.8%	100.0%	85.7%	92.3%	33.3%	100.0%	90.9%	92.3%	100.0%	85.7%	100.0%	87.5%	83.3%	85.0%	85.0%		90.1%		
	Total > 62 days		1.0	0.0	0.5	0.5	1.0	0.0	0.5	0.5	0.0	0.5	0.0	0.5	1.0	1.5			5.0		
Lung	% Within 62 days	▲£	81.5%	90.0%	91.7%	82.6%	100.0%	80.0%	87.5%	91.7%	68.2%	77.8%	100.0%	100.0%	73.7%	78.3%	85.0%		82.7%		
	Total > 62 days		2.5	0.5	0.5	2.0	0.0	1.0	0.5	0.5	3.5	1.0	0.0	0.0	2.5	2.5			13.0		RC
Haematological	% Within 62 days	▲£	100.0%	0.0%	50.0%	50.0%	100.0%	100.0%		66.7%	66.7%	100.0%	100.0%	100.0%	66.7%	80.0%	85.0%		77.6%		
	Total > 62 days		0.0	2.5	3.0	1.0	0.0	0.0		1.0	1.0	0.0	0.0	0.0	1.0	1.0			8.5		
Skin	% Within 62 days	▲£	96.0%	100.0%	97.3%	93.7%	95.7%	92.6%	97.4%	95.7%	95.7%	100.0%	100.0%	92.5%	93.9%	93.2%	85.0%		96.5%		
	Total > 62 days		1.0	0.0	0.5	2.0	1.0	2.0	0.5	1.0	1.0	0.0	0.0	1.5	1.0	2.5			9.5		
Unknown	% Within 62 days	▲£	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	66.7%	0.0%	50.0%	0.0%	100.0%	77.8%	85.0%		82.6%		
	Total > 62 days		0.0	0.0	0.0	0.0	0.0			0.0	0.5	0.5	1.0	1.0	0.0	1.0			2.0		
All Tumour Sites	% Within 62 days	▲£	88.0%	87.5%	85.8%	89.4%	87.9%	92.0%	86.6%	85.8%	89.1%	87.6%	89.3%	89.6%	81.3%	85.4%	85.0%		88.4%		
	Total > 62 days		12.0	10.0	11.0	9.5	9.0	6.0	9.5	11.0	8.0	7.5	8.5	7.0	12.5	19.5			107.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲£					100.0%		50.0%				100.0%				85.0%		83.3%		
	Total > 31 days						0.0		1.0				0.0						1.0		
Acute Leukaemia	% Within 31 days	▲£		100.0%													85.0%		100.0%		
	Total > 31 days			0.0															0.0		
Children's	% Within 31 days	▲£															85.0%				
	Total > 31 days																				

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)069
Title of paper: Executive Committee Assurance Report.
Purpose: To feedback to the Board key quality issues arising from the Executive Committee meetings.
Summary: 1. Between the15th June and 13th July four meetings of the Executive Committee have been held. The attached paper summarises the issues discussed at the meetings. 2. Decisions taken by the Committee included managing the IR 35 tax rule implementation **and the** temporary contract offer for Sherdley Medical Practice and Eldercare. 3. Assurances regarding agency usage, safer staffing, deep cleaning and availability of hand gel were obtained. 4. The business cases regarding e rostering business case, development of incentives to attract newly qualified nurses and HCA apprenticeships were approved. 5. There are no specific items requiring escalation to the Committee.
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 Trust Board are asked to note the contents of the report.
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 26th July 2017

Board REPORT

The following report highlights key quality related issues considered by the Committee.

15th June 2017

1. **Risk Report and CRR**

1.1. SR presented the Risk Report which was reviewed at the Risk Management Council.
1.2. There are currently 701 risks, of which 695 have been reviewed and graded as set out in the report.
1.3. 47.5% (330) of the Trusts risks are rated as Moderate or High.
1.4. 13% (91) have an overdue review date; these are being managed accordingly.
1.5. Two risks in ED were discussed and it was agreed to combine them as they were both related to staffing.
1.6. *ACTION: SR to meet with HOQ (MCG) to clarify the detail of AED risks for the report.*

2. Agency Usage

2.1. MS provided the monthly agency spend update for Month 2.
2.2. Agency spend has increased since Month 1. There had been a reduction in HCA and nursing staff agency spend compared to an increase in medical staff agency spend.
2.3. A Premium Payments Scrutiny Council has been set up to review agency and premium payments on a monthly basis.

3. IR35

3.1. MS provide an update on the changes to the IR25 legislation from NHSI and the impact this will have on the Trust.
3.2. A robust business as usual process for undertaking the assessment is currently being put in place.

4. eRostering Business Case

4.1. MS & SD presented the eRostering business case to extend the contract for the
Allocate system which has been in place at the Trust for 3 years.
4.2. MS presented the benefits to the wider Trust; such as identifying ward levels inclusive of skill mix, assisting with reducing agency spend and providing more accurate timely reporting of figures.
4.3. SD presented the safe care module which is a new module providing an accurate register of staff on duty, which will assist the matrons in the deployment of staff on duty.
4.4. The business case was agreed by Execs.

5. Development of an incentive 'package' for newly qualified nurses

5.1. SD presented the update to the Committee following discussions at Trust Board and previous Executive Committees.
5.2. The Trust requires a plan to attract newly qualified nurses and also to retain current nursing staff; there are currently 50WTE registered nurse vacancies at the Trust.
5.3. The option was discussed for the Trust to have a branded Perception/Mentorship/Leadership (PML) programme.
5.4. PML was agreed for one year

5.5. The HCA apprenticeships were also agreed by the Committee.

6. IPR

6.1. NK presented the key headlines of the IPR for Executive review and the Exec team agreed a number of changes.

22nd June 2017

7. Orthopaedic sessions, including LLP/WLI data and RMS inclusion

7.1. Phil Nee (PN) and John Foo (JF) attended to update the Committee on the process undertaken around orthopaedic sessions, including LLP/WLI data and RMS inclusion.

7.2. Further analysis of data and actions were recommended. To be presented at Exec in July

8. Safer Staffing/Vacancy Dashboard

8.1 The report for May was discussed. It was agreed that KH and SR would review and benchmark the report format

8.2 In May 2017, no patients experience severe harm following inpatient falls.

8.3 AMS confirmed that the vacancy dashboard correlated with Safer staffing figure

9. Infection control: Deep clean benchmarking and Hand gel dispenser audit

9.1 SR presented the infection control paper to the Committee.

9.2 SR reported the findings of the snap shot audit of requests for deep conducted during the period 1st to 14th June 2017. This was to determine if requests for deep clean were in accordance with the Trust cleaning guidance and algorithm.

9.3 The audit findings indicated during the 14 day period, 524 requests were made to the Maximo Help Desk for routine cleans and deep cleans - 384 (73%) were for deep cleans and approximately 99% were correctly identified as required level of environmental cleaning.

9.4 The reasons for deep cleans were predominantly related to patient confirmed Infection, MRSA, CDT, VRE resistant Pseudomonas and confirmed or high risk CPE.

9.5 The paper also provided information related to an audit conducted by the Audit Surveillance Nurse IPC on 31st May 2017 to determine whether alcohol hand gel was available in all ward entrances, and clinic area entrances and if they were in working order.

9.6 The audit findings indicated that 99.7% of the hand gel dispensers were functioning and dispensing gel for hand sanitization.

10. E-pay Slips

10.1 AMS presented the E-pay slip paper to the Committee which will enable all staff to access their pay slips electronically as soon as the payment is run.

10.2 The group did not approve the switch off date at the end of June 2017 and requested further information

10.3 AMS to benchmark against paperless Trusts and provide a list of case studies

29th June 2017

11. Lessons learned from recent cyber-attack and treat level increase

11.1. CW informed the group that the HIS Cyber Security response plan has been updated as a result of the attack. A group has been set up at STP level to look at cyber security. CW has fed back to NHS England regarding how the cyber-attack was managed from the centre.
11.2. It was identified that there was a lack of central guidance, poor management of regional NHSE update calls and lack of maintenance of Windows systems.
11.3. There was nothing to report regarding a threat level increase.
11.4. Following the Manchester major incident debrief, AM requested that reports are discussed at the Executive meeting following discussion at RMC

12. CQPG

12.1. SR updated the Committee on key quality issues arising from the latest CQPG meeting held in June.
12.2. Noted assurances regarding the ongoing management of safer staffing, A&E action plan, cost improvement programme, falls strategy and HCAI performance.
12.3. Noted that the quarterly Mid Mersey stroke update was presented.

13. Private/Overseas Patients

13.1. Sue Hill (SH) provided an update.
13.2. The Committee then discussed overseas patients and new guidance that has been issued.
13.3. Emergency treatment is always exempt from charges, as is treatment for asylum seekers.
13.4. CW will check that the new PAS can identify these patients and also veterans.

14. Incentives to attract newly qualified nurses

14.1. Sally Duce (SD) provided an update to the Committee.
14.2. Assurance was given that newly qualified nurses awaiting the NMC PIN undertake Band 4 Assistant Practitioner roles and further develop the skills of the staff nurse role,
14.3. it was agreed to increase pay to a Band 4. SD will complete a job description.
14.4. The Committee also discussed the Open University course to allow HCA's train as nurses. It is a four year training course and support of Practice Educator Facilitators needs to be put in place.

6th July 2017.

15. Temporary contract offer for Sherdley Medical Practice

15.1. Nicola Bunce (NB) and Mark Hogg (MH) joined the meeting to update Committee on the temporary contract offer for Sherdley Medical Practice. The CCG has requested an initial 7 month period.
15.2. The Committee agreed that the Trust will confirm to the CCG that they will undertake the temporary contract.

16. **OU Nurse Apprenticeships**

16.1. Sally Duce (SD) attended with a proposal to introduce a nurse apprenticeship degree level training programme.

16.2. This will be for one (or two) cohorts of 10 part time attendees from the Trust's existing Band 2-4 clinical workforce. The apprenticeships will be delivered in partnership with the Open University, with tuition fees paid through the Apprenticeship Levy. Band 4 Assistant Practitioners (APs) will be able to join the programme in year two (October 2017).

