St Helens and Knowsley Teaching Hospitals NHS Trust

Trust PublicBoard Meeting

TO BE HELD ON WEDNESDAY 29TH MARCH 2017
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

A G E N D A				Paper	Presenter
09:30	1.	Employee of the Month			Richard Fraser
		1.1	March		
09:35	2.	Chinese doctors introduction			Francis Andrews
09:45	3.	Patient Story			Sue Redfern
10:05	4.	Apologies for Absence			Richard Fraser
	5.	Declaration of Interests			
	6.	Minutes of the previous Meeting held on 22nd February 2017		Attached	
		6.1	Correct record & Matters Arising		
		6.2	Action list	Attached	
Performance Reports					
10:10	6.	Integrated Performance Report		NHST(17) 022	Nik Khashu
		6.1	Quality Indicators		Sue Redfern
		6.2	Operational indicators		Rob Cooper
		6.3	Financial indicators		Nik Khashu

		6.4	Workforce indicators		Anne-Marie Stretch
10:25	7.	Safer Staffing report		NHST(17) 023	Sue Redfern
BREAK					
Committee Assurance Reports					
10:45	8.	Committee report – Executive		NHST(17) 024	Ann Marr
10:50	9.	Committee Report – Quality		NHST(17) 025	David Graham
10:55	10.	Committee Report – Finance & Performance		NHST(17) 026	Denis Mahony
Other Board Reports					
11:00	11.	FT programme update report		NHST(17) 027	Nik Khashu
11:05	12.	Approval of budget plans		NHST(17) 028	Nik Khashu
11:15	13.	Board effectiveness review		NHST(17) 029	Peter Williams
11:20	14.	CQC registration		NHST(17) 030	Sue Redfern
11:25	15.	Mixed sex declaration		NHST(17) 031	Sue Redfern
11:30	16.	Review of staff survey		NHST(17) 032	Anne-Marie Stretch
11:40	17.	Approval of 2017/18 Trust objectives		NHST(17) 033	Ann Marr
11:50	18.	Loan conversion paper		NHST(17) 034	Nik Khashu
Closing Business					
12:00	19.	Effectiveness of meeting			Richard Fraser
	20.	Any other business			
	21.	Date of next Public Board meeting – Wednesday 29th March 2017			
LUNCH					

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 29TH MARCH 2017

No	Minute	Action	Lead	Date Due
1.	30.11.16 (6.4.2)	Appraisals. Ann Marr asked for an audit to be carried out to ensure that information regarding complaints is captured on medical staff appraisals.	AMS	29 Mar 17
2.	30.11.16 (6.4.4)	Accountability framework/lessons learned: Sue Redfern to feed back to Board regarding lessons learned and how this is co-ordinated. 22.02.17: Sue Redfern fed back to the Board regarding the accountability framework/lessons learned.		Action closed.
3.	25.01.17 (8.8)	Complaints, Claims & Incidents: Sue Redfern will provide an analysis of claims trends to Sarah O'Brien. 22.02.17: Sue Redfern has provided the analysis and is awaiting feedback from Sarah O'Brien.	SRe	29 Mar 17
4.	25.01.17 (11.5)	HR Indicators: A trend line is required in the next report for Bank, Agency and Overtime usage.	AMS	26 Jul 17
5.	25.01.17 (15.5)	FT Programme Update: Nik Khashu will liaise with NHSI regarding the FT pipeline. 22.02.17: Nik has spoken to NHSI and trusts are no longer expected to actively pursue FT status. Action closed.		Action closed.
6.	25.01.17 (19.1)	IT downtime: Denis Mahony asked that if the IT systems have gone down, could the NEDs receive the information in a different format i.e. telephone call. Christine Walters will take this forward. 22.02.17: Cathy Duffy, Executive Assistant to CEO and Chair, will develop a SOP for using text messages to Board members, clarifying when it would be needed and under what circumstances. Action closed.		Action closed.

No	Minute	Action	Lead	Date Due
7.	22.02.17 (9.3)	Occupancy figures: Ann Marr requested that a deep dive takes place regarding the figures.	NK	29 Mar 17
8.	22.02.17 (11.3)	Charitable Funds: Ann Marr requested that Anne-Marie Stretch speak to the Media office about raising awareness of the fund.	AMS	29 Mar 17
9.	22.02.17 (12.6)	5 Year Forward View Memorandum of Understanding: Ann Marr asked Nik Khashu to provide a SWOT analysis and recommendations for the Board.	NK	29 Mar 17

Paper No: NHST(17)022
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 February 2017. The year to date total is 2.

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

There was 1 C.Difficile (CDI) positive case in February. Year to date there have been 20 confirmed positive cases.
The annual tolerance for 2016-17 is 41 cases.

There was 1 grade 3 pressure ulcer in February, taking the YTD total to 3. There have no grade 4 pressure ulcers.

There were 2 falls that resulted in severe harm during January. Year to date there have been a total of 17.

Performance for VTE assessment for January was slightly below the required 95% target at 93.64%.

YTD HSMR is 103.7 up to November 2016.

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

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 16/17 financial outturn will have implications for the finances of the Trust
Stakeholders: Trust Board, Finance Committee , Commissioners, CQC, TDA, patients.
Recommendation: To note performance for assurance
Presenting Officer: N Khashu
Date of Meeting: 29th March 2017

Operational Performance

A&E performance was 74.1% (type 1) and 83.9% (type 1 & 3) in month.
A seasonal increase in non elective admissions and complexity of patients is impacting upon performance.
The key actions identified for recovery of this position are being driven forward by the senior leaders across the organisation, focusing on both the Emergency Department and the Inpatient wards

Emergency Department key actions:

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

Inpatient areas:

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

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

RTT incomplete performance was achieved in month (93.2%). 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. Additional activity funded by NHSE to reduce RTT backlog , will continue until end of march resulting in completion of pathways for circa 1000 dermatology and 18 T&O patients.

Financial Performance

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

Income & Expenditure

As at the month of February 2017 (Month 11) the Trust is reporting an overall Income & Expenditure surplus of £2.681m after technical adjustments which is slightly above the agreed plan. Trust income is ahead of plan by £2.259m, while expenditure is overspent by £2.118m, through delivering this additional activity. Expenditure on Agency stands at £9.930m for the year against a target for the full year of £7.256m. The Trust Executive team continues to meet with Specialties on a weekly basis to review the action plans in place to reduce agency expenditure in 2016/17.
The Trust's forecast outturn is to achieve its Annual plan of £3.328m surplus.

CIP - To date the Trust has delivered £13.672m of CIPs which is now just ahead of the year to date plan and the Trust is forecasting to achieve its £15.248m target for the year. The CIP Programme is formally reviewed both at a Trust and Specialty level on a monthly basis and is also part of the Operational Transformation Group agenda.
Capital - Capital expenditure to date is £3.059m out of a revised year forecast total of £3.509m, due to the deferral of the Salix CHP scheme.
Cash - Cash balance at the end of February 2017 is £8.432m which equates to 10 operating days.

Human Resources

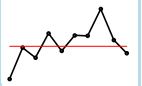
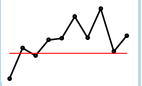
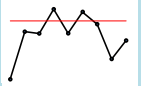
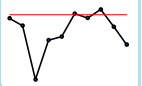
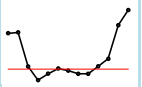
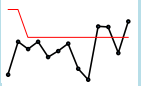
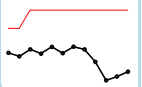
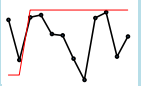
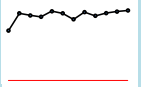
The 2016 staff satisfaction score has again increased and the Trust remains in the top 20% of acute Trusts nationally. A full report will be presented at the March 2017 Trust Board. The Trust exceeded the CQUIN flu vaccination target of 75% and is currently at 81% vaccination rate of frontline staff.
Mandatory training compliance is unchanged in month and is 7.1% above target at 92.1%. Appraisal compliance for January has also improved and is just 4.3% behind target at 80.7%, with work ongoing to recover the compliance rate to 85%.
Absence has decreased in February to 4.9% which is 0.22% behind Q4 target. YTD this aligns with last years outturn at month 11. Seasonal virus, flu and colds are the most common reasons for absence. Nursing sickness including HCAs was 0.71% above target with YTD 0.1% better than 2015/16 outturn.

The following key applies to the Integrated Performance Report:

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

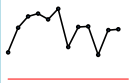
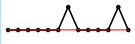
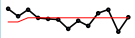
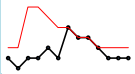
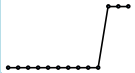
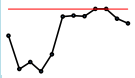
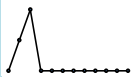
Feb-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 30-34)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Feb-17	2.2%	2.5%	No Target	2.5%		Overall SHMI and HSMR within control limits. Crude mortality fluctuates month-to-month, but is stable medium-term. Weekend mortality - has increased over 'Winter'.	Patient Safety and Clinical Effectiveness	Trust is exploring an electronic solution to improve capture of comorbidities and their coding. Focus on addressing R codes use by examining and improving the coding pathway. We aim to deliver Palliative care input earlier in the patient pathway to improve care and HSMR. Major initiatives to improve management of AKI and Sepsis are well underway to improve care and reduce mortality.	KH
Mortality: SHMI (Information Centre)	Q	▲	Jun-16	1.02		1.00						
Mortality: HSMR (HED)	Q	▲	Nov-16	96.3	103.7	100.0	99.7					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Nov-16	114.2	114.2	100.0	112.9					
Readmissions: 30 day Relative Risk Score (HED)	Q	T	Oct-16	96.7	98.5	100.0	96.4		Much improved over last 12 months.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	Action underway to address babies returning electively but documented as emergency admissions.	KH
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Nov-16	89.9	93.5	100.0	92.2		Sustained reductions in NEL LOS are assurance that medical redesign practices continue to successfully embed.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Nov-16	89.2	93.5	100.0	97.7					
% Medical Outliers	F&P	T	Feb-17	5.0%	1.5%	1.0%	2.2%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in LoS, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Feb-17	61.2%	46.8%	52.5%	50.9%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. Critical care rep now attending all bed meetings to agree plan and to highlight patients who will require transfer over the coming 24 hours. In month achieved target. Now utilising 4E medical which will support step down of appropriate patients	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients)	Q	▲	Jan-17	73.2%	76.5%	90.0%	79.9%		eDischarge performance poor. Historic backlog now quantified.		Pending ePR, ongoing drive to improve realtime completion on ward rounds, but trainee doctor numbers is an issue. Medium-term plan to supplement trainee doctor numbers with advanced nurses. Action plan to address unsent eDischarges has been agreed with commissioners.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients)	Q	▲	Jan-17	90.9%	91.0%	95.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E)	Q	▲	Jan-17	99.2%	99.0%	95.0%	98.5%					

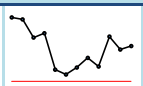
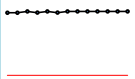
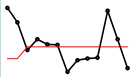
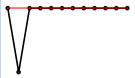
Feb-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Jan-17	93.6%	94.1%	83.0%	92.0%		Target is being achieved	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Continued focus on delivery of this KPI to ensure our patients continue to receive the best possible care	RC
PATIENT SAFETY (appendices pages 37-39)												
Number of never events	Q	▲ £	Feb-17	0	2	0	0		The National safety standards for invasive procedures will provide further mitigation against future never events.	Quality and patient safety	The RCA for the first never event has been submitted and lessons learnt cascaded. Actions implemented include central line insertion check list . The January 2017 never event is being made subject of a Serious Incident Investigation.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Feb-17	99.0%	98.8%	98.9%	98.9%		Figures quoted relate to all harms excluding those documented on admission. StHK performs well against its neighbours.	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	Feb-17	0	0	0	0		The trust continues to have no prescribing errors which cause serious harm. Trust has moved from being a low reporter of prescribing errors to a higher reporter - which is good.	Quality and patient safety	Intensive work on-going to reduce medication errors and maintain no serious harm. ePrescribing will be introduced, starting Spring 2017.	KH
Number of hospital acquired MRSA	Q F&P	▲ £	Feb-17	0	4	0	0		There were 0 cases of MRSA bacteraemia and 1 C.Difficile (CDI) cases in February. YTD there have been 23 CDI cases, of which 3 cases have been successfully appealed. This gives 20 confirmed avoidable cases against an annual tolerance of 41 cases.	Quality and patient safety	Both January cases of hospital acquired MRSA bacteraemia have been investigated and Trust-wide action plans are in place to reduce the risk of any further cases. The Infection Control Team continue to support staff to maintain high standards and practices. They also monitor and undertake RCA for any hospital acquired BSI and CDI. CDI and Antibiotic wards rounds continue to be undertaken on appropriate wards.	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲ £	Feb-17	1	20	41	26					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Feb-17	3	17	No Target	28					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Feb-17	1	3	No Contract target	1		A root cause analysis investigation is being undertaken to establish cause and learn lessons accordingly	Quality and patient safety	The Trust remains compliant with tissue viability training for all nursing staff including bank staff	SR
Number of falls resulting in severe harm or death	Q	▲	Jan-17	2	17	No Contract target	21		STHK moderate, severe and death harm from falls YTD is 0.14 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	▲ £	Jan-17	93.64%	93.08%	95.0%	93.31%		VTE performance fell slightly below target this month.	Quality and patient safety	E -Prescribing solution will resolve achieving target in 2017. Solutions to software interface issue being explored and manual work arounds in place.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Dec-16	3	21	No Target	38					
To achieve and maintain CQC registration	Q		Feb-17	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Feb-17	94.1%	95.1%	No Target	96.8%		Shelford Patient Acuity has been completed and will be reported to Trust Board in March 2017.	Quality and patient safety	Daily staffing huddles supported by escalation flow chart are in place. The Trust has an escalation protocol in place which includes Executive authorisation for requesting agency staff.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Feb-17	0	2	No Target	1					

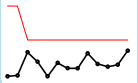
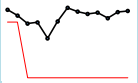
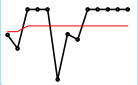
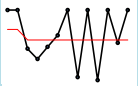
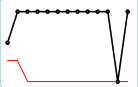
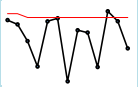
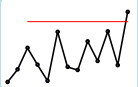
Feb-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 41-48)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Jan-17	95.3%	94.8%	93.0%	95.1%		Key access targets achieved	Quality and patient experience	A Programme approach is being utilised to monitor and improve the timeliness of the patients journey along the Cancer pathways.	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Jan-17	98.9%	97.9%	96.0%	97.8%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Jan-17	89.1%	88.3%	85.0%	88.6%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Feb-17	93.2%	93.2%	92.0%	95.5%		At specialty level T&O, Plastic Surgery, ENT, General Surgery are failing the incomplete target. the dermatology backlog clearance plan has significantly improved its and the Trust RTT position. The impact of the RMS scheme introduced in July by St Helens CCG, Knowsley CCG in November and Halton CCG pushed back to April is also impacting on RTT performance due to new referral drop.	There is a risk due to the current medical bed pressures and the increase in 2ww referrals and activity that the elective programme will be compromised.	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. A backlog management plan is in place and alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand. NHSE backlog clearance commenced beginning of February. reduced by 590 patients and improved overall position	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Feb-17	100.0%	99.997%	99.0%	99.99%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Feb-17	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Feb-17	0.4%	0.8%	0.8%	0.9%		Performance against the target improved in February and remains on track to achieve the national KPI by the end of March. This metric continues to be directly impacted by increases in NEL demand (both surgical and medical patients).	Patient experience and operational effectiveness Poor patient experience	The planned increase in elective surgical activity in St Helens has commenced. Potential to use external theatre and bed capacity continues to be progressed. Continued analysis of the referral drop and impact on RTT underway to include forecast year end position	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Jan-17	100.0%	100.0%	100.0%	99.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Feb-17	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Feb-17	74.1%	75.7%	95.0%	85.0%		Failure to ensure patients are managed within 4 hours in the Emergency Department All Type activity includes the Trusts contribution to the local urgent care centres.	Patient experience, quality and patient safety	The urgent and emergency care transformation plan has several interconnected workstreams designed to improve overall ED performance. **Emergency Department Enablers:** 1. Navigation and streaming at the front door - this allows patients to be assessed and directed to the appropriate pathway with the result of reducing overall time in ED. 2. Rapid assessment ant treatment - this enables senior medical staff to either discharge or redirect ambulance attenders to lower acuity areas and for those who need emergency treatment, instigate the appropriate clinical investigations/treatments within 15 mins of booking in which in turn, allows faster referral to specialty services and faster transfer out of ED. 3. Role of the Clinical shift lead - standardisation of the role to ensure effective management of flow through the department. **Medical Care Group Enablers:** 1. Implementation if the SAFER Care Bundle to increase hospital discharges before midday to 30% of all discharges and ensure that all patients receive a review of their care by a senior clinical decision maker daily. 2. The Medical Care Group is standardising ward level Board Rounds so that these are consistently delivered across the Care group, they will incorporate full attendance by all members of the MDT including doctors, to establish a clear plan for the day against the priorities of value added care and safe and effective admissions and discharges (flow). Specific attention will be focused on achieving a safe and effective discharge of at least one (golden) patient by 10.00 every morning. 3. Multi-Agency Discharge Events (MADE) are now taking place weekly within the Trust . These involve a structured board round on each ward in the presence of cross economy representatives, clinical leads and managers. the main aim is to remove barriers and blocks that prevent patients with complex needs being discharged safely from hospital.	RC
A&E: Total time in A&E: % < 4 hours (All Types)	F&P	▲	Feb-17	83.9%	84.9%	95.0%	89.4%					
A&E: 12 hour trolley waits	F&P	▲	Feb-17	0	0	0	2					

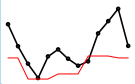
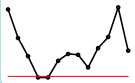
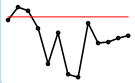
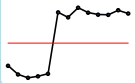
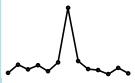
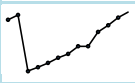
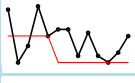
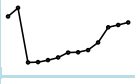
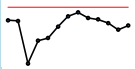
Feb-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Feb-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	Feb-17	30	305	No Target	291		A delay in responding to patient complaints leads to a poor patient experience. The 2015 - 16 resolution rate of 42.7% includes all stage 1 complaints resolved in 15-16 regardless of when the complaint was received. For stage 1 complaints both received and resolved in 15-16 the resolution rate was 61.4%	Patient experience	A revised structure to support performance has been implemented, but will require time to embed. The team will be supported from April 2017, with temporary additional resource to increase capacity to improve timeliness of responses. The process for responding to less complex complaints is also being streamlined. In addition, the process for obtaining statements is being reviewed with a view to making it as clear and simple as possible for the statement writer to provide the right information, supported by relevant actions being taken to prevent any reoccurrence.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Feb-17	28	269	No Target	372					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Feb-17	53.6%	59.1%	No Target	42.7%					
Friends and Family Test: % recommended - A&E	Q	▲	Feb-17	88.4%	86.7%	90.0%	91.5%		The YTD recommendation rates remain slightly below target for A&E, maternity (birth), maternity (postnatal community) and outpatients, but are above target for in-patients and other maternity services.	Patient experience & reputation	Feedback from the FFT responses are fed back to individual areas to enable actions to be taken to address negative feedback, as well as using positive feedback. The Patient Experience Manager is working with individual services, including the Emergency Department, to look at key areas of concern and the actions that need to be taken to address these. This is monitored via the Patient Experience Council monthly.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Feb-17	96.0%	95.4%	90.0%	96.4%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Feb-17	100.0%	98.4%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Feb-17	100.0%	97.9%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Feb-17	100.0%	99.1%	95.1%	95.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Feb-17	91.3%	92.6%	98.6%	98.6%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Feb-17	95.2%	94.4%	95.0%	94.7%					

