St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

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

A G E N D A				Paper	Presenter
09:30	1.	Employee of the Month			Richard Fraser
		1.2	October		
		1.3	November		
09:40	2.	Patient story			Sue Redfern
10:00	3.	Apologies for Absence			Richard Fraser
	4.	Declaration of Interests			
	5.	Minutes of the previous Meeting held on 25th October 2017		Attached	
		5.1	Correct record & Matters Arising		
		5.2	Action list	Attached	
Performance Reports					
10:10	6.	Integrated Performance Report		NHST(17) 097	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
Committee Assurance Reports					
10.30	7.	Committee report – Executive		NHST(17) 098	Ann Marr
10:40	8.	Committee Report – Quality		NHST(17) 099	George Marcall

10:50	9.	Committee Report – Finance & Performance	NHST(17) 100	Denis Mahony
11:00	10.	Committee Report – Charitable Funds	NHST(17) 101	George Marcall
BREAK				
Other Board Reports				
11:15	11.	Strategic & regulatory report	NHST(17) 102	Nicola Bunce
11:20	12.	Research & Development annual capability statement	NHST(17) 103	Kevin Hardy
11:25	13.	Review of compliance with NHS Constitution	NHST(17) 104	Nicola Bunce
11:35	14.	Trust Board meeting arrangements	NHST(17) 105	Nicola Bunce
11:40	15.	Trust objectives – review of current year	NHST(17) 106	Ann Marr
11:50	16.	Guardian of Safe Working reports		
		16.1 STHK Guardian report	NHST(17) 107	Mike Chadwick
		16.2 Lead Employer Guardian report	NHST(17) 108	
Closing Business				
12:05	17.	Effectiveness of meeting		Richard Fraser
	18.	Any other business		
	19.	Date of next Public Board meeting – Wednesday 31st January 2018		
LUNCH				

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

PUBLIC BOARD

Chair:	Mr R Fraser (RF)	Chairman
Members:	Ms A Marr (AM)	Chief Executive
	Mrs A-M Stretch (AMS)	Deputy Chief Executive/Director of HR
	Mrs C Walters (CW)	Director of Informatics
	Prof D Graham (DG)	Non-Executive Director
	Mr D Mahony (DM)	Non-Executive Director
	Mr G Marcall (GM)	Non-Executive Director
	Mr J Kozer (JK)	Non-Executive Director
	Prof K Hardy (KH)	Medical Director
	Ms N Bunce (NB)	Interim Director of Corporate Services
	Mr N Khashu (NK)	Director of Finance
	Mr P Williams (PW)	Director of Facilities Management/Estates
	Ms S Rai (SR)	Non-Executive Director
	Mrs S Redfern (SRe)	Director of Nursing, Midwifery & Governance
	Dr T Hemming (TH)	Director of Transformation
	Mrs V Davies (VD)	Non-Executive Director
Apologies:	Cllr G Philbin	Halton Council
	Mr R Cooper	Director of Operations & Performance
	Mr T Foy	St Helens CCG
In Attendance:	Mr R Little (RL)	Account Director, Liaison (observer)
	Mrs K Pryde	Executive Assistant (Minutes)

1. Employee of the Month

The award for Employee of the Month for September 2017 was presented to Lesley Carr, Assistant Practitioner, Ward 1B.

2. Apologies for Absence

2.1. Apologies were noted.

3. Declaration of Interests

3.1. None received.

4. Minutes of the previous meeting held on 27th September 2017

4.1. Correct Record and Matters Arising

4.1.1. Following removal of "KH confirmed that PHE had given this assurance" from paragraph 8.6, the minutes were approved as a correct record.

4.2. **Matters Arising**

4.2.1. Paragraph 8.5: Safeguarding training. KH confirmed that having written to all doctors, this is being tracked weekly, but can only be reported monthly. KH was also concerned that the ESR was not entirely accurate. AMS agreed to look into this.

4.2.2. Paragraph 8.5: Flu vaccinations. KH had sought further information regarding this year's vaccines effectiveness against new strains of flu. AMS clarified that the key message to staff regarding the importance of being vaccinated and protecting yourself, your family and patients was not changed. . SRe advised that NHSE have issued new guidance and the Trust will need to demonstrate that all staff have been offered the vaccine and record those that decide the decline.

4.3. **Action List**

4.3.1. Action 1. Minute 7.6 (31.05.17): Complaints, Claims & Incidents – context and data. Will be included in the next quarterly report to the Quality Committee. Action closed.

4.3.2. Action 2. Minute 7.8.2 (31.05.17): Relatives attendance at discussions regarding patient care plans. SRe has spoken to ward managers and matrons. Bedside handovers in the Medical Care Group are being trialled. Afternoon surgeries are also being held to discuss patient care plans, although patient consent must be obtained before such discussions take place. Action closed.

4.3.3. Action 3. Minute 7.8 (28.06.17): Board development agenda. The proposed plan has been circulated. Action closed.

4.3.4. Action 4. Minute 11.7 (26.07.17: High mortality in COPD. Agenda item. Action closed.

5. IPR – NHST(17)088

5.1. Quality Indicators

5.1.1. SRe provided an update on performance against the Quality Indicators.

5.1.2. There were no never events in September and zero cases in the year to date.

5.1.3. There were no MRSA bacteraemia cases in September. The positive sample in July has been submitted to NHSE for 3rd party appeal, with a summary of further evidence to support the appeal.

Unfortunately, there has been a case of MRSA on Ward 1A during October, which will be formally reported next month. The rapid

review has been completed and the full RCA will take place on 1st November.

5.1.4. There were 4 C.Diff positive cases in September. The total number of positive cases year to date is 19. There are two cases that will be appealed at the December panel.

5.1.5. There were no grade 3 or 4 pressure ulcers in September and 0 cases year to date (YTD).

5.1.6. The overall registered nurse/midwife Safer Staffing fill rate for August was 93.2%.

5.1.7. During the month of August there were no inpatient falls resulting in severe harm.

5.1.8. VTE performance for August was 93.57%, which remains below target. There was concern that performance was not improving and it was confirmed that KH was in the process of identifying options and would develop an action plan that would be monitored by the Executive Committee.

5.1.9. Provisional HSMR is 102.4

5.2. Operational Indicators

5.2.1. NK provided an update on the Operational Performance, in the absence of RC.

5.2.2. Performance against the 62 day cancer standard was 85.8% in August. Close monitoring of individual patient pathways continues and areas requiring improvement are being addressed through tumour specific action plans.

5.2.3. A&E performance was 82.9% (type 1) and 89.0% (type 1 & 3). The key actions for continued recovery of this position are being driven forward by the senior leaders across the organisation, focusing on both the Emergency Department and the inpatient wards.

5.2.4. RTT incomplete performance was achieved in month (92.8%). Specialty level actions to address this continue, including targeted backlog clearance plans.

5.2.5. VD enquired as to the particular issue with head and neck cancer waits. KH said there are two issues; firstly the clinical pathway is complex and secondly there is a long delay of patients being transferred and accepted by to Aintree Hospitals (the head and neck cancer centre) which resulted in the breaches. AM will escalate the Boards concerns to the CEO at Aintree Hospitals NHSFT.

5.3. Financial Indicators

5.3.1. NK provided an update of the Trust's financial position. For the month of September (month 6), the Trust is reporting an overall Income & Expenditure surplus of £3.67m, which is in line with the YTD profiled plan. Overall Trust income is £183.0m, which is also in line with plan. Clinical income is behind plan by £1.4m, which is offset by an over performance on non-clinical income by £1.3m.

5.3.2. Trust operating expenditure is £167.2m, which exceeded plan by £0.1m. Clinical supplies are £1.2m above plan which is partly offset by the additional non clinical income and pay is £3.2m higher than plan and this is offset by a £4.5m underspend against other costs. Pay control and monitoring is reviewed at the Premium Payments Scrutiny Council.

5.3.3. As discussed at the F&P Committee in some detail it was reported that the Trust is developing a recovery plan which includes productivity opportunities and robust cost control programmes for the remaining period of this year.

5.3.4. The Trust has delivered £5.8m of CIPs, and is £(0.8)m behind the YTD plan which is reflected in the Trust's overspend on expenditure.

5.3.5. The Trust's cash balance at the end of September was £3.4m, representing 4 days of operating expenses. The Trust has incurred £4.4m of capital expenditure in the six months to September.

5.3.6. Board members discussed cash reserves, pay budgets, activity and the financial risks the Trust was managing.

5.3.7. NK reported that there are signs of other NHS organisations not paying bills on time to ease their own cash positions. Payments should be received on 15th of the month, but the Trust is now seeing organisations paying anytime between 15th and the end of the month. NK has written to all debtors and if there is no improvement within the month, he will escalate the issue to NHSI, who have already been briefed.

5.3.8. AMS reiterated that from a lead employer perspective, the Post Graduate Dean has offered support with any organisations that are not paying on time.

5.4. Workforce Indicators

5.4.1. AMS provided an overview of the Workforce Indicators.

5.4.2. Absence in September has decreased to 4.9% from 4.3%. YTD absence is 4.2% which is 0.60% below the 2016-17 position of 4.8%

5.4.3. Mandatory training compliance has decreased slightly in month but continues to exceed the target by 3% at 88% compliant. Appraisal compliance is 6.9% behind target.

5.4.4. The board discussed A&E appraisals and reasons why they are not achieving target; i.e. pressures in the department.

6. Committee report - Executive – NHST(17)089

6.1. AM provided an update to the Board.

6.2. The Executive Committee approved the submission of a bid to provide Marshalls Cross Primary Care services. A business case to recruit and train advanced clinical practitioners for A&E was also approved. The business case to implement the SafeCare staffing system was approved.

6.3. The business case to create a shared care record for all St Helens patients had been reviewed.

6.4. Schematic plans for the A&E GP streaming capital scheme, funded from Department of Health allocated capital, were reviewed and agreed in principle subject to planning approval.

6.5. Other items discussed by the Executive Team included Stroke update, winter planning, and the Pseudomonas case on ward 4D

6.6. VD asked how Marshalls Cross fit into the bigger picture and the capacity of the Executive team to manage the new services. AM suggested this should be discussed at the Board time out on 1st & 2nd November.

7. Committee Report – Quality – NHST(17)080

7.1. DG provided feedback from the meeting held on 17th October. Key items discussed were:

7.2. Visit by the Secretary of State for Health, Mr Jeremy Hunt on 13th October.

7.3. Letter from Professor Ted Baker, Chief Inspector of the CQC. The letter from Professor Baker related to safety and quality of emergency care. The actions are laid out and a plan is being formulated to ensure they are implemented, which will be reported at the next meeting.

7.4. Complaints: 23 1st stage complaints were received and opened in September 2017; a decrease from 24 received in August. At the end of September, there were 59 open 1st stage complaints (an increase of 1), including 6 overdue (no change). The Trust responded to 63.6% of 1st stage complaints within agreed timeframes in September, an increased compared to August, when 58.8% were responded to within agreed timeframes. There was a 25% increase in PALS contacts compared to the previous quarter.

7.5. CQC action plan update: The committee were advised that 54 of the 57 actions had now been completed. The three overdue actions relate to

appraisals in A&E (area of particular focus over the next two months), implementation of the Maternity strategy (due to report back in January on the implementation of the low risk birth pathway) and the roll out of the amber care bundle (issues in primary and community care which were beyond Trust control).

7.6. ANNB screening update: An update was provided on the implementation of a robust action plan following a recent ANNB screening review.

7.7. Lord Carter review update: The proposal of a Cheshire & Merseyside collaborative staff bank was discussed. The project is now being supported by NSHI and used as a case study from which other regions may benefit from our learning. An STP level steering group has been established.

7.8. Francis action plan update: An executive discussion will take place regarding Freedom to Speak Up and the CQC well led assessment.

7.9. Medicines optimisation strategy: The Committee approved the updated strategy and an action plan to deliver it will be produced for next month.

7.10. HPTP strategy: A summary was provided of the current Pharmacy & Medicines Dashboard from the NHSI Model Hospital. A summary of progress on key HPTP activities was provided and important improvements (e.g. TTO's) were noted. The Committee asked S Gelder to feedback to Pharmacy staff their thanks for all improvements made.

7.11. Medicines storage and security audit update: The audit in August was unannounced and conducted by Pharmacy staff. Performance has deteriorated since the June audit, where overall Trust compliance was at 95%, compared to the August results showing 48%. The Executive team will discuss the results at their weekly meeting.

7.12. Items escalated to the Board were, CQC letter on safety and quality in ED, HPTP strategy, Medicines safety and concerns about the delivery of NIV.

8. Committee Report – Finance & Performance – NHST(17)091

8.1. GM summarised the report for the Board.

8.2. Items discussed for information:

8.2.1. A&E update. The committee reviewed progress against the performance improvement plan and were updated on the actions being taken. The issue of medically optimised patients and DTOC needs to be escalated to commissioners.

8.2.2. Finance report. The Committee had undertaken an in-depth review of the performance against the Trusts financial plan and the plans for mitigating the financial risks.

8.2.3. Key issues were e-rostering, CIP programme 2018-19, appraisals, VTE performance and the Trust financial position.

9. Committee report – Audit – NHST(17)092

9.1. SR provided an overview of the meeting.

9.2. External and internal audit, anti-fraud services and Trust governance and assurance were discussed.

9.3. SR asked for Board approval for the Business Conduct policy. There are a few minor changes from the previous version; threshold for gifts, more guidance regarding conflicts of interest.

9.4. The Board discussed in depth awareness training for staff about conflicts of interest, and should the awareness training be part of corporate induction. It was suggested that bullet points raising awareness of the policy should be given to staff as part of the Trust induction.

9.5. The Board approved the policy.

10. Charitable Funds Accounts and Annual Report – NHST(17)093

10.1. DM provided a summary to the Board.

10.2. The Charitable Funds Committee had reviewed and approved the accounts and annual report for charitable funds.

10.3. The Committee had considered two items; the development of a Charity Office and a fund raising plan for the future , both of which the committee felt needed Executive consideration.

10.4. Generalising the funds is a key issue. NK has written to all fund holders regarding this, but has not yet received a great response. AM commented that a lot of effort had gone into fundraising, but as an organisation, we needed to be forensic when reviewing what is being raised, to ensure the funds are coming in and covering the costs of the fundraising. NK will report back to the Executive Team.

10.5. AMS added that a pod in the foyer would be ideal for the Charity Manager; it would be the first thing that people see, coming into the Trust. DG said it would also be a good idea to publish what the funds are used for, “good news stories” and are staff aware of charitable funds. NK will write to Directorate Managers and widen the audience.

11. Strategic and Regulatory update report – NHST(17)094

11.1. NB provided an update.

11.2. Draft Health Service Safety Investigations Bill: In September, a Bill was laid before parliament to create a statutory Health Service Safety Investigations body. The draft bill will now be scrutinised by the Health Select Committee and if passed, will create another regulator who can come into the Trust and inspect.

11.3. CQC Regulating Health and Social Care 2016-17: Yearly publication of assessment of the quality performance, trends and themes from the provider organisations it has inspected. This detailed the operational and quality pressures being faced across health and social care

11.4. Board Development programme: Outline of the programme for the year ahead. This was approved by the Board.

11.5. Planning guidance: gave an an update on 2018-19 planning timetable and approach from NHSI.

12. Board assurance framework (BAF) – NHST(17)095

12.1. NB provided an overview of the report.

12.2. The Executive Committee review the BAF in advance of its presentation to the Trust Board and make proposed changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the proposed actions and additional controls are sufficient to mitigate the risks being managed by the Trust.

12.3. VD requested an update on the collaborative staff bank. AMS said that the bank is across Cheshire and Merseyside and NHSI are interested in the scheme. The issue is the rate of pay for bank work; this will need agreement. NB will add to the BAF.

12.4. The proposed amendments to the BAF were approved

13. COPD mortality – NHST(17)096

13.1. KH provided an overview of the report.

13.2. The Trust's Standardised Mortality Ratio (SMR) for COPD and Bronchiectasis diagnosis group is higher than expected for the period November 2015 – October 2016. There were 78 deaths against an expected 51.5, resulting in an SMR of 151.2. This is statistically higher than expected.

13.3. A casenote review for each of the 78 deaths took place. Each death reviewed had been attributed to one of seven groups. These groups had been agreed by the Analytical Services team, the Clinical Coding team and Dr Julie Hendry (who undertook the reviews).

13.4. The review showed that 12.8% of deaths attributed to COPD were coded inaccurately and 5.1% were inappropriately diagnosed as COPD. This alone reduces the SMR to within national confidence intervals i.e. not statistically significantly increased SMR.

13.5. In addition to the case note review, to gain further assurance, the Trust sought an external review of COPD mortality by CRAB Clinical Informatics. CRAB concluded that the apparent increased SMR in patients with COPD is related to the methodological approach used by SHMI and HSMR with regard

to the episodes of care and in fact the care of patients with COPD using trigger analysis appeared to be within the expected norms.

13.6. Both the internal and external analyses suggest that there is no clinical cause for concern for COPD patients. However, there are administrative issues that need to be addressed to ensure patients get attributed to the correct diagnosis groups.

13.7. Actions going forward:

13.7.1. Dr Hendry will work with consultants and trainees to improve diagnosis and documentation of COPD.

13.7.2. Coders will audit COPD coding quarterly for one year.

13.7.3. Dr Hendry will liaise with the Respiratory Team to discuss a COPD checklist which must include consideration of Specialty Palliative Care Team input.

14. Effectiveness of meeting

14.1. RL said that it was good to see the dynamics of the Board, very positive and lots of questions asked. There were situations that were relevant to RL that he could take away with him.

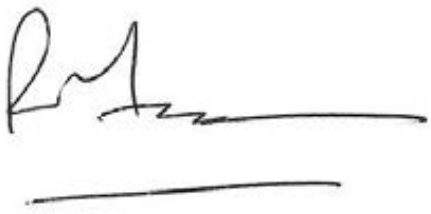
14.2. RF asked how the meeting compared to other Boards. RL said that it was a good meeting with positive culture and challenge.

15. AOB

15.1. None noted.

16. Date of next meeting

16.1. The next meeting is scheduled for Wednesday, 29th November 2017 in the Boardroom, Whiston Hospital, commencing at 9.30 am.