16.3. The rigid rules applied to utilisation of the Apprenticeship Levy were discussed, and AMS reported that Adam Rudduck will be attending a future Committee meeting to present on the Trust's plans for the management of this.

16.4. The recommendation to commence with the process for APs from October 2017, and the appointment of a Band 6 Nurse Educator was approved.

17. Continuation of Human Factors Training.

17.1 AMS reported on the requirement for all NHS organisations to develop a safe culture, and highlighted that the Trust is required to review the delivery of Human Factors (HF) training available to staff due to changes within the team and expertise available.

17.2 The three options presented in the paper were reviewed and debated, and it was agreed that an eLearning package would be the preferred method.

17.3 AMS will speak further to SR to ascertain whether this could be achievable for Level 1 training in the first instance. Update back to Committee at a later date.

13th July 2017

18. Agency Usage EC17-098

18.1 AMS reported the Month 3 agency spend to Committee, where the total number of shift requests and high fill rate for June was noted. AMS has asked Malise Szpakowska for a deep dive into the reason for this increase.

18.2 AMS reported that a Premium Payments Scrutiny Council has now been formulated which will investigate, monitor and review all key drivers for workforce expenditure not limited to temporary workforce spend (including PSCs), waiting list initiatives, annual leave % and overtime. The Council will report back to Committee on a regular basis.

19. Corporate Risk Register and Board Assurance Framework

19.1 NB reported on the risks from 26 May to 30 June. She noted that there were no new high risks escalated to the CRR and three risks had their scores reduced or were in the process of being closed.

19.2 The four out of date risks were discussed; three have ongoing actions and SR confirmed that 512 and Xx were closed.

19.3 NB confirmed that the BAF is reviewed by the Board four times a year; the last review was in April 2017. It was noted that the framework has now been aligned to the corporate objectives for 2017/18, which has resulted in a number of changes.

19.4 Action plans were discussed, and it was noted that there are plans in place to improve percentage scores for ED response rates and that ED had been charged with looking at pathways.

19.5 The review of corporate reporting and scheme of delegation is now complete and can be removed from the action plan.

19.6 The new Trust intranet is now scheduled for completion on 01 October

20. High level model hospital

20.1 Sarah Clark (SC), presented a 'live' online demonstration of the 'Carter: Model Hospital' programme. SC reported that NHSE have noted that this is still "under construction", and therefore the data is not assured as yet.

20.2 Following the demonstration, all were in agreement that this provides a wealth of data which can be utilised.

20.3 Acknowledged that the Trust must ensure that this is reflected in its IPR.

20.4 The Committee agreed that this would be a very useful tool going forward.

21. IPR

21.1 NK talked the Committee through the IPR.

21.2 The decrease in VTE performance was noted, and the Committee asked for an explanation as to why this is happening.

ENDS

TRUST BOARD

Paper No: NHST(17)070
Title of paper: Review of the Board Assurance Framework (BAF) – June 2017
Purpose: For the Trust Board to review the BAF and approve the proposed changes to ensure it reflects the risks to the Trusts plans for 2017/18 and the changing strategic environment.
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 April 2017. The Executive Committee has reviewed the BAF in advance of its presentation to the Trust Board to ensure it is updated, that the appropriate strategic risks are captured, and that the proposed actions and additional controls are sufficient to mitigate the risks being managed by the Trust, in accordance with the level of risk appetite acceptable to the Board. The BAF has been aligned to the corporate objectives for 2017/18. **Key to Changes:** ~~Score through~~ = proposed deletions Blue Text = proposed additions Red = overdue actions There are no suggested changes to the risk scores for any of the strategic risks.
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to assure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSI, CQC, Commissioners.
Recommendation(s): To review and approve the proposed changes to the BAF.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance.
Date of meeting: 26th July 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 2017/18 Objectives and Long Term Strategic Aims

2017/18 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						
Strategic 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~~ Single oversight 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 • GIRFT 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~~ Full Implementation of the midwifery led care pathway for women having low risk births Plans to achieve 30% of discharges by midday Improvement trajectories for Falls, Infection Control and Pressure Ulcers	Delivery of the remaining CQC (Should do) Actions (September 2017) Implementation plans the four key 7-day service standards in 2017/18 Implementation of Stroke Service integration with WHH – phase 2 planned completion in 2017/18 Action plan to improve the % ratings for ED and outpatients (December 2017) Benefits realisation from the delivery of the St Helens community services contract by March 2018	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~~ Two year Operational Plan and STP financial Modelling • 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 • STF Targets and Control Total Other; • NHSI monthly reporting • Contract Monitoring Board • NHSI Review Meetings	5 x 4 =20	Agree a shared health economy financial and sustainability strategy/control total Develop 2017 - 19 detailed CIP plans Establish a benchmarking and reference cost group	~~Commissioner engagement in joint long term financial modelling and planning~~ Develop capacity and demand modelling capability and a consistent approach to service development proposals approval Foster positive working relationships with health economy partners to help create a joint vision for the future of health services	PMO impact assessment and ROI –December 2017 Develop a detailed STP implementation plan with Alliance LDS and C&M partners in line with the priorities outlined in the Next Steps FYFV plan Secure maximum SFT funding ~~available for 2016/17 and then equivalent for~~ 2017/8 and 2018/19.	4 x3 = 12	NK

Risk 3 - Sustained failure to maintain operational performance/deliver contracts	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to deliver against national performance targets (ED, RTT, Cancer etc) • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting Effects; • Reduced patient experience • Poor quality and timeliness of care leading to poorer outcomes • Failure of KPIs and self-certification returns • Increases in staff workload/stress Impact; • Potential patient harm • Loss of reputation • Loss of market share/contracts • External intervention	4 x 4 = 16	• NHS Constitutional Standards • Care group activity profiles and work plans • Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIST review of A&E performance • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • Membership of CCG System Resilience Groups • Internal Urgent Care Action Group (UCAG) • Data Quality Policy	To Board; • Finance and Performance Committee • IPR • System Resilience Plan • Annual Operational Plan • Data Quality audits Other; • Contract review meetings/CQPG • NHSI monitoring and escalation returns/sitreps • CCG CEO Meetings	4 x 4 = 16	~~Mid-Mersey SRG Emergency Access Target action plan to reduce NEL hospital admission rate~~ ~~Speciality level capacity and demand delivery plans~~	Long term health economy emergency access resilience and urgent care services plans re NEL admissions and DTOC	~~Implementation of the DTOC Rapid~~ Improvement Event Action Plans and Internal Improvement strategy – on going Work with NHSI and ECIP for practical intensive support to achieve 4-hour trajectory – March 2018 Review of bed usage and allocation's to achieve maximum throughput to safeguard both RTT and emergency access and throughput performance	4 x 3 = 12	RC

Risk 4 - Failure to protect the reputation of the Trust	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff engagement and involvement • Failure to maintain CQC registration/Good Rating • Failure to report correct or timely information Effect; • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit 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 • NHSI Segmentation 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~~	Implementation plan to improve understanding of patients and carers' views	New Trust intranet to be developed and launched - October 2017 Achievement of 90% complaints response times target for 2017/18 – March 2018	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 • St Helens Peoples Board • Involvement in Halton and Knowsley ACS development • 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~~ • NHSI Review Meetings ~~TDA IDM's~~ • Review of digital media trends and trust mentions • Monitoring of and responses to NHS Choices comments and ratings • Charitable funds committee • Participation in the Alliance LDS leadership and programme boards	4 x 3 = 12	Annual programme of engagement events with key stakeholders to obtain feedback and inform strategic planning	C&M STP & Alliance performance and accountability framework reports to Board	C&M STP and Alliance shared implementation plans and accountability structures –to meet the requirements of Next Steps for the FYFV	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~~ Plans to optimise opportunities from the apprenticeship levy to create new roles and qualifications to address skills and capacity gaps Monitoring of the retention of overseas nurses.	~~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 Re-fresh of senior staff succession plans as part of the well-led assessment review	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 • H&S Committee	To Board; • Finance and Performance Committee • Finance Report • Capital Programme • Audit Committee • I.P.R. Other; • Major Incident Plan • Business Continuity Plans • ERIC Returns • PLACE Audits • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee, to capture: ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance	4 x 2 = 8	The estates strategy will need to be continually refreshed as the configuration of clinical, clinical support and back-office functions across a wider footprint develops. At this stage it is not envisaged that major changes to the Trust estate are anticipated but maximising the use of the high-quality accommodation for clinical services will be pursued.	To dovetail into the 5-year forward view programme. Maximise the potential from the GP Streaming investment to improve the A&E department flows. (September 2017)	Membership of the St Helens Strategic Estates Group Membership of the Alliance LDS Estates Enabling Group and Corporate Services programme Board	4 x 2 = 8	PW

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

TRUST BOARD

Paper No: NHST(17)071

Title of paper: Corporate Risk Register Report – July 2017.

Purpose: For the Trust Board to review the Trusts Corporate Risk Register (CRR) to ensure it is accurate and reflective of the risks faced by the Trust.

Summary:

The Risk Management Committee (RMC) reviews the risk register and provides monthly assurance to the Executive Committee, that all risks;

- Have been identified and reported
- Have been scored in accordance with the Trusts risk 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 and are having the required impact on the level of risk
- The level of risk appetite (target risk score) is realistic and achievable given the mitigations/actions being proposed.

The Executive Committee reports the CRR to the Trust Board 4 times a year.
This report covers the risks reported and reviewed from 26th May to 30th June.
The report shows that;

- The total number of risks on the risk register is 744 (of which 737 have been reviewed and graded) a further decrease in the number of risks reported.
- 47.5% (350) of the Trusts risks are rated as Moderate or High.
- 63 risks (8.5%) have an overdue review date – this continues the reducing trend.
- There are 11 high/extreme risks that have been escalated to the CRR, with no new high risks being escalated to the CRR in June and 3 risks having their scores reduced or being closed. The spread of risks is;
  - 2 in the Medical Care Group
  - 2 in the Surgical Care Group
  - 2 in Clinical Support
  - 5 in Corporate Services
- The risk categories of the CRR risks are;
  - 5x Patient Care, 2 x Money, 3 x Governance and 1 x Staff

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 Board; 1. Approves the risks that are included on the CRR and the target risk scores **2.** Notes the risks that have been removed from the CRR
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance.
Date of meeting: 26th July 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE RISK REGISTER REPORT – JULY 2017

1. Purpose

The purpose of this report is to provide an overview of the changes to the Trust's risks, and to focus on those risks which score 15 or above which are included on the Corporate Risk Register (CRR).

