St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 28TH FEBRUARY 2018
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

PUBLIC BOARD AGENDA				Paper	Presenter
09:00	1.	Employee of the Month			Chair: Denis Mahony
		1.1	February		
09:15	2.	Apologies for Absence			
	3.	Declaration of Interests			
	4.	Minutes of the Previous Meeting held on 31st January 2018		Attached	
		4.1	Correct Record & Matters Arising		
		4.2	Action List	Attached	
Performance Reports					
09:30	5.	Integrated Performance Report		NHST(18) 011	Nik Khashu
		5.1	Quality Indicators		Sue Redfern
		5.2	Operational Indicators		Rob Cooper
		5.3	Financial Indicators		Nik Khashu
		5.4	Workforce Indicators		Anne-Marie Stretch
Committee Assurance Reports					
09.50	6.	Committee Report – Executive		NHST(18) 012	Ann Marr
10.00	7.	Committee Report – Audit		NHST(18) 013	Su Rai
10:10	8.	Committee Report – Quality		NHST(18) 014	David Graham
10:20	9.	Committee Report – Finance & Performance		NHST(18) 015	Jeff Kozer
10:30	10.	Committee Report – Charitable Funds		NHST(18) 016	Denis Mahony

Other Board Reports				
10:35	11.	Strategic & Regulatory Report	NHST(18) 017	Nicola Bunce
10:45	12.	Safeguarding Annual Reports – Adults & Children	NHST(18) 018	Sue Redfern
11:00	13.	WRES External Review & Action Plan	NHST(18) 019	Anne-Marie Stretch
Closing Business				
11:15	14.	Effectiveness of meeting		Chair: Denis Mahony
	15.	Any other business		
	16.	Date of next Public Board meeting – Wednesday 28th March 2018		
BREAK				

Minutes of the St Helens and Knowsley Hospitals NHS Trust Board meeting held on Wednesday, 31st January 2018 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
	Ms S Rai (SR)	Non-Executive Director
	Prof D Graham (DG)	Non-Executive Director
	Mrs V Davies (VD)	Non-Executive Director
	Mr J Kozer (JK)	Non-Executive Director
	Prof K Hardy (KH)	Medical Director
	Mrs S Redfern (SRe)	Director of Nursing, Midwifery & Governance
	Mr N Khashu (NK)	Director of Finance
	Mrs C Walters (CW)	Director of Informatics
	Mr R Cooper (RC)	Director of Operations & Performance
	Ms N Bunce (NB)	Director of Corporate Services
Apologies:	Mr D Mahony (DM)	Non-Executive Director
	Mr P Williams (PW)	Director of Facilities Management/Estates
	Dr T Hemming (TH)	Director of Transformation
	Cllr G Philbin (GP)	Halton Council
In Attendance:	Mr T Foy	St Helens CCG
	Dr Ash Bassi	Divisional Director for Elective Medicine
	Ms J Byrne	Executive Assistant (Minutes)

1. Employee of the Month

The award for Employee of the Month for December 2017 was presented to Mr Alex Benson, Consultant Plastic Surgeon, Burns and Plastics and for January 2018 to Barry Atherton, Business Transformation Project Manager, Finance.

2. Patient Story

Board members were shown a video-recording of Mrs CG's patient story, which related to the care she had received following a fall whilst she was visiting a friend who was a patient at St Helens Hospital. Mr Alex Benson's and his clinic team's role in caring for Mrs CG was acknowledged. RF felt that this was an excellent example of staff demonstrating the Trust's values and delivering five star patient care.

3. Apologies for Absence

Apologies were noted.

4. Declaration of Interests

4.1. RF declared that he was still the interim Chair of Southport & Ormskirk Hospitals NHS Trust.

4.2. JK declared that he had now been nominated as the Trust Non-Executive member of the HIS Board (Informatics).

5. Minutes of the previous meeting held on 29th November 2017

5.1. Correct Record

5.1.1. Following revision of the wording in paragraph 6.1.3 to indicate one of the two cases YTD was a blood culture contaminant and not a bacteraemia, the minutes were approved as a correct record.

5.2. Matters Arising

5.2.1. Guardian of Safe Working (for junior doctors) – AMS explained this had been a new mandated role that had to be overseen by the Board. Now the role had been in place for 2 quarterly reporting cycles it was proposed that in future the reports should be scrutinised in detail via the Workforce Council and through the Quality Committee, which could escalate any issues of concern to the Board. Board members agreed that this was an appropriate governance route and was consistent with the reporting of other workforce issues.

5.3. Action List

5.3.1. Action 1. Minute 15.5 (27.09.17): Annual Workforce Race Equality Standard Report – feedback on the action plan has been postponed until the February Board meeting, as a result of the unplanned absence of the independent advisor.