Chairman: ……

29th November 2017

Date: ……

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 29th NOVEMBER 2017

No	Minute	Action	Lead	Date Due
1.	31.05.17 (7.6)	Complaints, Claims and Incidents: More context and data analysis of report is required. Agenda item. ~~AMS will meet with SRe to discuss national benchmarking and the context and data analysis~~ 25.10.17: Context and data analysis will form part of the next quarterly report. Action closed.		Action closed
2.	31.05.17 (7.8.2)	~~Availability of staff to discuss patient care plans with relatives to be considered; wards to be encouraged to be more proactive. Executive Committee report back to Board.~~ 25.10.17: SRe has spoken to ward managers and matrons. Action closed		Action closed
3.	28.06.17 (7.8)	Board Development agenda – AMS will ensure that CQC guidance is included 26.07.17: AMS and NB will meet with AM and RF to discuss. 25.10.17: Plan can now be circulated. Action closed.		Action closed
4.	26.07.17 (11.7)	High mortality in COPD – KH will provide a report for Board. Agenda item. Action closed		Action closed
5.	27.09.17 (15.6)	WRES report. AMS will bring a paper to Board following the external expert input.	AMS	31 Jan 18
6.	25.10.17 (10.3)	Charitable Funds – NK will take a forensic look at funds coming into the Trust and report back to the Executive Team.	NK	31 Jan 18
7.	25.10.17 (5.2.5)	Head and neck cancer waits: AM will escalate the Board's concerns to the CEO at Aintree Hospitals.	AM	29 Nov 17
8.	25.10.17 (10.5)	Charitable Funds: NK will write to Directorate Managers, to ensure that staff are aware of the Charitable Fund.	NK	29 Nov 17

Paper No: NHST(17)097
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 October 2017 and zero cases year to date.

There was 1 MRSA bacteraemia case in October 2017, totalling two confirmed cases year to date.

There was 1 C.Difficile (CDI) positive case in October 2017. The total number of CDI positive cases year to date is 20. Two cases currently awaiting appeal at the December panel.

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

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for October 2017 was 93.5%

During the month of September 2017 there were 4 inpatient falls resulting in severe harm. YTD total of 10.

Performance for VTE assessment for September 2017 was 93.7%.

Provisional HSMR for 2016-17 is 102.4

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 17/18 financial outturn will have implications for the finances of the Trust
Stakeholders: Trust Board, Finance Committee , Commissioners, CQC, TDA, patients.
Recommendation: To note performance for assurance
Presenting Officer: N Khashu
Date of Meeting: 29th November 2017

Operational Performance

The 62 day standard was not met in September, performance against the standard was 80.6% against the 85% target . Fewer numbers of overall patients in month and an increase in patients with complex pathways resulted in failure to meet the standard.
Following a root cause analysis of each patient pathway that breached the standard, clinically led plans at specialty level are in development in order to address opportunities identified for improvement.

A&E performance was 82.1% (type 1) and 88.1% (type 1 & 3) in month. The key actions identified for continued recovery and maintenance 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. Standard Operating Procedures in use to ensure consistent delivery of evidence based patient pathways.
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 RED/GREEN board rounds on inpatient wards
2. KPI of expected number of discharges per ward of which 33% to be achieved by midday
3. Senior daily review and escalation for patients who no longer need care in an acute bed, supported by twice weekly discharge planning meetings and monthly executive supported system wide Multi Agency Discharge Events (MADE).

RTT incomplete performance improved in month (93.4%). Specialty level actions to maintain this achievement continue, including ongoing targeted activity recovery and backlog clearance plans.

Financial Performance

Surplus/Deficit - For the month of October 2017 (Month 7) the Trust is reporting an overall Income & Expenditure surplus of £4.908m which is just behind YTD profiled plan, by £0.214m. Overall Trust Income is £215.56m, which is slightly ahead of plan; Clinical Income is behind plan by £1.1m which is offset by an over performance on Non clinical income of £1.5m.

Trust Operating expenditure is £196.5m, which exceeded plan by £0.7m. Clinical Supplies are £1.0m above plan which is partly offset by the additional non clinical income and Pay is £3.0m higher than plan and this is offset by a £3.6m underspend against Other Costs. The pay overspend relates to premium payments, agency and bank use. Pay control and monitoring is being reviewed at the Premium Payments Scrutiny Council.

The Trust is progressing a recovery plan which considers productivity opportunities and robust cost control programmes for the remaining period of this year and has seen an encouraging improvement in Month 7, particularly for Clinical Income. The YTD financial position has been supported by the utilisation of reserves which is a risk to delivery of the FOT.

The Trust has delivered £6.5m of CIPs and is £(1.5)m behind the YTD plan. The successful delivery of the £15.3m CIP target will also be aligned to the cost control programme. The Trust is planning to deliver its planned annual surplus of £8.5m, which equates to a £(0.6)m deficit excluding STF funding of £9.1m.

The Trust's cash balance at the end of October was £11.2m, representing 12 days of operating expenses. The Trust has incurred £4.8m of capital expenditure in the seven months to October.

Human Resources

Absence in October has increased from 4.3% to 4.8%. YTD absence is 4.3% which is 0.5% below the 2016/17 position. Nursing sickness including HCAs is 5.5%, an increase of 0.4% from last month (5.1%) and above the 2017/18 target of 5.3%.

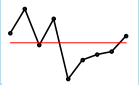
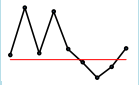
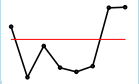
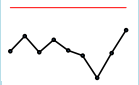
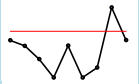
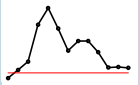
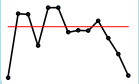
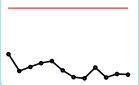
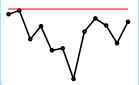
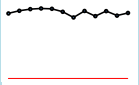
Mandatory training compliance has improved slightly in month and continues to exceed the target by 4.1%. Appraisals have also increased to 78.9%.

The following key applies to the Integrated Performance Report:

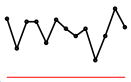
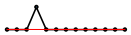
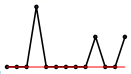
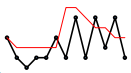
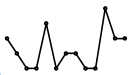
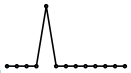
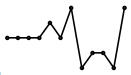
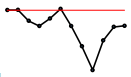
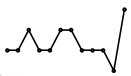
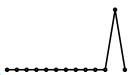
▲ = 2017-18 Contract Indicator
▲£ = 2017-18 Contract Indicator with financial penalty
● = 2017-18 CQUIN indicator
T = Trust internal target

Oct-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

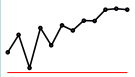
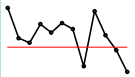
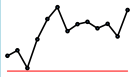
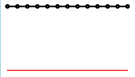
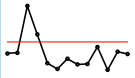
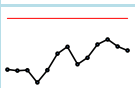
	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 31-37)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Oct-17	2.1%	2.3%	No Target	2.5%		Overall SHMI and HSMR within control limits. Mortality fluctuates month-to-month, but is stable medium-term. Weekend mortality - YTD position is lower than the 'Winter' increase (noisy metric).	Patient Safety and Clinical Effectiveness	Trust is exploring an electronic solution to improve capture of comorbidities and their coding and in the meantime we are exploring a system of emailing known co-morbidities of new admissions that we can identify from previous FCEs. Specific diagnostic groups with raised mortality are subject to intensive investigation (e.g. COPD). Major initiatives to improve management of AKI and Sepsis are well underway to improve care and reduce mortality.	KH
Mortality: SHMI (Information Centre)	Q	▲	Mar-17	1.03		1.00						
Mortality: HSMR (HED)	Q	▲	Jun-17	102.9	98.0	100.0	102.4					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Jun-17	108.4	95.7	100.0	115.0					
Readmissions: 30 day Relative Risk Score (HED)	Q	T	May-17	106.6	106.6	100.0	97.7		A recent peak bucks the trend. The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	Every effort is being made to ensure robust discharge despite extremely challenged social care and availability of packages to support independence.	KH
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Jun-17	95.2	90.1	100.0	93.8		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	Jun-17	95.9	96.4	100.0	92.1					
% Medical Outliers	F&P	T	Oct-17	1.3%	2.1%	1.0%	1.7%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in LoS, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place. Continued focused management of all patients requiring discharge support. A review of the Trust bed model has resulted in plans to reconfigure some surgical beds to medical by January, thus reducing outliers.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Oct-17	30.2%	47.0%	52.5%	48.3%		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.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Sep-17	69.7%	69.6%	90.0%	75.7%		eDischarge performance poor - there is insufficient trainee doctor resource to hit this target with existing paper-based systems.		Pending ePR, we are exploring a revised, automated eDischarge solution to address the problem that there are too few trainees to reliably hit the 95% target. Medium-term plan to supplement trainee doctor numbers with advanced nurses is ongoing.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Sep-17	91.9%	88.7%	95.0%	90.0%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Sep-17	99.0%	98.9%	95.0%	99.0%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

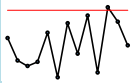
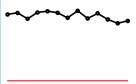
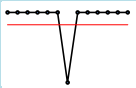
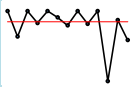
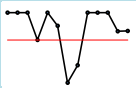
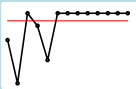
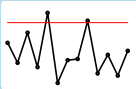
	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Oct-17	92.6%	91.6%	83.0%	94.0%		Target is being achieved. With effect from April 2017, STHK is also treating patients from the Warrington Area.	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Target achieved	RC
PATIENT SAFETY (appendices pages 39-42)												
Number of never events	Q	▲£	Oct-17	0	0	0	2		The National safety standards for invasive procedures will provide further mitigation against future never events.	Quality and patient safety	The RCA for the first never event has been submitted and lessons learnt cascaded. Actions implemented include central line insertion check list . The January 2017 never event is being made subject of a Serious Incident Investigation.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Oct-17	99.3%	98.9%	98.9%	98.8%		New harm free care continues to be recorded at high level	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	Oct-17	0	0	0	0		The trust continues to have no prescribing errors which cause serious harm. Trust has moved from being a low reporter of prescribing errors to a higher reporter - which is good.	Quality and patient safety	Intensive work on-going to reduce medication errors and maintain no serious harm. ePrescribing is being rolled out.	KH
Number of hospital acquired MRSA	Q F&P	▲£	Oct-17	1	2	0	4		There was 1 case of MRSA bacteraemia in October, Root Cause Analysis investigation on-going. There was 1 C.Difficile (CDI) case in October 2017. 2 cases are awaiting appeal at the December panel. Internal RCAs on-going with more recent cases.	Quality and patient safety	The Infection Control Team continue to support staff to maintain high standards and practices. They also monitor and undertake RCA for any hospital acquired BSI and CDI. CDI and Antibiotic wards rounds continue to be undertaken on appropriate wards.	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲£	Oct-17	1	20	41	21					SR
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Oct-17	2	10	No Target	17					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Oct-17	0	0	No Contract target	1		No grade 3 or 4 pressure ulcers in month	Quality and patient safety	The Trust remains compliant with tissue viability training for all nursing staff including bank staff	SR
Number of falls resulting in severe harm or death	Q	▲	Sep-17	4	10	No Contract target	22		Severe harm falls reported, RCA undertaken. Immediate and specific actions implemented	Quality and patient safety	Strategic falls actions being implemented as plan .	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲£	Sep-17	93.66%	92.48%	95.0%	93.36%		VTE performance lower than expected as data cleansing was affected by staff sickness and lower uptake by junior doctors for additional sessions. Funding for additional sessions under pressure as CIP challenges all extra spend.	Quality and patient safety	E -Prescribing solution will resolve achieving target in 2017. E-prescribing roll out now underway. As in previous years, it was not possible to secure additional trainee doctor time to support the process in August with the change-over but we are continuing to press for extra help.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Oct-17	2	16	No Target	28					
To achieve and maintain CQC registration	Q		Oct-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	Oct-17	93.5%	93.6%	No Target	94.9%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	Two Shelford audits to be reported together in November 2017.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Oct-17	0	1	No Target	2					

Oct-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 43-51)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Sep-17	96.3%	94.9%	93.0%	95.1%		Two week and 31 day targets achieved but the 62 day referral to treatment was not met in September. The Trust is reviewing and strengthening its action plan to mitigate the deteriorating performance.	Quality and patient experience	A Cheshire and Mersey Cancer Alliance PTL has been established is being established as part of the wider strategy to support system wide issues across patient Cancer pathways. Locally the focus is on accelerating pathway redesign and reducing variation in pathway performance by improved clinical engagement . Tumour specific dashboards are being redesigned to assist with visibility of clinical pathway performance. Increased scrutiny at patient level of open pathways and action planning at the weekly Cancer PTL review meeting. Actions arising from the reviews include working to establish improvements in booking by day 7, inter service transfers ,review of complex pathways requiring multiple MDT access and improved clinical and managerial accountability.	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Sep-17	99.5%	99.1%	96.0%	97.9%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Sep-17	80.6%	85.8%	85.0%	88.4%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Oct-17	93.4%	93.4%	92.0%	93.5%		4 specialties continue to fail the 92% incomplete target; General Surgery, ENT, T&O and Gynae. On going backlog clearance plans continue but similar issues regarding theatre and bed capacity remain. RMS and more recent MCAS primary care services also have compounded the position. However, RMS and MCAS remains unpredictable with short / no notice diverts back to secondary care	As we head into winter and there is an expectation that Surgical Beds will be handed to Medical Care Group. Bed availability to manage the Surgical demand will potentially risk the backlog increasing, causing more incomplete performance failures. Additional risk caused by impact of RMS and MCAS	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. A backlog management plan is in place and alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand. Actions to maintain and improve RTT performance reliant on theatre and bed capacity along with staff availability in collaboration with CCG's in ensuring RMS delivers in a sustainable and manageable way	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Oct-17	100.0%	100.0%	99.0%	100.00%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Oct-17	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Oct-17	0.6%	0.5%	0.8%	0.7%		The cancelled ops target was achieved again in October 2017 and YTD. This metric continues to be directly impacted by increases in NEL demand (both surgical and medical patients).	Patient experience and operational effectiveness Poor patient experience	The planned increase in elective surgical activity in St Helens has commenced including increasing GA capacity on Saturdays. Potential to use external theatre and bed capacity continues to be progressed. Continued analysis of the referral drop and impact on RTT underway to include forecast year end position	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Sep-17	100.0%	100.0%	100.0%	100.0%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Oct-17	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Oct-17	82.1%	81.5%	95.0%	76.1%		October 2017 Type 1 performance was 82.1% which was a slight deterioration compared with September 2017 of 0.8%.	Patient experience, quality and patient safety	The urgent and emergency care transformation plan has several interconnected work streams designed to improve overall 4 hour access performance. Emergency Department/Front Door encompassing a 90 day Improvement Programme. PDSA cycles tested a number of processes including 'walk in' streaming, Stretcher Triage streaming and internal departmental efficiencies and exit from ED. GP streaming in place as per NHSE recommendations. Flow through the Hospital Continuation of use of the SAFER Care Bundle to increase hospital discharges before midday to 33% and standardisation of daily Red to Green board rounds and afternoon huddles. Twice weekly discharge tracking meetings to manage medically optimised and DTOC escalation. Monthly Executive Multi-Agency Discharge Events (MADE) continue across the whole system to remove barriers and blocks that prevent patients with complex needs being discharged safely from hospital. Following 6a ECIP event and system resilience planning, commenced daily AMU/ED huddles and Community Matron in reach which is proving beneficial. Frailty in-reach to ED commenced. To commence 1pm Frailty/ED/SpR safety huddle from 16th October.	RC
A&E: Total time in A&E: % < 4 hours (All Types)	F&P	▲	Oct-17	88.1%	88.2%	95.0%	85.1%					
A&E: 12 hour trolley waits	F&P	▲	Oct-17	0	0	0	0					

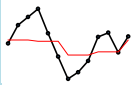
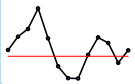
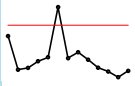
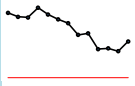
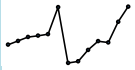
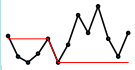
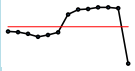
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Oct-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	Oct-17	15	143	No Target	338		% New (Stage 1) Complaints Resolved in month within agreed timescales continues to improve.	Patient experience	The Complaints Team are continuing to work on reducing the small backlog of overdue complaints and to improve the timeliness of responses. Complaints training continues to be provided for staff involved in both investigating complaints and drafting responses in order to ensure comprehensive statements are provided to reduce any delays. Feedback continues to be positive.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Oct-17	26	180	No Target	293					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Oct-17	80.8%	63.9%	No Target	58.0%					
Friends and Family Test: % recommended - A&E	Q	▲	Oct-17	87.5%	88.3%	90.0%	86.6%		The YTD recommendation rates are slightly below target for A&E and for maternity (birth and post-natal ward) and outpatients, but are improving and are above target for in-patients, antenatal and community maternity services.	Patient experience & reputation	Feedback from the FFT responses is fed back to individual areas to enable actions to be taken to address negative feedback, as well as using positive feedback. Reports to the Patient Experience Council now include updates on the number of areas who submit their actions to address the FFT feedback each month.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Oct-17	95.2%	95.5%	90.0%	95.5%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Oct-17	100.0%	99.1%	98.1%	98.5%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Oct-17	94.8%	97.3%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Oct-17	96.7%	95.0%	95.1%	98.7%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Oct-17	100.0%	100.0%	98.6%	93.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Oct-17	94.5%	94.4%	95.0%	94.4%					