2. Risk Register Summary for the Reporting Period

This table provides an overview of the "turnover" in the risk profile of the Trust.

RISK REGISTER	Current Reporting Period 03.07.17	Previous Reporting Period 26.05.17	Previous Reporting Period 02.05.17
Number of new risks reported	76	58	20
Number of risks closed or removed	35	28	34
Number of increased risk scores	3	2	6
Number of decreased risk scores	20	6	10
Number of risks overdue for review	63	91	143
Total Number of Datix risks	**744***	**701***	**674***

**Includes 4 new risks not yet scored and 3 unapproved high risks, so analysis calculated on 737 risks*

3. Trust Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
52	**54**	**28**	**84**	**11**	**158**	**57**	**138**	**37**	**105**	**4**	**7**	**0**	**0**
134 = 18.18%			**253 = 34.33%**			**339 = 45.99%**				**11 = 1.49%**			

3.1 Surgical Care Group

270 risks reported 36.63% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
10	**19**	**10**	**38**	**1**	**49**	**21**	**75**	**15**	**30**	**0**	**2**	**0**	**0**
39 = 14.44%			**88 = 32.59%**			**141 = 52.22%**				**2 = 0.74%**			

3.2 Medical Care Group

169 risks reported 22.93% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
14	**19**	**4**	**18**	**1**	**26**	**15**	**22**	**16**	**32**	**2**	**0**	**0**	**0**
37 = 21.89%			**45 = 26.63%**			**85 = 50.29%**				**2 = 1.18%**			

3.3 Clinical Support Care Group

47 risks reported 6.38% 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
3	**1**	**1**	**5**	**0**	**7**	**4**	**8**	**3**	**13**	**1**	**1**	**0**	**0**
5 = 10.64			**12 = 25.53%**			**28 = 59.57%**				**2 = 4.26%**			

3.4 Corporate (incl. Finance, HR, IT, Facilities, Quality & Risk, Pharmacy, IG)

251 risks reported 34.06% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
25	**15**	**13**	**23**	**9**	**76**	**17**	**33**	**3**	**32**	**1**	**4**	**0**	**0**
53 = 21.15%			**108 = 43.02%**			**85 = 33.85%**				**5 = 1.99%**			

The highest proportion of the Trusts risks continue to be identified in the Corporate Care Groups.

	High	Moderate	Low	Very low	Total
Health Informatics/ Health Records	**1**	**18**	**4**	**2**	**25**
Facilities (Medirest/TWFM)	**0**	**3**	**10**	**5**	**18**
Nursing, Governance, Quality & Risk	**1**	**19**	**13**	**4**	**37**
Finance	**0**	**6**	**18**	**23**	**47**
Pharmacy	**0**	**19**	**45**	**12**	**76**
Human Resource	**3**	**20**	**18**	**7**	**48**
Total	**5**	**85**	**108**	**53**	**251**

4. The Trusts Highest Scoring Risks – Corporate Risk Register

Risks of 15 or above are added to the CRR. New risks reported in the month are formally reviewed and consistency checked by the Risk Management Committee, prior to escalation to the Executive Committee (Appendices1).

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

ID	Risk Title	Risk Description	Previous Risk Score	Current Risk Score	Comments
1797	Air blenders for neonatal resuscitaires	Risk of a baby suffering brain damage because we cannot provide best practice resuscitation for neonates at birth because no neonatal resuscitaires on Delivery Suite have air/oxygen blenders.	5 x 3 = 15	5 x 2 = 10	Air blenders have been purchased and in place full training for all staff will be completed by 16th June 2017.
1989	E-rostering systems licence renewal funding	The Trust will not be able to roster nursing and doctors, utilise the bank	4 x 4 = 16		Risk closed –funding source agreed

		with effect from July 2017 if the extension of the current contract is agreed.			
1647	Risk to patients of multi – resistance pseudomonas on ward 4D and ward 4E	7 patients confirmed with MDR pseudomonas with the same typing since November 2015.	4 x 5 = 20	4 x 2 = 8	Patient with the outbreak strain with strict infection control precautions in place. Risk reduced as using en-suite shower and 1:1 nurse allocation. Patient due for discharge in next few weeks

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

KEY	Medicine		Surgical		Clinical Support		Corporate	

New Risk Category	Datix Ref	Risk	Description	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Target Risk Score I x L
Governance	222	Failure to ensure delivery of national performance targets	Failure to ensure delivery of national performance targets : *Achieve cancer 14.31.62 day targets	4 x 4 = 16	4 x 4 = 16	24/04/2017 Rob Cooper	4 x 2 = 8
Governance	1772	Risk of Malicious Cyber Attack	The HIS and neighbouring organisations have been targeted by malicious software via email links/attachments which if successfully bypassed our security controls could cripple the HIS Network.	3 x 4 = 12	4 x 4 = 16	09/11/2016 Christine Walters	4 x 3 = 12
Governance	1259	Serious Incidents Requiring Investigation (SIRI)	Failure to meet the prescribed deadlines in the management of SIRI's could lead to failure to learn lessons, implement changes and reduce risks, as well as, damage the Trust's reputation and reduce commissioner confidence	4 x 4 = 16	4 x 4 = 16	22/12/2016 Sue Redfern	3 x 2 = 6
Money	1555	Unplanned cost pressure from the introduction of an apprenticeship levy.	From April 2017, a new apprenticeship levy is being introduced by the government that will impact large organisations with a pay bill in excess of £3m. This is likely to be an unfunded cost pressure of £1m on the Trusts Lead Employer function if this cannot be recovered from host organisations.	3 x 5 = 15	3 x 5 = 15	01/04/2016 Anne-Marie Stretch	3 x 4 = 12
Money	1152	Potential impact for the Trust on quality of care, contract delivery and finance due to increased use of bank and agency	Increase of bank and agency affects 1) continuity of care 2) ability to deliver against planned activity 3) breaching the agency cap 4) Failure to meet agency spend control target 2016/17	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	4 x 3 = 12
Patient Care	1205	B&P Prosthetic Service - staffing situation, service delivery pressures	There are currently 3 qualified Prosthetists for a team that should be made up of 7. There is also 1 funded maxillofacial technician post. The Prosthetic Department delivers its services from 2 different hospital sites and receives referrals from Burns, Plastic Surgery, Dermatology, Neurology, ENT, Maxillofacial Surgery and GP's from across Merseyside, Cheshire, North Wales and IOM.	4 x 4 = 16	4 x 4 = 16	16/08/2016 Anne-Marie Stretch	4 x 2 = 8
Patient Care	1971	Brennan Skin Mesher Field Notice: limited capacity to treat plastics and burns patients	The Supplier of the Brennen Skin mesher (A medical device that expands the area of donor skin go further) has issued a field safety notice reports a failure in the sterilisation validation for the 2:1 Brennen skin mesher. Risks are:	4 x 4 = 16	4 x 4 =16	11/05/2017 Rob Cooper	4 x 1 = 4

			1. Reduces the Trust capacity to undertake cases requiring meshed skin including Burns patients and some plastics patients. 2. Affects the Trust's ability to receive and treat Burns patients (although other Burns units may be in the same position). 3. May be a need for patient review (c2,500) dependent on nature of validation failure and IPC view. Note this is supplier matter and not an issue with the sterile services provider				
Patient Care	1569	Consultant Recruitment within Clinical Support Services	Difficulty recruiting Histopathologists and Radiologists to manage increasing workload in line with business and operational requirements	2 x 5 = 10	3 x 5 = 15	17/11/2016 Anne-Marie Stretch	3 x 4 = 12
Patient Care	1285	Insufficient staffing levels on Frailty Unit affecting patient safety and operational effectiveness	Patient safety is potentially compromised and the ability to deliver a good quality standard of care due to staff vacancies.	4 x 4 = 16	3 x 5 = 15	12/04/2016 Sue Redfern	3 x 3 = 6
Patient Care	913	Patient safety risk due to staffing levels below establishment on DMOP	Patient safety is potentially compromised and the ability to deliver a good quality standard of care due to increase number of Registered Nurse vacancies.	3 x 5 = 15	3 x 5 =15	12/04/2016 Sue Redfern	2 x 2 = 4
Staff	762	Potential risk of the Trust not being able to provide safe levels of staffing	Unable to recruit staff with the knowledge, skills and experience required.	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	4 x 2 = 8

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

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)072

Title of paper: Committee report – Quality Committee

Purpose: To summarise the Quality Committee meeting held on 18th July 2017 and escalate issues of concern.

Summary: Key items discussed were:

1. Complaints – a slight increase in the number of 1st stage complaints received was noted. At the end of June there were 47 open 1st stage complaints (20% reduction), including 9 overdue (36% reduction). The Trust responded to 74.2% within the timeframe.

2. Safer Staffing – Information provided regarding nursing and midwifery staffing levels.

   (a) The Committee discussed recruitment and retention issues, in particular staffing issues on Ward 2B (Respiratory). A number of staff have left and there are 9 WTE vacancies. S Redfern advised that an Open day will take place in August and an incentive package for newly qualified staff has been approved by the Executive Team.

3. IPR – A&E performance, cancer targets, finance and HR targets were discussed. One concern noted was the performance for VTE assessments for May which was 91.92%.

4. Medicines Security – S Gelder informed the Committee that overall Trust performance was 98% (excluding ED). ED performance is poor (rated red or black), the situation requires continuing attention and vigilance. Audits are to be held weekly and the results fed back to S Redfern and R Cooper. A M Stretch asked what assurance could be given to the Committee and the Board that the audit would be done as well as Pharmacy would do it? S Gelder said that spot checks would be held to ensure compliance. D Graham asked that the Lead Nurse from ED attend the next Quality Committee in September to discuss the audit results.