5.3.2. Action 2. Minute 10.3 (25.10.17): Charitable Funds – NK had prepared a report that had been considered by the Executive Committee, which following some further analysis, would be reported to the Charitable Funds Committee. Action Closed.

5.3.3. Action 3: Minute 10.5 (25.10.17): Charitable Funds – NK has distributed a letter to charitable fund holders. Action Closed.

5.3.4. Action 4: Minute 5.2.5 (25.10.17): Head & Neck Cancer Waits – AM has met with Terry Jones, Professor of Head & Neck Surgery at Aintree Hospitals NHSFT, to discuss the pathway and give him assurance of the Trust's commitment to achieving an optimum pathway for patients. A review of the pathway was now taking place with all stakeholders. Action Closed.

5.3.5. Action 5. Minute 8.4 (29.11.17): CQC Well Led Presentation – a document outlining the potential content of CQC's briefing to the next Trust Board meeting was circulated. SRe had recently been part of an inspection team for another North West Trust and summarised some of the changes in the new inspection process.

5.3.6. SRe also informed the Board that the CQC were undertaking a system review of Liverpool and the Trust had been invited to participate as a stakeholder, this would take the form of a relationship questionnaire, rather than interviews. The main focus for the CQC in this review would be on how the adult social services worked with Aintree and RLBUHT.

6. Integrated Performance Report (IPR)– NHST(18)001

The key performance indicators (KPIs) were reported to the Board, following in-depth scrutiny of the whole IPR at the Quality and Finance and Performance Committees.

6.1. Quality Indicators

6.1.1. SRe presented the performance against the key Quality Indicators.

6.1.2. There were no never events reported in December, one case year to date. However, SRe brought Board members' attention to another more recent never event, in the same service. It was agreed the Trust needed to identify the causes and adequately disseminate lessons learnt once the investigation was completed. A Root Cause Analysis is being conducted into both the never events and the findings will be reported back via the Quality Committee.

6.1.3. There were no MRSA bacteraemia cases in December and two cases year to date. Of the two cases, one is being appealed and one was a contaminated specimen. SRe to chase the response from NHSI regarding the appeal.

6.1.4. There were no C.Diff positive cases in December. Two cases were appealed successfully at the December panel meeting, reducing the total number cases year to date to 17.

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

6.1.6. The overall registered nurse/midwife Safer Staffing fill rate for December was 94.0%. Although extremely challenging for some wards at times, the Trust had continued to achieve safe staffing levels overall,

6.1.7. During the month of November there were no inpatient falls resulting in moderate or severe harm. The year to date total is 12.

6.1.8. Venous thromboembolism (VTE) performance for November was 93.13%. Year to date performance is 93.18% against a target of 95%. Actions to sustain the recent improvement in performance were being continued.

6.1.9. Final Hospital Standardised Mortality Ratio (HSMR) for 2016/17 is 102.4.

6.2. Operational Indicators

6.2.1. RC presented the update on the Operational Performance.

6.2.2. Performance against the 62-day cancer standard improved in month to 90.3%. Specialities are continuing to ensure delivery of specific action plans which are in place to maintain compliance against the standard.

6.2.3. The 31-day cancer target was not achieved in month at 94.9%, due to patients unable to attend due to being unwell on the day of their appointment. As a result initial appointments will be brought forward to 'as soon as possible and within 7 days', which would give time to reschedule the appointment, within the 31 days if the patient is unwell. Year to date performance is 98.3% versus a target of 96.0%

6.2.4. A&E performance deteriorated in month to 73.1% (type 1) and 85.5% (all types). The Finance & Performance Committee members have received assured from the Clinical Director of Emergency Department that appropriate plans are in place to improve delivery, safeguard patient safety and continue to meet demand.

6.2.5. RTT incomplete performance was maintained in month (93.2%) versus a target of 92.0%.

6.3. Financial Indicators

6.3.1. NK presented the finance report for month 9.

6.3.2. The Trust has delivered to plan in December, reporting an overall income and expenditure surplus of £5.9m, inclusive of the Q3 STF Funding. The Trust continues to plan to achieve the control total of £9.4m, inclusive of the tranche 1 winter money allocation of £0.9m, however there are significant challenges to this, due to the high levels of non-elective demand and acuity of patients experienced in December and continuing into January, and the additional costs of staffing escalation beds.

6.3.3. The Finance & Performance Committee has reviewed the financial risk and mitigation plans in detail and has agreed to review the year end forecast when the month 10 position is reported.

6.3.4. The Trust has delivered £8.8m of the Cost Improvement Programme (CIP), which is £(2.1)m behind plan for December. The challenges of recovering this position with recurrent CIP were debated.