Feb-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 51-55)												
Sickness: All Staff Sickness Rate	Q F&P	▲	Feb-17	4.9%	4.9%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.9%		Absence has decreased in Feb to 4.9%, which is 0.22% behind the Q4 target. YTD this aligns with last years outturn at month 11. Seasonal virus, flu and colds are the most common reasons for absence. Nursing sickness including HCAs was 0.71% above target with YTD 0.1% better than 2015/16 outturn.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	Targeted HCA action plan in place continue to be accelerated during March 2017 along with audit on timely Return to Work interviews/stages/levels & recording onto ESR in timely way. There are departments where managers are not strictly complying with the Attendance Management policy, this is being addressed. Referrals to HWWB have also increased.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P	T	Feb-17	6.0%	5.9%	5.3%	6.0%					
Staffing: % Staff received appraisals	Q F&P	T	Feb-17	80.7%	80.7%	85.0%	87.2%		Mandatory Training compliance remains consistent and exceeds the target by 7.1%. Appraisal compliance continues to improve and is now 4.3% behind target.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The L&OD team continue to work with managers of non compliant staff to ensure continued improvement.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Feb-17	92.1%	92.1%	85.0%	77.6%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2	90.2%		No Contract Target			In Q2 a significant number of staff continued to recommend the Trust as a place to receive care. There has however, been a reduction in the number of staff recommending the Trust as a place to work. The response rate was low but comparable to Acute Trusts nationally	Staff engagement, recruitment and retention.	Actions identified to address the reduced number of staff recommending the Trust as a place to work are included in the OD plan monitored through Workforce Council.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2	69.0%		No Contract Target						
Staffing: Turnover rate	Q F&P	T	Feb-17	0.6%		No Target	8.9%		Staff turnover remains stable and well below the national average of 14%.		Turnover is monitored across all departments as part of the Trusts Recruitment & Retention Strategy with action plans to address areas where turnover is higher than the trust average. Further action is required by Ward Managers to provide more support to newly qualified nurses.	AMS
FINANCE & EFFICIENCY (appendices pages 58-62)												
UoRR - Overall Rating	F&P	T	Feb-17	3.0	3.0	3.0			The Trust's year to date performance is slightly ahead of plan. The Trust has significant contractual agreements with other NHS organisations which may impact on our ability to achieve Better Payment compliance.	Financial	Adherence against the submitted plan and delivery of CIP. Maintaining control on Trust expenditure. Agreeing with Commissioners and NHSE a more advantageous profile for receipt of planned income. Reducing agency expenditure in line with NHSI annual cap.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Feb-17	13,672	13,672	15,248	13,043					
Reported surplus/(deficit) to plan (000's)	F&P	T	Feb-17	2,662	2,662	3,328	(9,551)					
Cash balances - Number of days to cover operating expenses	F&P	T	Feb-17	10	10	2	2					
Capital spend £ YTD (000's)	F&P	T	Feb-17	3,059	3,059	4,088	4,169					
Financial forecast outturn & performance against plan	F&P	T	Feb-17	3,328	3,328	3,328	(9,551)					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Feb-17	93.9%	93.9%	95.0%	94.2%					

APPENDIX A

			Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	2016-17 YTD	2016-17 Target	FOT	2015-16	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲£	95.8%	100.0%	100.0%	100.0%	87.5%	93.1%	89.3%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	95.2%	85.0%		99.2%		
	Total > 62 days		0.5	0.0	0.0	0.0	1.5	1.0	1.5	0.0	0.0	0.0	0.0	1.0	0.0	5.0			1.0		
Lower GI	% Within 62 days	▲£	89.5%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	93.3%	81.8%	71.4%	58.3%	100.0%	91.7%	88.0%	85.0%		94.5%		
	Total > 62 days		1.0	0.0	0.0	0.0	2.0	0.0	0.0	0.5	1.0	1.0	2.5	0.0	0.5	7.5			3.0		
Upper GI	% Within 62 days	▲£	100.0%	100.0%	81.8%	75.0%	90.9%	0.0%	100.0%	100.0%	0.0%	85.7%	88.9%	100.0%	81.8%	85.9%	85.0%		88.9%		
	Total > 62 days		0.0	0.0	1.0	0.5	0.5	0.5	0.0	0.0	1.5	1.0	0.5	0.0	1.0	5.5			5.0		
Urological	% Within 62 days	▲£	83.3%	83.3%	84.0%	85.7%	84.6%	81.3%	75.0%	79.3%	76.9%	96.2%	82.6%	70.0%	95.7%	81.7%	85.0%		80.8%		
	Total > 62 days		2.0	2.0	2.0	2.0	3.0	3.0	4.0	3.0	4.5	0.5	4.0	6.0	0.5	30.5			28.0		
Head & Neck	% Within 62 days	▲£	57.1%	60.0%	50.0%	50.0%	100.0%	37.5%	71.4%	66.7%	100.0%	80.0%	33.3%	33.3%	100.0%	62.2%	85.0%		71.1%		
	Total > 62 days		1.5	1.0	0.5	0.5	0.0	2.5	1.0	0.5	0.0	0.5	1.0	1.0	0.0	7.0			6.5		
Sarcoma	% Within 62 days	▲£	100.0%		100.0%		85.7%			100.0%			100.0%	100.0%		91.7%	85.0%		87.5%		
	Total > 62 days		0.0		0.0		0.5			0.0		0.0	0.0	0.0		0.5			0.5		
Gynaecological	% Within 62 days	▲£	60.0%	66.7%	71.4%	66.7%	81.8%	100.0%	85.7%	92.3%	33.3%	100.0%	90.9%	92.3%	100.0%	89.0%	85.0%		76.4%		
	Total > 62 days		1.0	0.5	1.0	0.5	1.0	0.0	0.5	0.5	1.0	0.0	0.5	0.5	0.0	4.5			8.5		
Lung	% Within 62 days	▲£	90.5%	100.0%	88.2%	66.7%	81.5%	90.0%	91.7%	82.6%	100.0%	80.0%	87.5%	91.7%	68.2%	82.2%	85.0%		86.5%		
	Total > 62 days		1.0	0.0	1.0	1.0	2.5	0.5	0.5	2.0	0.0	1.0	0.5	0.5	3.5	12.0			10.5		RC
Haematological	% Within 62 days	▲£	83.3%	50.0%	86.7%	100.0%	100.0%	0.0%	50.0%	50.0%	100.0%	100.0%		66.7%	66.7%	72.1%	85.0%		70.5%		
	Total > 62 days		1.0	2.0	1.0	0.0	0.0	2.5	3.0	1.0	0.0	0.0		1.0	1.0	8.5			13.0		
Skin	% Within 62 days	▲£	94.4%	92.5%	96.7%	97.5%	96.0%	100.0%	97.3%	93.7%	95.7%	92.6%	97.4%	95.7%	95.8%	96.0%	85.0%		94.5%		
	Total > 62 days		0.5	1.5	0.5	0.5	1.0	0.0	0.5	2.0	1.0	2.0	0.5	1.0	1.0	9.5			13.0		
Unknown	% Within 62 days	▲£	100.0%		50.0%		100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	66.7%	94.4%	85.0%		83.3%		
	Total > 62 days		0.0		0.5		0.0	0.0	0.0	0.0	0.0			0.0	0.5	0.5			1.5		
All Tumour Sites	% Within 62 days	▲£	87.9%	90.1%	89.5%	91.8%	88.0%	87.5%	85.8%	89.4%	87.9%	92.0%	86.6%	85.8%	89.1%	88.3%	85.0%		88.6%		
	Total > 62 days		8.5	7.0	7.5	5.0	12.0	10.0	11.0	9.5	9.0	6.0	9.5	11.0	8.0	91.0			90.5		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲£		100.0%	100.0%					100.0%		50.0%				66.7%	85.0%		100.0%		
	Total > 31 days			0.0	0.0					0.0		1.0				1.0			0.0		
Acute Leukaemia	% Within 31 days	▲£					100.0%									100.0%	85.0%		100.0%		
	Total > 31 days						0.0									0.0			0.0		
Children's	% Within 31 days	▲£															85.0%				
	Total > 31 days																				

TRUST BOARD

Paper No: NHST(17)023
Title of paper: Safer Staffing Levels Report for February 2017
Purpose: To inform the Trust Board of the nursing and midwifery staffing levels (headcount only) in the Trust's inpatient areas during February 2017 in accordance with mandatory reporting requirements. Safer Staffing levels are one indication of the Trust's ability to provide safe, effective inpatient care.
Summary: • The Trust's mandated monthly submission of staffing (headcount) levels to NHS Choices presented the following overall % fill rates of planned inpatient staffing levels against actual staffing levels for the month of February 2017 as: ➢ RNs on days 93.12% ➢ RNs on nights 96.11 % ➢ Care staff on days 108.57% ➢ Care staff on nights 114.08%. • 10 wards experienced a monthly staffing headcount fill rate of below the accepted level of 90%; 9 wards for RNs and1 ward for care staff • Care Staff monthly fill rates is higher than the funded ward establishment in many inpatient areas because of extra staff employed to either provide 1 to 1 care to vulnerable patients or to compensate for a shortfall in RN headcount levels when efforts to backfill RN gaps have proven unsuccessful. • In February 2017, 5 patients experienced moderate or above harm following inpatient falls.
Corporate objectives met or risks addressed: Care, Safety
Financial implications: None directly from report.
Stakeholders: Patients, public, staff, commissioners, Trust Board
Recommendation(s): Members are asked to approve the report
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 29th March 2017

Trust Safer Staffing Levels Report for February 2017

Aims of Report

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

Background

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

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

1. Overall Fill Rates (appendix 1)

The February 2017 submission indicates an overall fill rate of 93.12% (94.94% in January 2017) for RNs on days, 96.11% (98.34 % previous month) for RNs on nights, 108.57% (103.01% January) for HCAs on days and 114.08% (106.9% previous month) for HCAs on nights. The overall fill rates for care staff are higher than 100% because the figures are raised by both the employment of additional 'specials' (i.e. 1 patient to 1 care staff member) to protect vulnerable patients and the wards compensating for a shortfall in the registered nurse headcount on a shift by employing an HCA when efforts to backfill with a bank and/or agency RN or the permanent RNs being offered extra time or overtime have proved unsuccessful.

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

2. **Recruitment and Retention** of nursing and midwifery staff remains a priority for the Trust and is an on-going challenge nationally. Trust workforce data shows there were 59.42wte RN and 10.23wte HCA vacancies at the end of January 2017 on the inpatient wards. Staffing remains on the Corporate Risk Register (CRR) which is reviewed monthly. Recruiting and retaining the nursing and midwifery workforce continues to be an area of increased focus:-

2.1. Indian Nurse Recruitment Update:

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

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

- 2 commenced in the Trust on 5th December 2016 and have now successfully passed their NMC OSCEs. They are still awaiting their NMC PINs to register and will require an on-going period of supernumerary status and preceptorship before they can be counted in the registered workforce staffing levels.
- 7 more nurses commenced at the beginning of February 2017 and have commenced the 6 week NMC OSCE preparation Trust programme. The pass rate for the OSCEs is very low, with only 2 attempts allowed, therefore the Trust's preparation programme to date has been highly successful.
- 3 more nurses from India are commencing in March 2017.

2.2. The Recruitment of Bank staff. Recruitment of bank HCAs is on-going, advertising on 1st of every month to recruit HCAs to the nurse bank and is proving very successful. Several RNs were also interviewed to join the Trust's nurse bank in February 2017 and positions offered.

2.3. Student Nurse Recruitment Update. HR Recruitment and the Trust's Student Nurse Practice Education Facilitators have met and arranged optimum Recruitment Open Day dates for 2017 to link with the stage in students training when they are job seeking. The dates for 2017 are 25th February and 3rd June. Recruitment of newly qualified staff has also been streamlined for this next intake to have a single point of employment access to the adult inpatient wards, accommodating requests but avoiding the situation where students apply and are interviewed for several staff nurse posts within the Trust. This is a far more coordinated approach and prevents duplication of the process for the interviewers and the HR Recruitment staff.

At the Open Day on 25th February, 26 job offers were made, 23 to students and 3 to qualified staff.

Trust representatives have attended student nurse Recruitment Open Days at both Edge Hill and John Moores Universities during February 2017.

2.4. On-going Recruitment of Qualified Staff

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

3. **Care Hours Per Patient Per Day (CHPPD) (Appendix 2)**
   CHPPD for RNs and Care staff has been reasonably consistent on the medical wards and surgical wards throughout the year. CHPPD is higher on the Assessment Units, (1B, 1C and 4B), Coronary Care (1E), the Burns Unit (4D), Critical Care (4E), Delivery Suite, the post natal ward (2E) and the Paediatric Wards (3F, 4F and SCBU) for registered staff as there is a higher patient to registered workforce ratio in these areas. Once the Carter model hospital dashboard is available for benchmarking at ward level with other Trusts, the data will be of greater value. Work is on-going with Information and the Corporate Nursing team in an attempt to make the information more meaningful, however updates from the Carter pilot sites are still awaited. Cost per CHPPD is to be incorporated in future.

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

5. **February 2017 Wards with staffing fill rates below 90% (Appendix 3)**
   There were 10 ward with a fill rate of less than 90%, 9 for RNs and1 for care staff. Of the 9 wards with a fill rate of less than 90% for RNs, 8 of them had fill rates above 100% for care staff to maintain the headcount numbers on a shift, fully appreciating skill mix is compromised. 5 wards have experienced fill rates for RNs of less than 90% consistently for the last 3 months, none for care staff. These 5 wards attended the Recruitment Open Day in February 2017.

6. **Inpatients experiencing moderate harm or above following a fall in February 2017**
   5 patients experienced a fall resulting in moderate harm or above, 2 categorised as moderate harm and 3 resulting in severe harm. Of the two falls resulting in moderate harm, both wards were staffed according to their planned fill rates, in fact ward 1C had 2 extra RNs and 1 extra HCA on duty at the time of the fall. Of the 3 inpatient falls resulting in severe harm, 1 ward had their planned filled rates at the time of the fall, the other two wards had 1 RN less than planned on duty. Each of these incidents are subject to on-going review when staffing will be reviewed in detail.

7. **Staffing Related Reported Incidents**
   A total of 14 incident forms were completed during January 2017 (17 completed in January 2017) regarding staffing shortages on shifts on the wards included in the Safer Staffing submission. Staff are requested to complete an incident form for shifts where there are skill mix issues or the actual headcount on shift is less than the planned.

8. **Future Developments.**
   - **8.1. Allocate SaferCare System**
     This system facilitates daily bedside patient acuity assessment real time entry by shift leaders of all inpatients. This information together with completion of staff registers on e-roster by shift leaders each shift informs a professional judgement database allowing the matrons at the daily staffing review meetings to make effective and robust decisions re allocating staff to actual patient need.

The successful implementation of this system according to Carter pilot sites and other Trust locally requires a senior nurse project lead and is not an overnight implementation as a culture change is required across the wards to achieve accurate patient acuity data entry.

A business case is to be taken to Executive Committee in April 2017.

8.2. Attracting Newly Qualified Staff to STHK
A paper is to be taken to Executive Committee in April 2017 outlining suggestions to attract newly qualified nurses to this Trust.

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

Summary
The report has presented information on staffing headcount fill rates on inpatient wards for the month of February 2017 and provided an update regarding on-going nursing and midwifery workforce recruitment activities to address vacancies.

Appendix 1 – Trust's NHS Choices Safer Staffing Submission

Ward	Specialty	Monthly Hours - Days						Monthly Hours - Nights						Care Hours Per Patient Day (CHPPD)			
		Qualified staff			HCA's			Qualified staff			HCA's			Monthly Pat's	Qual. staff	HCAs	Total
		Plan	Actual	Rate	Plan	Actual	Rate	Plan	Actual	Rate	Plan	Actual	Rate				
1A	Geriatric Medicine	1,982	1,802	91%	2,080	2,079	100%	840	779	93%	840	1,050	125%	800	3.2	3.9	7.1
1B	General Medicine	3,233	2,937	91%	1,463	1,925	132%	940	922	98%	560	692	123%	692	5.6	3.8	9.4
1C	General Medicine	3,111	2,856	92%	1,539	1,612	105%	1,710	1,581	92%	560	590	105%	762	5.8	2.9	8.7
1D	Cardiology	2,014	1,784	89%	1,464	1,510	103%	840	765	91%	560	670	120%	826	3.1	2.6	5.7
1E	Cardiology	2,062	1,965	95%	771	756	98%	1,120	1,080	96%	180	180	100%	430	7.1	2.2	9.3
2A	Gen. Medicine / Haematology	1,588	1,557	98%	813	786	97%	560	560	100%	280	270	96%	447	4.7	2.4	7.1
2B	Gen. Medicine / Respiratory	1,908	1,719	90%	1,446	1,688	117%	840	720	86%	560	870	155%	843	2.9	3.0	5.9
2C	Gen. Medicine / Respiratory	1,944	1,643	85%	1,359	1,500	110%	840	689	82%	560	910	163%	792	2.9	3.0	6.0
2D	General Medicine	1,290	1,148	89%	1,028	1,234	120%	560	640	114%	560	590	105%	466	3.8	3.9	7.7
2E	Obstetrics	2,592	2,528	98%	1,680	1,590	95%	1,160	1,150	99%	560	810	145%	737	5.0	3.3	8.2
3A	Plastic Surgery	1,697	1,682	99%	1,174	1,139	97%	740	760	103%	560	570	102%	497	4.9	3.4	8.4
3Alpha	Trauma & Orthopaedics	1,356	1,336	99%	1,112	1,107	100%	560	579	103%	280	270	96%	388	4.9	3.5	8.5
3B	Trauma & Orthopaedics	1,236	1,198	97%	1,653	1,925	116%	840	820	98%	560	660	118%	506	4.0	5.1	9.1
3C	Trauma & Orthopaedics	1,762	1,470	83%	1,466	1,649	113%	840	770	92%	840	859	102%	590	3.8	4.3	8.0
3D	Gen. Medicine / Gastro.	1,839	1,649	90%	1,189	1,406	118%	840	730	87%	560	786	140%	844	2.8	2.6	5.4
3E	Gynaecology	1,395	1,358	97%	831	794	95%	590	550	93%	280	290	104%	562	3.4	1.9	5.3
3F	Paediatrics	2,124	2,106	99%	430	429	100%	1,120	1,101	98%	280	280	100%	398	8.1	1.8	9.8
4A	101 - UROLOGY	1,952	1,836	94%	1,226	1,167	95%	840	820	98%	840	810	96%	800	3.3	2.5	5.8
4B	General Surgery / Urology	2,290	2,113	92%	1,582	1,734	110%	1,010	1,009	100%	440	421	96%	337	9.3	6.4	15.7
4C	General Surgery	1,949	1,693	87%	1,236	1,209	98%	840	861	102%	840	800	95%	790	3.2	2.5	5.8
4D	Plastic Surgery	1,552	1,574	101%	536	544	101%	600	600	100%	369	360	98%	125	17.4	7.2	24.6
4E	Critical Care	4,948	4,628	94%	795	845	106%	3,360	3,029	90%	560	490	88%	347	22.1	3.8	25.9
4F	Paediatrics	2,006	1,876	93%	474	438	92%	560	560	100%	340	330	97%	171	14.2	4.5	18.7
5A	Gen. Medicine / Geriatric	1,512	1,291	85%	2,066	2,648	128%	840	741	88%	851	1,170	138%	689	2.9	5.5	8.5
5B	Geriatric Medicine	1,670	1,567	94%	1,990	2,001	101%	840	840	100%	840	883	105%	655	3.7	4.4	8.1
5C	Geriatric Medicine	2,267	2,071	91%	1,647	1,932	117%	1,120	1,120	100%	840	1,091	130%	678	4.7	4.5	9.2
5D	Gen. Medicine / Geriatric	1,380	1,128	82%	1,197	1,579	132%	560	560	100%	560	529	94%	499	3.4	4.2	7.6
Duffy	Gen. Medicine / Geriatric	1,364	1,303	96%	1,442	1,707	118%	560	557	100%	560	570	102%	476	3.9	4.8	8.7
SCBU	Paediatrics	1,616	1,611	100%	428	391	91%	910	921	101%	220	222	101%	218	11.6	2.8	14.4
Delivery	Obstetrics	3,052	3,012	99%	794	741	93%	2,170	2,184	101%	560	530	95%	262	19.8	4.8	24.7
Seddon	Rehabilitation	1,518	1,487	98%	1,434	1,568	109%	560	560	100%	560	800	143%	215	9.5	11.0	20.5