5. Hospital Pharmacy Transformation Programme update – To update the Committee on progress on the Trust Medicines Optimisation Strategy and Hospital Pharmacy Transformation Programme. It was agreed a new strategy and plan be developed and reported to Quality Committee in September.

6. CQC action plan update – Progress in delivering the Trust's CQC action plan is reviewed quarterly and reported to the QC. This report covered progress to the end of June 2017. There are still 5 outstanding actions.

7. Lord Carter review update – To provide assurance to the Quality Committee of the actions taken in response to the recommendations detailed in the Trust response to the independent report for the DoH by Lord Carter.

8. Francis action plan update – To provide assurance to the Quality Committee on the Trust's progress to meet the recommendations following the publication of the Francis Report.

9. Medical Revalidation – Dr Hankin provided feedback and assurance to the Committee that the arrangements for Medical Appraisal and Revalidation have been operating effectively at the Trust since the regulations came into effect on 2012.

10. Clinical & Quality Strategy update – In the 2016 refresh of the Clinical & Quality Strategy, the Board chose to narrow its focus to 10 difficult and challenging goals, which cross refer to the IPR and Clinical Effectiveness.

    - 4 hour performance.
    - Weekend mortality SMR
    - 62 day cancer (all)
    - VTE assessment
    - eDischarge
    - Serious harm falls
    - Complaints in timeframe
    - Abs in Sepsis
    - #NOF to surgery
    - Critical Care SMR

11. Feedback from Councils:
    (a) Patient Safety Council (issue: higher than expected mortality in COPD and Bronchiectasis).
    (b) Patient Experience Council
    (c) Clinical Effectiveness Council (issue: poor glycaemic control on wards).
    (d) CQPG
    (e) Executive Committee

Items to be escalated to the Board:

- Recruitment and retention of nursing staff.
- ED failure of Medicines Security Audit.
- VTE assessment.

Corporate objectives met or risks addressed: Five star patient care and operational performance.

Financial implications: None directly from this report.

Stakeholders: Patients, the public, staff and commissioners

Recommendation(s): It is recommended that the Board note this report.

Presenting officer: David Graham, Non Executive Director

Date of meeting: 26th July 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)073

Title of paper: Committee Report – Finance & Performance

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

Summary:

Agenda Items

For Information

- GP streaming – Capital bid
  - The committee were briefed on the allocation of £985k which is required to deliver GP streaming by October 2017. Briefing paper of what it will be spent on to be shared by email to Committee members once agreed by Executive colleagues.
- Procurement Department & Review
  - Committee pleased with department function and relative performance. It was recommended they benchmark against a different but more comparable peer group and if performance was materially different to then come back to next F&P
- Medical SLR Quarter 4 2016/17
  - Report was well received and performance improvement in 2016/17 was noted.
- Latest Bank & Agency Usage was presented and accepted.
- STP/LDS update was presented and accepted.
- Forecast Outturn 2017/18
  - Committee welcomed an early insight into the possible financial risks for the year. Included issues of STF achievement requirements, contracting issues, HRG4+ and CIPs.
- CIP Council briefing was accepted.

For Assurance

- Bed modelling report
- Backlog Review
  - Report highlighted specific services which require management action to improve backlog. Accepted performances had not worsened recently but await the actual reduction in backlog from actions being implemented.
- Monthly profile of CIP delivery
  - Committee accepted report and that profile of CIPs this year was broadly in line with previous years.
- A & E update
  - Committee were assured about progress from 90 day project. Committee felt the issues are narrowing down to two main points from a department point of view only. They were resilience in the evening/night performance and general clinical

engagement for the A&E department.

- Integrated Performance Report Month 3 2017/18
  - 1 CDI case reported in June; A&E 86.6% for all types. It was noted for Board that VTE and appraisal performance was below target levels for June. 62 day cancer performance was also below target for May but accepted verbal update that for June this was now above the 85% target.

- Finance Report Month 3 2017/18
  - Delivered year to date surplus of £1.377m; £0.009m surplus excluding Q1 STF. In achieving this performance it was noted slippage in reserves was used and will need to be replenished over the year.
  - Generic risks in achieving outturn were noted and can be summarise as tariff, activity, cost control and STF allocation

- Governance Committee Briefing Paper:
  - CIP Council

Actions Agreed

- Backlog Review
  - Identify appropriate control levels (reasonable backlog levels) and monitor performance on that basis

- Procurement Review
  - Impact of PFI and depreciation to be presented to the Committee in September

- A & E update
  - next steps to improve performance to be presented at Trust Board

Corporate objectives met or risks addressed: Finance and Performance duties

Financial implications: None as a direct consequence of this paper

Stakeholders: Trust Board Members, NHSI

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

Presenting officer: Denis Mahony, Non-Executive Director

Date of meeting: 26th July 2017

TRUST BOARD

Paper No: NHST(17)074

Title of paper: Strategic and Regulatory Update Report

Purpose: To provide the Board with assurance that the Trust continues to take account of external strategic developments that could impact the future direction of the organisation and all regulatory requirements to comply with governance good practice.

Summary:

1. Winter Planning Requirements

   To make the Board aware of the expectations of NHSE/NHSI in respect of planning for 2017/18 winter pressures.

2. CQC Local System Review – Halton

   To inform the Board of the Local System review that the CQC is undertaking of the interface between the Local Authority and NHS in Halton, from 11th August.

3. New Ambulance Performance Standards

   To explain the new Ambulance Performance Standards

4. C&M FYFV Update

   To bring the Board up to date with developments in the last month.

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, C&M FYFV, Commissioners, NHSI

Recommendation(s):

1. The Board notes the report
2. The Board asks the Quality Committee to oversee the input to and outcomes of the CQC Local System Review for Halton and to develop an action plan in response to any recommendations that directly impact on the Trust or its partnership working with the local health system.

Presenting officer: Nikhil Khashu, Director of Finance and Information

Date of meeting: 26th July 2017

Strategic and Regulatory Update Report

1. Winter Planning Requirements

   NHS Improvement (NHSI) and NHS England (NHSE) issued joint guidance to Commissioners, Providers and Local Authorities on 14th July, setting out the expectations for creating additional bed capacity to cope with winter pressures this year by;

   - Increase available beds by up to 3,000 nationally by reducing delayed transfers of care (DTOCs). Each CCG and Local Authority has been given a target for reducing their proportion of DTOCs, and must produce plans to achieve this reduction by November (it is expected that the additional £2b allocated to Adult Social Care in the budget and Better Care Fund (BCF) monies will be targeted to achieve this reduction).
   - The CQC have been asked to undertake reviews in 12 areas that are experiencing high levels of DTOCs to understand what could be done to improve the interface between health and social care. Halton has been identified as one of these 12 areas (see section 2).
   - Reducing variation in best practice – by implementing guidance on improving patient flow
   - Introducing Primary Care Streaming to Emergency Departments by October 2017. StHK is one of the 90 Trusts that have received a capital allocation from the £100m fund to implement Primary Care Streaming.
   - Standardisation of urgent care provision outside of Emergency Departments, so that all Urgent Treatment Centres (UTCs) can offer;
     - A service for at least 12 hours a day, 7 days a week
     - Treatment by clinicians with access to diagnostic facilities e.g. x-ray
     - Bookable appointments via NHS111 and GP referral
   - Changing the Ambulance Service operating model (see section 3)
   - Improved flu planning and vaccination rates
   - Local A&E Delivery Boards must submit their detailed winter resilience plans by 8th September and then specific plans for the Christmas /New Year and Easter holiday periods on 1st December and 2nd March respectively

2. CQC Local System Review – Halton

   As referenced above the Halton has been selected as one of the Local Authority areas for a targeted CQC review of the interface between health and social care.

   The reviews will look specifically at how people move between health and social care, including delayed transfers of care, with a particular focus on people over 65 years old. The review will not include Mental Health Services or specialist commissioning but, through case tracking, will look at the experiences of people living with dementia as they move through the system.

The purpose of the reviews is to provide a bespoke response to support those areas facing the greatest challenges to secure improvement.

The review will take place during the week of 21st August 2017 and will include visits to the Trust to explore the experience of Halton patients and how we work with the Social Services department.

Once all of the reviews have been completed the CQC will be producing a national report of the findings, to identify key themes and recommendations.

A working group has been established to prepare for the review, which includes representation from the local provider trusts delivering services in Halton.

3. Ambulance Performance Standards

Following a major review and recommendations by Sir Bruch Kehoe, National Medical Director for NHSE proposals to change the national ambulance response time standards have been accepted and will come into effect from the beginning of Q3. The new standards are;

Category	Percentage of calls in this category	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Category 1	8%	7 minutes mean response time 15 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •30 seconds from the call being connected	The first ambulance service-dispatched emergency responder arriving at the scene of the incident (There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
Category 2	48%	18 minutes mean response time 40 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first ambulance service-dispatched emergency responder arriving at the scene of the incident stops the clock.
Category 3	34%	120 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance, service-dispatched emergency responder arriving at the scene of the incident stops the clock.
Category 4	10%	180 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

4. C&M FYFV Update

- In line with the guidance contained in the Next Steps for the Five year Forward View the C&M STP now has a new independent Chair; Andrew Gibson who is a former Trust Chief Executive from Northumberland

- Louise Shepherd the C&M STP lead is also stepping down, and a new STP lead is currently being sought. NHSI & NHSE have issued a joint advert asking for expressions of interest from existing CEO's/Chief Officers or senior Directors

- C&M FYFV have also now established a System Leadership Board, which has membership from all the constituent organisations, and will be accountable for system performance and the delivery of the sustainability and transformation plans

- NHSE & NHSI are to start producing system dashboards for each STP footprint, and undertaking joint performance management of each systems performance against core constitutional, access and financial targets

- The financial modelling supporting the STP has been updated to reflect the 2016/17 outturn position and 2017/18 financial plans and this has confirmed the overall financial challenge for the C&M footprint remains circa £1b (in the "do nothing" scenario)

- In 2017/18 the savings are principally delivered through business as usual – CIP or QIPP from Providers and Commissioners. Savings from transformational projects need to start to be delivered in 2018/19, if the control total financial sustainability plans are to be achieved

- All C&M Programmes, Cross Cutting Themes and the three Local Delivery Systems have been tasked with undertaking a stocktake of their current plans and projected savings in 2017/18 and beyond, by 28th July 2017 to facilitate a review and prioritisation of system activities

- All of the CCGs in C&M are establishing Joint committee arrangements – within each LDS footprint, but with the facility to come together to take C&M wide decisions on service configuration, when necessary. The joint committee will start to function in the autumn and will provide a strategic commissioning forum in each LDS.