The cash position had improved in the month as a significant proportion of the aged debt had been paid. However there remained substantial unpaid debt from local Trusts that were reliant on loans from HM Treasury. The issue had been raised with NHS Improvement (NHSI) and NK was continuing to speak to his Director of Finance colleagues. If required this would be escalated to CEO level and then to NHSI for action. NK confirmed that the Trust's CCGs had been very helpful in supporting the Trust's cash position.

6.3.5. NK confirmed the Trust's capital allocation would be used this year and the capital programme for 2018/19 was being developed with the services.

6.4. Workforce Indicators

6.4.1. AMS presented the Workforce Indicators.

6.4.2. Absence had increased in December to 5.5% as a result of winter illnesses. Similar levels of absence are expected to be reported in January.

6.4.3. In response to a query from VD, KH confirmed the staff absence did not correlate to the incidence of flu. 86.2% of staff had received the flu vaccine. The national data also showed that several types of flu virus were being experienced this winter.

6.4.4. The year to date absence is 4.5%, against a Q3 target of 4.72%.

6.4.5. Mandatory training compliance has risen slightly in month and continues to exceed the target. Appraisal compliance has decreased slightly and is now behind the target of 85% by 0.1%, this is due to operational pressures however plans are in place to improve the position and achieve the target for the year.

6.4.6. The board discussed winter absence levels and the efficacy of the flu vaccine.

7. Committee Report - Executive – NHST(18)002

7.1. AM presented the report to the Board, which summarised the Executive Committee meetings held between 16th November and 31st December 2017.

7.2. The Executive Committee had approved a business case for the appointment of an additional Pain Consultant and support staff.

7.3. The impact of the CCG Referral Management Schemes on both referrals to the Trust and Referral to Treatment Targets (RTT) is being closely monitored by the Executive.

7.4. Measures have been put in place to achieve the desired level of protection against future cyber security threats. A detailed action plan has been prepared and a cyber security dashboard is being monitored. CW assured Board members that although it was impossible to eliminate the risk completely, the Trust had invested in implementing additional levels of protection.

7.5. The Executive Committee had reviewed the breast reconstruction service offered by the Trust, which produced excellent outcomes for patients. The financial aspects of the service were also being reviewed as the tariff does not currently reflect the complexity and costs of each procedure.

7.6. An action plan to improve Staff, Friends and Family Test response rates is being developed. VD suggested an electronic version of the questionnaire may result in an improved response rate; although it was acknowledged a large proportion of staff do not have access to a computer. The staff ratings of the Trust remained high.

7.7. A Medway (the new patient administration system) business case and options appraisal on the optimum 'go live' date had been considered and a go live date of 27th April agreed.

7.8. The Executive Committee approved a proposal to bring bank staff payments for registered nurses in line with practices at other Trusts, which is designed to attract more staff to work on the bank. The impact will be reviewed in 6 months.

7.9. The increasing number of ambulances attending the Trust and its impact on the pressures in A&E had been discussed. A 'divert and deflection' report has been requested from NWAS to better understand the reason for this.

8. Committee Report – Quality – NHST(18)003

8.1. DG presented the Chair's report from the meeting held on 23rd January 2018.

8.2. The number of complaints has decreased for December and in Q3.

8.3. There has been considerable process improvement and DG commended the work of the team involved. It was agreed that the next stage in improvement was the need to concentrate on lessons to be learnt from complaints and ensure information was comprehensively disseminated throughout the Trust.

8.4. The Integrated Performance Report (IPR) was discussed, including a never event relating to a misplaced nasogastric tube, due to the misinterpretation of the chest X-ray. Changes to the process were being put in place to ensure that only appropriately trained staff can review X-rays going forward.

8.5. 55 out of 57 CQC actions have now been completed. The final two actions will be completed by the end of this financial year.

8.6. Mortality Surveillance Reviews – this is an area that the committee is recommending needs further to align to the avoidable deaths policy. Agenda Item NHST(18)009 refers - KH agreed and will undertake a review of current processes.

8.7. The Committee had received a report from the Patient Experience Council on the Trust's results from the national Maternity inpatient survey, in advance of the publication of the national results. The results were disappointing, and seemed at odds with other patient feedback, such as the friends and family test results for the service. The survey was undertaken in the summer of 2017, for mothers who had given birth in February 2017. Since then many changes had had taken place around choice, triage, patient safety and daily visits from Matrons. A further action plan has been developed and is being presented to the Executive. The Board expressed its concern and asked for an analysis of the changes to the department and whether these correlated to the survey responses. The Quality Committee will review the analysis and monitor the delivery of the action plan.