Oct-17

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 53-60)												
Sickness: All Staff Sickness Rate	Q F&P	▲	Oct-17	4.8%	4.3%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.8%		Absence in October has increased from 4.3% to 4.8%. YTD absence is 4.3% which is 0.5% below the 2016/17 position. Nursing sickness including HCA's is 5.5%, an increase of 0.4% from last month (5.1%) and above the 2017/18 target of 5.3%.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	Targeted action taken in September continued in October and will remain throughout November specifically towards HCA absence across the Trust. The Absence Support Team are currently focusing on ensuring reviews are undertaking prior to the 52 week expiry of stages/levels to ensure those staff are appropriately managed and action taken if absence has not improved significantly. The team are also commencing ward audits in relation to policy compliance working closely with the HRBP's	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P	T	Oct-17	5.5%	5.3%	5.3%	5.9%					
Staffing: % Staff received appraisals	Q F&P	T	Oct-17	78.9%	78.9%	85.0%	87.4%		Mandatory Training compliance has improved slightly in month and continues to exceed the target by 4.1%. Appraisal has also increased to 78.9%.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The Education, Training & Development team continue to work with managers of non-compliant staff to ensure continued improvement for both Mandatory Training & Appraisals. The recent TUPE of staff from other organisations has had a temporary impact on compliance while records are aligned and appraisals are completed with new managers	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Oct-17	89.1%	89.1%	85.0%	91.6%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2	85.0%		No Contract Target			Whilst response rates fluctuate we remain in the top 3 acute Trusts in our region for both response and recommendation rates.	Staff engagement, recruitment and retention.	The Trust is currently undertaking the Q2 survey with results expected in October.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2	76.1%		No Contract Target						
Staffing: Turnover rate	Q F&P	T	Oct-17	0.9%		No Target	9.8%		Staff turnover remains stable and well below the national average of 14%.		Turnover is monitored across all departments as part of the Trusts Recruitment & Retention Strategy with action plans to address areas where turnover is higher than the trust average. Further action is required by Ward Managers to provide more support to newly qualified nurses.	AMS
FINANCE & EFFICIENCY (appendices pages 61-66)												
UORR - Overall Rating	F&P	T	Oct-17	3.0	3.0	3.0	3.0		The Trust's forecast for year end performance is in line with plan. The Trust has significant contractual agreements with other NHS organisations which may impact on our ability to achieve Better Payment compliance.	Financial	Achievement against the submitted plan and delivery of CIP. Maintaining controls on Trust expenditure and delivering the planned activity while managing the variable costs. 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	Oct-17	6,493	6,493	15,315	15,248					
Reported surplus/(deficit) to plan (000's)	F&P	T	Oct-17	4,908	4,908	8,536	4,861					
Cash balances - Number of days to cover operating expenses	F&P	T	Oct-17	12	12	2	2					
Capital spend £ YTD (000's)	F&P	T	Oct-17	4,788	4,788	8,015	3,519					
Financial forecast outturn & performance against plan	F&P	T	Oct-17	8,536	8,536	8,536	4,861					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Oct-17	90.3%	90.3%	95.0%	94.3%					

APPENDIX A

			Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	2017-18 YTD	2017-18 Target	FOT	2016-17	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	100.0%	100.0%	100.0%	87.5%	100.0%	96.2%	94.4%	100.0%	84.6%	100.0%	100.0%	100.0%	100.0%	98.2%	85.0%		95.2%		
	Total > 62 days		0.0	0.0	0.0	1.0	0.0	0.5	0.5	0.0	1.0	0.0	0.0	0.0	0.0	1.0			6.0		
Lower GI	% Within 62 days	▲ £	81.8%	71.4%	58.3%	100.0%	91.7%	93.3%	100.0%	76.9%	100.0%	100.0%	92.3%	84.6%	69.2%	86.1%	85.0%		89.3%		
	Total > 62 days		1.0	1.0	2.5	0.0	0.5	0.5	0.0	1.5	0.0	0.0	0.5	1.0	2.0	5.0			8.0		
Upper GI	% Within 62 days	▲ £	0.0%	85.7%	88.9%	100.0%	81.8%	0.0%	87.5%	100.0%	100.0%	100.0%	33.3%	88.9%	80.0%	86.2%	85.0%		78.7%		
	Total > 62 days		1.5	1.0	0.5	0.0	1.0	4.0	0.5	0.0	0.0	0.0	1.0	0.5	0.5	2.0			10.0		
Urological	% Within 62 days	▲ £	76.9%	96.2%	82.6%	70.0%	95.7%	100.0%	67.6%	92.7%	59.3%	82.1%	83.3%	81.3%	87.5%	81.9%	85.0%		81.4%		
	Total > 62 days		4.5	0.5	4.0	6.0	0.5	0.0	6.0	1.5	5.5	3.5	3.0	4.5	1.5	19.5			36.5		
Head & Neck	% Within 62 days	▲ £	100.0%	80.0%	33.3%	33.3%	100.0%	80.0%	80.0%	66.7%	66.7%	75.0%	75.0%	42.9%	20.0%	53.8%	85.0%		67.3%		
	Total > 62 days		0.0	0.5	1.0	1.0	0.0	0.5	0.5	0.5	0.5	0.5	0.5	2.0	2.0	6.0			8.0		
Sarcoma	% Within 62 days	▲ £			100.0%	100.0%			100.0%	66.7%		100.0%		0.0%	100.0%	66.7%	85.0%		93.3%		
	Total > 62 days				0.0	0.0			0.0	0.5		0.0		0.5	0.0	1.0			0.5		
Gynaecological	% Within 62 days	▲ £	33.3%	100.0%	90.9%	92.3%	100.0%	85.7%	100.0%	70.0%	83.3%	100.0%	68.8%	55.6%	83.3%	74.6%	85.0%		90.1%		
	Total > 62 days		1.0	0.0	0.5	0.5	0.0	0.5	0.0	1.5	1.0	0.0	2.5	2.0	0.5	7.5			5.0		
Lung	% Within 62 days	▲ £	100.0%	80.0%	87.5%	91.7%	68.2%	77.8%	100.0%	100.0%	73.7%	85.0%	100.0%	72.7%	71.4%	83.5%	85.0%		82.7%		
	Total > 62 days		0.0	1.0	0.5	0.5	3.5	1.0	0.0	0.0	2.5	1.5	0.0	1.5	1.0	6.5			13.0		RC
Haematological	% Within 62 days	▲ £	100.0%	100.0%		66.7%	66.7%	100.0%	100.0%	100.0%	66.7%	50.0%	71.4%	100.0%	50.0%	67.6%	85.0%		77.6%		
	Total > 62 days		0.0	0.0		1.0	1.0	0.0	0.0	0.0	1.0	1.0	1.0	0.0	3.0	6.0			8.5		
Skin	% Within 62 days	▲ £	95.7%	92.6%	97.4%	95.7%	95.7%	100.0%	100.0%	92.5%	93.9%	98.1%	93.9%	93.0%	88.9%	93.7%	85.0%		96.5%		
	Total > 62 days		1.0	2.0	0.5	1.0	1.0	0.0	0.0	1.5	1.0	0.5	1.5	1.5	2.0	8.0			9.5		
Unknown	% Within 62 days	▲ £	100.0%			100.0%	66.7%	0.0%	50.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	78.9%	85.0%		82.6%		
	Total > 62 days		0.0			0.0	0.5	0.5	1.0	1.0	0.0	0.0	1.0	0.0	0.0	2.0			2.0		
All Tumour Sites	% Within 62 days	▲ £	87.9%	92.0%	86.6%	85.8%	89.1%	87.6%	89.3%	88.2%	81.6%	91.4%	87.1%	84.5%	80.6%	85.8%	85.0%		88.4%		
	Total > 62 days		9.0	6.0	9.5	11.0	8.0	7.5	8.5	8.0	12.5	7.0	11.0	13.5	12.5	64.5			107.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £	100.0%		50.0%				100.0%					100.0%		100.0%	85.0%		83.3%		
	Total > 31 days		0.0		1.0				0.0					0.0		0.0			1.0		
Acute Leukaemia	% Within 31 days	▲ £															85.0%		100.0%		
	Total > 31 days																		0.0		
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)098
Title of paper: Committee Report - Executive
Purpose: To feedback to the Board key issues from Executive Committee meetings.
Summary: The paper covers the Executive Committee meetings that took place between 12th October and 9th November 2017. There were 3 Executive Committee meetings held during this period, as the scheduled meeting on 12th October was cancelled as a result of the Secretary of State visit, and the meeting on 2nd November did not take place due to the Board time out event. The Executive Committee approved; the submission of a bid to provide Community Cardiac/Heart Failure Services, a delay in the roll out of e-prescribing, proposals to enable the delivery of NIV on the respiratory wards, a revised policy on document development , and the governance arrangements for oversight of the apprenticeship levy.
Trust objectives met or risks addressed: All 2017/18 objectives and operational risks managed by the Executive.
Financial implications: None arising directly from this report, requiring Board approval
Stakeholders: Patients, Patients Representatives, Staff, Commissioners, Regulators
Recommendation(s): That the report be noted
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 29th November 2017

EXECUTIVE COMMITTEE ASSURANCE REPORT
OCTOBER 2017

1. Introduction

There were 3 Executive Committee meetings between 12th October and 9th November, and this report provides a summary of the issues addressed and decisions made.

2. 19th October 2017

2.1 Impact of the introduction of CCG Referral Management (RMS)

RMS has been adopted by all the local CCGs, and for St Helens has been in place for 15 months. The Executive have regularly monitored the impact of RMS, and this paper provided the latest update.

RMS has impacted on the numbers of outpatient referrals and first outpatient appointments across most specialities but has had very little impact on the numbers of patients being listed for elective procedures. Overall RMS is not having a significant impact on the Trusts income or on the demand for elective procedures.

The impact of RMS on 18 week referral to treatment (RTT) performance is being carefully monitored across all specialities.

Further work is required to plan for changes in deployment of the Trust's capacity e.g. conversion of outpatient clinic sessions to theatre sessions as a result of these changes in activity patterns.

2.2 Apprenticeship Levy Governance

Anne-Marie Stretch presented the proposed arrangements for oversight and management of the apprenticeship levy to achieve maximum benefit for the Trust in developing the skills of the workforce.

The Trust is working with education providers to develop more targeted apprenticeship courses that meet the needs of the NHS.

All staff currently enrolled on apprenticeship courses will continue to be supported to complete their courses.

The proposals were approved.

2.3 Assurance Reports

The Committee reviewed the monthly reports on appraisal and mandatory training performance and highlighted those services /departments that were not achieving the targets.

The monthly Corporate Risk Register (CRR) report and quarterly Board Assurance Framework (BAF) reviews were undertaken. Bed capacity and patient flow over the winter period and the ability to attract and retain the required skilled staff, due to national staffing shortages, were agreed as the biggest operational risks facing the organisation. The development and delivery of the plans to mitigate these risks are a major focus for the Executive Team and senior managers.

2.4 E-Prescribing (ePMA) Rollout

Following software issues that had caused a delay in the roll out of the electronic prescribing system (ePMA), Christine Walters sought formal approval to delay the implementation of this system until after the new PAS was in place (March 2018). This was because of the resources needed to implement both systems and the increased risk of implementing them concurrently.

The request was approved and an alternative plan to deliver the VTE target until full implementation is being developed.

2.5 Estates Update

Peter Williams provided an update on proposals for the alternative use of the "bungalow" at St Helens, once the Whiston mortuary upgrade had been completed.

Peter Williams also presented an "option" to acquire a NHS building owned by another local NHS Provider that was adjacent to the Whiston site. Consideration of the financial options would be undertaken by the CEO and Director of Finance.

2.6 Community Cardiac/ Heart Failure Service Tender

Following an assessment of the specification the Medical Care Group recommended that the Trust had the expertise to provide the services requested and it was agreed that we should proceed to submit a bid.

3. 26th October 2017

3.1 Safer Staffing Report

Sally Duce attended to present the latest safer staffing report and vacancy dashboard for September. There was a reduction in reported vacancies as 30 FTE staff had started on the PML Foundation Programme.

There was also an update from the local nurse training institutions who reported that despite the loss of the nurse training bursary scheme, they had not experienced a drop in applications.

There was discussion about the current recruitment and retention initiatives and what more could be done to facilitate the recruitment of newly qualified staff.

It was confirmed that the forthcoming publication of the national Carter data would enable the Trust to benchmark its performance on safer staffing and turnover.

3.2 Non Invasive Ventilation (NIV)

Following a meeting with the lead consultants Kevin Hardy presented a proposal to enable the safe delivery of NIV on the respiratory wards. This move would require some additional staffing input and continuing back up from ICU. The proposal was agreed and would be implemented once the additional staff had been recruited.

3.3 CQPG

Sue Redfern reported on the CQPG meeting held on 19th September.

Issues discussed included; consultant to consultant referral policy review, patient safety alerts (nasogastric tubes), an update on the Medway implementation, the clinical audit annual report and safeguarding updates.

3.4 Deep Clean Requests

Sue Redfern reported on the audit of deep clean requests. The findings showed that 93% of requests were appropriate.

Next steps were to ensure that requests were made in real time, as patients were discharged, and not batched to ensure the most productive deployment of the cleaning teams and faster turnaround of beds.

A new protocol was being developed to clarify the type of clean that needed to be requested and how requests should be made.

3.5 Cancer Alliance

At the last mid-Mersey Cancer Alliance meeting Clatterbridge Cancer Centre had issued the bidding criteria for the Eastern Oncology Hub. The decision on where the new hub would be sited was expected in the New Year.

3.6 Community Cardiac /Heart Failure Bid Approval

The final bid against the service specification was presented to the Executive Committee and approved for submission.

4. 9th November 2017

4.1 Procedural Documents Development Policy

Anne Rosbotham-Williams attended the meeting to present the revised policy on developing procedural documents (Trust policies). This had been simplified to make it more "user friendly".

The policy was approved.

4.2 Draft Trust Board Agenda - November

The Executive reviewed the draft Board agenda.

4.3 Proposed changes to the Integrated Performance Report (IPR)

Chris Yates presented some proposals to change some of the indicators reported in the IPR to bring our reporting in line with changes to reporting requirements nationally and remove obsolete measures. These proposals were agreed.

4.4 Marshalls Cross Primary Care Centre – Update

Tiffany Hemming gave an update on the performance of the Marshalls Cross Primary Care Centre, how the Trust had responded to feedback, and strengthened operational monitoring to improve oversight of performance and enable earlier intervention, if risks emerged.

There was also an update on recruitment to key posts within the practice.

During the initial bedding in period the Executive would continue to monitor performance closely.

4.5 Medway Implementation Programme Progress Report

Christine Walters presented the monthly Medway implementation programme report. The functional design process is progressing well and all the other work steams remain on track. The first critical path milestone – the first data migration cycle has been completed successfully.

An independent assurance review of the data migration process has also been undertaken.

Risks are being identified as the programme progresses and mitigation plans developed.

4.6 Helipad Option Appraisal

The Trust had been approached by a charity to see if it wanted to explore the options for creating a helipad on site at Whiston Hospital. Only major trauma centres are required to have a helipad on site. The Trust has an existing arrangement for receiving air ambulance patients which requires a 3 minute

transfer via an ambulance. The options for siting a helipad on site all have implications for the future estates strategy. It was agreed to work with the charity to take forward the option appraisal, on the basis that the Trust did not have capital to invest itself.

4.7 Halton CCG Meeting

Ann Marr provided feedback from a recent meeting with Dave Sweeney the Chief Officer of Halton CCG, where the winter plan and options for improving performance had been discussed.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)099

Title of paper: Committee report – Quality Committee

Purpose: To summarise the Quality Committee meeting held on 21st November 2017 and escalate issues of concern.

Summary: Key items discussed were:

1. Complaints. 15 1st stage complaints were received and opened in October 2017; a decrease from 23 received in September. 43 open 1st stage complaints at the end of October, down from 59 the previous month. There are 10 overdue 1st stage complaints, up from 6 last month. 80.8% 1st stage complaints were responded to in October, within agreed timescales, an increase from 63.6% in September.

   100% of complaints were acknowledged within the 3 day target. 60% of complaints related to clinical treatment. 161 PALS contacts were received in October 2017. 3.7% of PALS enquiries (6 in total) converted to complaints. 96% of PALS contacts related to concerns and informal complaints, compared to 88% during Q2.

   GM commented that the latest figures were very good news.

2. IPR. A&E performance, infection control, finance & HR targets were discussed. VTE performance remains below target. Another MRSA was reported in October.

3. Safer staffing. Overall Trust % staffing fill rates for October 2017 were:

   - RNs on days 92.79% (September 92.14%)
   - RNs on nights 95.05% (September 93.51%)
   - Care staff on days 108.67% (September 101%)
   - Care staff on nights 115.76% (September 113.59%)

   The Committee discussed recruitment and retention at length.

4. Medicines Optimisation Strategy 2017-2020. The final version of the strategy provides clearer reference to Lord Carter and STP work stream priorities. An update to the action plan will be presented to Quality Committee in January. 2018.

5. CQC next phase inspections presentation. NB and SR updated the Committee on the key themes, characteristics of high performers, A&E safety, new inspection approach and what is different, inspection timetable, service inspections and well led review. An action plan will be presented to the Board in January 2018.

6. A&E escalation plan update. 18 actions have been identified from Professor Ted Baker's letter. The Trust is compliant with 16 out of the 18 actions. A live inspection will take place in December and a report presented to Quality Committee in January 2018.

7. Quality improvement initiatives in Surgical Care Groups in relation to fasting. Following an audit, results identified 100% compliance with the fasting policy for the morning theatre list, whereas compliance with the afternoon theatre list was variable, noting 11/32 (34%) of patients were starved in excess of 6 hours. Proposed actions included:

    - NHS England sponsored "Always Events" in surgery and orthopaedics.
    - Pre-loaded drinks initiative to support enhanced recover.
    - Proposal to lock down of afternoon theatre lists.

8. Feedback from Councils:
    (a) Patient Safety Council: Consensus and recommendation that Oramorph be recorded and managed as a controlled drug across all wards, although not legislated.

    Safety thermometer – data is quality checked and validated before it is uploaded.

    (b) Patient Experience Council: Potential risk that the 3 year training target for dementia will not be achieved due to capacity to deliver training sessions by the team.

    Issues re access to out of hours psychiatric support, which has been escalated to Rob Cooper.

    (c) Clinical Effectiveness Council – Nothing to escalate.

    (d) CQPG – nothing to escalate.

    (e) Executive Committee – nothing to escalate.

AOB

None noted.