- Across C&M plans to develop Accountable Care Organisations (ACO) are being developed to best fit the different geographies, local authority boundaries and population needs, the first ACO's plan to be operational from April 2018.

- The Alliance LDS has also appointed a Non-Executive Chair. This is Ingrid Fife who is a lay member of Halton CCG's Governing Body.

- In the Alliance LDS Accountable Care is being developed on a borough basis with each Local Authority, and StHK is a partner in the St Helens Peoples Board and is also involved in the planning process with Knowsley and Halton.

ENDS

TRUST BOARD

Paper No: NHST(17)075
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 is 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: 26th July 2017

HR/Workforce Strategy & Workforce Indicators Report

26th July 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 support our workforce.

2.1 National Workforce Changes

Junior Doctors Contract 2016

Following the implementation of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, the Trust has followed the phased implementation provided by NHS Employers and currently has a total of 52 junior doctors on this set of terms and conditions.

Mr Michael Chadwick, Consultant Surgeon, has been Guardian of Safe Working Hours for the Trust and Acute Lead Employer Trusts since September last year. Dr Peter Arthur is Guardian of Safe Working Hours for GP's and Public Health trainees employed under Lead Employer arrangements. As the Guardians they are responsible for:

- 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

The Guardians are required to present quarterly reports to the Board that relate to safe working hours and exception reporting. Mr Chadwick presented to the Trust Board in June in relation to the trainees that are currently on the 2016 contract here at the Trust and the exception reports that have been raised so far. A further report will be presented to the Board that relates to the trainees on the 2016 contract in Acute Lead Employer host Trusts under Mr Chadwick's remit. The GP quarterly report will be presented to the Board after

August 2017 when trainees have transitioned to the new contract as per the national implementation timetable.

3.0 Developing our Workforce

3.1 Trust Mandatory & Risk Management Training

The Trust has been leading on the Training Streamlining Programme for the Cheshire & Mersey region and has been reviewing its current provision for both Mandatory Training and Induction of new staff. The aim of the programme is to align training requirements across the region and to reduce the time committed to face to face training and repetition of unnecessary training on entry into the organisation. Under this Programme and subject to nationally agreed refresher periods for NHS Core Skills Framework subjects, the Trust refresher periods will be considered to be realigned from 24 to 36 months to match the Cheshire & Merseyside timeline. This will be considered in conjunction with subject matter experts. From the autumn, the Trust will be able to benefit from the new e-learning platform via a national upgrade of the ESR portal on 17th July. This will mean that staff will now be able to access e-learning solutions via Trust technology and personal devices. This will also allow access to induction training for new employees in advance of their joining the Trust. The Trust will carry out a structured pilot of the system from September prior to full Trust roll out to all staff groups during the autumn.

Mandatory Training compliance continues to remain a high priority across the Trust to ensure continued achievement of current performance targets of 85% (100% of available staff). Areas of underperformance are followed up directly with appropriate Service Leads to ensure remedial actions are put in place. Currently the Trust remains compliant with the 85% target.

3.2 Appraisals

Following a comprehensive review, testing and feedback process, the Education, Training & Development Team have developed revised bespoke Appraisal documentation for all staff groups. The new simplified documents can be completed both in hard copy or an ‘e’ format. Associated training for users is being developed and the revised process planned for roll out from August.

The Education, Training & Development Team is also developing an e-Talent Management Tool which will incorporate the revised appraisal documentation and allow more effective oversight of development needs, ability to identify ‘ready now’ leadership talent and plan development interventions in a cost effective way. The tool is expected to pilot in October and roll out to reach all areas by March 2018.

Appraisal activity continues to remain a high priority across the Trust in order to meet the performance target of 85% (100% of available staff). Performance data is included in the Integrated Performance Report presented to the Finance and Performance Committee. Any areas of underperformance are followed up directly with Service Leads to put in place remedial actions. Over the last quarter the Trust has been on average of 1.5% under the 85% target year to date.

3.3 Apprenticeships

The Trust has been carrying out an engagement programme through team brief, Care Group Management meetings, the Workforce Council and the JNCC to raise the profile and awareness of Apprenticeships across the organisation via a series of presentations to ensure the Trust optimises support and utilisation of Apprenticeships across all staff groups.

The levy spend during April to July 2017 has been utilised to provide apprenticeships for internal staff only and doesn't take into account, at this stage, any potential new roles that could be offered as apprenticeship roles in the future.

The Trust's digital account service (DAS) has registered funds of £149,344 on the 11 July 2017, of which actual spend is £124,000 with a remaining balance in month of £25,344. A further £30,000 spend has been committed for apprenticeships currently being registered throughout July. A Steering Group has been established to oversee and optimise opportunities for the apprenticeship levy spend.

Numbers, types and funding for current Apprenticeships are:

Apprenticeship	Level	Numbers	STATUS	Provider	Cost	Duration
Business Administration with Medical Administration	2	8	Live	South Cheshire College	£12,000	2 yrs
Leadership & Management	5	6	Live	St Helens Chamber	£54,000	2 yrs
Leadership & Management	3	4	Live	St Helens Chamber	£20,000	2 yrs
Team Leading	2	4	Live	St Helens Chamber	£20,000	15 months
Health Clinical Healthcare Support	3	3	Live	South Cheshire College	£6,000	18 months
Health Clinical Healthcare Support	2	4	Live	South Cheshire College	£8,000	15 months
Business Administration	4	1	Live	South Cheshire College	£4,000	2 yrs
		30			**£ 124,000.00**	

Following meetings with the Open University (OU) and a paper to Trust Executive Committee on 6th July, the Education, Training and Development Team are leading on the recruitment of existing Assistant Practitioners (AP) to a Nurse Degree Apprenticeship. The cohort of up to 10 APs will join the 4 year part-time degree programme in October 2017 at year two having been granted Accreditation of Prior Experiential Learning (APEL) for their Foundation Degree. The Cohort will run alongside existing students from our current Universities providing additional qualified nurses from July 2020. Further cohorts are planned, targeting the existing HCA workforce from February 2018.

3.4 Cultural Surveys

The Education, Training & Development Team continue to support services with the facilitation of cultural surveys. Full surveys were completed in February and June 2017 across for Pathology Services to support their Organisational Development planning processes. Plans are in progress to undertake full cultural surveys in Radiology & Microbiology in the next quarter. Owing to the volume and complexity of delivering and effectively analysing the surveys, the Education, Training & Development Team have identified a re-designed role to specifically focus on delivering this crucial piece of work going forward due to the increasing number of cultural surveys being implemented across the Trust to support the delivery of Trust objectives.

3.5 Overseas Nurse Recruitment & Clinical Development

3.5.1 Global Learners Programme

The Global Learners' Programme offers a three year work-based educational experience in the UK for nurses and other healthcare professionals whilst contributing to the UK workforce. This Programme will enhance and add to existing skills and provide an opportunity to work in the NHS whilst gaining new knowledge and experience. Each Global Learner will return to their home countries with developed skills and ultimately will apply this enhanced level of practice into their own hospitals or clinical environments.

Despite our numbers to date being small, there aren't many Trusts that have achieved the same degree of success demonstrated at STHK when preparing international recruited staff for practice in the UK. Failure to adequately prepare internationally recruited nurses, mainly in part, is due to organisations underestimating the time and expertise required to prepare nurses to undergo this process and successfully enter the UK workforce.

To date, STHK have received two cohorts of 6 internationally recruited nurses. Following the development of a robust educational package, clinical education has achieved a 100% pass rate in the Objective Structured Clinical Examination (OSCE) exam. This is exceptional across the region, and is only a reflection of the hard work and effort that the Educational Lead has given to the Programme. Following the outstanding success the Clinical Lead has been invited to accompany Health Education England North West to India to help shape future educational programs associated to the Global Learners Programme. Due to the Trust's success in the transition of our 12 Indian nurses and the superb work of Ann Rimmer, Practice Education Facilitator assigned to support the OSCE preceptorship programme, HEEN has asked if STHK would like 20 "ready to come to the UK" nurses from India who have already passed their International English Language Test System (IELTS), and if we have continued success we could receive another 20 next year.

3.5.2 School of Radiology Site Survey

In 2016/17 the School of Radiology introduced a new-style, more detailed analysis of the 6 monthly 'end of placement evaluations' for training sites. This new-style analysis covers the 24 training sites of the 'joint' HEENW School of Radiology, so it includes the 10 training sites of the 'Mersey Radiology Training Programme' as well as the 14 sites of the 'North West (Manchester) Radiology Training Programme.' Following the review, based on all the scores, the Radiology training at STHK was ranked number 1 out the 24 sites for the period August 2016 to January 2017 and was commended by Health Education England for these excellent results.

3.6 Leadership Coaching

The Trust continues to support a coaching culture through the delivery of a rolling coaching programme to c.40 leaders within the Trust at Bands 8b and above.

3.7 Core Management & Leadership Development

Feedback form the Core Management Programme sessions remains positive, with further sessions planned over the coming year to enhance and develop capability across all areas of management practice. This programme for cohorts of 12 managers provides a range of supervisory and management skills, e.g. time management, financial awareness and influencing skills for Ward Manager's and Matrons.

The Education, Training & Development Team are working with a range of Trust stakeholders across clinical and non-clinical areas to consider how the Trust can achieve a joined- up approach to the provision and delivery of Leadership Development, aligned to Talent Management, Apprenticeships and workforce development needs. A scoping exercise will be undertaken during August to inform the development of a revised Leadership Development Strategy to reflect national changes in the provision of funding for education and training.

3.8 Recruitment & Retention

The Francis Report published in 2013 highlighted that the shortage of doctors and nurses 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.