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

Care Hours Per Patient Day (CHPPD) Registered midwives/nurses											
Ward Name	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
1A	2.6	2.8	2.6	2.9	2.9	3.0	3.2	3.1	3.1	3.2	
1B	5.9	5.7	4.6	6.2	5.8	5.5	6.2	5.9	5.4	5.6	
1C	5.8	5.6	5.4	5.4	5.7	5.7	5.3	5.7	5.6	5.8	
1D	2.8	2.8	3.0	2.9	3.1	3.0	2.8	3.0	2.9	3.1	
1E	7.6	7.0	6.8	7.2	7.6	7.7	7.7	7.2	7.2	7.1	
2A	3.6	3.7	3.9	4.8	4.6	4.5	4.9	5.7	4.3	4.7	
2B	2.8	3.0	2.9	2.7	3.0	3.0	3.7	3.1	2.9	2.9	
2C	2.7	2.8	2.8	2.8	3.4	3.1	3.4	2.9	3.3	2.9	
2D	2.9	2.8	3.1	3.4	3.5	3.3	3.1	2.9	3.9	3.8	
2E	4.9	4.6	5.1	5.6	4.4	4.9	5.2	5.6	5.2	5.0	
3A	5.1	4.3	4.6	4.6	5.3	4.7	5.4	5.6	4.4	4.9	
3Alpha	4.8	4.2	4.9	5.2	5.7	4.7	5.7	6.4	4.5	4.9	
3B	3.6	3.3	3.5	3.2	3.9	3.6	4.1	3.8	3.7	4.0	
3C	3.4	2.9	3.2	3.6	3.5	3.1	3.4	3.5	3.6	3.8	
3D	2.8	2.8	3.1	3.0	2.9	3.1	3.2	3.0	2.8	2.8	
3E	3.4	3.4	3.1	3.4	3.8	3.2	3.3	3.4	3.0	3.4	
3F	7.4	9.1	7.1	10.7	8.5	7.3	6.1	8.1	8.2	8.1	
4A	3.3	3.2	3.2	3.1	3.2	3.2	3.4	3.2	3.3	3.3	
4B	7.6	7.0	7.6	8.6	8.8	8.9	8.0	8.2	8.7	9.3	
4C	3.2	3.1	3.2	3.0	3.2	3.6	3.7	3.4	3.0	3.2	
4D	12.6	16.9	15.5	16.5	33.2	13.0	17.3	16.9	11.2	17.4	
4E	27.7	25.2	26.0	26.1	27.9	26.2	26.2	23.1	18.9	22.1	
4F	7.9	10.0	11.5	16.7	15.4	13.6	8.5	11.4	11.5	14.2	
5A	3.5	3.6	2.7	3.0	2.8	3.4	3.0	3.2	3.6	2.9	
5B	2.6	3.8	3.4	3.3	3.4	3.3	3.8	3.1	3.8	3.7	
5C	4.8	4.7	2.0	2.1	5.3	4.7	4.6	4.7	4.4	4.7	
5D	3.7	3.4	4.4	5.2	2.5	3.9	4.3	3.4	3.4	3.4	
Duffy Ward	2.7	2.7	2.5	2.5	2.8	3.0	3.4	2.9	3.3	3.9	
SCBU	7.5	8.1	12.6	15.3	10.7	8.8	9.2	15.3	10.9	11.6	
Delivery Suite	17.0	15.8	18.6	18.2	16.1	18.2	20.3	19.9	20.9	19.8	
Seddon	5.2	5.5	5.5	4.6	5.3	5.9	4.7	25.3	9.8	9.5	

CHPPDs - Table 2 CHPPD for the care staff

Care Hours Per Patient Day (CHPPD) Care staff											
Ward Name	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
1A	3.8	3.8	3.5	3.8	3.9	3.6	4.1	3.6	3.8	3.9	
1B	2.8	3.3	4.0	3.7	3.3	3.4	3.5	3.2	3.1	3.8	
1C	3.3	3.0	3.0	3.1	3.7	3.5	3.3	3.3	2.8	2.9	
1D	3.0	2.6	2.8	2.9	3.5	3.1	2.7	2.6	2.8	2.6	
1E	2.3	1.9	1.7	1.7	1.9	2.0	2.1	2.1	2.1	2.2	
2A	2.1	2.1	2.1	2.2	2.3	2.4	2.5	2.5	2.2	2.4	
2B	2.5	2.6	3.3	2.8	2.9	3.0	3.0	2.7	2.6	3.0	
2C	2.8	2.4	2.5	3.1	3.6	3.5	2.5	2.2	2.4	3.0	
2D	2.9	3.5	4.2	4.6	3.5	3.7	2.9	3.2	4.6	3.9	
2E	2.3	2.3	2.2	2.2	2.1	2.2	3.3	3.4	3.2	3.3	
3A	3.5	3.0	3.3	4.0	4.0	3.4	3.7	3.7	3.1	3.4	
3Alpha	3.2	2.9	3.6	3.6	4.1	3.5	4.1	4.8	3.3	3.5	
3B	4.8	4.5	4.6	4.4	5.1	4.1	4.7	4.5	4.5	5.1	
3C	3.4	3.2	3.2	4.3	4.2	4.0	4.0	3.9	4.5	4.3	
3D	2.6	2.6	2.3	2.8	2.6	2.5	2.8	2.2	2.5	2.6	
3E	1.8	2.0	2.0	1.9	2.1	2.0	1.8	1.5	1.6	1.9	
3F	1.4	1.9	1.5	1.9	1.8	1.6	1.2	1.7	2.3	1.8	
4A	2.4	2.9	2.9	3.1	3.1	2.7	2.7	2.6	2.5	2.5	
4B	5.4	4.9	4.9	5.7	5.3	5.7	5.2	5.5	6.0	6.4	
4C	2.8	2.5	2.7	2.5	2.5	2.6	2.7	2.6	2.5	2.5	
4D	3.5	7.2	5.3	4.6	13.0	3.8	5.9	5.0	4.0	7.2	
4E	4.8	4.8	4.0	4.5	4.7	4.2	4.7	4.3	2.8	3.8	
4F	3.4	4.4	2.9	6.1	5.2	4.1	2.7	3.4	3.6	4.5	
5A	4.5	4.2	4.6	5.4	4.5	5.6	4.9	5.5	5.7	5.5	
5B	3.8	5.9	5.0	4.7	4.6	4.2	4.6	3.6	4.2	4.4	
5C	3.8	3.4	2.0	2.3	5.4	4.5	4.4	4.0	3.8	4.5	
5D	3.8	3.7	4.2	5.7	2.6	4.4	5.0	3.9	4.0	4.2	
Duffy Ward	4.3	3.5	3.8	4.3	4.5	3.7	3.9	3.4	4.1	4.8	
SCBU	1.9	2.1	2.4	3.5	2.9	2.6	2.5	4.4	3.5	2.8	
Delivery Suite	4.3	4.2	5.0	4.5	4.2	5.0	5.5	4.6	5.0	4.8	
Seddon	4.7	5.1	5.7	5.5	5.5	5.6	4.9	28.5	9.9	11.0	

CHPPDs - Table 3CHPPD for total nursing and midwifery workforce

Care Hours Per Patient Day (CHPPD) Overall											
Ward Name	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
1A	6.4	6.6	6.1	6.7	6.8	6.6	7.3	6.6	6.9	7.1	
1B	8.7	9.0	8.6	9.8	9.1	8.9	9.6	9.1	8.4	9.4	
1C	9.1	8.6	8.3	8.6	9.4	9.1	8.6	9.0	8.4	8.7	
1D	5.8	5.4	5.8	5.9	6.6	6.0	5.5	5.7	5.7	5.7	
1E	9.9	8.9	8.4	8.9	9.5	9.7	9.8	9.4	9.3	9.3	
2A	5.8	5.8	6.0	7.0	6.9	6.9	7.4	8.2	6.5	7.1	
2B	5.3	5.7	6.2	5.5	5.9	6.0	6.7	5.9	5.5	5.9	
2C	5.5	5.2	5.4	5.8	7.0	6.5	5.9	5.1	5.7	6.0	
2D	5.7	6.3	7.3	8.0	7.1	6.9	5.9	6.1	8.5	7.7	
2E	7.2	6.9	7.3	7.8	6.6	7.1	8.5	9.0	8.4	8.2	
3A	8.6	7.3	7.9	8.6	9.3	8.1	9.2	9.3	7.5	8.4	
3Alpha	8.0	7.1	8.5	8.8	9.8	8.2	9.8	11.1	7.8	8.5	
3B	8.4	7.8	8.0	7.6	9.0	7.7	8.8	8.3	8.2	9.1	
3C	6.8	6.2	6.4	7.8	7.7	7.1	7.4	7.4	8.2	8.0	
3D	5.4	5.4	5.4	5.9	5.5	5.6	6.1	5.2	5.3	5.4	
3E	5.1	5.3	5.2	5.3	5.9	5.2	5.1	4.9	4.6	5.3	
3F	8.8	11.0	8.6	12.6	10.2	8.9	7.4	9.8	10.6	9.8	
4A	5.6	6.1	6.1	6.2	6.3	5.9	6.1	5.8	5.7	5.8	
4B	13.0	11.8	12.4	14.3	14.1	14.6	13.2	13.7	14.6	15.7	
4C	6.0	5.5	5.8	5.5	5.7	6.2	6.4	6.0	5.6	5.8	
4D	16.1	24.0	20.8	21.1	46.2	16.7	23.2	22.0	15.2	24.6	
4E	32.5	30.0	30.0	30.6	32.6	30.4	30.9	27.4	21.7	25.9	
4F	11.3	14.3	14.3	22.9	20.7	17.7	11.2	14.8	15.1	18.7	
5A	8.0	7.8	7.3	8.3	7.2	9.1	7.9	8.6	9.3	8.5	
5B	6.4	9.8	8.4	8.0	8.1	7.5	8.4	6.7	8.0	8.1	
5C	8.6	8.1	4.0	4.4	10.8	9.2	9.0	8.7	8.1	9.2	
5D	7.5	7.1	8.6	10.9	5.0	8.2	9.3	7.2	7.4	7.6	
Duffy Ward	7.0	6.2	6.3	6.9	7.4	6.8	7.3	6.3	7.4	8.7	
SCBU	9.3	10.2	15.0	18.7	13.6	11.3	11.7	19.6	14.4	14.4	
Delivery Suite	21.3	20.0	23.6	22.7	20.3	23.2	25.9	24.5	25.9	24.7	
Seddon	9.9	10.7	11.2	10.0	10.8	11.5	9.6	53.8	19.8	20.5	

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

Table 1: 9 wards with fill rates below 90% for RNs February 2017

	Day		Night	
Ward name	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
1D	88.6%	103.1%	91.0%	119.6%
2B	90.1%	116.7%	85.7%	155.3%
2C	84.5%	110.4%	82.1%	162.5%
2D	89.0%	120.0%	114.2%	105.3%
3C	83.4%	112.5%	91.7%	102.2%
3D	89.7%	118.2%	86.9%	140.3%
4C	86.8%	97.8%	102.5%	95.2%
5A	85.4%	128.2%	88.2%	137.5%
5D	81.8%	131.9%	100.0%	94.4%

Table 2: 1 ward with a fill rate less than 90% for care staff February 2017

	Day		Night	
Ward name	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
4E	93.5%	106.3%	90.2%	87.5%

Table 3: The 5 wards with total fill rates less than 90% for the last 3 months

	Dec-16				Jan-17				Feb-17			
	Day		Night		Day		Night		Day		Night	
Ward	**RNs**	**care staff**	**RNs**	**care staff**	**RNs**	**care staff**	**RNs**	**care staff**	**RNs**	**care staff**	**RNs**	**care staff**
1D	86.6%	101.1%	88.9%	101.7%	91.3%	110.1%	82.4%	137.2%	88.6%	103.1%	91.0%	119.6%
2B	91.7%	101.5%	88.9%	134.8%	87.1%	99.4%	90.0%	138.3%	90.1%	116.7%	85.7%	155.3%
3C	87.9%	118.0%	95.6%	123.7%	84.8%	122.9%	97.8%	133.7%	83.4%	112.5%	91.7%	102.2%
3D	86.9%	93.6%	84.6%	126.7%	91.3%	102.1%	77.9%	139.8%	89.7%	118.2%	86.9%	140.3%
5D	89.6%	122.1%	111.7%	123.3%	84.4%	123.7%	100.0%	123.3%	81.8%	131.9%	100.0%	94.4%

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)024
Title of paper: Executive Committee Assurance Report.
Purpose: To feedback to members key issues arising from the Executive Committee meetings.
Summary: 1. Between the 10th February and 16th March three 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 risk assessment for the use of Chloraprep; restructure of the Legal Services Department and the format of patient's stories to Board. 3. Assurances regarding agency usage and interpretation of new rules; improvements in mandatory training and appraisals; safer staffing; management of risks; and e-Rostering were obtained. 4. Financial commitments included the transfer of some HR Services off-site; the business case to replace Heads of Quality with support; increased parking charges for staff; a further 5-year contract for picture archiving; and continued Brno doctor employment. 5. There are no specific items requiring escalation to the Board.
Corporate objective met or risk addressed: Contributes to the Trust's Governance arrangements, and its short and longer-term plans.
Financial implications: None directly from this report.
Stakeholders: The Trust, its staff and all stakeholders.
Recommendation(s): The Board are asked to note the contents of the report.
Presenting officer: Ann Marr, Chief Executive.
Date of meeting: 29th March 2017

EXECUTIVE COMMITTEE REPORT (10th February to 16th March 2017)

The following report highlights key issues considered by the Committee.

16th February

1. Proposals for Trust offices at Alexandra Park

    1.1. PW reported that he had spoken further to AM and AMS. The proposal to move elements of the HR offices was approved.

2. Mandatory training / appraisals

    2.1. AMS reported on the % achieved for each directorate. Improvements were noted, and AMS stated that the YE Trust target of 85% should be achieved.

3. Local Clinical Excellence Awards (LCEA)

    3.1. The Trust's approach to this year's LCEA round was discussed. This is no longer a contractual requirement and the Trust did not participate in 2016. The impact from the new consultant contract was considered. It was agreed that further intelligence from other Trusts was required.

4. Use of Chloraprep©

    4.1. John Clayton provided legal advice received from Hill Dickinson in relation to the use of Chlorhexidine (for skin preparation prior to surgery) and the views of the Trust's microbiologists. It was concluded that the level of risk appeared negligible but further assessment should be undertaken particularly for surgery with a higher infection risk.

    4.2. It was noted that a competitor to the current sole supplier is likely to emerge onto the market in the next 18 months, which will drive down current cost.

5. Safer Staffing / Vacancy Dashboard

    5.1. SR presented an update on the nursing and midwifery staffing levels and recruitment. Further clarification on the staffing in specific areas including ITU; the Trust bed occupancy data; root cause of falls; specialing of patients; excess bed days; and correlation with HR data was requested.

6. Head of Quality structure business case

    6.1. Sally Duce presented the case for replacement of the medical and surgical Heads of Quality (HoQ) and the need for increased Corporate Nursing support. Benchmarking data was noted, and the proposed structure going forward was considered in detail against the backdrop of pressure to reduce back-office functions.

    6.2. The replacement and pay scales of the HoQ posts were agreed along with the appointment of two support posts to focus on quality. The Band 2 corporate nursing administrator post currently employed through the bank would be made substantive. The case for additional corporate support was not approved.

    6.3. Nursing support for the implementation of new IT systems was discussed and reiterated that this needs to be included in any relevant business case.

7. Corporate Risk Register

    7.1. The monthly report from the Risk Management Council was discussed and the 15 high risks on the CRR reviewed.

8. Legal Services business case

8.1. Anne Rosbotham-Williams presented a proposal for restructuring the Legal Services department. Benchmarking data from other Trusts was noted. Following debate, it was agreed that the current structure is not fit for purpose, and this proposal could be met from existing financial resources. On the understanding that strict HR processes would need to be followed the proposal was agreed.

9. Staff car park charges

9.1. PW recommended the regular annual RPI increase to the staff car park charges for 2017/18.

9.2. He also advised of the growing demand for parking and that initiatives to reduce this have had little traction therefore increasing capacity appears the main option. Should this be possible the need for a more fundamental review of charges, to ensure parking remains self-financing, could be required.

10. EPR update

10.1. Mark Hogg provided an update on the approach for the EPR procurement following due diligence on the bids. Further work in advance of discussion at the Board was agreed.

11. 5YFV feedback

11.1. AM reported that Clare Duggan will be moving to NHSE Head Office; Graham Unwin from Lancashire will take on her role.

11.2. AM reported on ongoing discussions at the Working Group about whether the STPs should break up into smaller groupings.

2nd March

12. eRostering

12.1. AMS reported on the five KPIs noting that the results demonstrate the improvements being made, however it was confirmed that this remains work in progress. Noted that the next iteration of the report will include details on each ward's performance. The difference between this data and that of safer staffing was recognised and agreed that an explanation would be provided.

13. Cheshire and Mersey PACS Consortia Contract extension

13.1. David Anwyl attended to seek approval to extend the PACS contract for a further five years. The service refresh to the ten Trusts would be cost neutral and the proposal was approved.

14. NHSI locum and agency spend

14.1. AMS briefly outlined the new rules (both from Treasury and NHSI) due from 1st April, which are complex, and agreed that further explanation would be provided at the next meeting. Risk assessment and mitigation planning is ongoing.

14.2. It was noted that NHSI have appointed a project manager to look at formulating a 'north west bank' with a common rate of pay.

15. CCTV development

15.1. CW reported that the Information Governance Steering Group (IGSG) has been asked to consider the installation of CCTV cameras within sections of the

Mortuary to assist with auditing of processes. Following discussion concerns were expressed and the case was not approved.

16. Trust Board agenda

    16.1. PW presented the proposed Trust Board Agenda, which was approved.

17. Opera project update

    17.1. CW advised that the pause in implementation of the Opera system had allowed for issues to be addressed and roll-out would now proceed in July.