Items to be escalated to the Board:

- Improvement in complaints
- A&E – 401 attendances on 20th November – 70.8% performance.
- Debate on staffing.
- CQC well led inspections – January 2018 Board.
- Professor Ted Baker letter – 16/18 actions compliant. Live inspection in December and report back to Quality Committee in January.
- Cancer figures (failed in September, achieved in October). An action plan is in place to continue improvement.

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

Financial implications: None directly from this report.

Stakeholders: Patients, the public, staff and commissioners
Recommendation(s): It is recommended that the Board note this report.
Presenting officer: George Marcall, Non Executive Director
Date of meeting: 29th November 2017

TRUST BOARD

Paper No: NHST(17)100

Title of paper: Committee Report – Finance & Performance

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

Summary:

Agenda Items

For Information

- Medical SLR Quarter 1 2017/18
  - At the end of Q1 2017-18 MCG reported an overall £1.2m surplus due to an improved contribution from non-elective activity, particularly in ED, AMU / General Medicine and Haematology.
- Forecast Outturn 2017/18
  - The Committee discussed the forecast outturn and changes to the risk profile after October's improved performance against run rate. The committee discussed actions and mitigations implemented, with particular reference to the STP Funding and the Trust's cashflow. Other significant risks remain: contracting and CQUIN issues, HRG4+impact, Clinical income shortfall against plan, winter planning and CIP delivery. The Trust is still forecasting to achieve the annual plan of £(0.581)m deficit excluding STP, £8.536m including STP. It was agreed that this must be reviewed after Q3 performance is known as to whether outturn can be achieved.
- A&E Update
  - The Committee reviewed current performance in terms of volumes of patients and ambulances attending ED and the proportion of our patients by their commissioning CCG. The risks associated with the high levels of patients and ambulances attending ED were discussed and we will continue to escalate to Commissioners where appropriate.
- Budget setting 2018/19 v1
  - The Budget setting process was presented for 2018/19 and will be updated once guidance from NHSi has been published. The paper included a draft timetable for approval by the Committee.
- CIP Council
  - The briefing was accepted.

For Assurance

- Integrated Performance Report Month 7 was reported
  - Discussion took place around operational performance with specific reference to the reported MRSA and C difficile cases in October, VTE performance & the numbers of falls in one month.
  - 62 Cancer performance for September below target was discussed. Assurance was received that this was improved for October and actions in place for future months achievement.
- Finance Report Month 7 2017/18
  - Delivered year to date surplus of £4.9m, just behind the planned surplus. In October, the Trust delivered £26.6m of Clinical Income which is in line with plan and £1.5m better than in September.
  - Specific risks in achieving outturn were discussed and included the ability to fully

recover activity in the remaining months, exposure to tariff change, cost control / CIP risk and STF funding.

- The Recovery plan for Surgery has resulted in an encouraging improvement in productivity for October and targeted work on maintaining this subject to winter pressures.
- The Trust has delivered £6.5m of CIP against a target of £7.9m and this continues to be monitored at a departmental level.
- The Cash and Capital position was also discussed.

For Approval

- Temporary Loan Application (delayed STF monies)
  - The delay in receipt of STF funding had been discussed during the Finance presentation and NHSi have now recommended that Trusts apply for a temporary loan facility to cover the Q2 and Q3 STF values (£1.87m and £2.7m respectively), payment of which has been delayed against planned receipt.
- SLR – SLM Development Plan Update
  - The Trust is proposing to implement SLM in a phased approach, starting with a pilot with one specialty and the result will be presented to the Committee in February. The plan will be extended to illustrate the timeline to roll out SLR to all Specialties

Actions Agreed

- The committee approved the recommendation to the Trust Board that the loan should be requested.
- The committee approved the proposed approach to implementing SLM.
- The committee approved the proposed approach to budget setting for the 2018/19 Annual plan.

Issues to be raised at Board

- Risks to the Trust's Cash flow, due to commercial arrangements with other NHS organisations, particularly the HIS, Payroll and Lead Employer
- Temporary Loan Application regarding STF payments
- Trust Financial position, YTD and Forecast noting management action taken to date and risks going forward.

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 November 2017

TRUST BOARD

Paper No: NHST(17)101

Title of paper: Committee Report – Charitable Funds Committee

Purpose: To brief the Board on the main issues discussed and decisions made at the Committee meeting on 19th October 2017.

Summary:

1. Action Log - The Charity name change to Whiston & St Helens Hospitals' Charity, has been actioned by the Charities Commission and consolidation of the three main 'general' funds (St Helens & Knowsley Hospitals Charitable Fund, Whiston Hospital General Fund and St Helens Hospital General Fund) into one main fund (Whiston and St Helens Hospitals') is in progress.

2. Investment portfolio - Mrs D Pye, presented the latest position:

   The charitable fund shares are invested in 'Common Investment Funds' (COIFS) and managed on the Trust's behalf by Blackrock Investments who are expert fund managers. (COIFS are very common in the NHS.) Such investments will fluctuate up and down in value over time but hopefully there will be an overall upward gain.

   In the months since year-end to the valuation, as at 10th October 2017, presented at the October Charitable Funds Sub-Committee, the share value has increased by £34.6k, and overall the unrealised gain (ie. increase in value since purchase) is £215.7k.

   There was a general discussion around fund management and it was commented that the committee should consider how funds are managed in the future if the funds of the charity change significantly.

3. Mrs E Titley presented a report showing the response to a letter to fundholders requesting that they inform the committee of their intentions for use of their fund balances. There was a general discussion around dormant funds and funds with low balances. It was agreed that another letter be sent to all fundholders and copied to directorate managers informing them that the strategy around the retention of separate funds would be based on their responses. Mrs E Titley and Mrs K Hughes will review the status of funds in discussions with finance to see what can be done about moving funds to enable them to be used generally or have 'clever consolidation' of certain funds.

4. Approval of Expenditure - No one was in attendance at the meeting to promote the case for Digital Reminiscence Systems for Dementia Patients. The decision was deferred until the next meeting by which time either the proposers have made their case to Mr N Khashu, Director of Finance, previously, or attend the meeting.

5. Fundraising update

- Mrs E Titley, Charity Manager, gave details of over £24.5k of fundraising done since the last meeting.
- Mrs E Titley will keep the committee informed of any actions that may result from a consultation on the changes planned to the code of Fundraising Practice to include the requirements of the General Data Protection Regulation (GDPR) and also feed back to the Information Governance Committee.
- There was a proposal to look into putting a Charity office in the foyer at Whiston. Discussion took place around how this would raise the profile of the Charity and provide a meeting place for sensitive discussion. Hopefully it would also translate into more donations and fundraising. Further discussions need to be held.
- The Giant Cash Bonanza Lottery was discussed. Again concerns were raised on how it would be sold to people. It was acknowledged that it would be low risk but it was felt that executive approval is required.

6. Any Other Business

- The Annual Accounts and Report 2015-16 were approved by the Committee on behalf of the Trustee (ie the Trust Board) after the independent examiner's report done by Grant Thornton, external auditors.
- Christmas monies – the Committee agreed £5.00 per patient to be spent on Christmas gifts, plus biscuits/sweets for visitors.
- Mr A O'Brien, Directorate Manager, attended the meeting to get agreement in principle for a Spectralis OCT machine (£91k exc VAT), a piece of Ophthalmic equipment. The department have secured a grant of £58k and wish to use that and some of their fund balance to fund the purchase. It was endorsed by the committee but required further endorsement from Mr N Khashu from a strategic Trust perspective.

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

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff and all stakeholders.

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

Presenting officer: George Marcall, Non-Executive Director

Date of meeting: 29th November 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)102
Title of paper: Strategic and Regulatory Update Report
Purpose: To provide the Board with assurance that the Trust continues to take account of external strategic developments that could impact the future direction of the organisation and all regulatory requirements to comply with governance good practice.
Summary: 1. NHS Improvement (NHSI) Quarter 2 Performance Report for NHS Providers. 2. Care Quality Commission (CQC)/NHSI consultation on Use of Resources ratings. 3. National appointments – NHSI Chair and NHS England Medical Director. 4. NHSI publication of updated Standard Operating Framework (SOF).
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, C&M FYFV, Commissioners, Regulators
Recommendation(s): The Board is asked to note the report
Presenting officer: Nicola Bunce, Interim Director of Corporate Services
Date of meeting: 29th November 2017

Strategic and Regulatory Update Report – November

1. NHS Improvement (NHSI) Quarter 2 Performance Report for NHS Providers.

On 16th November NHSI published the quarter 2 (Q2) performance report for NHS Provider organisations. This showed that;

- The sector has seen a 3.4% increase in emergency admissions via type 1 A&E departments compared to the same period last year
- At the end of September there were around 168,302 delayed discharges across the England (accounting for 5.0% of all beds)
- During Q2, more patients were seen within the four-hour target for A&E than during the same period last year, and fewer patients waited over 12 hours to be treated, admitted or discharged.
- During Q2, 3.43 million patients were seen within 18 weeks, compared with 3.36 million during the same period last year.
- The waiting list for planned care has grown to over 4.1m – the highest since the RTT target was introduced.
- Based on Q2 results, providers forecast that the aggregate full year deficit will be £623 million, which is £127 million worse than planned. If do not receive the 0.5% CQUIN reserve assumed in their financial plans to deliver a control totals, the year end the provider financial position will deteriorate by at least a further £128 million.
- None of the national access targets are being achieved at a national level

Table 1 – NHSI Q2 Provider Sector Performance

Activity and Capacity					
	Q2 YTD 2017/18 Plan	Q2 YTD 2017/18 Actual	Q2 YTD 2016/17 Actual	Q2 YTD 2017/18 variance from plan	Variance from Q2 YTD 16/17
A&E attendances (millions)	10.86	10.94	10.76	0.8%	1.7%
Non-elective admissions (millions)	3.10	3.09	3.00	(0.4%)	2.9%
Elective admissions (millions)	3.99	3.91	3.93	(2.1%)	(0.7%)
1st Outpatients attendances (millions)	10.32	10.21	10.21	(1.1%)	0%
General & acute beds (average daily open – Q1 2017/18)	-	102,609	102,812	-	(0.2%)
Nurses (WTE)	348,281	343,259	347,989	(1.4%)	(1.4%)
Medical staff (WTE)	119,357	120,668	118,748	1.1%	1.6%
Cost weighted activity growth	2.3%	2.2%	3.3%	(0.1%)	(1.1%)

2. Care Quality Commission (CQC)/NHSI consultation on Use of Resources ratings.

On 8th November 2017 the CQC and NHSI launched a further consultation on plans to fully implement the process that both organisations will use to report on how NHS non-specialist acute Trusts use their resources to provide high quality, efficient and sustainable care.

They are seeking views on;

- Working with NHS Improvement to reflect their assessment of trusts' use of resources in published CQC inspection reports and trust-level ratings.
- Seeking feedback on how to combine the rating that will be awarded for use of resources with CQC's five trust-level quality ratings, and how the new combined ratings at the trust level, will be decided.

NHSI has already started undertaking Use of Resources (UoR) assessments of non-specialist acute Trusts.

The CQC are currently piloting how to incorporate the NHSI findings from the UoR assessments with our judgements on quality.

The responses from this consultation will be combined with feedback from the Trusts involved in the initial UoR assessments, to shape the final approach.

The consultation will close on 10th January 2018.

At the current time there is no indication from NHSI that this Trust will have a UoR assessment before January 2018, but will review the proposals for the UoR assessments and CQC ratings and respond to the consultation if appropriate.

3. National appointments – NHSI Chair and NHS England Medical Director.

Baroness Dido Harding has been confirmed as the new Chair of NHSI, with effect from 30th October 2017.

Professor Stephen Powis has been appointed as the new Medical Director for NHS England. He will replace Sir Bruce Kehoe who retires at the end of December 2017.

4. NHSI publication of updated Standard Operating Framework (SOF).

Following consultation NHSI have now published the final version of the updated SOF. A briefing on the proposed changes was included in this report at the September Board meeting. There are no material changes to the SOF as a result of the consultation.

ENDS

TRUST BOARD

Paper No: NHST(17)103
Title of paper: Research & Development Operational Capability Statement (RDOCS)
Purpose: As part of the National Institute for Health Research (NIHR) Research Support Services Programme, each NHS organisation is required to publish a Research and Development Operational Capability Statement (RDOCS). This Statement provides a Board level approved operational framework which sets out how the organisation plans to meet its research related responsibilities/requirements as stated in the UK Policy Framework for Health and Social Care Research Clinical Trials Regulations, Operating Framework for the NHS in England, Handbook to the NHS Constitution and other relevant guidance and regulations.
Summary: The statement provides researchers with an operational overview of resources available to support Research & Development in the organisation and an overview of research collaborations and partnerships with other organisations, including areas of special interest. The statement is a tool to improve effectiveness and collaborations in research activities.
Corporate Objective met or risk addressed: • We will maintain a positive organisational culture that supports the achievement of the Trust's objectives • We will achieve national performance indicators including - the National Institute for Health Research (NIHR) recruitment targets • We will collaborate with partners in reviewing integrated patient pathways which offer alternative ways of working to the benefit of patient care, safety and efficiency of services
Financial Implications: None, however the RDOCS is viewed by commercial companies who are looking to invest in research and will use the RDOCS to seek out potential sites.
Stakeholders: • St Helens & Knowsley Teaching Hospital's NHS Trust • North West Coast Clinical Research Network (NWC CRN) • Commercial Partners • External Partners
Recommendation(s): This statement should be on STHK website as we have to provide a link to the NWC CRN and they in turn submit to the DOH.
Presenting officer: Professor Kevin Hardy
Board date: 29th November 2017

NIHR Guideline B01
RDI Operational Capability Statement

May 2011

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

Version History

Version number	Valid from	Valid to	Date approved	Approved by	Updated by
Statement 001					
Statement 002	01/11/2013	01/11/2014	27/11/2013	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 003	18/11/2014	18/11/2015	18/11/2014	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 004	31/12/2015	31/12/2016	27/01/2016	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 005			12/01/2017	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 006	01/12/2017	01/12/2018			

Contents

Organisation RDI management arrangements

Information on key contacts.

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

Contact number:	
Contact email:	

Information on staffing of the RDI office.

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

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

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

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

Research networks	
Research network (name/location)	Role/relationship of the research network e.g. host organisation
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Research Nurse, band 7 (Cancer) 0.8WTE
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Research Nurse, band 6 (Cancer) 1 WTE
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Research Nurse, band 6 (Cross Divisional) 1 WTE

Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Research Nurse, band 6 (Cross Divisional) 1 WTE
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Research Nurse, band 6 (Stroke /Cross Divisional) 1 WTE
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Research Nurse, band 6 (Rhuematology) 1 WTE
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Research Nurse, band 6 (Paediatic / Cross Divisional) 0.5 WTE
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Research Nurse, band 6 (Matenity /Cross Divisional) 0.4 WTE
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Research Nurse, band 6 (Matenity /Cross Divisional) 0.5 WTE
Clinical Research Network, North West Coast (CRN NWC)	Nursing and Midwifery, Research Nurse, band 6 (Emergency Department) 0.5 WTE
Clinical Research Network, North West Coast (CRN NWC) & St Helens and Knowlsey Teaching Hospitals NHS Trust	Nursing and Midwifery, Research Nurse, band 7 (Commerical) 1 WTE
Clinical Research Network, North West Coast (CRN NWC)	Data Support, band 3, 0.6WTE
Clinical Research Network, North West Coast (CRN NWC)	Data Support, band 4, 0.6WTE
Clinical Research Network, North West Coast (CRN NWC)	Data Support, band 4, 0.8WTE

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

Current collaborations / partnerships

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

Innovation Agency (Academic Health Science Network, North West Coast)	The Trust is a partner of the AHSN, we work together to embed innovation as a core part of the business within STHK .	Dr Liz Mear	info@nwcahsn.nhs.uk	01772 520250
Clinical Commissioning Groups	The Trust is involved in a small number of primary care research projects.	For further information contact Jeanette Anders, RDI Manager	jeanette.anders@sthk.nhs.uk	0151 430 2334
Liverpool University	The Trust is involved in a number of research projects with Liverpool University.	For further information contact Jeanette Anders, RDI Manager	jeanette.anders@sthk.nhs.uk	0151 430 2334
St Helens Clinical Commissiong Group	The Trust has links to Primary Care through the CCG. These links are vital and offer us the potential to collaborate on joint research projects as well as recruiting from the primary care sector.	Professor Sarah O'Brien Interim Chief Executive St Helens CCG	Sarah.OBrien@sthelensccg.nhs.uk	01744 624268
Liverpool University	Mr Rowan Pritchard Jones, Consultant Plastic Surgeon at STHK and Honorary Clinical Lecturer at Liverpool University	Mr Rowan Pritchard Jones	rowan.pritchardjones@sthk.nhs.uk	

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Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
Go to top of document

Organisation study capabilities

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

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

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

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

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

Number/notes on General Practitioner (GP) practices

Organisation services

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

Clinical service departments					
Service department	Specialist facilities that may be provided (e.g. number/type of scanners)	Contact name within service department	Contact email	Contact number	Details of any internal agreement templates and other comments
Pathology	Minus 20, 30 and 80 freezers	Samantha Bonney	samantha.bonney@sthk.nhs.uk	0151 430 1838	
Pharmacy	Designated Research Pharmacist	Jodie Kirk	jodie.kirk@sthk.nhs.uk	0151 290 4284	
Pharmacy	Back up Research Pharmacist	Hannah Webster	Hannah.Webster@sthk.nhs.uk	0151 430 1678	
Radiology	Clinical Radiation Expert	Nabile Mohsin	Nabile.Mohsin@sthk.nhs.uk	0151 426 1600	Clinical Director for Radiology
Radiology	Medical Physics Expert	Paul Connolly	paulconnolly@irs-limited.com	0151 709 6296	Paul Connolly from IRS Ltd is the Medical Physics expert for the Trust
Radiology	2x 1.5 GE MRI 1 x 3.0T MRI 3 X GE 64 slice CT scanners	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Radiology	2x Digital Mammography	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Radiology	2x Digital dental including cephalometry	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Radiology	2x Fluoroscopy /1 x interventional	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Radiology	20X Ultrasound including Cardiac /Elastography	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Radiology	6x Digital radiography including tomosynthesis	David Anwyl	david.anwyl@sthk.nhs.uk	0151 430 1263	
Cardio-Respiratory Department	24 hour ambulatory electrocardiography Extended ambulatory electrocardiography Cardiomemo Event Recording Tilt table testing [HUTT] Carotid sinus massage test Ambulatory blood pressure monitoring Electrocardiograms: 12 lead ECGs Transthoracic echocardiography Transoesophageal echocardiography Stress echocardiography Exercise electrocardiography Spirometry Measurement of maximum expiratory and inspiratory flow volume loop Oximetry assessment Carbon monoxide transfer factor test Simple lung function exercise test Measurement of static lung volume Measurement of respiratory muscle strength Measurement of maximum expiratory and inspiratory flow volume loop Bronchial Reactivity Overnight oximetry (Includes: Measurement of oxygen desaturation index	Gina Rogers	gina.rogers@sthk.nhs.uk	0151 430 2424	