3.9 EU Citizens after Brexit

In June, the Government published a proposals paper which sets out an offer to secure the rights of EU citizens and their families in the UK post exit from the EU. At this stage these are proposals and are subject to the UK reaching agreement with EU member states over UK nationals receiving reciprocal arrangements. NHS Employers anticipate proposals will be published for consultation shortly and employers are being kept informed as this work progresses.

4.0 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 May 2017 the Trust is recruiting to seven consultant vacancies (a number of which are covered by temporary staff) and there are 41.72 ward based Registered Nurse (RN) vacancies. Key shortage areas for medical staff (nationally as well as locally) include Respiratory, Dermatology, Histopathology, Stroke, Care of Elderly and Emergency Medicine.

During 2017, seven non-training grade doctors were appointed via various international recruitment activities including the implementation of the Medical Training Initiative Scheme and working in partnership with the British Association of Physicians of Indian Origin (BAPIO). A further 12 doctors will commence at the Trust in August following a successful recruitment campaign which targeted final year medical students from Masaryk University in the Czech Republic.

100 offers of employment were made to nurses during the recruitment campaign held in India. Due to difficulties in the nurses passing the IELTS, this has delayed them joining the Trust. 12 nurses have now commenced employment with one more expected in August 2017. A further 26 continue to face difficulties in passing the IELTS.

We continue to work closely with the Nursing Directorate Team, Education & Training and clinical teams regarding recruitment and retention initiatives when examining reasons for leaving, such as education and training, working conditions, improved rostering and pastoral support specifically for newly qualified returning to practice nurses. Our Recruitment and Retention plans continue to be reviewed ensuring the recruitment and HR Advisory team work closely together.

NHSI recently announced a new nationwide retention programme in June to support NHS Trusts who are struggling to retain nurses by providing a tailored approach. Trusts with above average turnover rates are being targeted initially therefore StHK will not be in this cohort due to our turnover rate being 11.07% compared to the national average of c.17%.

NHSI Plans include:

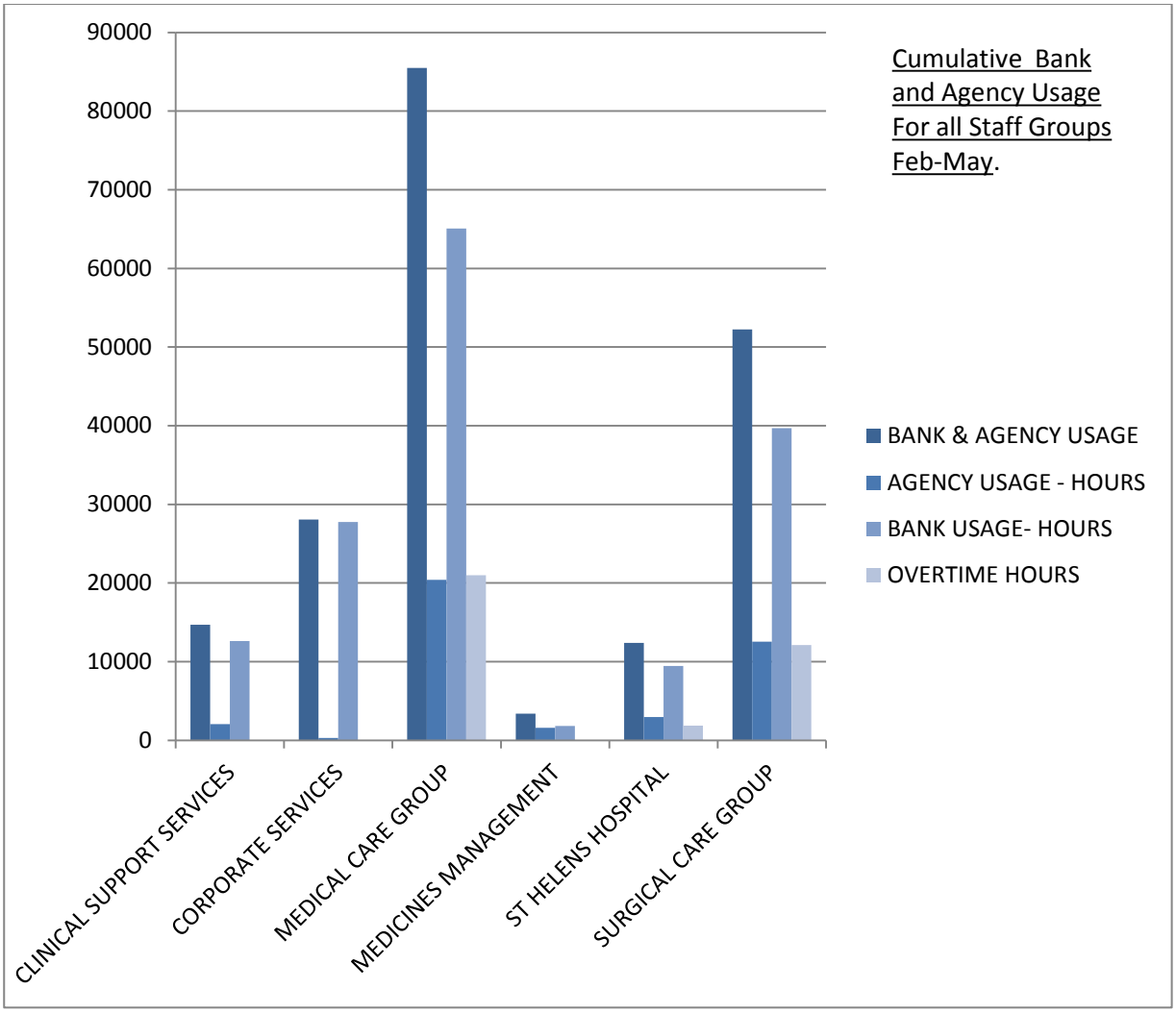
- The provision of an evidence based improvement guide and toolkit, later this year, to share measures from Trusts that have successfully retained staff.
- Classes for Nursing & HR Directors, as well as piloting an engagement tool to help Trusts understand why staff may be leaving and support the analysis of data.
- It is recognised by NHSI that lots of Trusts are already addressing these issues; one of the aims of the programme is to spread best practice.

The Team continue to takes steps in progressing with the reservist agenda together with the Director of Transformation in the delivery of a bespoke recruitment campaign targeted at medical and nursing veterans resettling out of HM Armed Forces, to fill suitable existing gaps within the Trust.

4.1 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 do remain the principle reason for usage and as such there is a premium financial cost. The Trust's agency expenditure is detailed in the Finance 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 is set out below:



4.2 NHSI – Agency Spend Reduction

The Trust continues to execute action plans to minimise the 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 continues to work with a number of partners to reduce agency pay and commission rates as well as encouraging the movement of workers from agency to the Trust Medical Workforce Bank. This so far has generated positive feedback from the medics that have done so. The recruitment campaigns for HCAs and qualified nurses to join the Trust Clinical Nurse Bank are on-going.

In line with NHSI recommendations to reduce agency spend, other opportunities to work across Cheshire and Merseyside as a collaborative bank are being explored by a regional project being led by StHK. This has also been agreed as a HR strategic objective across Cheshire & Merseyside.

4.3 Off Payroll Working in the Public Sector

The HMRC regulations and guidance on the application of Intermediaries Regulations (IR35) came into force on 1st April 2017. The Trust has put in a place a robust process for managing these types of engagements.

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

5.1 Systems Innovation

The HWWB Department have implemented a number of new systems and processes to support the productivity and efficiency of administration processes. In Q4 of 2016/17, HWWB launched the use of online pre-employment medicals via the Cohort system. This has allowed for more efficient screening and supports recruitment processes .The system enhances the interface between recruitment, HWWB and the candidate in relation to pre-employment health checks, tracking the progress continually and flagging when appropriate for action. It is paperless, thus saving costs and time producing outcome letters.

The triage telephone system is being improved to assist with immediate and timely direction to the appropriate team enhancing patient experience. The text messaging reminder service is also being implemented over the next couple of months to prompt appointments 2-3 days prior thus allowing for the opportunity to re-arrange or cancel. This in turn will result in efficiencies for the department's appointment clinic.

The Trust's Lead Employer Service continues to host the new Physicians Associate trainee role on behalf of HEE NW to be deployed in Trusts across the North West.

The Trust continues to provide HWWB support to external organisations e.g. local CCGs and as the Lead Employer of c.2,300 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, c.1,100 from the East of England from the 1st February 2017 and further c.900 from East Midlands from the 1st July 2017.

The Trust's HWWB service continues to lead 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.

6.0 Human Resources Advisory Team – Attendance Management

The Human Resources Advisory Team continues to assist managers in the consistent application of the Trust's Attendance Management policy working closely with the Absence Support Team and Health, Work & Well Being on all aspects of attendance including wellbeing initiatives.

The benchmarking data below shows that the Trust's sickness absence for the period July to June 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 Finance and Performance Committee. Our Nursing and Midwifery % absence rate is particularly lower when comparing the three Trusts by 1.15%. The Trust total is the lowest out of the three Trusts by 0.55%.