18. Overtime payments to part-time staff

    18.1. It was agreed to undertake an audit for payment of overtime to part time staff to test out the systems in place.

19. **9th March**

20. New format for patient story to Board

    20.1. SR presented a proposal for a more structured format going forward and with some required amendments it was approved.

21. Orthopaedic sessions gap

    21.1. RC gave an overview of the capacity shortfall to meet the current activity plan and demand within orthopaedics. The reasons for not recruiting substantive staff were acknowledged, as well as the current flexibility offered from the use of LLP. Further review is required with the new NHSI rules and regulations on the use of LLPs.

22. NHSI locum and agency spend revisited

    22.1. Pauline Jones and Rob Simonds attended to explain the HMRC regulations to off-payroll working engagements in the public sector which effect both tax and NI Trust payments. The impact of the changes has resulted in some locum staff resigning and clearly the consequences need to be risk assessed.

    22.2. Trusts are strongly encouraged to ensure that all staff are contractually paid via PAYE mechanisms, and where this is not the case approval from NHSI is required.

    22.3. This will require careful handling to protect clinical services to patients.

23. Brno recruitment

    23.1. Pat Keeley presented a paper requesting continuation of the funding for the Masaryk post graduate programme, where funding is available for six posts, with a request for a further six at a cost pressure. Continued non-recurrent appointments were approved for the existing posts only providing funding could be identified from the care group.

24. LCEA

    24.1. Further debate had on LCEA rounds, and a table of local trusts' intentions was circulated. Further discussion to be held outside the meeting.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)025
Title of paper: Committee report – Quality Committee
Purpose: To summarise the Quality Committee meeting held on 21st March 2017 and escalate issues of concern.
Summary: Key items discussed were: 1. Complaints 2. Safer Staffing 3. IPR 4. 1st Draft – Quality Account 5. Falls report 6. Safeguarding report and action plan 7. Savile recommendations/action plan 8. CQC registration 9. Mixed Sex Declaration 10. Annual Meeting Effectiveness Review
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: 29th March 2017

QUALITY COMMITTEE ASSURANCE REPORT

Summary of the discussions and outcomes from the Quality Committee meeting held on 21st March 2017.

Action Log

1. All actions on the log were reviewed.

Complaints Report

2. John Culshaw (JC) summarised the report:

   2.1. 30 1st stage complaints were received and opened in February 2017; an increase from 13 received in February 2016.

   2.2. At the end of February 2017, there were 74 open 1st stage complaints, including 19 overdue. The Trust responded to 53.6% of 1st stage complaints within agreed time frames during February 2017, leading to a year to date response rate of 59.1% and an increase from 26.7% in January.

   2.3. The top complaint themes during February 2017 were:

      2.3.1. Clinical treatment

      2.3.2. Admissions and discharges

   2.4. There were 162 PALS contacts/enquiries during February 2017; an increase of 15% in comparison to January 2017. The majority of PALS contacts were concerns or complaints resolved locally, as opposed to signposting or dealing with enquiries.

   2.5. A number of actions are being taken to improve response rates, including the secondment of a member of staff from Legal Services, identification of complaints suitable for early resolution and using short term contracts to ensure maximum staffing levels within resource. JC informed the committee that the process for obtaining statements is being reviewed with a view to making it as clear and simple as possible for the statement writer to provide the right information, supported by relevant actions being taken to prevent any reoccurrence.

   2.6. David Graham (DG) commented that although the resolution rate within the timeframe is better, it is still disappointing. JC said that he was looking at Trust wide pressures, especially A&E late responses, but also mentioned that there were three breaches in Respiratory Medicine in February. J Hendry queried this figure and JC will discuss outside of the meeting.

Safer Staffing report

3. Sally Duce (SD) provided an update for the Committee.

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

      3.1.1. RNs on days 93.12%

      3.1.2. RNs on nights 96.11%

      3.1.3. Care staff on days 108.57%

      3.1.4. Care staff on nights 114.08%

   3.2. 10 wards experienced a monthly staffing headcount fill rate of below the accepted level of 90%; 9 wards for RNs and 1 ward for care staff.

3.3. Care staff monthly fill rates is higher than the funded ward establishment in many inpatient areas because of extra staff employed to either provide 1:1 care to vulnerable patients or to compensate for a shortfall in RN headcount levels when efforts to backfill RN gaps have proven unsuccessful.

3.4. In February 2017, 5 patients experienced moderate or severe harm following inpatient falls.

3.5. SD discussed overseas recruitment with the Committee, commenting that the Indian recruitment drive was becoming more successful. Two nurses now had their NMC PINs; seven nurses arrived in February and are now preparing for the OSCE later in March and three more nurses are due to arrive in March.

3.6. SD informed the Committee that HENWE are challenging the NMC regarding their OSCE scoring which is set at 7, whilst the GMC score is 6.5.

3.7. 47 newly qualified staff are joining the Trust in March and April and at the open day on 25th February, 26 nurses were offered posts.

IPR

4. Nik Khashu (NK) summarised the report.

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

4.2. There were no cases of MRSA bacteraemia in February 2017. Year to date there have been a total of 3 MRSA incidents and 1 contaminant. Ann Marr (AM) requested that NK amend the figure in the IPR to 3 (rather than 4) in order to make it clear that one case was a contaminant.

4.3. There was 1 C.Diff positive case in February. Year to date there have been 20 confirmed cases. The annual tolerance for 2016-17 is 41 cases. DG asked what the target was for 2017/8 and Sue Redfern (SR) informed the committee that the total was again 41 cases. DG further commented on the improvement from last year.

4.4. SR also informed the Committee that for 2017-18, E.Coli cases are also reportable, but the majority of cases are community acquired, as our catchment area has quite a high number of cases. AM asked SR to prepare a paper for Quality Committee next month regarding E.Coli.

4.5. There was 1 grade 3 pressure ulcer in February, taking the year to date total to 3.

4.6. There were 2 falls that resulted in severe harm during January. Year to date there have been a total of 17.

4.7. VTE assessment for January was slightly below the required 95% target at 93.64%. The Committee discussed VTE assessments and the systems in place to reach the target, although it was felt that the target for the year would not be met.

4.8. HSMR stands at 103.7 up to November 2016.

4.9. A&E performance was 74.1% (type 1) and 83.9% (type 1 & 3) in month. A seasonal increase in non-elective admissions and complexity of patients is impacting upon performance. The key actions identified for recovery of this position are being driven forward by the senior leaders across the organisation, focusing on both the Emergency Department and the inpatient wards.

4.10. 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. Additional activity funded by NHSE to reduce RTT backlog, will continue until the end of March, resulting in completion of pathways for circa 1000 dermatology and 18 T&O patients.

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

4.12. As at the end of February, the Trust is reporting an overall Income & Expenditure surplus of £2.681m, which is slightly above the agreed plan. Trust income is ahead of plan by £2.259m, while expenditure is overspent of £2.118m, through delivering extra activity. Expenditure on agency stands at £9.930m for the year against a target for the full year of £7.256m. The Trust's forecast outturn is to achieve its annual plan of £3.328m surplus.

4.13. To date the Trust has delivered £13.672m of CIPS, which is now just ahead of the year to date plan and the Trust is forecasting to achieve its £15.248m target for the year. Capital expenditure to date is £3.059m out of a revised year forecast total of £3.509m, due to the deferral of the Salix CHP scheme. Cash balance at the end of February 2017 is £8.432 which equates to 10 operating days.

4.14. Both NK and George Marcall assured the Committee that A&E performance and financial performance will be discussed in depth at the Finance & Performance meeting on 23rd March.

4.15. The 2016 staff satisfaction score has again creased and the Trust remains in the top 20% of acute trusts nationally A full report will be presented at the March 2017 Trust Board.

4.16. Mandatory training compliance is unchanged in month and is 7.1% above target at 92.1%. Appraisal compliance for January has also improved and is just 4.3% behind target at 80.7%. Absence has decreased in February to 4.9% with is 0.22% behind Q4 target.

1st Draft Quality Account

5. SR provided a summary for the Committee.

5.1. The purpose of the report is to provide the Quality Committee with the opportunity to review and comment on an early draft of the Quality Account. Any comments should be sent to SR and Anne Rosbotham-Williams no later than 31st March.

5.2. SR did comment that the report was not as positive as last year as there had been an increase in falls, never events and MRSA bacteraemia. The Committee asked for a narrative on what happened regarding the negative things and SR will deliver a presentation at the next Quality Committee. It was agreed that the priorities for next year must include the above areas.

Falls Report

6. Rajesh Karimbath (RK) summarised the report.

6.1. The report is to provide assurance to the Quality Committee of the on-going activity within the Trust to reduce the number of patient falls.

6.2. A review of incidents in the category of severe and death reported between January and December 2016 was undertaken to identify key issues or root causes:

6.2.1. Lack of personalisation of risk assessment or updating risk assessments.
6.2.2. Co-morbidities.
6.2.3. Delay in the discharge process.
6.2.4. Visibility of patients.
6.2.5. Communication
6.2.6. Failure to carry out a falls risk assessment.
6.2.7. Time of falls.

6.3. Innovations in falls prevention and supporting initiatives/projects have been developed by the Trust, and include:

6.3.1. Pressure pads falls alarms (currently being used across the Trust).
6.3.2. Pilot of a pager system.
6.3.3. “Wall of falls” has been developed to identify areas where falls occur.
6.3.4. Weekly audits.
6.3.5. Pharmacy stamp is being piloted on Ward 1A.
6.3.6. Bedrail ties with advisory labels are in development.

6.4. A new national audit will be carried out in May, with the results expected in October.

6.5. NK asked when the results of the pressure pads falls alarms would be available. RK said there would be a three month trial and he would then report back to Quality Committee.

Safeguarding report and action plan

7. SD provided an update.

7.1. The inspection of Knowsley CCG included the Trust as one of the local acute health care providers and included 22 recommendations for the Trust.

7.2. The Committee discussed the action plan at length and it was decided that while there are many recommendations, there were no specific concerns to be escalated to the Board as action plans are in place.

7.3. AM enquired as to why the Trust did not know about the concerns prior to the visit. SD replied that we were aware of some of the issues, but not all.

Savile recommendiations action plan

8. SR provided an update:

8.1. All actions within the Savile action plan are now complete and the completed action plan was submitted to NHSE in February 2017.

CQC Registration

9. SR summarised the report.

9.1. The Trust is fully compliant with all standards set out in the Health and Social Care Act 2008.

9.2. NK did bring to the attention of the Committee that the fees have risen 300% in two years; £95k to 289K.

Mixed Sex Declaration

10. SR summarised the report.

10.1. There were no mixed sex breaches or complaints in the last year.

Annual Meeting Effectiveness Review

11. Peter Williams (PW) discussed the review with Committee members.

11.1. Minor changes are required to the groups reporting to Councils.

11.2. Efforts will be made to reduce the size of reports and stop the use of embedded documents.

11.3. Improvements will be sought regarding attendance.

11.4. The existing ToR remain appropriate and should be accepted.

12. DG and AM queried the attendance figures and asked whether informed deputies should be counted in the attendance figures. PW said that presently, it is only core members that are counted for, but agreed to revisit this.

Feedback from Patient Safety Council

13. Sally Duce (SD) provided an update.

    13.1. There was nothing to escalate to the Committee, but SD would like to highlight that a request was made by Healthwatch for an update on the decontamination scope incident and Duty of Candour letters to be provided to patients. SR informed the Committee that letters had already been sent to the patients concerned.

    13.2. JC informed the Committee that a legal claim has been received from one of the patients involved.

Feedback from Patient Experience Council

14. There was nothing to escalate to the Committee.

Feedback from Clinical Effectiveness Council

15. There was nothing to escalate to the Committee.

Feedback from CQPG Meeting

16. There was nothing to escalate to the Committee.

Feedback from Executive Committee

17. There was nothing to escalate to the Committee.

Effectiveness of meeting

18. PW said that it had been a good meeting, with good discussion and paperwork.

AOB

19. DG thanked Ali Kennah for all her hard work for the Quality Committee and the Trust and wished her well in her new position.

Date of next meeting

20. Tuesday, 18th April 2017.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)026

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance and Performance Committee, 23rd March 2017

Summary:

Agenda Items

For Information

- Q2 SLR medicine, including DMOP review
- IR35 Guidance
- DoH Temporary Loan Facility
- Final Budget Setting for 2017/19

For Assurance

- C-Diff RCA – Key actions
- A & E update - the Committee were assured by the update on the action plan to improve performance and will continue to monitor progress
- Integrated Performance Report Month 11 2016/17 - concern around MRSA, Pressure ulcers and never event incidents
- Month 11 2016/17 Finance Report – still forecasting to achieve £3.328m surplus
- Governance Committee Briefing Papers:
  - CIP Council
  - Procurement Council

For Approval

- Cheshire & Merseyside 5YFV Governance

AOB

- Impact of St Helens CCG Referral Management System (RMS) was discussed

Actions Agreed

- IR35 guidance review and present key areas of risk for the Trust
- A&E performance update
  - Identify quantitative impact of actions within the Improvement programme
  - Invite Improvement team to present progress at next meeting
- RMS – planned quarterly review in April to be presented to the Committee
- Temporary Loan facility to be ratified 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: 29th March 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)027
Title of paper: Regulatory Update (Formerly FT Programme Report)
Purpose: To provide the Board with assurance that the Trust continues to take account of all regulatory requirement s and comply with governance good practice.
Summary: This report includes briefing on; 1. Single Oversight Framework Trust Segmentation 2. NHS Mandate for 2017- 2018 3. An update on the St Helens Community Services contract mobilisation 4. The proposed governance arrangements for the Cheshire and Merseyside Five Year Forward View delivery programmes.
Corporate objectives met or risks addressed: Provide high quality sustainable services
Financial implications: This paper does not include a request for additional funding
Stakeholders: Patients, Staff, Alliance LDS Partners, Commissioners, NHSI
Recommendation(s): The report is intended to inform and assure the Board The Board approves the C&M FYFV governance framework.
Presenting officer: Nik Khashu, Director of Finance and Information
Date of meeting: 29th March 2017

Regulatory Update (Formerly FT Programme Report)

1. Single Oversight Framework Trust Segmentation

NHS Improvement has published the quarterly assessment of Trusts against the Single Oversight Framework. The Trust has remained categorised as Segment 2, with 1 being the lowest risk, with no support needs and 4 being the highest risk with major or complex support needs.

The means that the Trust will continue with quarterly Performance Review meetings with the local NHS Improvement delivery team.

2. NHS Mandate for 2017- 2018

On the 20th March 2017 the Department of Health published the governments mandate to the NHS for 2017 – 18.

"NHS England is responsible for arranging the provision of health services in England. The mandate to NHS England sets the Government's objectives and any requirements for NHS England, as well as its budget. In doing so, the mandate sets the direction for the NHS, and helps ensure the NHS is accountable to Parliament and the public. Every year, the Secretary of State must publish a mandate to ensure that NHS England's objectives remain up to date.

NHS England is legally required to seek to achieve the objectives, and comply with the requirements in this document."

The government's objectives for the NHS in the coming year are;

OBJECTIVE 1: Through better commissioning, improve local and national health outcomes, and reduce health inequalities.

OBJECTIVE 2: To help create the safest, highest quality health and care service.

OBJECTIVE 3: To balance the NHS budget and improve efficiency and productivity.

OBJECTIVE 4: To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.

OBJECTIVE 5: To maintain and improve performance against core standards.

OBJECTIVE 6: To improve out-of-hospital care.

OBJECTIVE 7: To support research, innovation and growth.

3. An update on the St Helens Community Services contract mobilisation

The Out of Hours Community Services contract for ST Helens CCG will go live on Saturday 1st April. The primary objective for the first few weeks and months is a

safe transfer of the existing services, with the work on implementing the new contract specification to commence after April.

Over 80 staff will TUPE to the Trust, for the intermediate care and community continence services, and over 200 will transfer to Five Boroughs Partnership who is sub contracted to deliver the District Nursing, and Treatment Room services.

This is a block contract and will be managed separately from the main CCG contract, via the consortium governance arrangements and in collaboration with the CCG to achieve the vertical integration that is the aspiration of the St Helens People's Board for Accountable Care in the Borough.

4. The proposed governance arrangements for the Cheshire and Merseyside Five Year Forward View delivery programmes.

Following the discussion at the Board meeting in February a more detailed briefing paper was circulated to Board members about the Cheshire and Merseyside Five Year Forward View (C&M FYFV) governance proposals. Consideration of any feedback and comments was delegated to the Finance and Performance Committee, which met on 23rd March.

The recommendation from the Committee is that the proposals should be supported by the Trust at the C&M FYFV membership group meeting.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)028

Title of paper: Approval of Budget Plans

Purpose: For the Trust Board to approve the revised submission of the Trust's Annual Plan 17/19

Summary:

The purpose of this paper is to update the Committee on the current status of the Trusts' Annual Plan and Budget setting process for 2017/19.

The final plan was approved by the Trust Board and submitted on 23rd December 2016, in line with NHSI planning guidance.

All Trusts have subsequently been advised by NHSI (on 14th March 2017) that we may resubmit a revised plan to include any changes to the following items:

- profile of income and expenditure to reflect detailed budget setting
- reflect a material change to 2016/17 Forecast Outturn
- reflect signed contracts in planned income by commissioner
- changes to Statement of Cashflow and the Statement of Financial Position
- add efficiency programme detail, profile, split and status

The Trust is proposing to resubmit its Annual plan to reflect the following significant items which were not confirmed in December:

- the award of St Helens Community Tender in January 2017
- the impact of the Tariff pricing issued on 21st December 2016
- changes to the Capital plan due to deferral of the CHP scheme
- the additional loan in March 2017, due to the delay in receipt of Q4 STF funding

The final 2017/19 Annual Plan will be submitted to NHSI on 30th March 2017 after being presented to the Board for review and approval at the March Trust Board meeting.

Corporate objectives met or risks addressed: Financial Performance, Efficiency & Productivity

Financial implications: none directly from this paper

Stakeholders: Trust Board Members, NHSI, DoH

Recommendation(s): Members are asked to approve the re-submission of the Annual Plan.

Presenting officer: Nik Khashu Director of Finance and Information

Date of meeting: 29th March 2017

1. Introduction

This paper outlines the proposed revised Annual Plan for 2017/18 based on guidance issued by NHSI and proposals for growth submitted by the Care Groups. The Trust is taking the opportunity to refresh the plans submitted in December 2016 to account for changes identified since that submission.