Cardio-Respiratory Department	Assessment for fitness to fly (hypoxic challenge) - flight assessment Pacemaker Implantation - single / dual [plus Box Changes] Implant/Removal of electrocardiography loop recorders ILRs Remote Follow-up inc. Pacemakers /ICDs Coronary Angiography	Gina Rogers	gina.rogers@sthk.nhs.uk	0151 430 2424	

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

Management Support e.g. Finance, legal services, archiving					
Department	Specialist services that may be provided	Contact name within service department	Contact email	Contact number	Details of any internal agreement templates and other comments
Archiving	Archiving arrangements are part of the Trust approval process and are detailed in the Clinical Trial Agreement for each study. The Trust holds a corporate archiving contract with Cintas.	Jeanette Anders	jeanette.anders@sthk.nhs.uk	0151 430 2334	
Contracts (study related)	Advice and support - See comments	Jeanette Anders	jeanette.anders@sthk.nhs.uk	0151 430 2334	The model agreement for non-commercial research and the model agreement for pharmaceutical and biopharmaceutical industry sponsored research is used by St Helens and Knowsley Teaching Hospitals NHS Trust
Contracts (study related)	Sign off of clinical trial agreements	Professor K Hardy	kevin.hardy@sthk.nhs.uk		The model agreement for non-commercial research and the model agreement for pharmaceutical and biopharmaceutical industry sponsored research is used by St Helens and Knowsley Teaching Hospitals NHS Trust
Finance	Corporate Accountant	Michelle Booth	Michelle.Booth@sthk.nhs.uk	0151 426 1600	The RDI Department has links with finance and are fully supported in all areas relating to research.
Information Technology	Director of Informatics	Christine Walters	christine.walters@sthk.nhs.uk	0151 430 1134	RDI Department is fully supported by the Director of ICT. IT training, IT system set up, hardware and software configuration set up, firewall configuration and connection to external servers.
Legal	Head of Complaints & Legal Services	Tom Briggs	TBC	0151 426 1600	Support and advice with the legal aspects of research is provided when necessary.
HR	Research Passports, Honorary Contracts, Letters of Access	Andrea Wisdom	andrea.wisdom@sthk.nhs.uk	0151 290 4185	
Training	Essential In house Standard Operating Procedure Training	Jeanette Anders, Amanda McCairn, Susan Dowlling	research@sthk.nhs.uk	0151 430 2334/ 2315	In house training on essential Standard Operating Procedures is provided for new starters or as updates if required.
Training	Good Clinical Practice (GCP) training. The Trust has 2 NIHR GCP Facilitators.	Jeanette Anders, Susan Dowlling	research@sthk.nhs.uk	0151 430 2334/ 2315	The GCP facilitators are required to facilitate 4 courses per year.

Study Management	EQMS Document Management System	Paula Scott	research@sthk.nhs.uk	0151 430 2334/ 2315	EQMS Document Manager delivers control over critical documentation for research.To be fully implemented in 2017.
Performance Management of studies	Audit and on-going review of studies.	Contact via RDI Department	research@sthk.nhs.uk	0151 430 2334/ 2315	During the RDI approval process, feasibility, capacity and capability checks take place including requirement for nurse support, appropriate resources, equipment & facilities, realistic recruitment target etc. After approval is granted, the RDI Department remain a point of contact, reviewing the progress of each study. A yearly Research Governance Framework (RGF) audit is conducted and when a need is identified ad hoc audits will be completed..

Organisation RDI interests

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

Organisation RDI areas of interest				
Area of interest	Details	Contact name		Contact number
Anaesthetics	Anaesthetist for Obs & Gynae	Dr P Yoxall	peter.yoxall@thk.nhs.uk	0151 430 1267
Anaesthetics		Dr K Mukhtar	karim.mukhtar@sthk.nhs.uk	0151 430 1268
Anaesthetics		Dr Goel	Vandana.Goel@sthk.nhs.uk	
Burns and Plastics		Mr R Pritchard-Jones	rowan.pritchardjones@sthk.nhs.uk	
Burns and Plastics		Mr P Brackley	philip.brackley@sthk.nhs.uk	0151 430 1664
Burns and Plastics		Mr K Shokrollahi	kayvan.shokrollahi@sthk.nhs.uk	
Cancer		Ms Leena Chagla	leena.chagla@sthk.nhs.uk	
Cancer		Professor R Audisio	riccardo.audiso@sthk.nhs.uk	01744 646672
Cancer		Dr T Nicholson	toby.nicholson@sthk.nhs.uk	0151 430 1825
Cancer		Dr E Hindle	elaine.hindle@sthk.nhs.uk	
Cancer		Dr Z Khan	zahed.khan@clatterbridgecc.nhs.uk	
Cancer		Dr R Lord	rosemary.lord@clatterbridgecc.nhs.uk	
Cancer		Dr H Innes	helen.innes@clatterbridgecc.nhs.uk	
Cancer		Dr E Marshall	ernie.marshall@sthk.nhs.uk	01744 646771
Cancer		Miss T Kiernan	Tamara.Kiernan@sthk.nhs.uk	
Cancer		Mr A Khattak	Altaf.Khattak@sthk.nhs.uk	
Cancer		Mr Samad	Ajai.Samad@sthk.nhs.uk	
Care of the Elderly		Dr Gandecha	Dipen.Gandecha@sthk.nhs.uk	
Cardiology		Dr R Katira	Ravish. Katira@sthk.nhs.uk	0151 430 1041
Palliative Care		Dr S Coyle	SeamusC@willowbrookhospice.org.uk	0151 430 8736
Critical Care		Dr J Wood	julie.wood@sthk.nhs.uk	0151 430 2394
Critical Care / Acute Medical Unit		Dr F Andrews	francis.andrews@sthk.n	
Critical Care		Ascanio Tridente	Ascanio.Tridente@sthk.nhs.uk	0151 430 1421
Dermatology		Dr J Ellison	judith.ellison@sthk.nhs.uk	01744 646584
Dermatology		Dr E Pang	evelyn.pang@sthk.nhs.uk	01744 646614
Dermatology		Dr M Walsh	Maeve.Walsh@sthk.nhs.uk	
Dermatology		Dr K Eustace	Karen.Eustace@sthk.nhs.uk	
Dermatology		Dr Ngan	Kok.Ngan@sthk.nhs.uk	
Diabetes		Professor K Hardy	kevin.hardy@sthk.nhs.uk	01744 646490
Diabetes		Dr N Furlong	naill.furlong@sthk.nhs.uk	01744 646496
Diabetes		Dr P Narayanan	Prakash.Narayanan@sthk.nhs.uk	
Emergency Medicine		Dr H Kataria	himanshu.Kataria@sthk.nhs.uk	0151 430 1063
Emergency Medicine		D Frazer	David.Frazer@sthk.nhs.uk	0151 430 2373
Emergency Medicine		Dr J Matthews	john.matthews@sthk.nhs.uk	
Musculoskeletal		Dr R Abernethy	rikki.abernethy@sthk.nhs.uk	01744 646586
Musculoskeletal		Dr J Dawson	Julie.Dawson@sthk.nhs.uk	
Gastro		Dr A Bassi	ash.bassi@sthk.nhs.uk	
Gastro		Dr R Chandy	rajiv.chandy@sthk.nhs.uk	
Gastro		Dr J McLindon	john.mclindon@sthk.nhs.uk	
Gastro		Dr D McClememts	dave.mcclements@sthk.nhs.uk	
Gastro		Dr S Priestley	Sue.Priestley@sthk.nhs.uk	
Gastro		Dr V Theis	Vanessa.Theis@sthk.nhs.uk	0151 290 4274
Haematology		Dr M Gharib	majed.gharib@sthk.nhs.uk	0151 430 1315
Haematology		Dr Taylor	David.Taylor4@sthk.nhs.uk	
Orthopaedics		Mr Ballester	Jordi.Ballester@sthk.nhs.uk	0151 290 4234
Orthopaedics		Mr Lipscombe	Stephen.Lipscombe@sthk.nhs.uk	
Paediatrics		Dr M Aziz	maysara.aziz@sthk.nhs.uk	
Paediatrics		Dr L Chilukuri	lakshmi.chilukuri@sthk.nhs.uk	
Paediatrics		Dr H Bentur	Hemalata.Bentur@sthk.nhs.uk	
Paediatrics		Dr Basavaraju	Jasavanth.Basavaraju@sthk.nhs.uk	
Paediatrics		Dr Ijaz Ahmad	ijaz.ahmad@sthk.nhs.uk	0151 430 1636
Reproductive and Child Health		Mrs Sandhya Rao	Sandhya Rao@sthk.nhs.uk	0151 430 2289
Reproductive and Child Health		Miss Vicky Cording	vicky.cording@sthk.nhs.uk	0151 430 1495
Reproductive and Child Health		Mrs Nidhi Srivastava	nidhi.srivastava@sthk.nhs.uk	
Reproductive and Child Health		Mrs Susmita	susmita.pankaja@sthk.nhs.uk	
Sexual Health		Dr E Acha	Estibaliz.Acha@sthk.nhs.uk	
Stroke		Dr Lalitha Ranga	Lalitha.ranga@sthk.nhs.uk	0151 430 2441
Stroke		Dr S Mavinamane	sunandra.mavinamane@sthk.nhs.uk	0151 430 1224
Stroke		Dr S Meenakshisundaram	sanjeevikumar.meeakshisundaram@sthk.nhs.uk	

Stroke		Dr A Hill	andrew.hill@sthk.nhs.uk	
Stroke		Dr T Smith	tom.smith@sthk.nhs.uk	0151 430 1245
Surgery		Mr R Rajaganeshan	raj.rajaganwshan@sthk.nhs.uk	
Urology		Mr J McCabe	john.mccabe@sthk.nhs.uk	
Urology		Mr A Omar	Ahmad.Omar@sthk.nhs.uk	
Urology		Mr A Samsudin	azi.samsudin@sthk.nhs.uk	

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

Specialty group membership (local and national)					
National / local	Specialty group	Specialty area (if only specific areas within group)	Contact name	Contact email	Contact number
North West	Managers meeting	Research and Development	*Jeanette Anders*	jeanette.anders@sthk.nhs.uk	*0151 430 2334*

Organisation RDI planning and investments

Planned investment			
Area of investment (e.g. Facilities, training, recruitment, equipment etc.)	Description of planned investment	Value of investment	Indicative dates
Grant Development	Advice and support in the development of new STHK led grant applications		

Organisation RDI standard operating procedures register

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

Information on the processes used for managing research passports.

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

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

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

Planned and actual studies register

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

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

Other information

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

Other information (relevant to the capability of the organisation)
Building our research strength is an important part of the Trust's strategy, which clearly states our vision for the continued advancement of Research Development and Innovation at STHK, and sets clear goals and objectives that will enable us to promote a culture where RDI drives better patient care, to improve the Trust's capacity, capability and delivery of clinical research.

TRUST BOARD

Paper No: NHST(17)104
Title of paper: Compliance with the NHS Constitution
Purpose: To provide assurance to the Board on the Trust's compliance with the patient, public and staff rights contained within the NHS Constitution
Summary: The NHS Constitution establishes a number of rights for patients and staff, with pledges that the NHS is committed to achieving and outlines the responsibilities of staff and patients to make the NHS work more effectively. The Trust is legally required to take account of the NHS Constitution in performing its NHS functions, in both the decisions made and actions taken. The Constitution contains seven areas relating to patients and nine areas to staff. It is good governance practice for Boards to gain assurance that the Trust meets, and can continue to meet, the requirements. This paper provides a summary of the Trust's position to provide the Board with assurance about our compliance. The last review was undertaken in 2015, and it was felt timely for this to be repeated now and biennially going forward. Appendix 1 provides the position statement for the Trust's compliance with the rights of patients and the public and Appendix 2 outlines compliance with rights of staff.
Corporate objectives met or risks addressed: 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.
Financial implications: There are no direct financial implications arising out of this assurance report.
Stakeholders: Patients, public, staff, commissioners and regulators.
Recommendation(s): Members are asked to consider the assurances provided in the report and approve the actions proposed to strengthen assurance.
Presenting officer: Nicola Bunce, Interim Director of Corporate Services
Date of meeting: 29th November 2017.

Appendix 1: NHS Constitution – Patients and public rights

No.	Right	Position statement	Exec Lead	Lead officer	Comment/ Evidence
1.	Access to health services				
1.1.	You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.	The Trust provides NHS services free of charge, other than the exceptions sanctioned by Parliament (e.g. overseas visitors)	Director of Operations and Performance		Private Patient / Overseas Visitors Policy
1.2.	You have the right to access NHS services. You will not be refused access on unreasonable grounds.	Patients can access emergency care through A&E or via their GP to access specific assessment units. Elective care is accessed via a patient's GP. Where necessary, referral criteria are agreed with commissioners to ensure that the most appropriate care is delivered to those who need it. The Trust has a Patient Access Policy in place to ensure that patients receive treatment in accordance with national objectives and targets and the Trust follows all the national guidance and criteria for patient selection. The Trust complies with the Equality Act 2010, ensuring that patients are not refused treatment on unreasonable grounds. It uses the Equality Delivery System for the NHS (EDS) as the mechanism for reviewing compliance and this is monitored through the Trust's Equality and Diversity Steering Group, which includes representatives from the local community. Improved patient access and experience is rated as achieved for the 2016 submission of EDS. The Trust has an Equality and Human Rights Policy which aims to: • Ensure that the Trust meets its statutory requirements as defined by the Equality Act 2010 • Support the Human Rights of patients, visitors and employees in the Trust as defined by the Human Rights Act 2008 • Ensure that the Trust anticipates the consequences of its actions on our local communities and ensure that, as far as possible, negative consequences are eliminated and opportunities for promoting equality are maximised wherever possible. Patients who have paid privately for some elements of the care are still able to access free NHS services at the Trust. Non-EEA residents are able to access free NHS care in certain circumstances including emergency care in line with national guidance.		Named Professional Safeguarding Adults/Patient Inclusion and Experience Lead	Equality and Human Rights Policy Equality and Diversity Steering Group reports to Patient Experience Council (PEC) EDS2

1.3.	You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.	Assessment of patients' individualised needs and plans of care are documented within clinical records, including a number of risk assessments. These are regularly audited for completeness. A system of electronic alerts is in place to identify those who require reasonable adjustments to be made to their journey and adjusted pathways have been developed in a number of areas to provide bespoke processes for those with additional needs/protected characteristics, including accessible information. Suitably qualified staff are in place to support this right, with all staff required to complete robust recruitment checks, induction, mandatory training and annual appraisals.	Director of Operations and Performance & Director of Nursing, Midwifery and Governance		Trust wide record keeping audit programme reported to the Clinical Effectiveness Council (CEC) Patient surveys and complaint reports reviewed by the PEC
1.4.	Not Applicable – Commissioning responsibility to commission and put in place services to meet community needs.				
1.5.	Not Applicable – Commissioning responsibility in certain circumstances, to go to other countries for treatment				
1.6.	You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.	See 1.2 above	Director of Nursing, Midwifery and Governance	Named Professional Safeguarding Adults	See 1.2 above
1.7.	You have the right to access certain services commissioned by NHS bodies within maximum waiting times or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution and relate to 2 week cancer target and 18 week target.	Overall, the Trust is meeting the national referral to treatment times, which are monitored by the Board monthly.	Director of Operations and Performance		Integrated Performance Report (IPR)

2.	Quality of care & environment				
2.1.	You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.	The Trust is registered with the CQC without conditions. Clinical and Quality Strategy in place and progress reported to the Board. All staff are subject to the full recruitment checks prior to commencing in post and are required to complete induction/mandatory training and annual appraisals. Monthly safer staffing reports are reviewed by the Quality Committee. Medical and nursing staff are required to complete revalidation. Patient Safety Council maintains overview of the safety of services, including incident reporting and follow-up of actions arising from root cause analysis investigations into serious incidents. Lessons learnt are shared via bimonthly safety briefing issued with Team Brief and team meetings at ward level to ensure safety culture across the Trust. System in place for cascading and acting on patient safety alerts via the Central Alerting System (CAS).	Director of Nursing, Midwifery and Governance		Clinical and Quality Strategy progress report IPR including training figures & CQC registration. Annual medical Revalidation Report. Patient Safety Council reports to the Quality Committee (QC) CAS report to Patient Safety Council. Safer staffing reports to the QC and the Board
2.2.	You have the right to be cared for in a clean, safe, secure and suitable environment.	Services are provided from two relatively new hospitals that are well-maintained through the PFI contract. The Trust was ranked first in the latest patient-led assessment of the care environment (PLACE) and scored 100% for standards of cleanliness. Regular infection prevention and control audits are completed and actions developed to improve standards. The Trust is meeting its C-Difficile target. The Trust is compliant with Health and Safety legislation. The Trust has a local security management specialist in place to actively promote a safe and secure environment.	Director of Estates and Facilities		PLACE inspection reports IPR Health and Safety reports to the Workforce Council (WC) Friends and Family Test (FFT) results and Patient Surveys reported to the PEC Complaints and PALS reports to the QC