9. Committee Report – Finance & Performance – NHST(18)004

9.1. JK presented the Chair's report from the meeting held on 25th January 2018.

9.2. Of the £1.5m winter monies received from NHS Improvement, £0.6m can be used to fund the additional cost of winter pressures. The NHSE elective cancellation programme was implemented in December as a consequence of escalating winter pressures and has been extended to the end of January, which will have a significant impact on Trust activity plans and PbR income. The Committee had debated the challenges of balancing patient safety and the quality of services during the winter against the access and financial targets.

9.3. The Committee approved the methodology to be used to develop the CIP for 2018/19 which used the Model Hospital and Service Line Reporting (SLR) data to inform the programme. Clinical engagement in the CIP processes was felt to be critical to success.

9.4. The Trusts overall financial position and the challenges in achieving the 2017/18 outturn position had been thoroughly explored, with the mitigations and management actions being taken to reduce the risks.

Su Rai left the meeting @ 11.30 am

Strategic and Regulatory update report – NHST(18)005

9.5. NB presented the report which provided an update on the regulatory and strategic of importance since the last Trust Board meeting.

9.6. Updated guidance has been published for Trusts placed into special measures for *quality* reasons. Parallel guidance for Trusts placed into special measures for *financial* reasons will be published in the near future.

9.7. NHSI had produced updated guidance for Trusts undertaking Significant Transactions, including mergers and acquisitions – the guidance aligns the transaction review process to the Integrated Support and Assurance Process (ISAP) to create a standardised transaction framework NHSI will use to risk assess all significant transactions, including the creation of new care models.

9.8. Health Education England (HEE) has published the first national Workforce Strategy for the period up to 2027. The draft strategy is subject to consultation and has been developed with input from NHS England, NHS Improvement, Public Health England and the Department of Health. AMS confirmed that the Cheshire and Merseyside Directors of Human Resources were developing a collective response, and she would report back at the next meeting

9.9. Board members noted Jeremy Hunt's expanded brief to cover Social Care and members agreed it would be interesting to see how it would support integration over time. TF added there would be an expectation that the integration work St Helens had already undertaken would be replicated nationally.

9.10. 2018/19 Planning Guidance had not been published, however it is anticipated that a draft financial, quality, operational performance and workforce plan will need to be submitted before the end of February/early March.

10. Board Assurance Framework (BAF) – NHST(18)006

10.1. NB presented the quarterly review of the BAF.

10.2. The Executive Committee had reviewed the BAF and had 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.

10.3. The Board accepted the proposal to change the wording of Risk 2 to reflect wider system working and place-based care developments.

10.4. It was agreed that the score of risk 3 (Sustained failure to maintain operational performance/ deliver contracts) should be increased from 15 to 20 in light of the increased demand being experienced by the Trust.

10.5. A discussion was held in relation to how the Board could have more involvement with stakeholders (Risk 5). It was agreed the current level of contact with the main CCGs and in the developing integrated care models was appropriate, given the Trust's attendance at the Health & Wellbeing Boards, and membership of other strategic groups.

10.6. JK highlighted the need to mention 'cyber-attack' as a cause against Risk 8(major and sustained failure of essential IT systems). NB to amend the BAF to reflect these changes.

11. Overview of Complaints, Claims & Incidents – NHST(18)007

11.1. SRe presented the report for Q2 2017/18.

11.2. The increase in PALS contacts was noted, along with a corresponding drop in complaints, which could possibly be attributed to earlier intervention by PALS. SRe to analyse the results and compare against PALS activity of other Trusts.

11.3. The benchmarking data for clinical negligence claims shows STHK as higher than other local hospitals. The Board asked that this be looked at in more detail by the Claims Governance Group. It was noted part of the impact of claims is the CNST insurance premium which is to increase by £2.5m in 2018/19. NK noted that NHSI had indicated that Trusts control totals would be adjusted to reflect the CNST premium changes.

11.4. AM asked for an analysis to understand whether it was coincidence that a number of high value claims had been received recently and stressed the importance of learning lessons. KH confirmed there would be quicker intervention going forward which may resolve most of the issues.

12. HR/Workforce Strategy & Indicators – NHST(18)008

12.1. AMS presented the paper, which reviewed all the workforce strategy indicators and objectives.

12.2. Workforce challenges are one of the Trusts biggest strategic risks and there are a number of initiatives in place to attract and retain staff; including international recruitment, the global learners programme, targeting service personnel and links with universities. There were some challenges in working through the complex immigration rules, but approximately 3 nurses a month were now starting with the Trust . The Board expressed concern at the time and cost of to the individual and to the Trust of employing overseas staff, and AMS confirmed that these concerns had been raised with NHS Employers.

12.3. The Trust has also developed an action plan to improve the retention of existing staff. NHS Employers has published a toolkit and AMS will speak to the two local trusts that have lower turnover rates to ensure we adopt best practice.