The conditions around the re-submission of the Annual Plan are that:

- Financial Control Totals must remain in place (where previously agreed)
  - £8.536m 17/18; £8.636m in 18/19
- And/or, there must be no deterioration to the bottom line financial position

2. Updated bridge between 2016/17 Forecast outturn and 2017/18 Plan

Table 1: Bridge between 16/17 Forecast Outturn (M7) and 17/18 Plan

		Income	Expenditure	EBITDA	ITDA	Net S/(D)	Technical	Current Annual Plan Adj S / (D)	Dec submitted Annual Plan Adj S / (D)
1	**2016/17 M12 Outturn as at Month 7**	**345.198**	**-317.474**	**27.724**	**-24.438**	**3.286**	**0.042**	**3.328**	3.328
2	Impact of Non-Recurrent CIP in 2016/17		-2.000					**-2.000**	-2.000
3	Removal of STF 2016/17	-10.100						**-10.100**	-10.100
4	2017/18 Tariff Inflation inc HRG4+	6.006						**6.006**	5.756
5	2017/18 National cost pressures		-5.509					**-5.509**	-5.469
6	PFI inflation	-0.790						**-0.790**	-0.581
7	1.9% Indicative Growth *	6.409	-4.486					**1.923**	2.396
8	Community Services Tender	11.267	-11.267					**11.267**	
9	Executive Contingency		-1.000					**-1.000**	-1.000
10	**Other Cost Pressures:**								
	Rates		-1.150					**-1.150**	-1.150
	Apprentice Levy (0.4%)		-0.880					**-0.880**	-0.880
	Junior Doctor Contracts		-0.700					**-0.700**	-0.700
	CNST Increase		-2.100					**-2.100**	-2.100
	EPR Implementation		-1.000					**-1.000**	-1.000
11	*Technical Accounting adjustment (tbc)*								
	Adj Surplus / (Deficit)	**357.990**	**-347.567**	**10.423**	***-24.438***	**-14.015**	*0.042*	**-13.973**	-13.500
	S & T Funding 17/18	*9.117*						***9.117***	*9.117*
	Adj Surplus / (Deficit)	**367.107**	**-347.567**	**19.540**	***-24.438***	**-4.898**	*0.042*	**-4.856**	-4.383
12	17/18 CIP at **3.9%**		13.392					**13.392**	12.919
	Annual Plan 2017/18 (£8.536m surplus)	**367.107**	**-334.175**	**32.932**	***-24.438***	**8.494**	*0.042*	**8.536**	8.536
	Total CIP including contribution from income growth							***15.315***	*15.315*
	Notes:							4.2%	4.4%
	1. Forecast outturn is in line with original plan of £3.328							***8.536***	

2. Recurrent CIP gap at Month 7
4. Tariff inflation is after confirmation of HRG4+ impact, Dec 22 tariff
5. National cost pressures - per planning Guidance 2.1%
7. Growth assumptions based on agreed contract and Care Group Service Developments
9. Indicative Cost pressures above those within 16/17 outturn: Apprentice levy; Junior Doctor contract; EPR implementation; Rates.
10. CIP (excluding Income growth contribution) is currently at 4.2% (3.9%) - this is subject to change once income growth has been confirmed.

3. Updated Items

The following items are the key changes from the papers previously presented to the Finance & Performance Committee and the Trust Board in November 2016:

- the Community Service Tender awarded by St Helens CCG starting in April 2017 in both Income and Expenditure
- Income now reflects the impact of the December 22nd Tariff HRG 4+ pricing
- Capital plan – 2016/17 items deferred into 2017/18:
    - CHP and some PFI MES lifecycle items
- Trust Loans – a temporary Trust loan to offset the delay in STF Q4 funding
- Known activity changes advised by Finance Business Partners

The Trust's Surplus position and CIP target remain unchanged:

£m	Surplus	CIP
2017/18	8.536	15.315
2018/19	8.636	12.138

4. Key Dates and Tasks

The approved revised plan is due to be submitted to NHSI on 30th March 2017.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)029

Title of paper: Annual Meeting Effectiveness Review.

Purpose: To summarise the 2016/17 annual meeting effectiveness review for the Trust Board.

Summary:

1. The Terms of Reference (ToR) for each Trust forum include the requirement for an annual meeting effectiveness review.
2. The process used for the reviews in 2014/15 will continue to form the basis of the reviews across the governance structure.
3. The attached paper summarises the review for the Trust Board.
4. The conclusion of the review is that the purpose and remit of the Trust Board remains appropriate.

Corporate objectives met or risk addressed: Contributes towards the Trust governance arrangements.

Financial implications: None as a direct consequence of this paper.

Stakeholders: The Trust Board, Trust staff, patients and local partners.

Recommendation(s): Members are asked to note the information provided and confirm their approval to the recommendations namely:

1. The structure and reporting arrangements are appropriate and clear.
2. There is still room for minor improvement with meeting administration and documentation.
3. Membership, attendance and meeting arrangements are seen as appropriate, and the reasons for attendance below the agreed level have been explored.
4. The existing ToR remain appropriate and should be accepted.
5. The feedback from the survey is encouraging. Addressing the areas of lower scoring and the comments made will be actioned.

In summary, the purpose and remit of the Trust Board remains fundamentally appropriate with relatively minor changes proposed.

Presenting officer: Peter Williams, Director of Corporate Services.

Date of meeting: 29th March 2017.

INTRODUCTION

6. The Terms of Reference (ToR) for both the Trust Board and its Committees include the requirement to review meeting effectiveness each year.

7. The following paper details the review undertaken for the Trust Board and includes:

   7.1. A review of the meeting structure and reporting arrangements

   7.2. A sample audit of compliance

   7.3. A review of attendance

   7.4. A members questionnaire

   7.5. A review of the ToR and annual meeting programme

   7.6. Summary and recommendations from the chair and lead officer.

CORPORATE MEETING STRUCTURE

8. There are no proposed changes to the meetings structure relevant to the Trust Board.

9. The Corporate Meeting Structure is as detailed in Appendix 1.

MEETING COMPLIANCE REPORT

10. A high level audit was undertaken by reviewing the documentation surrounding a single sample meeting on 25th January 2017 and RAG rating the findings to provide a flavour of performance (although these are not scientifically based).

    10.1. Paper distribution – Electronic and hard copies of papers were due for distribution on 20th January, three working days prior to the meeting. Unfortunately one paper (HR Indicators) was not finished so incomplete packs were distributed with the outstanding paper circulated on 23rd with hard copies tabled on the day. Throughout the year only 37% of reports were sent to the Board administrator by the agreed deadline, and clearly efforts need to be made to improve this performance.

    10.2. Minutes – Minutes of the previous meeting on 30th November were very good with clear evidence of constructive challenge from attendees. When invited to comment a senior member of staff observing the meeting stated “there was a full agenda, but the dialogue was impressive with lots of challenge. The tone of the meeting remained positive …..”

    10.3. Action log – The log accurately captures the ongoing actions with clear leads and dates for reporting.

    10.4. Format of papers - The agenda indicated twelve papers, and no presentations or verbal reports:

    - Ten papers were fully compliant with the agreed standard cover sheet with all sections appropriately completed. Two used incorrect headings in the table on the cover sheet.

    - There were a total of 114 pages in the reports, giving each an average of 9.5 pages. This seems slightly excessive and efforts should be made to reduce the size of reports where possible.

    10.5. In conclusion, this audit found that the documentation is generally of a good quality with only a few minor improvements required regarding the timeliness of production of papers and the volume of reports.

MEETING ATTENDANCE

11. The following chart summarises attendance at the Trust Board from April 2016 to date.

TRUST BOARD		A	M	J	J	A	S	O	N	D	J	F	M	Att	%
Meetings held 2016/17		✓	✓	✓	✓		✓	✓	✓		✓	✓		9	
Richard Fraser	Chairman	✓	✓	✓	✓		✓	✓	✓		x	✓		8	89%
Bill Hobden	Deputy Chairman / SID	✓	✓	✓	✓		✓	✓	✓		✓	✓		9	100%
Denis Mahony	NED	✓	✓	✓	x		✓	✓	✓		✓	✓		8	89%
Su Rai	NED	✓	✓	✓	✓		✓	✓	✓		✓	✓		9	100%
George Marcall	NED	x	✓	✓	✓		✓	✓	✓		✓	✓		8	89%
David Graham	NED	x	x	✓	✓		✓	✓	✓		x	✓		6	67%
Sarah O'Brien	Associate NED	✓	✓	✓	x		✓	x	✓		✓	x		6	67%
Ann Marr	Chief Executive	✓	✓	✓	✓		✓	✓	✓		✓	✓		9	100%
Anne-Marie Stretch	HR Director / Deputy CE	✓	✓	✓	✓		✓	✓	✓		✓	✓		9	100%
Nik Khashu	Finance Director	✓	✓	✓	✓		✓	✓	✓		✓	✓		9	100%
Sue Redfern	Nursing Director	✓	✓	✓	✓		✓	✓	x		✓	✓		8	89%
Kevin Hardy	Medical Director	✓	✓	✓	x		✓	✓	✓		✓	x		7	78%
Peter Williams	Director of Corporate Services	✓	✓	✓	✓		✓	✓	✓		✓	✓		9	100%
Amanda Risino	Director of Modernisation														
Christine Walters	Director of Informatics	✓	✓	✓	✓		x	✓	✓		✓	✓		8	89%
Paul Williams	Director of Operations *(to 03/06/16)*	✓	✓											2	100%
Rob Cooper	Director of Operations *(From 01/01/17)*										✓	x		1	50%

12. It should be noted that all meetings were quorate.

13. Attendance of three of the Board members was slightly below the agreed target for the part-year. In the case of RC it can be explained by the small tenure of his employment and in the case of DG the target should be met by the end of the financial year.

TERMS OF REFERENCE & ANNUAL MEETING PROGRAMME

14. A high-level review of all ToR was undertaken to ensure they continue to align with latest guidance, given that a detailed review was completed as part of the 2015/16 exercise.

15. No changes in the ToR are proposed and a copy is included as Appendix 2.

16. The Annual Meeting Agenda has been reviewed and is included as Appendix 3.

MEETING EFFECTIVENESS MEMBER QUESTIONNAIRE

17. Questionnaires were distributed on 19th January 2017 and 12 were returned. The results are charted in the table overleaf.

18. In general the feedback was very good with an average score of 4.4.

19. The three joint highest scoring areas were clarity of agendas, interaction of members and the overall success of the meeting.

20. The timeliness and conciseness of papers and the standard of delivery of reports didn't score so well, and these areas will be targeted for improvement in 2017/18.

21. The following comments were received in questionnaire responses which will be considered:

    21.1. The agenda is sometimes too structured

    21.2. Papers are timely but Executive summaries require improvement, particularly nursing

    21.3. Sometimes roles are confused between Committees and the Board

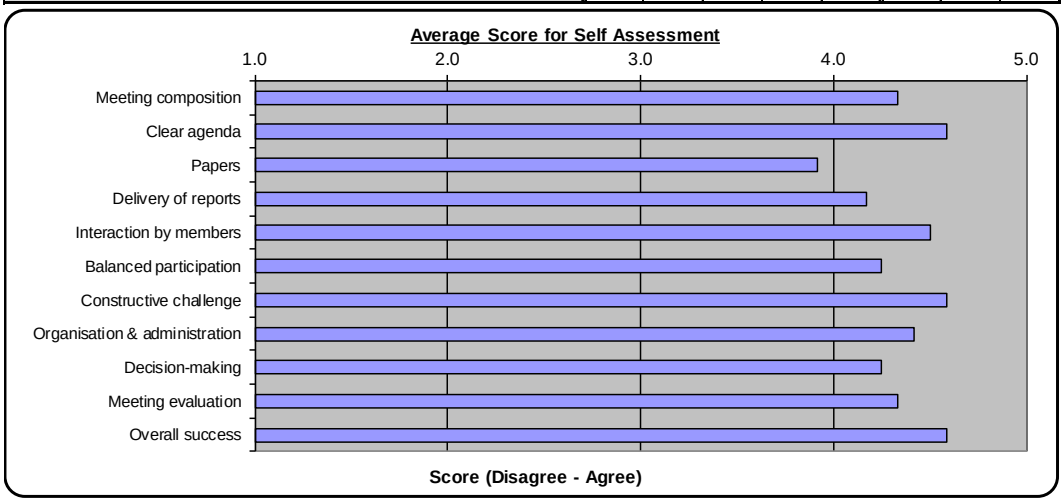
    21.4. Good meeting

    21.5. Consider whether time could be reduced

21.6. Overall the meetings are run well

21.7. Decision making action planning at the end of each item could be improved.

TRUST BOARD ANNUAL MEETING EFFECTIVENESS REVIEW - 2016/17	12 questionnaires returned							
	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Mean	Mode	Range
	1	2	3	4	5			
Adherence to agenda, topics & timeframes is good				8	4	4.3	4.0	2
The agenda is clear			1	3	8	4.6	5.0	3
Meeting papers are concise & received in a timely fashion			3	7	2	3.9	4.0	3
The standard of delivery of agenda items is good			1	8	3	4.2	4.0	3
The members interact well				6	6	4.5	4.5	2
Meeting participation is balanced			1	7	4	4.3	4.0	3
There is a good degree of challenge from members				5	7	4.6	5.0	2
Meeting facilitation / leadership is good				7	5	4.4	4.0	2
There is a good decision-making process			1	7	4	4.3	4.0	3
At the end, the meeting is evaluated				8	4	4.3	4.0	2
Overall, the meeting is a success				5	7	4.6	5.0	2



CHAIR AND LEAD OFFICER REVIEW

22. Richard Fraser and Peter Williams have jointly considered and confirmed the findings of the review. In summary they have reached the following conclusions:

22.1. The structure and reporting arrangements are appropriate and clear.

22.2. There is still room for minor improvement with meeting administration and documentation.

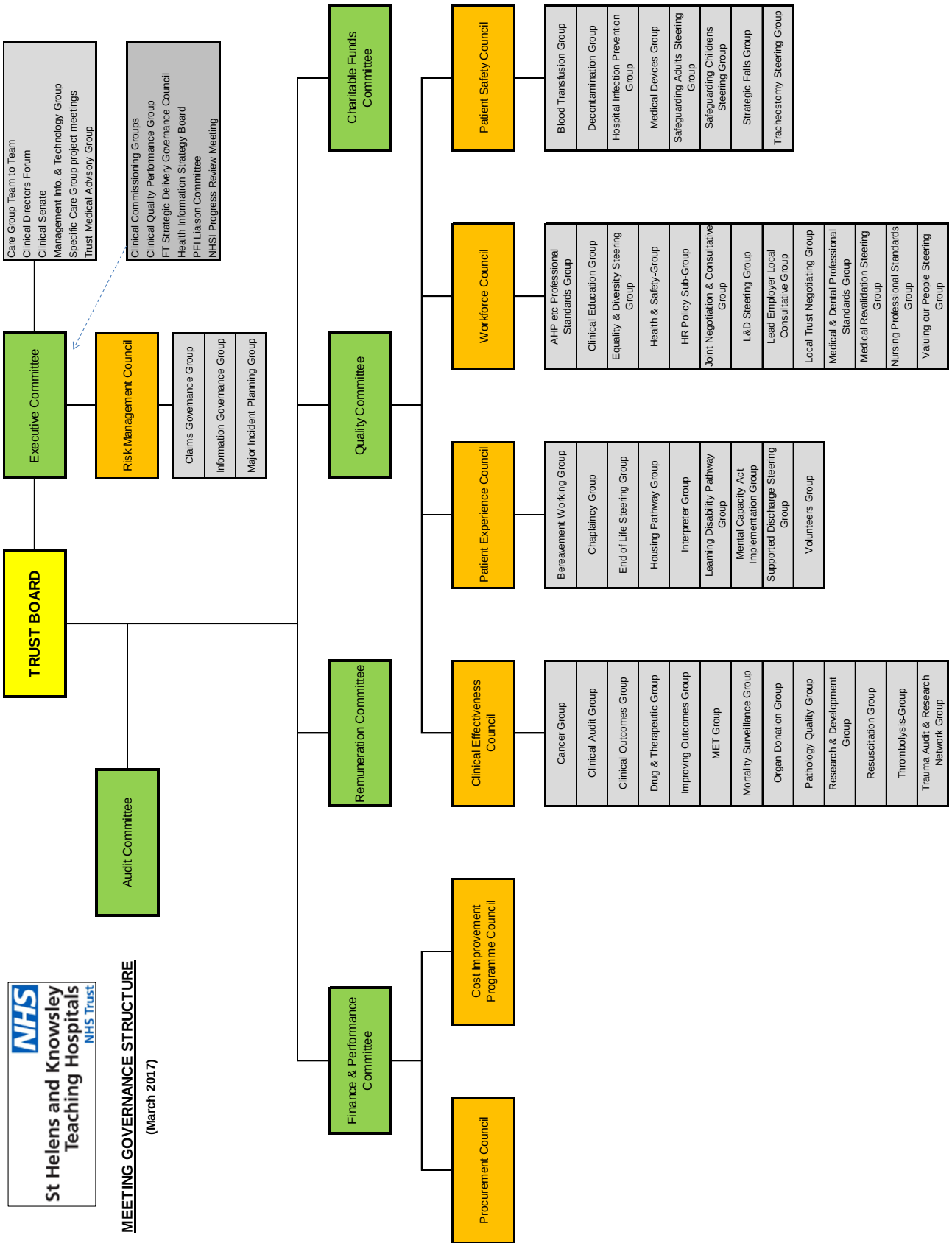
22.3. Membership, attendance and meeting arrangements are seen as appropriate, and the reasons for attendance below the agreed level have been explored.

22.4. The existing ToR remain appropriate and should be accepted.

22.5. The feedback from the survey is encouraging. Addressing the areas of lower scoring and the comments made will be actioned.

22.6. In summary, the purpose and remit of the Trust Board remains fundamentally appropriate with relatively minor changes proposed.

Appendix 1 – Corporate Meeting Structure



Appendix 2 – Terms of Reference

TRUST BOARD – Terms of Reference	
Authority	St Helens and Knowsley Teaching Hospitals NHS Trust (the Trust) is a body corporate which was established under the St Helens and Knowsley Hospital Services National Health Service Trust (Establishment) Order 1990 (SI 2446) amended by 1999 (No 632) (the Establishment Order). The principal place of business of the Trust is the address as per the establishment order. The terms under which the Trust Board operates are described in the Standing Orders section of the Corporate Governance Manual (section 7.3).
Delegated Authority	The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, and their specific executive powers shall be approved by the Board, and appended within the Corporate Governance Manual. The Board has delegated authority to the following Committees of the Board i) Audit Committee ii) Remuneration Committee iii) Quality Committee iv) Finance & Performance Committee v) Charitable Funds Committee vi) Executive Committee
Agendas	The Board will have a forward work programme for the ensuing year that provides an outline plan for reporting throughout the year. This will include items on quality, performance and statutory compliance as well as reports from the Trust's Committees where more in-depth scrutiny of items has occurred in the presence of both Non-Executive and Executive Directors. This does not prevent agenda items being added as required and may result in items being deferred to another month if the agenda becomes too congested. A Board member desiring a matter to be included on an agenda shall make their request to the Chairman at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman. Where a petition has been received by the Trust the Chairman of the Board shall include the petition as an item for the agenda of the next Board meeting.
Accountability and reporting	All ordinary meetings of the Board are open meetings which members of the public can attend to observe the decision-making process of the Trust. They are not open meetings where the public have a right to contribute to the debate, however, contributions from the public at such meetings can be considered at the discretion of the Chairman. Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers. Exceptionally, there may be items of a confidential nature on the agenda of these ordinary meetings from which the public may be excluded. Such items will be business that:

	i) relate to a member of staff, ii) relate to a patient, iii) would commercially disadvantage the Trust if discussed in public, iv) would be detrimental to the operation of the Trust.
Review	In March each year the Board will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the ToR.
Membership	**Core Members (voting)** Non-Executive Chairman (chair) 5 Non-executive Directors (one of which will be appointed Vice Chair, and one appointed Senior Independent Director) Chief Executive 4 Executive Directors (to include Director of Finance, Medical Director, Nursing Director plus one other. One to be nominated Deputy Chief Executive) Collective Responsibility - Legally there is no distinction between the Board duties of Executive and Non-Executive Directors; both share responsibility for the direction and control of the organisation. All Directors are required to act in the best interest of the NHS. There are also statutory obligations such as quality assurance, health and safety and financial oversight that Board members need to meet. Each Board member has a role in ensuring the probity of the organisation's activities and contributing to the achievement of its objectives in the best interest of patients and the wider public. <u>In attendance</u> The Board shall be able to require the attendance of any other Director or member of staff.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year.
Quorum	50% of the core membership must be present including at least one Executive Director and one Non-Executive Director.
Meeting Frequency	The Trust Board will meet monthly (with the exception of August and December). All meetings will have public and private elements.
Agenda Setting and papers	Minute production and distribution is via the office of the Director of Corporate Services. Documents submitted to the Trust Board should be in line with the corporate standard.