2.3.	You have the right to receive suitable and nutritious food and hydration to sustain good health and wellbeing.	Nutrition and hydration for patients is monitored via the monthly audits of nursing care indicators, which are reported to the Patient Experience Council. Patients are risk assessed using the National Institute for Health and Care Excellence (NICE) recommended Malnutrition Universal Screening Tool (MUST) to ensure appropriate nutrition is provided to the patients as per the documented plan of care. A number of wards throughout the hospital have protected mealtimes, which is assessed via the Quality Care Assessment Tool (QCAT). Significant improvements have been noted with the recording of MUST assessments since the introduction of e-risk assessments.	Director of Nursing, Midwifery and Governance		Healthwatch, patient survey and Nursing Care Indicator reports to Patient Experience Council. QCAT accreditation
2.4.	You have the right to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.	The Clinical and Quality Strategy has a number of key performance indicators to help monitor the delivery of the Strategy. These are reported to the Board via the IPR, which has a range of quality and safety targets. The Trust has a comprehensive Clinical Audit programme in place, which includes action plans to address any areas identified for improvement as part of the audit process. There is a QCAT accreditation scheme in place, which is reported to the Patient Experience Council and QC. Patient feedback is used to drive continuous improvement, through the FFT, Healthwatch reports and patient surveys. Wards display their FFT results and the actions being taken to address issues. The Trust sets annual objectives, which include quality targets. The published Annual Quality Account provides a succinct summary of the quality of care provided by the Trust. Commissioners hold the Trust to account to deliver CQuIN and other quality targets. The Trust has implemented its policy for learning from deaths, 'Mortality Review – Responding to and Learning from the Death of Patients under the Management and Care of the Trust'	Medical Director/ Director of Nursing, Midwifery and Governance		Clinical and Quality Strategy progress report IPR Clinical Audit Programme reports to the CEC QCAT report to QC FFT report to PEC Annual Quality Account Trust's annual objectives Nursing Strategy progress report Reports to Clinical Quality and Performance Group (CQPG)

3.	Nationally approved treatments, drugs & programmes				
3.1.	You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you.	The Trust has a Medicines Management Policy and a Medicines Optimisation Strategy and Implementation Plan in place to ensure that patients receive appropriate drugs. All NICE guidance is reviewed to ensure it is relevant and compliance is monitored when guidance does apply, in line with the Policy for the Implementation of NICE Guidelines. Please note that a key part of this right relates to the funding of drugs and treatments, which is a commissioning responsibility.	Medical Director	Head of Pharmacy	NICE and medicines management reports to the CEC
3.2.	Not applicable – Commissioner responsibility regarding drug funding				
3.3.	Not applicable – Relates to national immunisation programme				

4.	Respect, consent & confidentiality				
4.1.	You have the right to be treated with dignity and respect, in accordance with your human rights.	The Trust has a Human Resources & Workforce Strategy in place that outlines the Trust's explicit values and behavioural standards. There are procedures in place for managing any instances where these standards are not maintained. Staff are actively encouraged to challenge poor behaviour and compliance with this is assessed during local quality reviews. Code of Confidentiality applicable to all staff, Chaperone Policy and Policy and Procedure for Eliminating Mixed Sex Accommodation in place. Professional standards and codes of conduct in operation for a number of clinical staff, including medical and nursing staff, through their regulatory bodies. The Trust got a positive score (8.9/10) for ensuring privacy for patients being treated in the latest in-patient survey.	Director of Nursing, Midwifery and Governance		Human Resources & Workforce Strategy Trust vision, values and behavioural standards Policies available on intranet 2016 In-patient Survey reported to the PEC
4.2.	You have the right to be protected from abuse and neglect, and care and treatment that is degrading.	Safeguarding Policy and Procedures in place. Safeguarding Steering Groups for adults and children meet regularly to review the effectiveness of the policy and the Trust's arrangements for protecting patients from abuse. Safeguarding training is part of the mandatory training requirement for staff, with compliance monitored by the Steering Groups. Staff aware of the need to report any abuse and to take action to prevent further abuse. Any allegations of abuse raised by patients/ carers are thoroughly investigated and actions taken.		Named Professional Safeguarding Adults/ Named Nurse for Safeguarding Children	Safeguarding Policy Safeguarding Steering Group minutes reported to PSC IPR Incident Reporting and Management Policy
4.3.	You have the right to accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests	Consent Policy in place and being implemented. Consent audits undertaken as part of the Trust's Clinical Audit Programme. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Policy supported by checklist to aid communication. MCA/DoLS training is mandatory for all staff. Learning Disability passports in use in the Trust.	Medical Director	Assistant Medical Director	Clinical Audit Programme reports to the CEC All policies are available on the intranet Mandatory training figures reported in IPR

4.4.	You have the right to be given information about the test and treatment options available to you, what they involve and their risks and benefits.	Consent Policy has been updated to reflect the Montgomery ruling and the need to ensure greater level of detail is provided when gaining consent. Where possible consent is obtained during pre-operative appointment to allow maximum time for information to be provided to patients and considered by them. Detailed information relating to changes in case law circulated to key staff, following training session to raise awareness. Consent audits undertaken as part of the Trust's Clinical Audit Programme. Number of information leaflets in place for patients to support decision-making	Medical Director	Assistant Medical Director	Consent Policy Information leaflets Consent audit
4.5.	You have the right of access to your own health records and to have any factual inaccuracies corrected.	Access to Health Records Policy available on the Trust's website for patients/public. The policy includes flowchart of the process to obtaining health records and how to have amendments to inaccurate entries recorded.	Director of Informatics	Head of Complaints and Legal Services	Access to Health Records Policy
4.6.	You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure.	Code of Confidentiality applicable to all staff which gives staff clear guidance on how to keep information and secure. Information Governance training is mandatory for all staff and we have a proactive Information Governance Team who issue regular updates to all staff groups on the importance of information security. The Trust is compliant with all elements of the IG Toolkit and is externally audited on this annually. The Trust scored 80% for 2016-17 submission. The Trust has a robust Information Governance Structure and has a Caldicott Guardian and Senior Information Risk Owner (SIRO) in place.		Information Governance Manager	IG Toolkit monitoring via Audit Committee IG report to the Board IG Steering Group Minutes
4.7.	You have the right to be informed about how your information is used.	In line with its obligations under the Data Protection Act the Trust displays its "fair processing notice" on the Trust website which informs service users how we use their information. This information is also displayed in all wards and other public facing locations in the form of leaflets entitled, "The NHS & Your Information" and "How We Use and Protect Your Personal Information" these leaflets clarify how service user information is used, stored, shared and kept secure.			Patient leaflets available on the Trust website

4.8.	You have the right to request that your confidential information is not used beyond your own care and treatment and to have your objections considered, and where your wishes cannot be followed, to be told the reasons including the legal basis.	See 4.7 above	Director of Informatics	Information Governance Manager	See 4.7 above
5.	Informed choice				
5.1.	Not applicable – Relates to Primary Care duty for GP practices				
5.2.	Not applicable – Relates to Primary Care duty for specific doctor within GP practices				
5.3.	You have the right to transparent, accessible and comparable data on the quality of local healthcare providers, and on outcomes, as compared to others nationally	The Trust publishes its Quality Account on an annual basis, complying with the information requirements established by the Department of Health and provides performance information as part of the public Board papers on-line. In addition, information is provided centrally and uploaded to the MyNHS website for comparative purposes, including PROMS, friends and family test, infection prevention and control. The Trust publicises its CQC rating in line with the legal requirement	Director of Operations and Performance		MyNHS website NHS Choices website
5.4.	You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs. Details are set out in the Handbook to the NHS Constitution	The Trust provides information about its services through the website and via GPs. Patients are able to select their provider of choice for services accessed through the NHS e-referral service (choose and book). Please note partial responsibility for upholding this right rests with commissioners – please refer to the NHS Constitution Handbook for further details.	Director of HR	Head of Communications	Patient & Visitor and GP sections of Trust's website.

6.	Involvement in your healthcare & in the NHS				
6.1.	You have the right to be involved in planning and making decisions about your health and care with your care provider or providers, including your end of life care, and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers. This includes being given the chance to manage your own care and treatment, if appropriate.	A key part of the care planning process and patient documentation includes involvement of patients/carers. Individual Care and Communication Record for patients at the end of their life includes sections for communication and patient/carer preferences. Results from the latest in-patient survey show a score of 7.4/10 for patients feeling they were as involved as much as they wanted to be in decisions about care and treatment, which is in line with the national average. Please note an element of upholding this right rests with commissioners, including the options for personal health budgets.	Medical Director/ Director of Nursing, Midwifery and Governance		Clinical and nursing documentation Individual Care and communication record
6.2.	You have the right to an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which, in the opinion of a healthcare professional, has caused, or could still cause, significant harm or death. You must be given the facts, an apology, and any reasonable support you need.	The Trust has being open and honest as one of its five values. There are systems and processes in place to support staff and to ensure compliance with the duty of candour, including a Being Open Policy and mandatory fields when reporting moderate and severe harm incidents. Being open and the duty of candour are covered in the incident reporting section of mandatory training. In addition, the Trust has recently approved its policy for learning from deaths.	Director of Nursing, Midwifery and Governance	Assistant Director of Safety & Governance	Being Open Policy Duty of Candour fields on Datix Letters submitted to patients/carers following investigations. Mortality Review – Responding to and Learning from the Death of Patients under the Management and Care of the Trust Policy
6.3.	You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.	Improvements to services are made as a result of feedback from patients through the friends and family test and through the complaints system. Full public consultations are undertaken as required. Please note an element of upholding this right rests with commissioners when planning which services to commission.	Director of HR	Deputy Director of HR	Quality Account includes information on changes made as a result of patient input.

7.	Complaint and redress				
7.1.	You have the right to have any complaint you make about NHS services acknowledged within three working days and to have it properly investigated	Managing Concerns and Complaints Policy includes requirement to acknowledge complaints within 3 working days, which is reported to the Quality Committee. There is a formal process in place for ensuring that all complaints are managed appropriately, including a full investigation and feedback to complainants.	Director of Nursing, Midwifery and Governance	Head of Complaints and Legal Services	Managing Concerns and Complaints Policy Complaint report to QC Complaints section in Quality Account
7.2.	You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent	Managing Concerns and Complaints Policy includes section on discussing the handling of the complaint with the complainant. The Complaints Team ensure that patients are fully involved in the process as required.			Managing Concerns and Complaints Policy
7.3.	You have the right to be kept informed of progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken	The Complaints Team liaise with the complainant to ensure they are aware of any delays. Each complaint has a written response, which informs the complainant of the outcome of the investigation and what actions are to be taken to resolve any issues identified. Where required, face-to-face meetings are held between complainants and members of the Trust to ensure that the complainant is satisfied with the Trust's response. Complaint surveys are undertaken to ascertain if patients are happy with the process and the results are presented to the Quality Committee quarterly. Complaint responses are signed off by the Chief Executive, the Director of Nursing, Midwifery and Governance or the Deputy Chief Executive/Director of HR.			Managing Concerns and Complaints Policy
7.4.	You have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman or Local Government Ombudsman, if you are not satisfied with the way your complaint has been dealt with by the NHS	Managing Concerns and Complaints Policy includes a section on Parliamentary and Health Service Ombudsman The quarterly Complaints Report to the Quality Committee provides an update on the number of complaints that have been sent to the Ombudsman.			Managing Concerns and Complaints Policy Complaint report to QC
7.5.	Not applicable – Relates to the right to seek judicial review, but any person with a direct/personal interest in a decision made or action taken by the Trust would seek independent legal advice				

7.6.	You have the right to compensation where you have been harmed by negligent treatment	Claims Handling Policy in operation and overseen by the Legal Department. Trust is covered by the NHS Litigation Authority and works closely with them on responding to any claims that are received.	Director of Nursing, Midwifery and Governance	Head of Complaints and Legal Services	Summary of claims included in Aggregated Data Report

Appendix 2: NHS Constitution – Staff rights

No.	Right	Position statement	Exec Lead	Lead officer	Comment/ Evidence
1.	Have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives				
1.1.	Right to fair treatment regarding leave, rights and flexible working and other statutory leave requests relating to work and family, including caring for adults with whom you live.	There are a number of workforce policies in place to ensure fair treatment including those for Equality & Diversity, Annual Leave and Flexible Working The Trust has positive staff survey results and was in the top 20% of Trusts where the staff would recommend the organisation as a place to work in the last survey.	Director of HR	Deputy Director of HR	2016 Staff survey results Policies available on the intranet
1.2.	Right to request other 'reasonable' time off for emergencies (paid and unpaid) and other statutory leave (subject to exceptions).	Special Leave Policy in place, allowing for staff to take time off for emergencies and to undertake work in public positions, for example as a school governor or justice of the peace			Policies available on the intranet Staff survey results
1.3.	Right to expect reasonable steps are taken by the employer to ensure protection from less favourable treatment by fellow employees, patients and others (e.g. bullying or harassment)	Range of policies in place to protect staff, including Equality and Diversity, Respect and Dignity at Work, Grievance. Staff satisfaction is measured through the SFFT and the national staff survey, which reported a better than average score for staff experiencing bullying or harassment.			Policies available on the intranet Staff survey results Staff Friends and family test (SFFT)
2.	Have a fair pay and contract framework				
2.1.	Right to pay; consistent with the National Minimum Wage or alternative contractual agreement and right to fair treatment regarding pay.	All non-medical roles below very senior manager level are covered by Agenda for Change (A4C) – all these posts are reviewed against the job evaluation handbook. Medical and dental staff pay scales are compliant with appropriate Terms and Conditions. VSM posts are job evaluated as per the role and pay scales set accordingly – these are published in the Remuneration Report in the Trust's Annual Report Local negotiating committees meet to agree workforce policy.	Director of HR	Deputy Director of HR	A4C T&C and job evaluation handbook Trust Annual Report Hay evaluation of VSM JNCC & TJLNC minutes

3.	Be involved and represented in the workplace				
3.1.	Right to be accompanied by either a Trade Union official or a work colleague at disciplinary or grievance hearings in line with legislation, your employer's policies or your contractual rights	This statutory right is covered in the relevant policies, including Disciplinary Policy and Grievance Policy	Director of HR	Deputy Director of HR	Policies available on the intranet in line with ACAS guidance and best practice
3.2.	Right to consultation and representation either through a Trade Union or other staff representatives (for example where there is no Trade Union in place) in line with legislation and any collective agreements that may be in force	Please see 3.1 Range of trade union representation throughout the Trust.			Policies available on the intranet Partnership Agreement signed by all trade unions representing a range of staff groups and professional bodies
4.	Have healthy and safe working conditions and an environment free from harassment, bullying or violence				
4.1.	Right to work within a healthy and safe workplace and an environment in which the employer has taken all practical steps to ensure the workplace is free from verbal or physical violence from patients, the public or staff, to work your contractual hours, take annual leave and to take regular breaks from work	Number of workforce policies in place, e.g. The Respect at Work policy, ACE Behavioural Standards, Violence & Aggression Against Staff policy – In addition there are a number of other relevant policies in place, including Incident Reporting and Management, Health and Safety and Security Management. Local Security Management Specialist in place in the Trust to provide expert advice and guidance. All frontline staff are required to undergo conflict resolution training every three years. Health and Safety Group meets and reports to Workforce Council Action plan in place to address any issues highlighted in staff survey, which is monitored by the Workforce Council Health Work and Wellbeing Service in place which offers a wide range of support for staff	Director of HR	Deputy Director of HR	H&S reports to Workforce Council Staff Survey results and action plan report to Workforce Council Analysis of incidents against staff at Valuing our people Steering Group with assurance on remedial action to Workforce Council

5.	Be treated fairly, equally and free from discrimination				
5.1.	Right to a working environment (including practices on recruitment and promotion) free from unlawful discrimination on the basis of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status	Equality and Human Rights Policy in place, supported by a number of other policies, including Recruitment and Selection, to reduce risk of discrimination. The Trust monitors compliance with the Equality Act through the Equality Delivery System (EDS2) which is overseen by local Healthwatch. This includes key elements relating to staff and working practices within the Trust.	Director of HR	Deputy Director of HR	Policies available on the intranet Equality Delivery System (EDS2) report 2014 Annual Staff Survey HR case tracker
6.	Can in certain circumstances take a complaint about their employer to an Employment Tribunal				
6.1.	Right to appeal against wrongful dismissal	This is covered in the Disciplinary Policy, which states that staff have the right of appeal for all the stages of the disciplinary procedure. There is a clear appeal process. It is also covered in the Capability Policy.	Director of HR	Deputy Director of HR	Policies available on the intranet
6.2.	If internal processes fail to overturn a dismissal, you have the right to pursue a claim in the employment tribunal, if you meet required criteria	The Trust Disciplinary Policy is in line with ACAS guidance and employment law. Staff have the right to an appeal against their dismissal. The Trust works with ACAS conciliation service try to mitigate cases being pursued at Employment Tribunal			Policies available on the intranet
7.	Can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest				
7.1.	Right to protection from detriment in employment and the right not to be unfairly dismissed for 'whistleblowing' or reporting wrongdoing in the workplace	The Raising Concerns Policy provides protection for staff who report wrongdoing. The Trust has signed up to the "Speaking our Safely" campaign and has 4 nominated Freedom to speak our Guardians, as well as a confidential telephone line and the anonymous Speak in Confidence email option for staff to raise concerns.	Director of HR	Deputy Director of HR	Policies available on the intranet
7.2.	Right to protection from detriment in employment and the right not to be unfairly dismissed for 'whistleblowing' or reporting wrongdoing in the workplace	The Raising Concerns Policy provides protection for staff who report wrongdoing. The trust has signed up to the "Speaking our Safely" campaign, has 4 nominated Freedom to speak our Guardians and has the anonymous email route, Speak in Confidence in place.			Policies available on the intranet
8.	Have employment protection (NHS employees only).				
8.1.	Right to employment protection in terms of continuity of service for redundancy purposes if moving between NHS employers	There are a number of contractual obligations and Trust Policies in place for staff that are legally compliant, including Pay Protection and Managing Organisational Change.	Director of HR	Deputy Director of HR	Policies available on the intranet Agenda for Change Terms and Conditions Handbook

9.	Can join the NHS Pension Scheme				
9.1.	Right to join the NHS Pension Scheme	All new starters who are eligible to join the NHS Pension Scheme are automatically registered.	Director of HR	Deputy Director of HR	Included with new starter information when staff join the Trust

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)105
Title of paper: Arrangements for 2018/19 Board Meetings.
Purpose: To advise Board members of the proposed dates for Trust Board meetings throughout the next Financial Year; the supporting timetable, and scheduled agenda items.
Summary: 1. Board meetings have been held on the last Wednesday of each month and it is proposed that this arrangement will continue during 2018/19. 2. The paper attached confirms the dates for agenda setting, collation and distribution of papers and of actual meetings. 3. The Board also maintains a business schedule of planned agenda items throughout each year to ensure that it meets all statutory requirements and delivers the duties and responsibilities in the Trust's standing orders. 4. This schedule, once approved, will be used to inform the business cycle of the Board committees
Corporate objective met or risk addressed: Contributes to the Trust's Governance arrangements which ultimately support the Trust in achieving its Annual Objectives.
Financial implications: None directly from this report.
Stakeholders: The Trust, its Commissioners, its regulators and other stakeholders.
Recommendation(s): The Trust Board are asked to: 1. Approve the proposed dates and associated administrative timetable for Trust Board meetings. 2. Approve the proposed schedule of planned agenda items for Trust Board meetings.
Presenting officer: Nicola Bunce, Interim Director of Corporate Services.
Date of meeting: 29th November 2017.