12.4. The Board noted the number of qualified nurses who could potentially retire over the next 12 months and that discussions regarding flexible retirement options are being encouraged, as is the promotion of the various NHS Pension Scheme options.

12.5. TF noted large numbers of GPs and community nurses were also due to retire in the next 5 years however there wasn't an integrated initiative across the local health economy in relation to international recruitment. AMS agreed to help wherever possible.

12.6. In response to a query from VD, AMS confirmed there were KPIs for each stage of employee relations cases. The Trust had invested in a case tracker, which enabled better monitoring and reporting of the cases to ensure they were managed in a timely manner.

13. Learning from deaths updating and reporting – NHST(18)009

13.1. The paper details the data to Q2 2017/18 and the reviews undertaken. KH explained the criteria for selecting the cases for review, in addition to the prescribed groups and the proposals for embedding sharing lessons and learning.

13.2. The process has evolved since September following further guidance and discussion with other Medical Directors and KH is proposing a small number of changes to the Learning from Deaths policy, which will be reviewed at the next Quality Committee and brought back to Board for approval.

13.3. It was agreed lessons learnt should be included in junior doctors' training, team briefings as well as repeated on a regular basis due to the turnover of junior medical staff. KH explained the intention was to create a database of learning and conduct a quarterly thematic audit to check the effectiveness. There was also a will to share learning more broadly, as opposed to just Trust-wide, however, it was agreed it was important to develop a robust internal processes initially.

13.4. Future Board updates will be provided quarterly in accordance with the national policy.

13.5. The Board was assured that the Trust is developing an effective system to identify, review, report and learn lessons from any deaths where there is a concern that the death could have resulted from problems in care delivery or service provision.

14. One Halton – Approval of Trust membership and Agreement to the Memorandum of Understanding and Partnership Board Terms of Reference – NHST(18)010

14.1. NB presented the paper on behalf of the Director of Transformation.

14.2. The Board endorsed the Trust's membership of the One Halton Partnership.

15. Effectiveness of meeting

15.1. RF asked Dr Bassi for his feedback on the effectiveness of the meeting. He felt it had been an engaging meeting with succinct feedback and concentration from all in the room. He was reassured the Board was not sitting in an 'ivory tower' and has a good feel what is happening at ground level.

15.2. RF thanked Dr Bassi for his honesty.

16. AOB

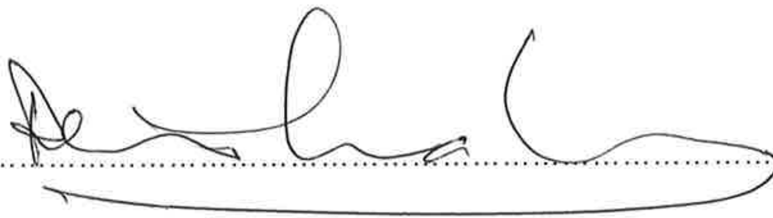
16.1. RF thanked JK for succeeding George Marcall as the STHK Non-Executive representative on the HIS Board.

16.2. RF thanked TF for his input and influence in arranging the recent successful board to board meeting with St Helens CCG.

16.3. RF was pleased to feedback that both he and a family friend had recently experienced excellent inpatient care and treatment at St Helens Hospital.

17. Date of next meeting

17.1. The next meeting is scheduled for Wednesday, 28th February 2018 in the Boardroom, Whiston Hospital, commencing at 9.30 am.



Chairman: ....

Date: 28.02.18

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 28TH FEBRUARY 2018

No	Minute	Action	Lead	Date Due
1.	27.09.17 (15.5)	WRES report. AMS will bring a paper to Board following the external expert input. 31.01.18 The external reviewer was unwell so item has been postponed until 28th Feb.	AMS	28.02.18
~~2.~~	~~25.10.17 (10.3)~~	~~Charitable Funds – NK to undertake further analysis and take through the Charitable Funds Committee~~. Action closed.	~~NK~~	~~31.01.18~~
~~3.~~	~~25.10.17 (10.5)~~	~~Charitable Funds: NK will write to Directorate Managers, to ensure that staff are aware of the Charitable Fund.~~ ~~29.11.17: Draft letter has been formulated but needs amends. Will be sent out w/c 4th Dec.~~ Action closed.	~~NK~~	~~31.01.18~~
~~4.~~	~~25.10.17 (5.2.5)~~	~~Head and neck cancer waits: AM will escalate the Board's concerns to the CEO at Aintree Hospitals.~~ ~~29.11.17: AM will report back to the January Board. Forensic description is required of what Aintree need to be doing regarding waits.~~ ~~31.01.18: AM spoken to Terry Jones at Aintree and agreed the Trust's priority is an optimal head and neck cancer pathway. TJ to progress with other organisations.~~ Action closed.	~~AM~~	~~31.01.18~~
5.	31.01.18 (13.3)	AMS to contact the local Trusts with lower staff turnover to ensure all good practice is being following in relation to retention of staff.	AMS	28.02.18

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(18)011
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 delivery of national and local performance standards whilst ensuring affordability across the whole health economy.