Appendix 3 – Annual Agenda and scheduled meetings for 2017/18

ANNUAL TRUST BOARD CALENDAR 2017/18																	
			ToR	A	M	J	J	A	S	O	N	D	J	F	M	Report	Presenter
Scheduled agenda items	General	Employee of the month		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Anne-Marie	Richard
		Patient story			✔		✔		✔		✔		✔		✔	Sue	Vary
		Apologies		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Declaration of interests	8	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Minutes of the previous meeting		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Action list / matters arising		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Review of meeting		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
		Any other business		✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Richard	
	Committee Reports	Audit (including CGM & SFI approval)	2,6,7,10,11,14 15,32,33,34	✔	✔				✔	✔				✔		Nik	Su
		Executive (including MIP approval)	3,11,16,18	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Peter	Ann
		Finance and performance	11	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Nik	Denis
		Quality	11,25	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Sue	David
		Charitable Funds	11			✔				✔				✔		Nik	Denis
		Remuneration (or as required)	6,11			✔										Anne-Marie	Richard
	Operational performance reports	Agency staffing self-certificate checklist	3	✔	✔	✔	✔	*	✔	✔	✔	*	✔	✔	✔	Nik	
		FT & STP update	3	✔	✔	✔	✔	*	✔	✔	✔	*	✔	✔	✔	Nik	
		Integrated Performance Report	3,4	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Nik	All
		Safer staffing report	3	✔	✔	✔	✔	*	✔	✔	✔	*	✔	✔	✔	Sue	
		Board Assurance Framework	3	✔			✔			✔			✔			Sue	
		Complaints, claims & incidents report	3,9		✔				✔				✔			Sue	
		HR indicators	3				✔						✔			Anne-Marie	
		Infection control report	3				✔				✔				✔	Sue	
	Annual reports	Adoption of Annual Accounts	1		✔											Nik	
		Approval of Quality Account	25		✔											Sue	
		Audit Plan approval	33		✔											Nik	
		Board and Committee Effectiveness Review	5,12,13		✔											Peter	
		Information Governance Report	1,3		✔											Francis Andrews	
		Trust objectives - review of previous year's	3		✔											Peter	Ann
		Medical revalidation	20				✔									Terry Hankin	
		Public Health report	24				✔									Kath	CCG Rep
		Audit Letter sign-off	1,33						✔							Nik	
		Charitable Funds Accounts / Annual Report	1								✔					Nik	Denis
		Research & development statement	4								✔					Kevin	
		Review of NHS Constitution (Bi-annual)	1								✔					Peter	
		Trust Board meeting arrangements	1								✔					Peter	
		Trust objectives - review of current year's	3								✔					Peter	Ann
		Clinical and quality strategy update	24,25										✔			Kevin	
		Research capability statement	3										✔			Kevin	
		Safeguarding report (Adult / Children)	1										✔			Sue	
		Approval of budget plans	1,27,29,30												✔	Nik	
		Board effectiveness review	2												✔	Peter	
		CQC registration	1,25												✔	Sue	
		Mixed sex declaration	1												✔	Sue	
		Review of staff survey	20												✔	Anne-Marie	
		Trust objectives - approval of next year's	3,24,31												✔	Peter	Ann
	Total scheduled items			15	22	15	19	0	17	16	20	0	20	15	21		
Closed Session	Chair and NED meeting			✔		✔				✔				✔		Richard	
	Chief Executives report				✔		✔		✔		✔		✔		✔	Ann	
	Serious untoward incidents		1		✔		✔		✔		✔		✔		✔	Sue	
	Suspensions		17		✔		✔		✔		✔		✔		✔	Anne-Marie	
	Feedback from external meetings and events				✔		✔		✔		✔		✔		✔	All	
	Review of meeting performance				✔		✔		✔		✔		✔		✔	Richard	
	Approval of Strategic Plans (dates TBA)		24,31,33													Ann	
	Director mandatory training / Corporate Law update		20							✔						External facilitators	

* To be approved under delegated authority

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)030

Title of paper: Care Quality Commission (CQC) compliance and registration

Purpose:

This paper provides a summary of policies, process and practices across the Trust to demonstrate how on-going compliance is maintained with the fundamental standards required by the CQC (Appendix 1), to enable the Trust Board to provide assurance to the Board.

Summary:

The Trust is required to register with the CQC and has a legal duty to be compliant with the fundamental standards set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). In 2015, the Trust underwent a comprehensive Chief Inspector of Hospitals' visit and was found to be compliant with the fundamental standards, with no requirement for enforcement action in any area. The Trust was rated as good overall with outstanding features and has remained registered with the CQC without conditions. Appendix 1 provides an updated summary of compliance against each of the relevant standards.

Corporate objectives met or risks addressed:

Care, safety and communication

Financial implications:

The CQC charges all providers an annual registration fee to cover its regulatory activities. Central funding for the CQC was reduced in 2016/17 and higher charges have been passed on to providers in a phased approach across two years, with full recovery of costs planned by 2017-18.

The fees are shown below:

2015-16 - £94,966
2016-17 - £166,243
2017-18 - £288,912 – indicative fee

Stakeholders: Trust Board, patients, carers, staff, regulators, including the CQC and commissioners

Recommendation(s):

For the Trust Board to:

- Review the information provided to confirm compliance with the fundamental standards and on-going CQC registration requirements and to determine if further information or evidence is required.

Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 29th March 2017

Appendix 1

St Helens and Knowsley Teaching Hospitals NHS Trust

Compliance with CQC Regulations and Fundamental Standards

Key	This paper was updated on 24th February 2017
	Full assurance in place in STHK
	Process in place, further work required until full assurance can be given
	No assurance in place
	Position not yet assessed and, therefore, not known.
	Not applicable

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Comment including any further actions to strengthen compliance if required
No FS maps to this regulation	5 - Fit and proper persons: directors	People with director-level responsibility for meeting the standards are fit to carry out this role.	**Well-led**	Remuneration	DoHR		Process in place for confirming all current Directors including Non-Executive Directors meet the required standard and will be applied to all new appointments. The process being followed is in line with the process shared across a number of north west foundation trusts.	Chair approved process in place and adhered to for all new starters.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Comment including any further actions to strengthen compliance if required
No FS maps to this regulation	6 - Requirement where the service provider is a body other than a partnership	Provider is represented by an appropriate person nominated by the organisation who is responsible for the management of regulated activity.	**Well-led**	Executive	DoNMG		Director of Nursing, Midwifery and Governance is the Accountable Person registered with the CQC.	Director of Nursing registered with the CQC as responsible officer and confirmed in updated certificate received May 2016.
No FSs map to this regulation	8 - General	Registered person must comply with regulations 9 to 19 in carrying on a regulated activity	**Well-led**	Quality	DoNMG		See information below for compliance	See below

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Comment including any further actions to strengthen compliance if required
1	9 - Person-centred care	Providers must do everything reasonably practicable to put patients at the centre and to reflect personal preferences, taking account of people's capacity and ability to consent.	Safe, **Caring,** Responsive	Quality	DoNMG		All patients are assessed on admission and have comprehensive treatment/care plans in place. Trust has examples of adjustments made to meet individual needs, including electronic alerts, health passports, side-rooms, additional staffing where needed, carer beds, hearing loops & communication aids. In outpatients, double, early and late appointments are used with desensitising visits to clinics. Specialities have developed their own pathway supporting people with additional needs and include imaging, endoscopy and pre-operative assessment. For complex patients, best interest decision-making and journey planning involving multi-disciplinary teams are routine. This was demonstrated in a patient story to the Board in January. Mental Capacity Act included in mandatory training with 92.9% compliance achieved year-to-date in 2016-17. Consent Policy in date and available on the Trust's intranet. Compliance with nursing care indicators is regularly audited and reported to each ward. and the Patient Experience Council on a quarterly basis.	The Trust was rated first nationally for patient experience, using a number of indicators, highlighting the importance the Trust places on all aspects of patient care in 2015-16 and shortlisted again in 2016-17. The Trust received an overall rating of outstanding for the caring domain, with examples of compliance sited in the CQC inspection report, including the fact there were sufficient numbers of trained nursing and support staff with an appropriate skill mix to ensure that patients' needs were met appropriately and promptly. The CQC observed positive interactions when staff were seeking consent.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Comment including any further actions to strengthen compliance if required
2	10 - Dignity and respect	Have due regard to the Equality Act 2010 protected characteristic – staff demonstrating compassion and respect. Maintain privacy **at all times**, inc when sleeping, toileting and conversing.	Safe, **Caring,** Responsive	Quality	DoNMG		The Trust's values include respectful and considerate and these are reiterated at interview, on induction and during appraisals. Privacy and dignity assessed as part of CQC inspection and external PLACE assessments. Any areas of concern highlighted through the complaints process are responded to and actions taken to address shortfalls. Additional structural changes were made in 2016 to the Coronary Care Unit to enhance privacy and dignity of patients. Paper submitted to the Policy Governance Group to confirm adherence to the Eliminating Mixed Sex Accommodation Policy. Breaches are reported via the Datix system	Additional assurance to be gained through audit of mixed sex breaches and responses to audit findings. On-going observation through internal Quality Inspections.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Comment including any further actions to strengthen compliance if required
3	11 - Need for consent	All people using the service or those acting lawfully on their behalf give consent. (Meeting this regulation may mean not meeting other regulations eg this might apply in regard to nutrition and person centred care. However, providers must not provide unsafe or inappropriate care just because someone has consented.)	**Safe,** Responsive	Quality	MD		Consent Policy has been updated and rolled out. Patients are consented using standard Trust forms for all procedures.	Audit of patient records and compliance with consent policy and Mental Capacity Act (MCA) 2005 and report through Clinical Effectiveness Council to the Quality Committee. CQC observed positive interactions when staff were seeking consent

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Comment including any further actions to strengthen compliance if required
4	12 - Safe care and treatment	Assessing risks against health and safety standards, mitigating risks, staff providing care have relevant qualifications, competence, skills and experience, ensure premises and equipment used are safe for intended purpose. Ensure sufficient quantities of medicines/ equipment to remain safe. Proper oversight of safe management of medicines. Infection prevention and control (IPC).	**Safe**	Quality; Workforce Council; Executive	DoHR, DoNMG, DoCS,		H&S risk assessments in place and outlined in H&S Policy & supporting documents. Work place inspections reported to Health and Safety Committee which reports to Workforce Council and programme of environmental checks in place reporting to Patient Experience Council. Relevant checks against job description/ person specification undertaken as part of recruitment process for all staff. Missed doses of medication are recorded in patient notes, on Datix and are audited. Pharmacy undertake audits of missed doses and security, providing feedback to individual wards for improvement. Considerable improvement noted in the latest medicines security audit (January 2017) Programme of medical device maintenance in place. Compliance with infection prevention and control is audited monthly.	Redesign process for embedding lessons learnt from incidents and complaints is to remain as a quality improvement priority for 2017-18.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Comment including any further actions to strengthen compliance if required
5	13 - Safeguarding service users from abuse and improper treatment	Zero tolerance approach to abuse and unlawful discrimination and restraint, including neglect, degrading treatment, unnecessary restraint, deprivation of liberty. All staff to be aware of local safeguarding policy and procedure and actions needed if suspicion of abuse.	**Safe**	Quality, Workforce	DoNMG, DoHR		The Trust has a zero tolerance approach to abuse, discrimination and unlawful restraint. The Trust has a Raising Concerns Policy and also Disciplinary Policy and Procedure in place for any staff who fail to meet the Trust's values and ACE behavioural standards. Each clinical area has a Safeguarding file with key information to ensure all suspicions are reported appropriately. Safeguarding level 1 is the minimum mandatory requirement for all staff, with level 2&3 targeted at those who require it, ie those working with children and young people and those in decision-making roles respectively. Current compliance with training is meeting the target for level 1. Awareness of Deprivation of Liberty Safeguards (DoLS) is included in induction and mandatory training. The Trust provides training in conflict resolution (Customer Service Training).	CQC inspection report highlighted that the relevant policies and procedures are in place, with robust training and support from the Safeguarding Team to ensure patients receive appropriate care. On-going action required to deliver the recovery plan for safeguarding training for levels 2&3.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Comment including any further actions to strengthen compliance if required
6	14 - Meeting nutritional and hydration needs	People who use services have adequate nutrition and hydration to maintain life and good health.	**Effective**	Quality	DoNMG		Nutrition and hydration screening tools in place (MUST) and relevant patients have food charts. There is a red tray and red jug system in place for patients who require additional support with eating and drinking. All general wards operate protected mealtimes. Patients are regularly assessed to note any changes in nutrition and hydration status. Trust rolled out the Malnutrition Universal Screening Tool (MUST) for adults to ensure compliance with NICE guidance in 2015 and this will be included in the electronic risk assessments to be introduced Spring 2017. Currently rolling out electronic fluid balance charts to support appropriate recording of hydration.	Audit of patient records, including fluid balance charts, appropriate risk assessments and resulting care plans.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Comment including any further actions to strengthen compliance if required
7	15 - Premises and equipment	Premises and equipment are clean, secure, suitable, properly used/maintained, appropriately located and able to maintain standards of hygiene. Management of hazardous/clinical waste within current legislation. Security arrangements in place to ensure staff are safe.	**Safe**	Quality	DoCS		The Trust was rated first acute Trust in the north west in 2016 for PLACE inspection. A comprehensive internal environmental audit is undertaken and reported to the Patient Experience Council. Workplace inspections and COSHH risk assessments in place.	

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Comment including any further actions to strengthen compliance if required
8	16 - Receiving and acting on complaints	All staff to know how to respond when receiving a complaint. Effective and accessible system for identifying, receiving, handling and responding to complaints, with full investigation and actions taken. Providers must monitor complaints over time looking for trends and areas of risk.	**Responsive**	Quality	DoNMG		Staff aware of how to manage complaints at a local level, including local resolution where possible, with involvement of PALS. Arrangements for responding to formal complaints within agreed timescales were reviewed in 2015 and amendments made to the system to improve timeliness of responses. Effective processes in place for logging, acknowledging and tracking complaints throughout the process in place. Themes identified and reported to Patient Experience Council and the Quality Committee.	Continue to improve response times to complainants. Strengthen the process for identifying and disseminating lessons learnt across the Trust.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Comment including any further actions to strengthen compliance if required
9	17 - Good governance	Robust assurance and auditing processes in place to drive improvement in quality and safety, health, safety and welfare of patients and staff. Effective communication system for users/staff/ regulatory bodies/ stakeholders so they know the results of reviews about the quality and safety of services and actions required.	**Well-led,** Responsive	Board	CEO		An annual Board effectiveness review is undertaken, including a review of the Board Committees and the outcomes are considered by the whole Board. MIAA review the governance arrangements within the Trust including compliance with the CQC processes. MIAA reviewed patient experience processes and found significant assurance. External Audit review the annual governance statement. The Trust complies with the NHS Publication scheme, it has an internal team briefing system in place to ensure staff are aware of the results of external reviews. Ward accreditation scheme in place (Quality Care Assessment Tool – QCAT) that is aligned to CQC standards. Three wards were presented with gold awards in 2016-17.	Assess methods of communicating to users, staff and stakeholders the outcomes of quality reviews. CQC noted that there was effective staff engagement in the development of the Trust's vision and values, which were widely understood across the organisation.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Comment including any further actions to strengthen compliance if required
10	18 - Staffing	**Sufficient numbers** of suitably qualified, competent, skilled and experienced persons deployed to meet CQC requirements.	**Safe, Effective**	Workforce Council	DoHR		Comprehensive workforce strategy in place supported by a Recruitment and Retention Strategy, including targeting workforce hotspots. There is also a comprehensive workforce performance dashboard, which enables detailed monitoring and oversight. A safer staffing report is presented every month to the Board, with a 6 monthly detailed staffing review reported to the Board including nurse establishment and patient acuity.	Review of clinical supervision delivery. CQC inspection report noted that the Trust maintains a rolling programme of nurse recruitment that meant vacancies were filled in a timely way and that where there were medical vacancies patients received prompt and appropriate care.
11	19 - Fit and proper persons employed	Staff to be of good character with appropriate qualifications, competence, skills and experience ie all staff are fit and proper – honest, trustworthy, reliable and respectful	**Well-led**	Workforce Council	DoHR		Effective procedures in place for pre-employment and on-going revalidation of relevant staff. The Trust has range of HR policies and procedures. Staff are aware of the requirement to raise any concerns about patient care and anything that may affect them personally in fulfilling their duties.	Audit recruitment policies and procedures, with all relevant checks.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Comment including any further actions to strengthen compliance if required
No FS maps to this regulation	20 - Duty of candour	Open and transparent with people who use services/people acting lawfully on their behalf. Promote culture of openness, transparency at all levels, with focus on safety to support organisational and personal learning. Actions taken to ensure bullying and harassment is tackled in relation to duty of candour.	**Safe**	Quality Committee	DoNMG		Electronic reporting system, Datix, amended to include mandatory field to confirm compliance with Duty of Candour Compliance to be included in future Serious Incident Board reports Training is provided to staff within the following training programmes: • Trust's induction. • Mandatory training • Root cause analysis training Awareness of duty of candour has also been raised with staff via team brief and presentations at large events such as nurses' day. From June 2015 all line managers trained as speak up safely champions and received a training video, which also includes their responsibilities under duty of candour. Speak in confidence launched in 2016-17 as a further route for staff to report concerns anonymously. Assistant Director of Patient Safety appointed as Freedom to Speak Up Guardian.	Increased level of duty of candour recording on Datix for moderate harms is required. CQC confirmed in their inspection report that the Trust has good systems in place to fulfil its obligations in relation to the Duty of Candour Regulations.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Comment including any further actions to strengthen compliance if required
No FS maps to this regulation	20A - Requirement as to display of performance assessments	Notify via all websites and in each premise where services are provided the latest CQC rating, including principal premises. The information is to include the CQC's website address and where the rating is to be found and for each service/premise the rating for that service/premise.	**Responsive,** Well-led	Executive	DoCS		Ratings available on internet with links to the full reports using the CQC widget. Full list of clinics and sites where services provided collated for staff to display ratings in individual clinics.	

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)031
Title of paper: Elimination of Mixed Sex Accommodation Declaration
Purpose: For discussion and Approval
Summary: All Trusts are required to declare an annual compliance with the guidance in relation to elimination of mixed sex accommodation. Should they not be in a position to do so, they may declare non-compliance however significant financial penalties may apply under such a circumstance. The annual declaration must be published on the Trust website.
Corporate objectives met or risks addressed: Safe, Effective care
Financial implications: Financial penalties apply if breaches occur
Stakeholders: All staff and external partners
Recommendation(s): For discussion and approval
Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance
Date of meeting: 29th March 2017

Eliminating Mixed Sex Accommodation Declaration

1. Background

1.1 In November 2010, the Chief Nursing Officer (CNO) and Deputy NHS Chief Executive wrote to all NHS Trusts. The letter (PL/CNO/2010/3) set out the expectations that all NHS organisations 'are expected to eliminate mixed sex accommodation, except where it is in the overall best interests of the patient, or their personal choice'. The CNO letter included detailed guidance on what was meant by 'overall best interests', including situations, for example, when a patient is admitted in a life threatening emergency.