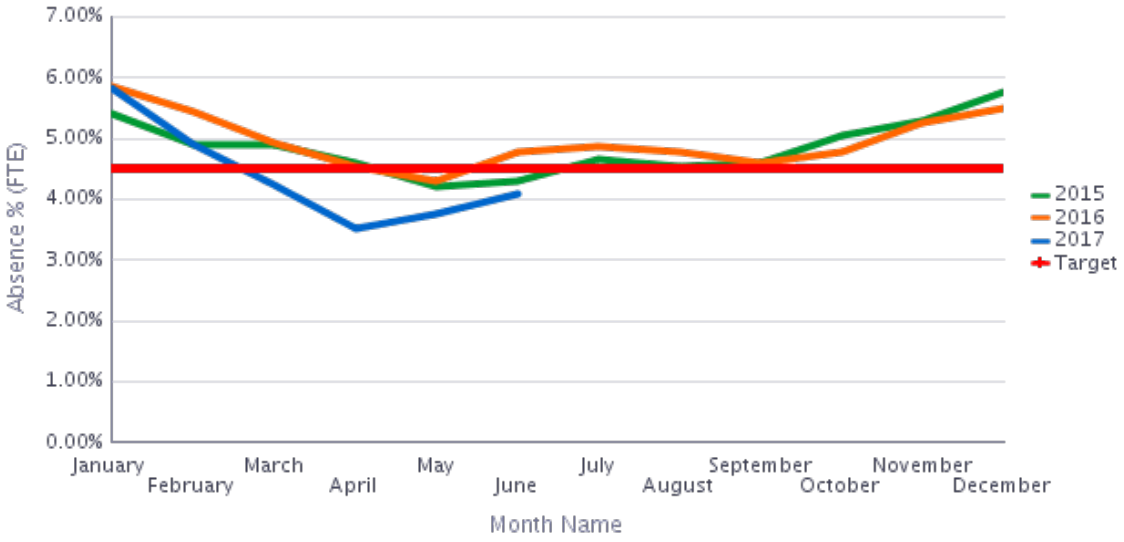
Benchmarking of Cumulative Absence July 2016 to June 2017			
Staff Group	**St Helens and Knowsley**	**Merseyside Trust A**	**Merseyside Trust B**
Add Prof Scientific and Technic	4.32%	4.72%	4.65%
Additional Clinical Services	7.46%	6.37%	7.89%
Administrative and Clerical	3.70%	4.21%	4.87%
Allied Health Professionals	2.95%	3.38%	3.07%
Estates and Ancillary	6.40%	9.30%	8.28%
Healthcare Scientists	2.94%	2.29%	4.95%
Medical and Dental	1.59%	2.11%	1.06%
Nursing and Midwifery Registered	4.60%	5.70%	5.75%
Trust Total	**4.67%**	**5.09%**	**5.22%**

Trust Trend Summary

Since January 2017, the Trust's absence rate% has continually decreased in comparison to the last 2 years as illustrated in the table below. This month on month reduction has continued until June 2017 the latest reporting period.

A factor in this reduction has been due to the continued multidisciplinary approach the HR Directorate has taken to managing sickness absence and associated factors with managers, demonstrated in this paper. The Absence Support Team also continue to be a value asset to the Trust by supporting managers with their application of the policy and ensuring the procedure and toolkit are adhered to.

In addition the health roster systems now allows nursing staff to request their own shifts swaps to be approved by their managers. Since the increase in notice of shift rotas from 4 to 8 weeks in quarter one staff now have more notice of the shifts which is improving working lives of our staff.



	2015	2016	2017
January	5.40%	5.85%	5.82%
February	4.91%	5.45%	4.90%
March	4.90%	4.94%	4.24%
April	4.59%	4.55%	3.51%
May	4.21%	4.30%	3.76%
June	4.30%	4.79%	4.07%
July	4.66%	4.87%	
August	4.55%	4.79%	
September	4.59%	4.61%	
October	5.05%	4.76%	
November	5.29%	5.26%	
December	5.77%	5.49%	

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. Both teams meet on a monthly basis to discuss cases and appropriate actions.

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 relate to short term absence which is treated as a conduct case and Levels which are treated as capability in line with the Equality Act 2010.

Stages and Levels	MCG	SCG	St Helens	CSSG	Pharmacy	Corp	Non-Clinical	Trust Total
Stage 1	161	133	38	51	13	23	61	**480**
Stage 2	45	37	9	11	2	5	10	**119**
Stage 3 (Non-Dismissal)	0	4	0	0	0	0	0	**4**
Stage3 (Dismissal)	0	0	0	0	0	0	0	**0**
Stage 4	0			0	0	0	0	**0**
Level 1	89	69	34	28	5	16	41	**282**
Level 2	10	14	10	13	0	6	8	**115**
Level 3 (Non-Dismissal)	3	1	1	3	0	0	0	**8**
Level 3 (Dismissal)	0	0	0	1	0	0	0	**1**
Level 4	0	0	0	1	0	0	0	**1**
Total	**308**	**258**	**92**	**117**	**20**	**50**	**120**	**962**

Stage – Managing Short Term/Intermittent Absence with No Single Underlying Medical Reason

Level – Managing Absence with Underlying Medical Reason

6.3 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 continues to make progress with the Equality Delivery System (EDS2) and the Workforce Race Equality Standard (WRES) for 2017/18 has recently been completed with milestones for the 2016/17 action plan being completed. NHS England and NHS Equality and Diversity Council continue to consult and engage with NHS organisations regarding the new Workforce Disability Equality Standard (WDES). It is proposed the WDES is mandated from April 2018. The Trust will be consulting with its key stakeholders in preparing our 2018/19 action plan when the WDES standards are published later this year. A new Equality and Human Rights policy to replace the current Equality, Diversity & Inclusion policy covering matters relating to both patient and our staff was approved at the Patience Experience and Workforce Councils in July 2017. A report will be presented to the Trust Board in September 2017.

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 made in November 2016. The Trust is developing an integrated workforce systems plan for the next 2 years to ensure an ambitious roll out plan continues and that systems benefits and efficiencies are realised.

8.1 Health Roster (E-Rostering)

Implementation of the system is on-going and there are now 56 clinical areas live with Health Roster across the Trust. A further nine departments were implemented in April 2017. The Trust is working towards full implementation across Clinical Support Services and Administration and Clerical areas in 2017/18. The E-Rostering team are about to commence junior doctor and non-training grade medical workforce implementation starting with the Emergency Department from August 2017.

8.2 E-Rota

E-rota which is the medics part of the Allocate Health roster has been used since August 2016 to test compliance of junior doctor rotas under both the 2002 and 2016 contracts, and to calculate the pay elements for those on the 2016 contract. E-rota also provides the exception reporting functionality for doctors on the 2016 contract. The software provider Allocate will be supporting the Trust in the software implementation for junior doctors in GP practices/Public Health onto the system so that they can exception report from August 2017.

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.

9.0 Workforce Planning & Information Team

The Workforce Planning Team were finalists in the recent HPMA Awards 2017 in the category “Innovation for the Use of ESR” for their project of rolling out self service to over 900 GP practices in the North West, West Midland and East of England to support the Lead Employer Model.

9.1 ESR Portal Update

The Team launched the new ESR Portal on the 18th July. The Portal has new technology and a significantly improved user experience. This will allow employees to configure their portal page to suit their needs. The Trust can broadcast messages via the portal and can target specific staff groups. The new portal is mobile and tablet friendly which allows for flexible access and staff can access data such as payslips, P60’s Total Reward Statements at any time by using the ESR App.

9.2 e-Expenses

E-Expenses has been rolled-out to 600 staff working in Corporate Services and staff now submit expense claims electronically. Work is underway to continue further roll out to the remainder of the Trust with all expense claims being processed electronically by the end of October 2017. The Trust recently became the Lead Employer for Health Education East Midlands with 700 GP trainee doctors. The Trust has rolled out e-Expenses to all the GP Trainees within the East Midlands and these staff will claim expenses electronically with effect from the 1st July 17. Further roll out to trainees from Health Education North West and Health Education West Midlands will commence in August and all 5000+ trainees will claim expenses electronically.

9.3 Payroll Services

The Trust's Payroll Department is now processing circa 40,000 payslips a month with a client base of 26.

Updates & Achievements year to date:

- Expanded product portfolio that we offer to clients to include transactional HR
- Increased number of clients
- Increased number of services provided to clients including weekly payroll
- Implemented weekly payroll for the Trust's bank staff
- Commenced implementation of E-Expenses
- Efficiencies from service improvement processes and 'e' functionality
- Extension of all client contracts that have expired
- 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 2017, the figure for staff in post increased overall by 13.25 wte. Increases in Nursing & Midwery staff account for the 9.09wte of the increase. There are currently c.87.13 wte of staff currently on maternity leave.

Whole Time Equivalent by Staff Groups		Month			
Staff Group		Apr-17	May-17	Jun-17	Difference
Add Prof Scientific and Technic		154.23	158.03	154.11	-0.13
Additional Clinical Services		963.52	950.40	955.30	-8.22
Administrative and Clerical		1,000.81	1,003.27	1,002.61	1.80
Allied Health Professionals		235.65	238.26	237.47	1.82
Estates and Ancillary		292.74	297.19	297.58	4.84
Healthcare Scientists		189.98	190.11	189.71	-0.27
Medical and Dental		404.74	404.60	409.05	4.31
Nursing and Midwifery Registered		1,410.15	1,419.67	1,419.24	9.09
Grand Total		**4,651.81**	**4,661.53**	**4,665.06**	**13.25**

Staff Turnover Rates

Turnover rate is currnetly 11.07% for the period July 2016 to June 2017 compared to the national average of c.17%.

Benchmarking of Cumulative Turnover July 2016 to June 2017			
Staff Group	St Helens and Knowsley	(Specialist) Merseyside Trust A	(Acute) Merseyside Trust B
Add Prof Scientific and Technic	10.95%	8.73%	10.91%
Additional Clinical Services	8.86%	7.41%	11.24%
Administrative and Clerical	9.84%	11.71%	8.75%
Allied Health Professionals	12.00%	8.54%	9.17%
Estates and Ancillary	6.64%	3.35%	14.48%
Healthcare Scientists	8.83%	4.72%	12.40%
Medical and Dental	22.32%	17.82%	22.55%
Nursing and Midwifery Registered	11.22%	11.07%	14.15%
Trust Total	**11.07%**	**10.23%**	**12.52%**

Retirement Age

Staff Group	Retirements Due @ July 17	Retirements Due in 3 Months	Retirements Due in 6 Months	Retirements Due in 9 Months	Retirements Due in 12 Months
Add Prof Scientific and Technic	3	3	3	3	3
Additional Clinical Services	46	48	50	51	53
Administrative and Clerical	28	29	34	36	39
Allied Health Professionals	2	2	2	2	2
Estates and Ancillary	33	34	34	37	40
Healthcare Scientists	4	4	4	4	4
Medical and Dental	12	14	15	16	17
Nursing and Midwifery Registered	22	22	23	25	25
Grand Total (Aged 65+)	**150**	**156**	**165**	**174**	**183**
Nurses Aged 55+	**296**	**305**	**313**	**329**	**342**
Nurses Aged 60+	**97**	**107**	**113**	**122**	**126**

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.