Patient Safety, Patient Experience and Clinical Effectiveness

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

There was 1 reported never event in January 2018, making a total of 2 year to date (target = 0).

There were no MRSA bacteraemia cases in January 2018 but 2 cases year to date (target = 0). Of the 2 cases, 1 case is under appeal and 1 was a contaminated specimen.

There were 2 C.Difficile (CDI) positive cases in January 2018. The total number of confirmed CDI positive cases year to date is 19 (threshold = 41).

There have been no grade 3 or 4 avoidable pressure ulcers year to date.

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for January 2018 was 93.8%. YTD performance is 94.0%.

During the month of December 2017 there was 1 inpatient fall resulting in severe harm . YTD total is 13.

Performance for VTE assessment for December 2017 was 94.74%. YTD performance is 93.35% against a target of 95%. (Quarter 3 achieved the target with performance of 95.01%).

Final 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: 28th February 2018

Operational Performance

Performance against the 62 day cancer standard improved again in month to 90.6% v target of 85.0%. Specialties are continuing to ensure delivery of specific action plans, which are in place to maintain compliance against the standard. Following a single month of failure to achieve the 31 day target, this was achieved in month at 96.1% v target of 96.0%.

Continued high volume NEL activity and acuity of patients presenting in ED, resulted in a deterioration in A&E performance, which was 71.8% (type 1) and 86.0% (Mapped STHK Footprint - all types) in month. SAFER start command centre was in place in ED for the first 2 weeks of Jan in conjunction with partners to support management of the increased demand . Due to the level of activity, all available additional bed capacity was opened to support flow, resulting in a bed occupancy level of over 100% against the core bed base. Staffing of the increased capacity has been a challenge, utilising additional hours from medical and nursing staff from within the organisation plus agency staff.

The Emergency Care Improvement Programme team continue to support the trust, with further improvement work related to key actions focusing on both the Emergency Department and the Inpatient wards.

Despite a reduction in the elective programme in month to support NEL activity, RTT incomplete performance was maintained at 93.3% v target of 92.0%. Specialty level actions to maintain this achievement continue.

Financial Performance

Operational pressures through December and January were worse than expected. This is reflected in A&E attendances, higher acuity of patients requiring admission, challenges in discharges across the patch and staff sickness level. The trust objective was to maintain safe care and to try to minimise the impact on operational performance and costs.

As at January 2018 (Month 10), the Trust is reporting an overall Income & Expenditure surplus of £6.6m in line with plan. The position includes the utilisation of appropriate Tranche 2 and Tranche 1 funding and all of the YTD STF allocation. This has been offset by the exceptional increase in pay run rates costs for staffing safely our escalation beds and A&E department.

The YTD financial position has been supported by the full utilisation of relevant reserves and Balance sheet provisions.

The Trust has delivered £9.8m of CIPs and is £(2.6)m behind the YTD plan which is reflected in the Trust’s overspend on expenditure. The delivery of the £15.3m CIP target has been compromised by the non elective operational pressures in the Trust.

The Trust is currently expecting to deliver the planned annual surplus of £8.5m, which equates to a £(0.6)m deficit excluding original allocation of STF funding of £9.1m.

The Trust recognises the risks to achieving the planned surplus, which include remaining CIP achievement, exceptional costs of winter not funded, continued contract and CQUINs challenges from Commissioners, A&E performance (STF 30%) and adverse impact of HRG4+ to this position.

The Trust's cash balance at the end of January was £18.6m, representing 19 days of operating expenses. The Trust has incurred £6.6m of capital expenditure in the ten months to January.

Human Resources

Absence in January has increased to 5.7% against the Q4 target of 4.68%. YTD absence is 4.6% against last year outturn of 4.8%.

Mandatory training compliance has fallen slightly in month to 88.2% and continues to exceed the target by 3.2%. Appraisal compliance has improved to 86% and is now above the target by 1%.