SCHEDULE OF BOARD MEETING DATES (2018/19)

1. Meeting Schedule

1.1. Board meetings are held on the last Wednesday of each month with the exception of August and December where no meetings are scheduled.

1.2. The Trust believes in being open and transparent and members of the public are able to attend the public section of each Board meetings. Public Board Meetings, commence at 9:30a.m.and generally run for between 2 and 3 hours.

1.3. Four meetings a year (April, June, October and February) include discrete sessions for discussion on strategy, which are held in private following Public Board Meetings.

1.4. In addition, where necessary, meetings include discrete closed sessions for discussion on items of a sensitive or confidential nature, which are held in private following Public Board Meetings.

2. Administrative Arrangements

2.1. Board agendas are developed by the Executive Committee on behalf of the Chairman at least ten days in advance of meetings.

2.2. Both hard copies and electronic versions of the Board papers are distributed to members on the Friday preceding each Board meeting.

2.3. Papers for Public Board Meetings are uploaded onto the Trust internet site on the day preceding each meeting.

2.4. The following table captures the schedule for the 2018/19 Financial Year. Meetings that include a strategy session are shaded grey.

Financial Year 2018/19	Draft Agenda to Executive Committee	Agenda set	Board papers to be received	Electronic & hard copies circulated	Electronic copies on internet	Board date
April	Thu 05 Apr	Mon 09 Apr	Tue 17 Apr	Fri 20 Apr	Tue 24 Apr	Wed 25 Apr
May	Thu 10 May	Mon 14 May	Tue 22 May	Fri 25 May	Tue 29 May	Wed 30 May
June	Thu 07 Jun	Mon 11 Jun	Tue 19 Jun	Fri 22 Jun	Tue 26 Jun	Wed 27 Jun
July	Thu 05 Jul	Mon 09 Jul	Tue 17 Jul	Fri 20 Jul	Tue 24 Jul	Wed 25 Jul
August	No scheduled Board meeting					
September	Thu 06 Sep	Mon 10 Sep	Tue 18 Sep	Fri 21 Sep	Tue 25 Sep	Wed 26 Sep
October	Thu 11 Oct	Mon 15 Oct	Tue 23 Oct	Fri 26 Oct	Tue 30 Oct	Wed 31 Oct
November	Thu 08 Nov	Mon 12 Nov	Tue 20 Nov	Fri 23 Nov	Tue 27 Nov	Wed 28 Nov
December	No scheduled Board meeting					
January	Thu 10 Jan	Mon 14 Jan	Tue 22 Jan	Fri 25 Jan	Tue 29 Jan	Wed 30 Jan
February	Thu 07 Feb	Mon 11Feb	Tue 19 Feb	Fri 22 Feb	Tue 26 Feb	Wed 27 Feb
March	Thu 07 Mar	Mon 11Mar	Tue 19 Mar	Fri 22 Mar	Tue 26 Mar	Wed 27 Mar

3. TRUST BOARD CALENDAR (2018/19)

ANNUAL TRUST BOARD CALENDAR 2018/19																	
Month			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 (inc approval of Corp Governance Manual and Standing Financail Instructions)	2,6,7,10, 11,14,15, 32,33,34	✔		✔			✔	✔				✔		Nik	Su
		Executive (inc approval of Major Incident Plan)	3,11,16,18	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Nicola	Ann
		Finance and Performance	11	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Nik	Jeff
		Quality (inc Safer Staffing and infection control)	11, 25	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Sue	David
		Charitable Funds	11			✔				✔				✔		Nik	Denis
		Remuneration (or as required)	6,11			✔										Anne-Marie	Richard
	Operational performance reports	Strategic and regulatory report (inc annual complaince declarations)	3	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Nicola	
		Integrated performance report	3,4	✔	✔	✔	✔		✔	✔	✔		✔	✔	✔	Nik	
		Corporate Risk Register	3	✔			✔			✔			✔				
		Board Assurance Framework	3	✔			✔			✔			✔			Nicola	
		Complaints, claims & incidents report	3,9		✔				✔				✔			Sue	
		Informatics report and strategy update	3		✔				✔				✔			Christine	
		HR indicators	3				✔						✔			Anne-Marie	
	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 Annual Report	1,3		✔											Francis Andrews	
		Trust objectives & mid year review	3,24,31		✔						✔					Nicola	Ann
		Medical revalidation annual declaration	20				✔									Terry Hankin	
		Public Health Annual Report	24				✔									Kath	CCG Rep
		Audit Letter sign-off	1,33						✔							Nik	
		Charitable Funds Accounts & Annual Report	1							✔						Nik	Denis
		Research & development compliance statement	4								✔					Kevin	
		Biennial Review of NHS Constitution	1								✔					Peter	
		Trust Board meeting arrangements	1								✔					Peter	
		WRES Report and Action Plan	1,3						✔							Anne-Marie	
		Clinical and quality strategy update	24,25										✔			Kevin	
		Safeguarding report (Adult / Children)	1										✔			Sue	
		Budget and activity plan approval	1,2,7,29, 30												✔	Nik	
		Infection Control Annual Report	3		✔											Sue	
		CQC registration	1,25												✔	Sue	
		Mixed sex annual declaration	1												✔	Sue	
		Staff survey report and action plan	20												✔	Anne-Marie	
		Guardian of Safe Working Reports - StHK and Lead Employer	1,3		✔				✔		✔			✔		Anne-Marie	
		Learning from Deaths Quarterly Report		✔			✔			✔			✔			Terry Hankin	Kevin
	Total scheduled items			16	23	15	19	0	18	18	18	0	21	14	17		
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 effectivness				✔		✔		✔		✔		✔		✔	Richard	
	Director mandatory training / Corporate Law update		20							✔						External facilitators	

* Bi ennial unless national changes to the NHS Constitution

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)106

Title of paper: Mid-Year Review of Trust Objectives

Purpose: To present the mid-year progress review against the 2017/18 Trust objectives.

Summary:

1. The Trust Board agreed twenty-seven objectives for 2017/18 at the Board meeting in May 2017.
2. The objectives are split into 9 categories; 5 representing the Trusts Five Star Patient Care criteria of care, safety, pathways, communication, and systems. There are then 4 categories covering; organisational culture and support for the workforce, operational performance, financial performance, efficiency and productivity and strategic plans
3. This paper summarises the progress achieved to date and gives an assessment of the likely delivery by the end the financial year;

	Completed or on track for full completion by 31st March 2018
	In progress but with risk to full achievement by 31st March 2018
	Behind schedule or risk of not achieving

4. The ratings show that:
   a. 18 objectives are rated green (67%)
   b. 9 objectives are rated graded amber, and have recovery plans in place (33%)
   c. No objectives are rated red, at this time (0%)

Trust objective met or risk addressed: provides assurance to the Board that the Trust is making sufficient progress in delivering its annual plan.

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff and all stakeholders.

Recommendation(s): The Board is asked to note the progress being made to deliver the 2017/18 objectives.

Presenting officer: Ann Marr, Chief Executive.

Date of meeting: 29th November 2017.

Trust Objectives 2017/18 – Mid Year Progress Review

	Completed or on track from full achievement by 31st March 2018		In progress but risk to full achievement by 31st March 2018		Behind schedule or risk of not achieving

Objective	Lead Director	Progress to date	Rating (RAG)
1. 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***			
1.1 Through improved planning we will bring forward the time of patient discharges so that at least a third leave hospital by midday with the appropriate medication and care packages in place.	DoOps	More patients are now being discharged before noon with appropriate medication and care packages in place and that this has been associated with an improvement in 4 hr performance. However, the targets have not yet been achieved.	
1.2 In support of "Johns Campaign" we will ensure that carers of people with dementia are welcomed to spend as much time with patients as they want to and be involved in their care.	DoN	Johns Campaign implemented in DMOP and NoF ward and will be rolled out to the rest of the Trust by March 2018.	
1.3 We will actively seek suggestions to improve patient experience and where appropriate standardise care throughout the week.	DoOps /MD	The Trust has recently completed the latest national audit against the 7 day service standards. The results of the audit are expected to be published in the new year and will provide an opportunity to benchmark our position against other acute trusts, and develop an action plan to address any shortfalls. The area that has been most challenging for the Trust to achieve has been the standard for 14 hour consultant review, which requires all vacant posts to be filled and potential re-distribution of resources across the week. 7 day therapy and pharmacy services cover has been increased and there is improved patient streaming to enhance experience throughout the week	
2. 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***			
2.1 We will take active measures to improve safety and clinical outcomes particularly in the areas of infection control (MRSA); falls; and pressure ulcers ensuring that lessons are learned and appropriate actions	DoN	Weekly incident and learning forum in place. Quality and safety bulletin is regularly published. There have been no grade 3 or 4 pressure ulcers in the year	

Objective	Lead Director	Progress to date	Rating (RAG)
implemented throughout the Trust.		to October. 2 MRSA cases YTD (1subject to appeal) 10 falls resulting in harm YTD compared to 16 YTD in 2016/17	
2.2. We will ensure that incidents are reviewed within 72-hours of their occurrence and clear action plans are in place to prevent recurrence and are widely shared.	DoN	In place.	
2.3. We will implement a new system for learning from hospital deaths, using best-practice national guidance.	MD	On track to publish data in Q3, following approval of new Policy to meet the national guidance and appointment of Assistant Director to improve learning from mistakes, near misses, deaths, incidents and complaints	
3. 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***			
3.1. We will increase the scope of emergency ambulatory care pathways to reduce non-elective admissions ensuring they are embedded and appropriately accessed.	DoOps	Ambulatory care pathways implemented for medicine, surgery and emergency care. A generic pathway is also in development to maximise the number of patients identified for ambulatory care. A health system review of ambulatory care pathways has commenced so that primary care can identify patients and make direct referrals.	
3.2. We will implement a new midwifery-led care pathway for women having low risk births.	DoN	All capital works have been completed to create a Midwifery Led Unit and the new low risk birth pathways being implemented.	
3.3. We will achieve the planned benefits from taking over the management of adult community Nursing services in St Helens.	DoOps	Safe transfer of the services and implementation of the service specification; • Increased clinical leadership • Integration of the community Intermediate Care Service • Increase in bed occupancy and decrease in LoS for Newton • Community Nursing teams aligned to the agreed localities • Frailty team established • IASH (single point of contact) now coordinating referrals • Community Nurse in-reach to A&E Overarching service objectives to increase the quality of	

Objective	Lead Director	Progress to date	Rating (RAG)
		community nursing, reduce duplication across the system to improve patient experience and reduce reliance on acute hospital care are being demonstrated	
4. 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**			
4.1. We will pursue improvements in the systems used to investigate and respond to complaints and strive to respond to 90% within the agreed timescale. We will ensure that lessons are learned and shared.	DoN	October 2017 performance = 80.8% compared to 61.2% at the same time last year.	
4.2. We will review and improve patient information and communications ensuring that we are delivering concise, clear messages regarding all aspects of the individual patient's care.	DoN	Standard template for patient information booklets has been updated and re- launched, including the electronic versions via the internet site. There is a reader panel that reviews all leaflets before they are published All patient information leaflets are being reviewed during the year.	
4.3. We will continue to work with patient focus groups to enable a fuller understanding of patients' and carers' views and experiences in order to respond appropriately.	DoN	Positive relationship with and feedback from Healthwatch F&F test responses are over 95% favourable. In the recent PLACE assessment the Trust achieved the highest scores nationally for privacy and dignity in the care environment.	
5. 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***			
5.1 We will manage the smooth transition to the new Patient Administration System with minimal disruption to contractual or operational performance.	DoI	The project is on track to go live as planned at the end of March 2018. External independent reviews are being undertaken to provide reassurance that the plans for each of the workstreams are robust to help a smooth transition	
5.2 We will undertake benefit realisation exercises following the introduction of each new system to ensure that the planned benefits have been realised, or highlight where additional opportunities for efficiencies exist.	DoI	There is a benefits realisation workstream with executive leadership, whose responsibility is to ensure that the maximum amount of benefits are realised .	
5.3 We will finalise the 3-year IM&T Strategy to support clinical transformation across a wider footprint.	DoI	Complete and approved by the Trust Board	
6. 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.***			
6.1 We will identify creative approaches to recruitment and retention to ensure the Trust remains an employer of choice.	DepCEO	The Trust is working with education institutions to maximise available student recruitment and offering development incentives. The Trust is building on the experience gained from the Indian recruitment campaign and exploring other	

Objective	Lead Director	Progress to date	Rating (RAG)
		international opportunities across all shortage occupation staff groups. Listening events and Pulse surveys are undertaken with staff to aid retention.	
6.2 We will optimise the opportunities offered by the Apprenticeship Levy with innovative approaches to new roles & higher level qualifications.	DepCEO	Process developed to offer staff apprenticeship opportunities at all levels, aligned to organisational need and the qualifications currently	
6.3 We will explore opportunities for innovative ways of staff training and working to address skill shortages such as nurse and pharmacist prescribing to help overcome junior doctor shortages.	DepCEO	Assistant Practitioners are being supported to undertake Nurse Apprenticeships through the OU. One cohort commenced Oct17 and a second cohort will commence in Feb18. Discussions are underway to commence additional cohorts through Edge Hill university from Feb18. Funding has been secured from HEE to support Pharmacists and Nurses to complete Non-medical prescribing and also for the development of Advanced Nurse Practitioner roles in ED and Frailty. A second cohort of Physicians Associates is being supported alongside recruitment from the initial cohort. Biomedical Scientists are being supported to complete their degrees funded through the Apprenticeship Levy	
7. OPERATIONAL PERFORMANCE ***We will meet and sustain national and local performance standards***			
7.1 We will 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	DoOps	a. Stepped change in emergency access performance b. YTD cancer performance is above target c. 18 weeks targets achieved YTD d. Diagnostic targets achieved YTD e. Ambulance handover performance is improving and the trust continues to work closely with NWAS	
7.2 We will achieve local performance indicators including: a. CQUINS b. Contract performance indicators and compliance c. Activity levels to meet Trust operational plans.	DoOps	a. CQUINS on track to be delivered b. Contract indicators being delivered and no concerns raised by commissioners c. There are targeted recovery plans in place to increase productivity and achieve the elective activity plan, including improvement of theatre utilisation at St Helens hospital that will support recovery and help reduce the 18 week backlog	
7.3 We will use benchmarking and comparative data to highlight areas for improvement and seek to learn from best practice.	DoF	The Trust uses a range of different benchmarking sources including the Model Hospital, GIRFT, PLICS, NHSI Corporate services benchmarking (Carter), national audit comparators etc. that drive the identification of areas for	

Objective	Lead Director	Progress to date	Rating (RAG)
		improvement	
8. 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***			
8.1 We will establish a benchmarking and reference cost group to learn from the multitude of comparative performance information and improve data shared.	DoF	Have set up a costing group (which covers reference costs, CTP and SLR) within finance to review how we allocate costs for our internal and externally reporting and make improvements to the process. A Trust wide group to look at taking SLR (Service Line Reporting) to SLM (Service Line Management) is also being established, with the Assistant Medical Director as clinical champion. This group will meet for the first time in December and will focus on an individual speciality and how we can improve the profitability of the service.	
8.2 We will develop capacity and demand modelling capability at divisional level and ensure a consistent approach to service development proposals using regular source information	DoF	The demand and capacity modelling capability has been developed and the system used to inform the winter plan bed modelling and proposals to change the distribution of beds between medicine and surgery	
8.3 We will continue to review the opportunities for running non-clinical back-office functions and other services across a wider footprint where economies of scale can be demonstrated	DoF	DoF continues to be involved in the C&M Carter at scale work programme, and also the "Alliance" collaborative work which is taking forward opportunities such as the staff bank, payroll, procurement, pathology.	
9. 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***			
9.1 We will foster positive working relationships with health economy partners and help create the joint 5-year strategic vision for health services across wider footprints	All	Working with St Helens, Knowsley and Halton to support the development of Accountable care systems as a 2 – 5 year strategy depending on the pace in each Borough	
9.2 We will collaborate with partners in reviewing integrated patient pathways which offer alternative ways of working to the benefit of patient care, safety and efficiency of services	DoT	Membership of the St Helens Cares Executive and Peoples Boards.	
9.3 We will meet all the compliance requirements set by NHSI for long-term sustainability of the Trust's clinical services, collaboratively with partners where appropriate	DoCS	Adoption of Well Led framework and Use of Resources ratings, also preparation for the new style CQC Inspection process. Maintained a NHSI Segmentation rating of 2	

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)107
Title of paper: Quarterly Report on Safe Working Hours: Doctors and Dentists in Training (May 2017 – October 2017) – StHK trainees
Purpose: Following the implementation of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 the Guardian of Safe Working is required to ensure that issues of compliance of safe working hours are addressed by the doctor, employer, host organisation as appropriate and provide assurance to the Board of the employing organisation that doctors' working hours are safe.
Summary: The following paper pertains only to employees of the Trust under the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016. It covers the subsequent period from the last board report, 30th May 2017 – 31st October 2017. It does not include data regarding Lead Employer Trainees nor Community, Public and Mental health trainees, which will be the subject to a separate report. The Lead Employer GP/Public Health trainees will also be subject to a separate report presented by Dr Peter Arthur, Guardian of safe working hours.
Corporate objectives met or risks addressed:
Financial implications: Potential incurrence of fines and/or penalties owing to unsafe working practices
Stakeholders: Trust-wide
Recommendation(s): For information
Presenting officer: Mr Michael Chadwick, Guardian of Safe Working Hours
Date of meeting: 29th November 2017

Contents

1. Introduction

Following the implementation of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 the Guardian of Safe Working is required to ensure that issues of compliance of safe working hours are addressed by the doctor, employer, host organisation as appropriate and provide assurance to the Board of the employing organisation that doctors' working hours are safe.