1.2 This was followed by another letter from the Chief Nursing Officer and Deputy NHS Chief Executive in February 2011 (Gateway ref 15552) setting out expectations regarding a Declaration exercise.

1.3 Trusts are required to declare an annual compliance with the statement above. Should they not be in a position to do so, they may declare non-compliance however significant financial penalties may apply under such a circumstance.

1.4 The Trust has continued to declare annual compliance.

2. Declaration of Compliance

2.1 The Trust Board of St Helens and Knowsley Teaching Hospitals NHS Trust confirms that mixed sex accommodation has been virtually eliminated within all its hospitals, except where it is in the overall best interest of the patient, or reflects their personal choice.

2.2 We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen by exception based on clinical need. (Example, where patients need specialist equipment such as in critical care areas).

2.3 Sleeping accommodation does not include areas where patients have not been admitted, such as accident and emergency (A&E) cubicles.

2.4 If our care should fall short of the required standard, the Trust will report it. St Helens and Knowsley Teaching Hospitals NHS Trust have assurance mechanisms in place to monitor compliance, the management structure to manage any breaches and the desire to ensure we are communicating to patients and the public that we are delivering our commitment to eliminating mixed sex accommodation.

3. Data collection and performance

3.1 2016/17 year to date there has been zero breaches reported via Unify.

3.2 Financial penalties apply to all non-clinical breaches. This is defined as £250 per person that the breach applies to. (for example 4 bedded bay 1 female and 3 male = 4 breaches).

4. Current Situation

4.1 Gender mixing only occurs within critical care units and the emergency department. This is in line with the overall best interests criteria stated by the CNO.

4.2 All adult in-patient wards are either single sex, or where they are mixed sex, areas within the ward are designated as male or female, with separate designated toilets and bathrooms. Where admissions and transfers may potentially cause a mixed sex breach ward teams move patients to prevent this occurrence.

4.3 Children, young people and their parents will be asked at time of admission if they wish to be cared for with others of a similar age in a single sex bay or in a single room. The preference chosen will be used as the basis upon which to decide where to place a child or young person in our children's wards.

4.4 Any changes to the environment include risk assessment to ensure the mixed sex is not breached.

4.5 The Trust Elimination of Mixed Sex Accommodation policy has been reviewed and is available on the Trust website.

5. Patient experience

5.1 Year to date there have been no complaints specifically about breaches of single sex accommodation.

Recommendation

The Trust Board is asked to approve the declaration of compliance, for it to be published on Trust website and to enable the Trust to declare compliance to NHSE.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)032
Title of paper: 2016 NHS Staff Survey Trust Board Report
Purpose: To provide the Trust Board with an overview of the outcomes of the Staff Survey for 2016 and recommended actions.
Summary: This paper highlights the outcome from the 2016 staff survey which is overwhelmingly positive and places the Trust in the top 20% of acute trusts nationally for 24 of the 32 key findings. The level of violence and aggression still remains an area of concern as do the results for the quantity of appraisals and quality of non-mandatory training. These will be addressed as part of the 2017-18 staff engagement action plan.
Corporate objectives met or risks addressed: Developing Organisational Culture and supporting our workforce, Safety, Communication
Financial implications: No new financial requirements from this paper
Stakeholders: Staff, Staff Side colleagues, Service users, Line Managers, Staff Side, Service users, CCG, CQC.
Recommendation(s): Members are asked to approve: The Board is requested to note the outcomes and accept for progression into a detailed milestone plan interventions to address the proposed actions.
Presenting officer: Anne-Marie Stretch, Director of HR & Deputy CEO
Date of meeting: 29th March 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

2016 NHS Staff Survey Report

1. INTRODUCTION

316 NHS organisations in England took part in the 2016 NHS Staff Survey. Over 982,000 NHS staff were invited to participate using an online or postal self-completion questionnaire. Responses were received from over 423,000 NHS staff, a response rate of 44% (41% in 2015). Full-time and part-time staff who were directly employed by an NHS organisation on September 1st 2016 were eligible. Fieldwork for the survey was carried out between late September and early December 2016.

The questionnaire used for the 2016 survey was unchanged from 2015. There have, however, been some minor changes to the Key Findings for 2016. The names of the following 2 Key Findings (KF) have been amended to more accurately reflect what they are measuring.

- KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months.
- KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves.

In addition, the calculations for KF24, percentage of staff/ colleagues reporting most recent experience of violence and KF27, percentage of staff/ colleagues reporting most recent experience of harassment, bullying or abuse, have been updated to bring them in line with how other, similar, Key Findings are calculated. This report contains recalculated historical data for Key Findings 24 and 27 so that comparisons can be made across years. Due to this, 2016 results for these two Key Findings are not comparable with data that was published in previous years. Details of each of these changes can be found in the explanatory document, 'Making Sense of your Staff Survey Data' document available at www.nhsstaffsurveys.com .

Between October and December 2016 St Helens and Knowsley Teaching Hospitals NHS Trust (STHK/ the Trust) took part in the Survey, the results of which were published nationally on 7th March 2017.

The survey, administered on our behalf by Quality Health, was completed by a sample of staff determined by the total number of staff employed on a national sliding scale. The sample was generated at random from all those employed on 1st September 2016 and included those on maternity leave. The official sample size for the Trust was 1250. A 50% increase on the sample used in 2015.

The data generated from this sample is for the purposes of the Care Quality Commission(CQC) monitoring assessments, and is also used by other NHS bodies such as the Department of Health.

Questionnaires were distributed to staff by hand through the network of Staff Survey Champions. Staff responded by using a pre-paid response envelope provided by the contractor. Two reminders were sent; a first reminder letter, and a further mailing which included a repeat questionnaire.

This report provides an overview of all the conclusions arising from the survey into an Executive Summary.

Detailed results will be available on the Trust Intranet Staff Survey pages, with a breakdown of the responses to each question available from the following site;

http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2016-Results/

2. QUESTIONNAIRE CONTENT

The questionnaire content is agreed nationally after extensive consultation between the CQC, the Department of Health, and the Survey Advice Centre, responsible for coordinating the Staff Survey.

The feedback reports, published by the Survey Advice Centre, map the response to individual questions to “Key Findings”.

As in previous years, there are two types of Key Finding (KF):

- **Percentage scores:** i.e. percentage of staff giving a particular response to one, or a series of survey questions.
- **Scale summary scores:** calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5.

In a change to the previous staff survey reports which were structured around the pledges of the NHS Constitution, the 2016 survey has been structured thematically so that Key Findings are grouped appropriately into the following nine themes:

• Appraisals & support for development

• Equality & diversity

• Errors & incidents

• Health and wellbeing

• Working patterns

• Job satisfaction

• Managers

• Patient care & experience

• Violence, harassment & bullying

In this report, the results of the questionnaire have been summarised and presented in the form of 32 Key Findings (Appendix 1).

3. RESPONSE RATE

3.1 Local

686 completed questionnaires were returned from this sample. The response rate to the Staff Survey was therefore **55%** (686 usable responses from a final sample of 1,238).

3.2 National

The overall national response rate for Acute Trusts in England was 43%. 12% less than that of St. Helens & Knowsley Teaching Hospitals.

3.3 Respondent Demographics

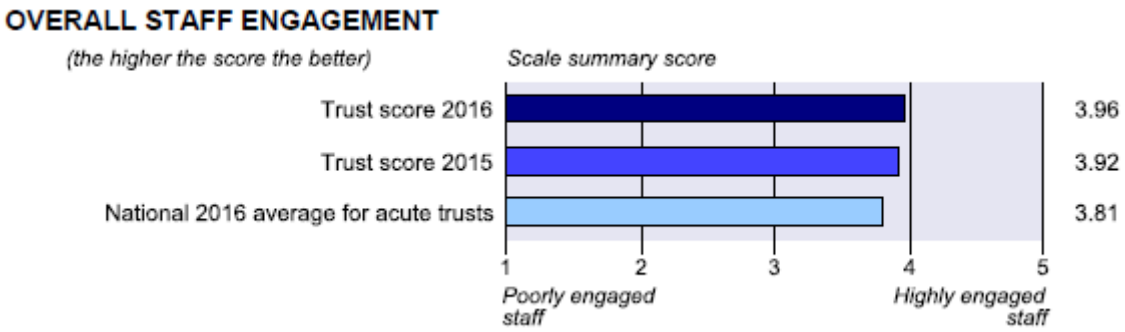
The 686 respondents comprised the following groups;

Ethnicity	%	Age	%
White	93	66+	3
Mixed	1	51-65	41
Asian/Asian British	5	41-50	27
Black/ Black British	1	31-40	17
Chinese and other ethnic groups	1	21-30	12
		16-20	0
Length of Service	**%**	**Occupational Group**	**%**
More than 15 years	34	AHP, Scientist, Technical	19
11-15 years	20	Medical & Dental	6
6-10 years	16	Nurses & Midwives	24
3-5 years	13	Healthcare Assistants	12
1-2 years	11	Wider Healthcare Team	36
Less than 1 year	6	General Management	3

4.0 RESULTS

4.1 Overall Staff Engagement

The figure below shows how the Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating poorly engaged staff (with their work, their team and their trust) and 5 indicating a highly engaged workforce. The Trust's score of **3.96** was in the **highest (best) 20%** when compared with trusts of a similar type nationally and places the Trust **best** in the Northwest.



The most notable contributory response to this overall indicator of staff engagement is the 'Staff Friends and Family test question, " Staff members' willingness to recommend the Trust as a place to work or receive treatment" (KF1), for which the Trust again returned a score in the **best 20%** of acute hospitals nationally and **best** in the Northwest.

Other contributory responses to this measure include KF4. 'Staff motivation at work (the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs)' having a score in the **best 20%** of acute hospitals nationally and KF7. Staff ability to contribute towards improvements at work (the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work) which improved from the 2015 score and is now above the national average.

4.2 Patient Focus

85% of staff agreed that care of patients / service users is the organisation's top priority.

With an increase of 2% on the 2015 survey score, this is well above the national average of 76% and compares well with all other similar acute trusts where STHK is in the top 4% of acute trusts nationally. Further underlining the Trusts commitment to placing the patient at the centre of all we do.

4.3 Key Findings

The Trusts' results for a significant number of the Key Findings have maintained the improvements made in the previous 2 year's surveys (Appendix 2).

Of the 32 Key Findings, 3 have shown a statistically significant change;

- KF16. Staff working extra hours.
- KF25. The percentage of staff reporting most recent incidence of violence and aggression.
- KF14. Staff satisfaction with resourcing and support

For all of these, the Trust is now in the best 20% of acute trusts nationally, a significant positive shift from 2015.

Twenty four of the 32 Key Findings have a score in the best 20% of acute trusts nationally (Appendix 1). Details of the changes for all Key Findings are provided in Appendix 2, with the most notable responses set out in the following tables.

Key Finding	Scores out of 5		
	STHK	National Average	Best
KF1. Staff recommendation of the organisation as a place to work or receive treatment	4.03	3.76	4.10
KF2. Staff satisfaction with the quality of work and patient care they are able to deliver	4.26	3.95	4.26
KF4. Staff motivation at work	4.02	3.94	4.07
KF5. Recognition and value of staff by managers and the organisation	3.65	3.45	3.67
KF8. Staff satisfaction with level of responsibility and involvement	4.06	3.92	4.06
KF10. Support from immediate managers	3.89	3.73	3.92
KF12. Quality of appraisals	3.28	3.11	3.49
KF19. Organisation and management interest in and action on health /wellbeing	3.93	3.61	3.93
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.88	3.72	3.89
KF31. Staff confidence and security in reporting unsafe clinical practice	3.77	3.65	3.88

KF32. Effective use of patient / service user feedback	3.87	3.70	3.95

Key Finding	%		
	STHK	National Average	Best
KF3. % agreeing that their role makes a difference to patients / service users	94	90	94
KF5. % staff reporting good communication between senior management and staff	42	33	46
KF17. % suffering work related stress in last 12 months	25	35	25
KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	22	28	19
KF20. % staff experiencing discrimination at work in the last 12 months	8	11	5
KF21. % believing the organisation provides equal opportunities for career progression / promotion	92	87	95
KF29. % reporting errors, near misses or incidents witnessed in the last month	94	90	95

Work from the 2015 survey action plan focussing on communication, eliminating discrimination, improving equality of access to career development and improvements to the quality of staff appraisals has led to significant shifts in responses for the following Key Findings which now place the Trust in the **best 20%** of acute hospitals nationally for these measures.

- KF 20. The percentage of staff stating they had experienced discrimination at work in the last 12 months.
- KF21. The percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.
- KF6. The percentage of staff reporting good communication between senior management and staff.
- KF 12. The quality of appraisals.

4.4 Whilst the overwhelming majority of responses are positive, there are 3 areas for which the results are not as positive as we would wish. Areas of note are:

- KF13. Quality of non-mandatory training and development which has seen a reduction by 0.08 points to 4.04.
- KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months – at 18% this is 3% worse than the national average and 10% higher than the best acute trust.
- KF23. Percentage of staff experiencing physical violence from staff in last 12 months – Despite work in the previous action plan, this has remained unchanged at 3%. 1% above the national average and 3% higher than the best acute trust nationally.
- KF11. Percentage of staff appraised in the last twelve months. This has remained unchanged since the 2015 survey at 87% and although equal to the average for acute trusts nationally, is significantly behind the best acute score of 95%.

5.0 CONCLUSIONS AND RECOMMENDATIONS

The Trust has continued to work hard over the last 12 months in the delivery of the 2016-17 staff survey action plan and to engage with, support and develop its workforce and would like to recognise the progress made in what continues to be an extremely challenging operational environment.

Our staff continue to be our most vital resource and we will use the results from the Survey to continuously improve staff experience and service to our patients.

Appendix 3 details the suggested action points, based on those areas where the Trust has responded less favourably to other acute trusts or where performance is not what we would aspire to. The headline areas recommended for the Board to keep under close review throughout the year are highlighted below and progress will be monitored monthly as part of the combined workforce report through the Workforce Council. Whilst some of the areas of focus are consistent with those from the previous survey results it should be recognised that progress has been made with the Trust improving its overall standing across a wide range of measures.

5.1 Publicising the results

Results will be presented to staff and managers by Quality Health on 3rd May 2017, it is important that staff see the benefits of participating in this survey and are aware both of the outcomes from the Staff Survey and the resultant actions. In support of this, with the support of the Media and Communications team, the results of the staff survey will be publicised through all available channels including:

- Display presentations in appropriate locations on St Helens & Whiston Hospital sites.
- The management and full reports to be uploaded and available on the Intranet.
- Copies to Clinical Governance teams and to Divisional and Departmental Heads.
- Summary of findings at Team Brief.
- Summary with links to full report on Global emails.
- Copies to the local Staff Side representatives.
- Circulation to the Valuing Our People Steering Group.

Reporting to staff on the outcomes of the survey, and telling staff what has been done about key issues arising from it is a major help in maximising response rates at the next survey and significantly improves the credibility of the process.

6.0 ACTION REQUIRED BY THE BOARD

The Trust Board are asked to note the content of this report and to approve and support the recommendations. Actions to address the limited areas of concern will be incorporated into the Combined Workforce Action Plan for 2017-18. This will be monitored by the Workforce Council and assurance of delivery will be provided to the Quality Committee as part of the Board Governance Assurance Framework.

APPENDIX 1
Comparison of all Key Findings for St Helens & Knowsley Teaching Hospitals

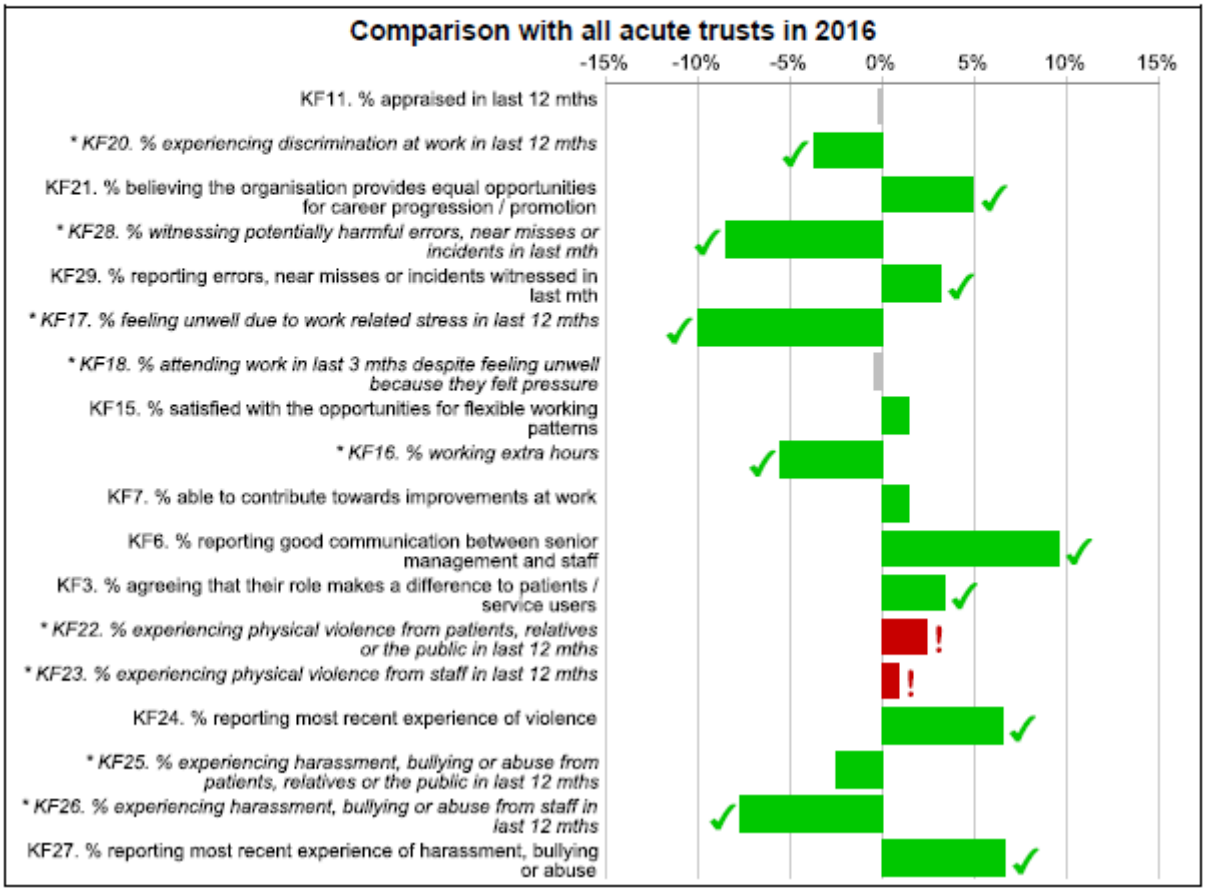
KEY

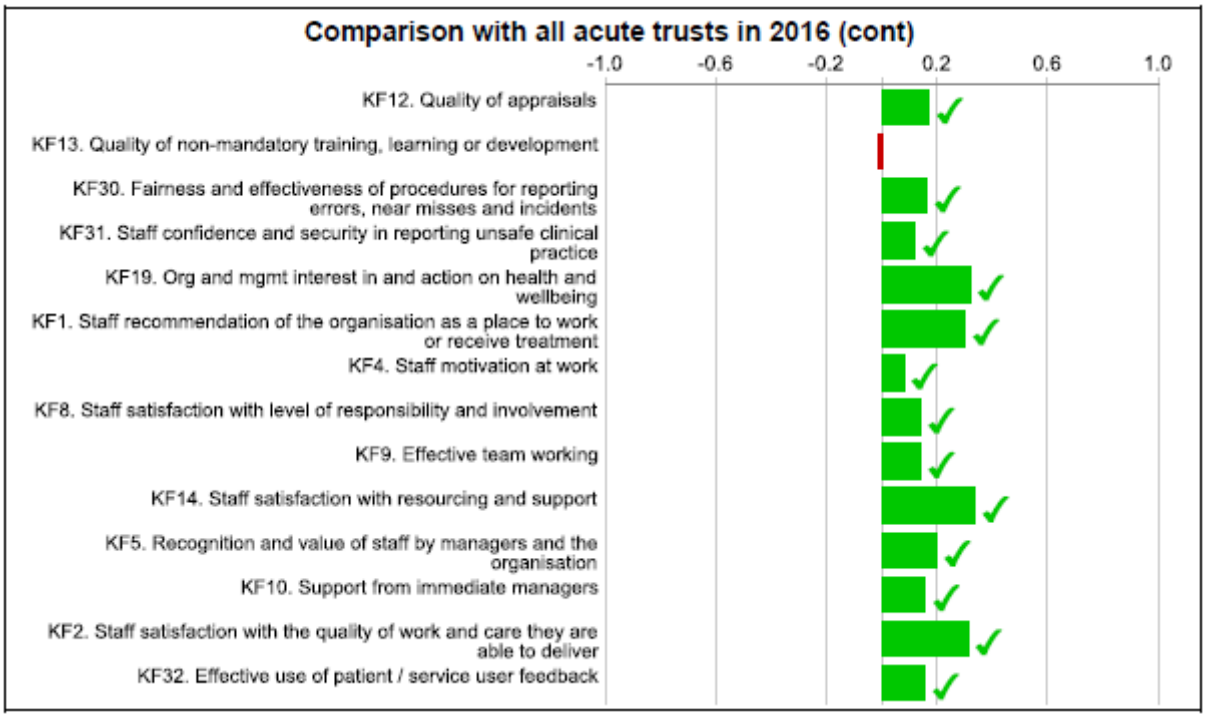
Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, i.e. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.