One of the key polices introduced was the Trust's Equality & Human Rights Policy in July, replacing the previous Workforce Equality and Diversity Policy. It is an overarching policy covering both patients and staff issues. The policy aims to help build a fully inclusive organisation by helping the organisation meet its statutory equality duties; ensuring that due regard is given to patients and staff from all protected groups and ensuring human rights are upheld for both patients and staff.

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 have commenced the OD diagnostic process with a programme of cultural surveys and OD interventions taking place throughout 2017.

11.3 Case Management

The HR Advisory Team continue to support managers through a range of cases such as disciplinary, grievances, promoting speaking out safely and Respect & Dignity at work for all staff groups. The team also provide a mediation service as required to support individuals and teams as part of the Trust's Grievance, Equality & Diversity and Respect & Dignity at work policies.

11.4 Organisational Change Programmes

Many of the organisational changes implemented during 2017/18 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, c.60 staff from Bridgwater Community Health transferred (TUPE) to the Trust on 1st April 2017.

On 1st July, 60 members of the HR Department from Southport and Ormskirk Hospital NHS Trust (SOHT) TUPE transferred their employment to St Helens and Knowsley Teaching Hospitals NHS Trust, as part of a partnership approach to the provision of Human Resources services across the Alliance LDS footprint. This includes the Payroll, Recruitment and Resourcing which have moved with Whiston and Alexandra Park sites, with Education and Training, Medical Staffing, HR Advisory and Health & Wellbeing teams remaining based at Southport and Ormskirk hospitals.

Recent and ongoing consultation programmes, internal to the Trust, include the following services:

- Orthodontics Service. The service at St Helens Hospital will be closing in 2017/18. The Trust is working closely with Commissioners to ensure minimal disruption to the patient journey. Staff are being consulted with and supported appropriately with both nursing and medical and dental staff being affected.
- Pharmacy – Extension of opening hours to support 7 day services
- Blood Sciences staff at SOHT - out of hours service consultation ongoing.
- Phlebotomy Service based at Southport and Ormskirk working in line with 7 days working within our Trust, so that all staff to be available for 7 day working. This review has been prompted in part by the situation of some SOHT services being TUPE'ed out to Lancashire Care and Virgin Care.
- Phlebotomy Service at Whiston and St Helens + community service: so that in line with 7 days working within our Trust, all staff to be available for 7 day working together with the introduction of weekend Phlebotomy services in the Trust and Community.
- TUPE of Vocational Rehabilitationist post from STHK Therapies to The Walton Centre occurred on 1st June 2017

- Speech and Language Therapy Service - Introduction of a 7 day service to support patient care commenced on 1st July 2017
- 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.
- Informatics Training Team – Re-organisation to align the structure and roles to meet the needs of the Trust and partnership organisations.
- Sexual Health – Review of administration roles are ongoing
- Recovery Theatres – Expansion of 7 days working and on call arrangements.

12.0 Lead Employer Arrangements

The Trust is now the Lead Employer to c 5,300 junior doctors in training which also an over view role for the Guardians of Safe Working. In July 2017 the Lead Employer service was also commissioned by HEE to deliver a HR Advisory telephone service until March 2018 to GP Practices in the Humber and Yorkshire region where lead employer arrangements do not currently exist to support the implementation of the new 2016 Junior Doctors contract. The Trust has also been invited to host a new GOSW network for the North West Trusts Guardian of Safe Working.

13.0 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.

14.0 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.

15.0 Recommendations

The Trust Board is 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
July 2017

TRUST BOARD

Paper No: NHST(17)076
Title of paper: Infection Prevention & Control Report
Purpose: To provide the Trust Board with an update on the current Trust infection control status against Department of Health objectives.
Summary **Number of cases for financial year 2017-18:** **1.** HCAI MRSA bacteraemia: 0 cases (target 0) **2.** HCAI CDI: 8 Positive samples (target 41) of which the Trust is to appealed 3 cases to date. **3.** HCAI MSSA bacteraemia: total number of cases for this financial year is 2 **4.** HCAI E coli bacteraemia: total number of cases for this financial year is 20, 14 RCA's have been completed and only 2 cases were deemed avoidable. **5.** ANTT : 78% against a target of 85% **6.** MRSA screening : 99% compliant **7.** Trust wide blood contamination rate : 5% against a benchmark of 3%
Corporate objectives met or risks addressed: Patient Safety and Patient Care
Financial implications: There is a risk of financial penalties if the Trust does not achieve the CDI target.
Stakeholders: Trust, patients and stakeholders
Recommendation(s): That the Trust Board receive the report and discuss the contents to identify any actions required.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance
Date of meeting: 26th July 2017

IPC Report

1. **Methicillin-resistant Staphylococcus Aurous (MRSA) bacteraemia**

1.1. All Trusts have been given the target of zero hospital-acquired cases.

1.2. In 2016-17 the Trust had 3 cases and one contaminant.

1.3. Year to date there has been no MRSAB.

2. **Meticillin Sensitive Staph Aureus (MSSA) bacteraemia**

2.1. The Trust is now required to report all MSSA blood cultures. There is currently no external target.

2.2. Year to date there were 2 hospital acquired cases.

2.3. Compared to the same reporting period in 2015-16 when there were x 3 case, this is a 33% reduction

2.4. One RCA has been conducted and was agreed that this was unavoidable (existing deep infection) and there were lapses in care identified.

2.5. The Trust has 181 ANTT key trainers and the first of the trainer the session was well attended on 26th June 24 staff members were trained to undertake peer review.

2.6. ANTT compliance is 78% against target of 85%. Actions are in place to increase compliance rate.

2.7. The Trust continues to monitor blood culture contamination rates Contaminated blood cultures can lead to increased length of stay and cost of care (e.g. due to increased investigations and treatment). The maximum acceptable contamination rate is 3% of all blood cultures taken. The Trust compliance during June was 5%

3. **MRSA hospital acquired colonisation**

3.1. There were no cases of hospital-acquired MRSA within the Trust this financial year.

3.2. MRSA screening is 99% compliant.

4. **E coli bacteraemia**

4.1. The external target for a 10% reduction in health economy acquired E Coli bacteraemia.

4.2. There has been a total of 7 hospital attributable (by date) E Coli bacteraemia since 1st April 2017. RCA s are in progress.

4.3. In the month of June there were 6 cases, in comparison to 20 community acquired cases.

4.4. On 26th June 2017, Ruth May, Executive Director of Nursing, NHS Improvement, wrote to all NHS Trust's and CCG's to request that Trust's and CCG's jointly focus **on** *E.coli* (*Eschericia coli*: which is one of the largest Gram Negative Blood steam infection groups) to achieve the "Ambition to reduce healthcare associated Gram-negative blood stream infections by 50% by March 2021**".**

4.5. **Working together as a system , NHSI asked *providers and commissioners to :***

- Jointly discuss this ambition and agree a reduction plan. This could be through existing meetings or local groups, such as Quality Surveillance Groups, or Sustainability and Transformation Partnerships. Action: discussed and agreed at CQPG

- Jointly develop an improvement plan by September 2017 that describes how your health economy will achieve a 50% reduction in healthcare associated GNBSIs by March 2021, with a focus on a 10% or greater reduction of *E.coli* in 2017/18. Action: Task and finish group established to develop action plan

- Identify an Executive level lead who will act as the main point of contact within the Trust and within CCGs Action: Trust lead Director of Nursing, Midwifery and Governance / DIPC

- Trusts to collect key data:
- From 1 April 2017, Trusts will be able to enter ***E. coli* data** within the voluntary risk factor fields. CCGs are required to collect this data for the Quality Premium. Action: In place

- Voluntary data collections for *Klebsiella* spp. and *Pseudomonas aeruginosa.* BSIs have been enabled on the Data Capture System. Data entered by Trusts from 1 April 2017 to 31 March 2018, will be used to determine baseline counts and infection rates. We encourage Trusts to support this voluntary collection by entering cases as soon as possible. Action: In Place

5. Clostridium difficile infection (CDI 2017-2018)

5.1. The target for 2017-2018 is no more than 41 cases of hospital acquired cases.

5.2. To date, there has been 8 confirmed positive cases; 1 in April, 6 in May and 1 in June. RCAs are in progress.

5.3. Findings from recent RCAs:

- May 2017: Avoidable infection. Patient was started on low dose trimethoprim prophylaxis when not required.
- Action: avoid long term antibiotic prophylaxis to prevent urinary tract infection in patients with long term urinary catheters.
- Good practice identified: Patient isolated and specimen sent in a timely manner. Antibiotics used (in contrast to prophylactic antibiotics) were appropriate, based on previous history, allergy history and culture results.

- May 2017: Avoidable infection. Patient continued to receive antibiotics after infection excluded.
- Action: Ensure antibiotics stopped when no longer indicated.
- Good practice identified: Adequate completion of Bristol Stool Chart; appropriate and timely stool sampling for C.Difficile; good quality RCA and appropriate lessons identified by ward clinical team.

- May 2017: Unavoidable infection. Case for appeal.
- Good practice identified: Appropriate antibiotics given, good liaison with medical microbiology, blood cultures taken in a timely manner, Bristol Stool Chart completed, PPI reviewed on admission and excellent quality RCA.

6. Outbreaks

6.1. There has been 1 outbreak which was related to Ward 1A related to scabies.

7. Carbapenemase – producing Enterobacteriasceae (CPE)

7.1. There have been no cases since 1st April 2017.

8. Vancomycin-resistant Enterococcal (VRE) bacteraemia

8.1. There has been 1 case of VRE bacteraemia since 1st April 2017. RCA in progress

9. The Trust has 4 CQUIN indicators related to sepsis management and antimicrobial prescribing for the financial years 2017-2019

9.1. Timely identification of sepsis in the Emergency Department and in inpatients.

9.2. Timely treatment (within 1 hour of diagnosis) of sepsis in the Emergency Department and in inpatients.

9.3. Appropriate and documented review of antibiotics started for sepsis within 72 hours of commencement for which at least **90%** compliance is required to achieve the CQUIN target.

9.4. Appropriateness of use (appropriateness in relation to indication used plus appropriateness of duration) for all antibiotics and specifically also for piperacillin-tazobactam and carbapenems (i.e. ertapenem and meropenem) for which at least **85%** compliance is required to achieve the CQUIN target.

ENDS.