The following report covers the period of 30th May 2017 – 31st October 2017

As part of the Terms and Conditions of Service for NHS Doctors and Dentists in training (England) 2016 all trainee doctors are provided an opportunity to report exceptions to their standard work schedules, as set out below;

- Working beyond the average weekly hours limit
- Extended hours of work beyond their expected shift length
- Breaches of weekend or night work frequency
- Failure of opportunity to take adequate natural rest breaks
- Failure of opportunity to attend formal teaching sessions in their work schedule
- Lack of support available to doctors during service commitments

2. High level data

Number of doctors/ dentists in training (total)	234	
Number of doctors/ dentist in training on 2016 Terms and Conditions	39	Foundation Year 1 Trainees
	37	Foundation Year 2 Trainees
	91	Core/Specialty Trainees
	167	**Total**
Amount of time available in job plan for guardian role	1 PA	
Admin support provided to the guardian	1.0 WTE	
Amount of job-planned time for educational supervisors	0.25 PA per Trainee	

3. Exception reports (with regard to working hours)

Exception reporting is the mechanism used by trainees subject to the Terms and Conditions of Service for NHS Doctors and Dentists in training (England) 2016 to notify the trust when their day-to-day work varies significantly, or regularly from their agreed work schedule.

Where a trainee raises an exception report this must be acted upon by Educational Supervisors (delegated to Clinical Supervisors.) This may result in no further action, time off in lieu (TOIL) or recommendation for payment for extra hours worked. In addition there are certain breaches which necessitate a fine for the involved department which is reinvested in part back to the trainee and in part in training and educational activity.

During the reporting period a total of 57 exception reports have been raised by a total of 15 trainees. Table 1 below offers further detail broken down by specialty.

Table 1

Specialities	Number Raised/Closed		Decision Outcome			No. that are on-going
	Raised	Closed	TOIL	Payment	Other	
General Surgery FY1	32	31	15	14	2	1
General Medicine FY1	23	23	3	3	17	0
Burns and Plastics ST4	1	-	-	-	-	1
General Medicine FY2	1	-	-	-	-	1
Total	57	54	18	17	19	3

On review of the exception reporting data the common theme reported is relating to trainees exceeding their working hours set out in their work schedule. The vast majority of cases, the trainees have stayed past their finish time and received time off in lieu in return.

4. Work schedule reviews

The work schedule is a document distributed to trainees before they commence their placement with the trust. It includes generic information relating to the placement, such as learning opportunities and the rota template.

There hasn't been any work schedule reviews as a result of exception reports during the report period.

5. Locum bookings

The tables below outline the total number locum bookings for areas and grades that are subject to the Terms and Conditions of Service for NHS Doctors and Dentists in training (England) 2016.

Table 1: Foundation Year One

Specialty	Total shifts filled by StHK trainees	Total shifts filled by agency
*Haematology	0	43
General Medicine	28	0
DMOP	2	0
Cardiology	1	1
*Diabetes and Endocrinology	72	0
Medical Emergency Unit	1	0
A&E	1	0
Total	105	44

**a non-training grade medical vacancy within Haematology has been filled by agency the position has subsequently been filled from August 2017 with a doctor from the international Brno recruitment project.*

**From August 17 Diabetes and Endo required shifts to be covered due to an international recruitment doctor awaiting full GMC approval. The GMC registration has since been successfully obtained.*

Table 2: Foundation Year Two & Core Trainees

Specialty	Total shifts filled by 2016 Trainees	Total shifts filled by agency
Burns and Plastics	7	106
A&E	415	38
Orthopaedics	147	117
ENT	20	87
Paediatrics	7	3
AMU	14	0
DMOP	65	0
General Surgery Medical	6	2
General Surgery Pre-Op	42	54
ICU	3	0
MEU	2	0
Obs and Gynae	6	38
Respiratory	39	22
Theatres Med Staff	24	0
Total	**797**	**467**

Table 3: Specialty Trainee ST3+

Specialty	Total shifts filled by 2016 Trainees	Total shifts filled by agency
General Surgery	4	33
Paediatrics	71	108
A&E	40	47
AMU	7	8
Burns &Plastics	5	0
Cardiology	20	2
DMOP	181	11
Gastro	10	0
Haematology	61	0
ICU	2	0
Medical Emergency Unit	20	0
Orthopaedics	38	0
Respiratory	2	0
Theatres Medical Staff	18	0
Urology	2	0
Obs and Gynae	104	0
Total	**585**	**209**

6. Vacancies

The below tables identify the trainee vacancies across the specialties subject to the Terms and Conditions of Service for NHS Doctors and Dentists in training (England) 2016 during the reporting period. As the reporting period covers junior doctor rotation, the tables have been split to show vacancies before and after August.

Table 1 – May 2017 – August 2017

Specialty	Grade	Funded Establishment (FTE)	Vacancy (FTE)
Paediatrics	Specialty Trainee	6	1.8
Trauma & Orthopaedics	Specialty Trainee	1	1
Obs & Gynae	Specialty Trainee	5	2
ENT	Core Trainee	1	1
Total		**13**	**5.8**

Table 2- August 17 to October 17

Specialty	Grade	Funded Establishment (FTE)	Vacancy (FTE)
Trauma and Orthopaedics	GPST	1	1
ENT	CT1/2	1	1
Emergency Medicine	GPST	5	1
Obs and Gynae	GPST	5	1.8
Obs and Gynae	ST3+	9	2.6
Total		**21**	**7.6**

**Trauma and Orthopaedics experienced a significant amount of vacancies from August 2017 due to 4 lost headroom posts and 1 Fy2 vacancy due to an Fy1 resigning. Despite attempts to recruit to the positions the positions have been filled by bank and agency. From December 18, they will have no vacancies.*

7. Fines

No fines have been applicable for this reporting period.

8. Issues arising and actions taken to resolve issues

Following poor attendance to the previously held Junior Doctor Forum meetings the timing has since been changed and in November had a much better attendance.

9. Conclusion and Recommendations

The guardian is assured with the overall safety of working hours in the organisation for trainees under the 2016 T&Cs based on evidence from the exception reports thus far. The guardian would ask the Board to note this report and to consider the assurances provided.

END

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)108

Title of paper: Lead Employer Report on Safe Working Hours: Doctors and Dentists in Training (December 2016 – October 2017)

Purpose: Following the implementation of the Terms and Conditions of Service for NHS Doctors and Dentists in training (England) 2016 the Guardian of safe working is required to ensure that issues of compliance of safe working hours are addressed by the doctor, employer and host organisation as appropriate and provide assurance to the Board of the employing organisation that doctors' working hours are safe.

Summary: The following paper pertains only to employees of the Trust under the Terms and Conditions of Service for NHS Doctors and Dentists in training (England) 2016. It covers the period from the inception of the contract 7th December 2016 – 31st October 2017. The data held within the report relates to all Lead Employer Trainees including GP, Community, Public and Mental health trainees who are based within acute host organisations, of which St Helens and Knowsley Teaching Hospitals NHS Trust are the Lead Employer for. The 72 Trusts are listed in Appendix 1.

The Lead employer GP/Public Health trainees are subject to a separate report presented by Dr Peter Arthur, Guardian of safe working hours. The table below shows the number of trainees split by region on the 2016 contract:

Region	Total number of doctors employed under the Terms and Conditions of Service for NHS Doctors and Dentists in training (England) 2016
Cheshire and Mersey	960
West Midlands	855
East Midlands	637
East of England	544
TOTAL	**2996**

Corporate objectives met or risks addressed:

Financial implications: Potential incurrence of fines and/or penalties owing to unsafe working practices

Stakeholders: Trust-wide

Recommendation(s): For information

Presenting officer: Mr Michael Chadwick, Guardian of Safe Working Hours

Date of meeting: 29th November 2017

Contents

1. Introduction

Following the implementation of the Terms and Conditions of Service for NHS Doctors and Dentists in training (England) 2016 the Guardian of safe working is required to ensure that issues of compliance of safe working hours are addressed by the doctor, employer, host organisation as appropriate and provide assurance to the Board of the employing organisation that doctors' working hours are safe.

The following report covers the period of 7th December 2016 – 31st October 2017.

As part of the Terms and Conditions of Service for NHS Doctors and Dentists in training (England) 2016 all trainee doctors are provided an opportunity to report exceptions to their standard work schedules, as set out below;

- Working beyond the average weekly hours limit
- Extended hours of work beyond their expected shift length
- Breaches of weekend or night work frequency
- Failure of opportunity to take adequate natural rest breaks
- Failure of opportunity to attend formal teaching sessions in their work schedule
- Lack of support available to doctors during service commitments

2. High level data

Number of doctors/ dentist in training on 2016 Terms and Conditions (total)	2996	
Total number of host organisations	72	
Total number of host organisations returned exception report data	Number of Organisations	% return rate
	48	67%
Amount of time available in job plan for guardian role	1 Programme Activity	
Admin support provided to the guardian	1 WTE	

3. Exception reports (with regard to working hours)

Exception reporting is the mechanism used by trainees subject to the Terms and Conditions of Service for NHS Doctors and Dentists in training (England) 2016 to notify the trust when their day-to-day work varies significantly, or regularly from their agreed work schedule.

Where a trainee raises an exception report this must be acted upon by Educational Supervisors (delegated to Clinical Supervisors.) This may result in no further action, time off in lieu (TOIL) or recommendation for payment for extra hours worked. In addition there are certain breaches which necessitate a fine for the involved department which is reinvested in part back to the trainee and in part in training and educational activity.

Of those host organisations who have returned exception report data Appendix 1 sets out the exception reports made during December – October 2017. Feedback from host organisation's suggests that the majority of their exception reports have been raised by

their foundation trainees, and a further period of continuous observation is required to gain more meaningful data.

4. Work schedule reviews

The work schedule is a document distributed to trainees before they commence their placement with the trust. It includes generic information relating to the placement, such as learning opportunities, rota template and pay details.

Appendix 2 highlights the work schedule reviews that have taken place within host organisations.

5. Fines

The only Guardian fine levied that was reported was from Southend University Hospital in the East of England. The total amount of the fine was £31.72.

6. Issues arising and actions taken to resolve issues

The guardian would like to thank those host organisations who have submitted the exception reporting returns and we will be working with our guardian and human resources colleagues based in the host organisations to ensure returns are submitted to enable thorough analysis of any trends or concerns.

9. Summary

On review of the exception reporting data received thus far the common theme reported is relating to trainees exceeding their working hours set out in their work schedule. In the vast majority of cases, the trainees have stayed past their finish time and received time off in lieu or compensation in pay in return.

10. Conclusion and Recommendations

The guardian is assured with the overall safety of working hours across the host organisations for trainees under the 2016 T&Cs based on evidence from the exception reports submitted thus far. The guardian would ask the Board to note this report and to consider the assurances provided thus far.

END

Appendix 1 – Exception Reporting

	Trusts	No.at CT1/2 Level		No.at ST3+ Level		No. given TOIL or payment			No. that are on-going
		Raised	Closed	Raised	Closed	TOIL	Payment	Other	
Cheshire and Mersey	St Helens and Knowsley Teaching Hospitals	0	0	1	0	0	0	0	1
	5 Boroughs Partnership NHS Foundation Trust	0	0	0	0	0	0	0	0
	Aintree University Hospital NHS Foundation Trust	0	0	0	0	0	0	0	0
	Alder Hey Children's NHS Foundation Trust	0	0	0	0	0	0	0	0
	Central Manchester University Hospitals NHS Foundation Trust	0	0	0	0	0	0	0	0
	Cheshire and Wirral Partnership NHS Foundation Trust	0	0	0	0	0	0	0	0
	Clatterbridge Centre for Oncology NHS Trust	0	0	0	0	0	0	0	0
	Countess of Chester Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Glan Clwyd Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Leighton Hospital	2	2	1	1	2		1	4
	Liverpool University Dental Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Liverpool Heart & Chest Hospital NHS Trust	0	0	0	0	0	0	0	0
	Liverpool Women's Hospital	6	5	0	0	5	0	0	1
	Macclesfield District General Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Mersey Care NHS Trust	2	2	3	3	5	0	0	0
	Royal Liverpool and Broadgreen University Hospital NHS Trust	0	0	0	0	0	0	0	0
	Southport and Ormskirk Hospital NHS Trust	9	0	0	0	8	1	0	0
	Walton Centre for Neurology & Neurosurgery	0	0	0	0	0	0	0	0
	Warrington & Halton Hospital	0	0	0	0	0	0	0	0
	Wigan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Wirral University Teaching Hospital	0	0	0	0	0	0	0	0
	Birmingham & Solihull Mental Health NHS Foundation Trust	0	0	0	0	0	0	0	0
	Birmingham Children's Hospital NHS Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Birmingham Community Healthcare NHS Foundation Trust	0	0	0	0	0	0	0	0
	Birmingham Women's NHS Foundation Trust	0	0	0	0	0	0	0	0
	Black Country Partnership NHS Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Burton Hospitals NHS Foundation Trust	0	0	0	0	0	0	0	0
	Coventry and Warwickshire Partnership NHS Trust	1	0	1	1		1	1	0
	Dudley and Walsall Mental Health Partnership Trust	0	0	0	0	0	0	0	0
	Dudley Group NHS Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Heart of England NHS Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

West Midlands	North Staffordshire Combined Healthcare NHS Trust	0	0	0	0	0	0	0	0
	Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Royal Orthopaedic Hospital NHS Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Royal Wolverhampton Hospitals NHS Trust	0	0	0	0	0	0	0	0
	Sandwell & West Birmingham Hospital NHS Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Shrewsbury and Telford Hospital NHS Trust	0	0	0	0	0	0	0	0
	Shropshire Community Health	6	0	3	0	0	0	0	0
	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	South Warwickshire NHS Foundation Trust	4	0	0	0	0	4	0	0
	Staffordshire and Stoke on Trent Partnership NHS Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	University Hospital of North Midlands NHS Trust	0	0	0	0	0	0	0	0
	University Hospitals Birmingham NHS Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	University Hospitals Coventry & Warwickshire NHS Trust	0	0	0	0	0	0	0	0
	Walsall Healthcare	0	0	0	0	0	0	0	0
	Worcestershire Acute Hospitals NHS Trust	0	0	0	0	0	0	0	0
	Worcestershire Health and Care NHS Trust	0	0	0	0	0	0	0	0
	Wye Valley NHS Trust	0	0	0	0	0	0	0	0
	2gether NHS Foundation Trust	3	0	0	0	0	3	0	0
	HEWM	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
East Midlands	Chesterfield Royal Hospital	1	1	0	0	0	0	0	0
	Derbyshire Healthcare Foundation Trust	0	0	0	0	0	0	0	0
	Derby Teaching Hospitals NHS Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Kettering General Hospital NHS Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Leicestershire Partnership NHS Trust	0	0	0	0	0	0	0	0
	Lincolnshire Partnership NHS Foundation Trust	0	0	0	0	0	0	0	0
	Northampton General Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Northamptonshire Healthcare NHS Foundation Trust	3	2	0	0	2	0	0	1
	Nottingham Healthcare Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Nottingham University Hospitals NHS Trust	4	2	0	0	2	0	0	0
	Sherwood Forest Hospitals NHS Trust	2	2	0	0	0	2	0	0
	United Lincolnshire Hospitals NHS Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	University Hospital of Leicester NHS Trust	0	0	0	0	0	0	0	0
	Basildon and Thurrock University Hospitals NHS Foundation Trust	0	0	0	0	0	0	0	0

East of England	Bedford Hospital NHS Trust	0	0	0	0	0	0	0	0
	Cambridge University Hospitals NHS Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Cambridgeshire and Peterborough NHS Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Cambridgeshire Community Services NHS Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Colchester Hospital University NHS Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	East & North Hertfordshire NHS Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	East London Foundation Trust	24	24	0	0	0	20	4	0
	Essex Partnership University NHS Foundation Trust (NORTH)	0	0	0	0	0	0	0	0
	Essex Partnership University NHS Foundation Trust (SOUTH)	0	0	0	0	0	0	0	0
	Hertfordshire Partnership University NHS Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Hinchingbrooke Health Care NHS Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Ipswich Hospital NHS Trust	0	0	0	0	0	0	0	0
	James Paget Hospital NHS Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Luton and Dunstable NHS Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Mid Essex Hospitals Services NHS Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Norfolk and Norwich University Hospitals NHS Foundation Trust	0	0	0	0	0	0	0	0
	Norfolk and Suffolk NHS Foundation Trust	0	0	0	0	0	0	0	0
	Peterborough & Stamford Hospitals NHS Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Princess Alexandra Hospital NHS Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Southend University Hospital NHS Foundation Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	0	0	0	0	0	0	0	0
	West Hertfordshire Hospitals NHS Trust	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	West Suffolk NHS Foundation Trust	0	0	0	0	0	0	0	

Appendix 2 – Work Schedule Reviews

Work Schedule Reviews								
Trusts	No.at CT1/2 Level		No.at ST3+ Level		No. given TOIL or payment			No. that are on-going
	Raised	Closed	Raised	Closed	TOIL	Payment	Other	
Southport and Ormskirk Hospital NHS Trust	9	2	0	0	0	0	0	0
Northampshire Healthcare NHS Foundation Trust	11	0	0	0	0	0	0	0
Ipswich Hospital NHS Trust	1	1	0	0	0	0	0	0
Southend University Hospital NHS Foundation Trust	0	0	1	1	0	0	0	0