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

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	Jan-18	3.4%	2.4%	No Target	2.5%		Overall SHMI and HSMR within control limits. Mortality fluctuates month-to-month, but is stable medium-term. Crude mortality typically increases (nationally) in Winter. It is high in January. Latest NHS evidence supports previous work that patients admitted at weekends and out of hours are sicker. Specific diagnostic groups with raised mortality (e.g. COPD and stroke) are subject to intensive investigation	Patient Safety and Clinical Effectiveness	Trust is implementing an electronic solution to improve capture of comorbidities and to prompt palliative care review in those known to that service. Major initiatives to improve management of AKI and Sepsis are well underway to improve care and reduce mortality.	KH
Mortality: SHMI (Information Centre)	Q	▲	Jun-17	1.04		1.00						
Mortality: HSMR (HED)	Q	▲	Sep-17	105.5	103.1	100.0	102.4					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Sep-17	101.8	100.8	100.0	115.0					
Readmissions: 30 day Relative Risk Score (HED)	Q	T	Aug-17	104.8	102.1	100.0	97.7		The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms. Readmissions have risen in recent months which is being dominated by ambulatory care. It was suggested that ambulatory readmissions might have been a result of inappropriate coding of elective returns - audit has shown that this is not the case.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	There were a small number of misattributed elective returns and this process has been corrected.	KH
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Aug-17	97.9	91.7	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	Aug-17	109.7	99.6	100.0	92.1					
% Medical Outliers	F&P	T	Jan-18	4.5%	2.4%	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 thus reducing outliers.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Jan-18	50.0%	48.9%	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	▲	Dec-17	67.1%	69.1%	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 have devised an automated eDischarge notification which will be computer generated and send within 24 hours. Thereafter a full discharge summary will be sent within 14 days. Development time is days. We're seeking CCG approval at CQPG before implementation.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Dec-17	84.1%	88.9%	95.0%	90.0%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Dec-17	99.1%	99.0%	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	▲	Jan-18	84.3%	90.9%	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	▲ £	Jan-18	1	2	0	2		The National safety standards for invasive procedures will provide further mitigation against future never events.	Quality and patient safety	The RCA for never events reported is being developed. Immediate actions have already been implemented including communication to staff, development of training (medical and non-medical) and policy review.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Jan-18	99.5%	98.9%	98.9%	98.8%		Achieving standard	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	Jan-18	0	0	0	0		The trust continues to have no inpatient prescribing errors which cause serious harm. Trust has moved from being a historic 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.	KH
Number of hospital acquired MRSA	Q F&P	▲ £	Jan-18	0	2	0	4		Two MRSA cases YTD (1 case under appeal and 1 contaminated specimen). 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	▲ £	Jan-18	2	19	41	21					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Jan-18	1	17	No Target	17					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Dec-17	0	0	No Contract target	1		No grade 3 or 4 avoidable pressure ulcers YTD	Quality and patient safety	The Trust provides ongoing tissue viability training for all nursing staff including bank staff	SR
Number of falls resulting in severe harm or death	Q	▲	Dec-17	1	13	No Contract target	22		1 severe harm fall reported in December.	Quality and patient safety	Immediate review undertaken to implement immediate actions. Root cause Analysis being carried out. Strategic falls actions being implemented as plan .	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲ £	Dec-17	94.74%	93.35%	95.0%	93.36%		VTE performance remains inconsistent. A recent survey of successful units showed that they all have electronic solutions. The ePrescribing solution implementation has been delayed because of problems with this version of the software.	Quality and patient safety	Every effort is being made to supplement routine reviews with additional activity to improve performance pending an electronic solution.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Dec-17	3	24	No Target	28					
To achieve and maintain CQC registration	Q		Jan-18	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	Jan-18	93.8%	94.0%	No Target	94.9%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	Two Shelford audits to be reported together in January 2018.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Jan-18	0	1	No Target	2					

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	▲ £	Dec-17	94.7%	95.1%	93.0%	95.1%		All targets achieved in month	Quality and patient experience	A Cheshire and Mersey Cancer Alliance PTL has been 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	▲ £	Dec-17	96.1%	98.1%	96.0%	97.9%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Dec-17	90.6%	87.3%	85.0%	88.4%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Jan-18	93.3%	93.3%	92.0%	93.5%		4 specialties are currently failing the 92% incomplete target; General Surgery, ENT, Plastics and T&O. On going backlog clearance plans continue with good effect 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	▲	Jan-18	100.0%	100.0%	99.0%	100.00%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Jan-18	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Jan-18	0.7%	0.6%	0.8%	0.7%		The cancelled ops target continues to be achieved in January 2018 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	▲ £	Dec-17	100.0%	100.0%	100.0%	100.0%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Jan-18	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Jan-18	71.8%	79.8%	95.0%	76.1%		January 2018 Type 1 performance was 71.8%. All types performance was 86.0%. January 2018 Type 1 performance was only slightly better than January 2017 (69.6%) . It was an extremely challenging month due to flu outbreak, high volume of admissions and acuity - plus increased sickness amongst staff. All available bed capacity was opened to support flow, additional medical and nursing staff were deployed plus SAFER start January Command Centre was in place for first 2 weeks of Jan in conjunction with partners to support flow.	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 processes in place 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. 1pm Frailty/ED/SpR safety huddle in place.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Jan-18	86.0%		95.0%	85.1%					
A&E: 12 hour trolley waits	F&P	▲	Jan-18	0	0	0	0					