APPENDIX 2
Summary of all Key Findings for St Helens & Knowsley Teaching Hospitals

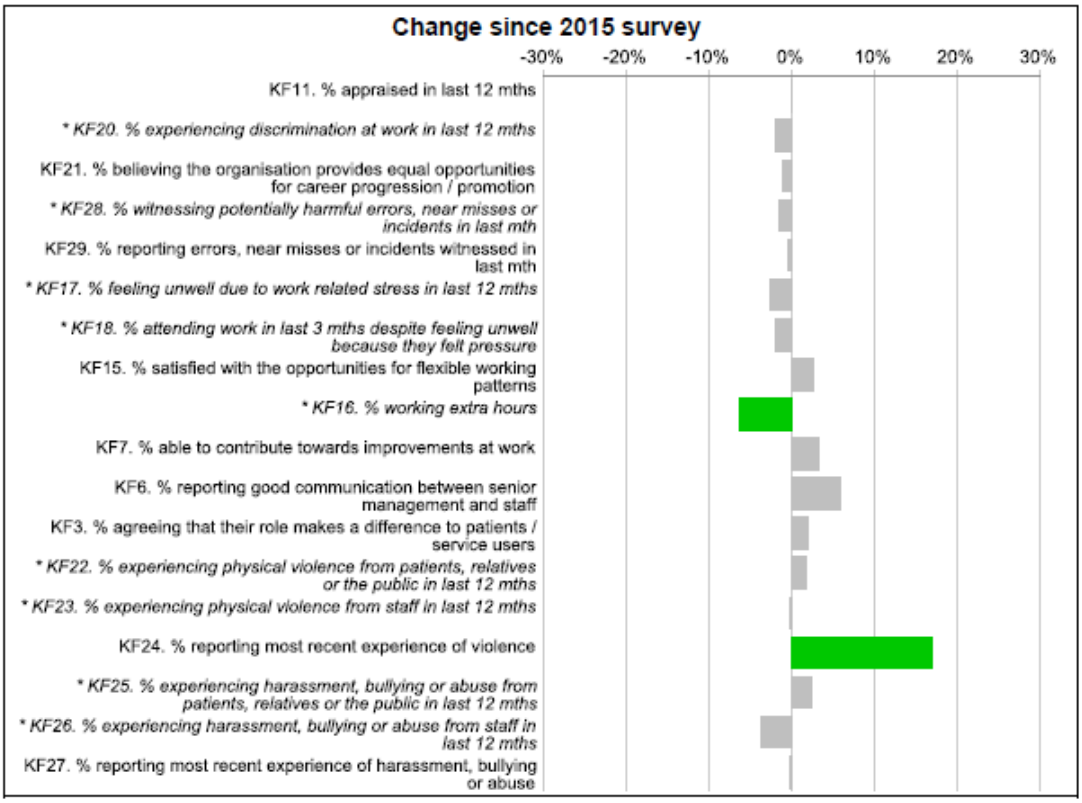
KEY

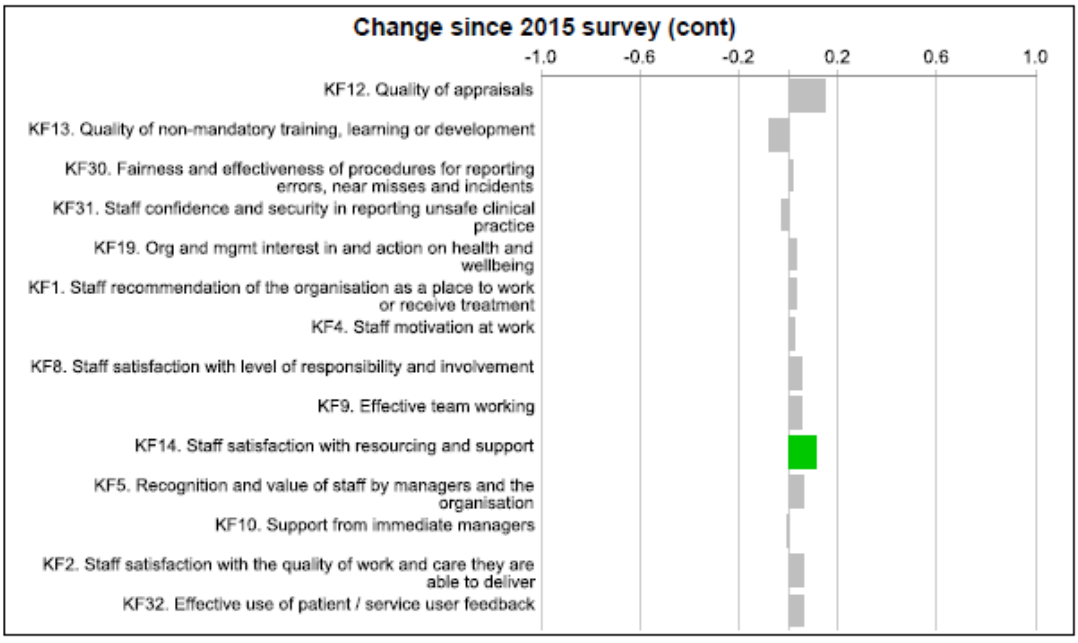
Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2015 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2015 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2015 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.





Staff Survey Recommended Actions 2017-2018

Theme	Recommendation	Intervention	Lead	Anticipated deadline
Violence, harassment & bullying	KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	Implement targeted and measurable solutions to support and protect staff based on staff survey results and deep dive analysis carried out during 2016/17.	Carole Whewell – Head of Non-Clinical Risk Management	June 2017
	KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months	Implement targeted and measurable solutions to support and protect staff based on staff survey results and deep dive analysis carried out during 2016/17	Carole Whewell – Head of Non-Clinical Risk Management	June 2017
Job satisfaction	KEY FINDING 7. Percentage of staff able to contribute towards improvements at work	Work with managers in those areas highlighted in the survey to establish systems that encourage staff to contribute to developments at work	Janet Stanton – Head of Leadership and OD	September 2017
Appraisals & support for development	KEY FINDING 11. Percentage of staff appraised in the last twelve months.	Work with managers in those areas that have lower than expected appraisal rates to establish systems that encourage timely completion of staff appraisals.	Janet Stanton – Head of Leadership and OD	June 2017
	KEY FINDING 13. Quality of non-mandatory training and	Ensure robust talent management and associated development opportunities linked to service need and patient care.		August 2017

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)033

Title of paper: Trust Objectives.

Purpose: To advise Trust Board members of the proposed Trust Objectives for the financial year 2017/18.

Summary:

1. Each year in March, the Executive Directors review the Trust's objectives taking into account the national and local healthcare landscape, and the Trust's own strategic and operational plans.
2. The Board then reviews the resulting proposals from the Chief Executive for the coming year's objectives.
3. Subject to approval at the March meeting of the Board (and embracing any agreed modifications), the objectives are then launched at the annual Start of Year Conference for Trust Senior Managers, planned this year for 24th April 2017.
4. These objectives are then flowed-down through the management structure into the personal goals for each individual member of staff.
5. The proposed objectives follow the format of the previous year, comprising five key objectives linked directly to patient care, and four associated and supporting objectives.
6. Performance against 2016/17 objectives will be finalised in April 2016 and a report summarising this information will then be provided to the May Board meeting.

Corporate objective met or risk addressed: Contributes to the Trust's Governance arrangements, and its short and longer-term plans.

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff and all stakeholders.

Recommendation(s): The Board are asked to:

1. Consider and approve the proposed Trust Objectives for 2017/18 for launching throughout the Trust.
2. Note that performance against 2016/17 objectives will be formally presented to the May Board meeting.

Presenting officer: Ann Marr, Chief Executive.

Date of meeting: 29th March 2017.

PROPOSED 2017/18 TRUST OBJECTIVES

ACTIONS	ASSESSMENT	ASSURANCE MECHANISM
5 STAR PATIENT CARE - Care		
We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families		
1. Improve the patient experience, based on the national inpatient survey, and national cancer survey results 2016/17 2. Review the key performance indicators (KPIs) outlined in the nursing strategy by September 2017 and where appropriate set revised targets 3. Make suitable progress towards implementation of the four key 7-day service standards 4. Improve the timeliness of patient discharges and transfers and the patient experience 5. Promote cost-effective and sustainable stroke services, and work towards full integration of acute stroke services with Warrington Hospital 6. All specialist nurses will dedicate time to support education and ward based training 7. Roll out and embed "Johns Campaign" to 50% of inpatient wards	• Nursing indicators • Audit results • CQC registration requirements • Ward dashboard scores • Survey results	• Reports from Quality Committee and Councils • Audit Committee • Overview of quality improvement in the annual Quality Report • Quality Accounts • Quality ward rounds

5 STAR PATIENT CARE - Safety		
We will embed a culture of safety improvement that reduces harm, improves outcomes and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care		
1. Fully utilise the "sign-up for safety" indicators to improve safety and clinical outcomes: • Zero tolerance on never events, MRSAb and Grade 3 pressure ulcers • 5% reduction in avoidable blood stream infections and falls 2. Further embed the 72-hour review of incidents to ensure lessons are learnt and actioned 3. Maintain in-hospital mortality below the north west average and aim for less than the national average 4. Continue to close the gap between in-hospital mortality for weekend and weekday admissions 5. Create new system for learning from hospital deaths 6. Explore incidents, complaints, and claims to identify areas for improvement, learning and for safeguarding patients in our care 7. Develop robust systems for effective venous thromboembolism screening	• Mortality indicators • National Safety Thermometer - Harm-free Care • National Serious Incident reports • National Safety Thermometer • National Safety Reporting • DATIX incident reporting system • Dr Foster Intelligence	• Integrated Performance Report (IPR) • Quality Committee and its Councils • Mortality Surveillance Group • Finance & Performance Committee and its Councils • Audit Committee

8. Further improve prescribing and administration of medicines and improve error reporting supported by successful implementation of e-prescribing 9. Ensure practices are appropriate to achieve the national targets for improvements in the treatment of Acute Kidney Injury and Sepsis		

5 STAR PATIENT CARE - Pathways		
As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient		
1. Use benchmarking data intelligence to reduce variation and improve outcomes 2. Embed the ambulatory emergency care pathways to reduce non-elective admissions 3. Introduce a new midwifery-led care pathway for women having low risk births 4. Work closely with CCG colleagues to advance emergency access performance in line with the agreed improvement trajectory 5. Work collaboratively with neighbouring health and social care partners to improve patient care, and simplify the patient journey, for example frailty pathways and discharge to assess 6. Achieve the planned benefits from managing adult community services in St Helens	• New pathways in place • Reduced avoidable admissions and readmissions • Reduced unnecessary delays in the discharge pathway	• Activity reports to Board • Improving Outcomes Group • Clinical Effectiveness Council • IPR

5 STAR PATIENT CARE - Communication		
We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services		
1. Continue to improve response rates and outcomes from the Friends & Family Test (FFT) 2. Improve the timeliness of responding to complaints and explore themes to enable lessons to be learned leading to changes in practices 3. Improve patient information and communications via the Website and other social media channels, as well as more traditional routes 4. Implement and monitor the revised system for using patient stories to learn lessons and share best practice 5. Improve opportunities for communications with patients and relatives, to support their experiences and to help the Trust plan future service developments	• Patient survey results • Complaints monitoring • Availability of appropriate information leaflets	• Patient stories presented to Board meetings • Survey results presented to Board • Complaints summaries • Information from Quality Ward Rounds • Patient Experience Council

5 STAR PATIENT CARE - Systems		
We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes		
1. Maintain the national data quality standards stipulated in the IG toolkit 2. Continue to implement the next phase of IT systems including: a clinical portal, e-prescribing, theatre system and replacement Patient Administration System (PAS) 3. Finalise the 3-year IM&T Strategy to support clinical transformation 4. Ensure the implementation of PAS and other key IT systems does not compromise contractual or operational performance	• Improved electronic records • Reduced length of stay and earlier discharge • NICE guideline compliance	• Exception reports to Board and Executive Committee • Benefits realisation reports to Executive Committee • IG Steering Group • Scheme specific Project Boards

DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE		
We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce that feel valued and supported to care for our patients.		
1. Re-launch the Trusts Freedom to Speak Up campaign, empowering staff to raise concerns 2. Develop new approaches to celebrate innovation to further enhance public and staff engagement 3. Continue to raise the profile of the Trust's ACE Behavioural Standards and support staff against violence an aggression 4. Implement department level organisation development plans 5. Maintain positive staff survey and FFT outcomes and develop the Workforce Race Equality and Disability Standards 6. Identify creative approaches to recruitment and retention to ensure the Trust remains an employer of choice 7. Achieve the planned benefits from e-rostering including aligning staff to patient acuity 8. Ensure safe staffing levels are maintained, whilst adhering to guidance for agency usage caps 9. Continue delivering core HCA competencies and enable new starters to achieve care certificates 10. Optimise the opportunities offered by the Apprenticeship Levy with innovative approaches to new roles & higher level qualifications	• Training statistics • Appraisal rates • Staff feedback • Culture surveys • Staff Friends & Family test • Turnover rates • Sickness rates • Agency, bank and overtime usage • E-rostering utilisation • E-job planning utilisation • HR Dashboard • Incident reports • Respect at work, disciplinary and grievance cases	• Quality Committee • Workforce Council • Finance & Performance Committee • IPR • Equality & Diversity Steering Group

OPERATIONAL PERFORMANCE		
We will meet and sustain national and local performance standards		
1. Achieve national performance indicators including: a. The agreed trajectory for emergency access standards b. Cancer treatment standards c. 18 week access to treatment for planned care d. Diagnostic tests completed within 6 weeks e. Ambulance handover 2. Achieve local performance indicators including: a. CQUINS b. Contract performance indicators and compliance c. Activity levels to meet Trust operational plans.	• Performance against National Operating Framework targets • Benchmark information	• Reports to Executive Committee • Reports to Trust Board

FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY		
We will achieve statutory and other financial duties set by Regulators within a robust financial governance framework, delivering improved productivity and value for money		
1. Achieve the financial control total agreed with NHS Improvement (NHSI) 2. Continue to refine service and patient level information reporting to support decision making at organisational and service level 3. Manage the Trust's capital programme within the resources available 4. Develop capacity and demand modelling capability at divisional and departmental levels 5. Use available benchmarking data to assess performance and where appropriate underpin service transformation initiatives 6. Review the financial systems, processes and controls to enhance effective financial governance 7. Pursue an increase in Trust charitable funds to support development initiatives, whilst promoting community and staff engagement.	• BCBV indicators • Monitoring of performance against targets • Audit reporting • Productivity information • Benchmarking • Business Cases • Lord Carter Report targets • NHSI benchmarking tool • Purchasing Price Index Benchmarking	• Reports to Board on operational and financial performance • Reports from Finance Committee and Councils, and monitoring by the Audit Committee • Reports to the Executive Committee

STRATEGIC PLANS		
We will work closely with NHS Improvement, and commissioning, local authority and provider partners to develop proposals to improve the clinical and financial sustainability of services		
1. Meet all the compliance requirements set by NHSI for long-term sustainability of clinical services 2. Foster positive working relationships with health economy partners and help create the joint 5-year strategic vision for health services, incorporating patient pathway improvements from sharing patient information 3. Continue to deliver the Communication and Engagement Strategy to ensure that staff, patients and visitors are kept informed of the Trust's future plans.	• Progress against agreed trajectory and milestones • 5-year Forward View • Successful system-wide contract negotiations	• Reports to Trust Board • Monthly Strategic Delivery Governance Council • Monthly Integrated Delivery Meeting • Regional and National transformation events

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)034
Title of paper: DoH Temporary Loan Facility
Purpose: For the Trust Board to ratify the Temporary Loan Facility taken out in March 2017
Summary: Initial planning guidance provided by NHSI stated that organisations should plan for receipt of Quarter 3 and 4 Sustainability and Transformation funding before 2016/17 year-end. Recent guidance by NHSI has now advised organisations to plan for receiving Quarter 4 funding after 31st March 2017 as it could not be guaranteed that the funding would be distributed before then. As a result, the Trust has had to take out a temporary loan for £2.525m which will be paid back on receipt of the funding. Due to the DoH timescales for processing the loan, the Chief Executive approved the application on behalf of the Board and this decision needs to be ratified by the Trust Board. The loan has since been approved by the DoH and £2.525m was received by the Trust on 13th March 2017. Please note that the Trust's new temporary loan carries an interest rate of 1.5% and not the previous loan agreement rate of 3.5%. The Board Resolution Letter is included as Appendix 1 to this paper.
Corporate objectives met or risks addressed: Finance and Performance duties
Financial implications: The loan incurs interest at 1.5%, but will be repaid as soon as the Q4 STF funding is received.
Stakeholders: Trust Board Members, NHSI, DoH
Recommendation(s): Members are asked to ratify the temporary loan facility approval.
Presenting officer: Nik Khashu Director of Finance and Information
Date of meeting: 29th March 2017