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
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Jan-18	0	0	0	0		Increased demand for IP capacity has a direct bearing on the ability to maintain this quality indicator.	Patient Experience	Maintained focus and awareness of this issue across 24/7.	RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Jan-18	14	189	No Target	338		% new (Stage 1) complaints resolved in month within agreed timescales continues to improve overall. The decrease in the number of new complaints received in the last few months has continued for January with 14 received compared to 41 in January 2018.	Patient experience	The Complaints Team are continuing to work on reducing the small backlog of overdue complaints and to improve the timeliness of responses. There is now a stable central Complaints Team in place, with additional input from a senior clinician that is supporting this improvement.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Jan-18	15	239	No Target	293					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Jan-18	66.7%	64.9%	No Target	58.0%					
Friends and Family Test: % recommended - A&E	Q	▲	Jan-18	89.3%	88.3%	90.0%	86.6%		The YTD recommendation rates are slightly below target for A&E and for maternity (birth) and outpatients, but are above target for in-patients, antenatal, post-natal ward and community maternity services. The majority of areas saw an increase in recommendation rates in January 2018, with a slight decease in inpatients, which remains above target and a dip in community maternity, which relates to one response that was rated 'don't know'.	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 to improve morale. 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. The Patient Experience Manager continues to work with leads in each area where performance is below target, to identify specific themes for improvement.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Jan-18	96.2%	95.8%	90.0%	95.5%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Jan-18	100.0%	98.3%	98.1%	98.5%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Jan-18	98.0%	97.7%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Jan-18	100.0%	96.9%	95.1%	98.7%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Jan-18	94.7%	99.4%	98.6%	93.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Jan-18	95.0%	94.5%	95.0%	94.4%					

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	▲	Jan-18	5.7%	4.6%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.8%		Absence in January has increased to 5.7%, against a Q4 target of 4.68%. Qualified & HCA sickness also increased to 7.5%, 2.2% above the 2017/18 target of 5.3% and 1.6% above 2016/17 outturn. National increases in the Flu/virus's has caused many staff to require 1-2 weeks off work	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	In anticipation of the spike in absence due to cough/cold/flu the absence support team have postponed ward audits and have been providing telephone/ward visit advice regarding opening/closing absence, recoding absence, reiterating advice from infection control & HWWB and also ensuring policy management. Each day an open ended report is generated from roster and ESR and the team follow up on the cough/cold/flu reasons as well as the unknown/other which is followed up with managers routinely. During February and March, the Absence Support team will support the HR Advisors with welfare visits and stages to ensure timely action is taken and staff and managers are supported during this very busy period.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P	T	Jan-18	7.5%	5.6%	5.3%	5.9%					
Staffing: % Staff received appraisals	Q F&P	T	Jan-18	86.0%	86.0%	85.0%	87.4%		Mandatory Training compliance has fallen in month however and continues to exceed the target by 3.2%. Appraisal has seen an improvement and now exceeds the target at 86%.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The Education, Training & Development and Workforce Planning teams continue to work with managers to monitor non-compliant staff to ensure on-going maintenance of compliance for both Mandatory Training & Appraisals.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Jan-18	88.2%	88.2%	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.	Continue to expand the number of local FFT trainers to scrutinise comments; ensure FFT posters are widely disseminated; and expand the use of "You said, we did" posters. Results for the Q2 survey completed in the Surgical Care Group with results having been circulated to relevant managers for action planning	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2	76.1%		No Contract Target						
Staffing: Turnover rate	Q F&P	T	Jan-18	0.6%		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	Jan-18	2.0	2.0	3.0	3.0		The Trust's forecast for year end performance is in line with original 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	Jan-18	9,751	9,751	15,315	15,248					
Reported surplus/(deficit) to plan (000's)	F&P	T	Jan-18	6,554	6,554	8,536	4,861					
Cash balances - Number of days to cover operating expenses	F&P	T	Jan-18	19	19	2	2					
Capital spend £ YTD (000's)	F&P	T	Jan-18	6,633	6,633	8,015	3,519					
Financial forecast outturn & performance against plan	F&P	T	Jan-18	8,536	8,536	8,536	4,861					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Jan-18	91.1%	91.1%	95.0%	94.3%					

APPENDIX A

			Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	2017-18 YTD	2017-18 Target	FOT	2016-17	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	87.5%	100.0%	96.2%	94.4%	100.0%	84.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	85.0%		95.2%		
	Total > 62 days		1.0	0.0	0.5	0.5	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0			6.0		
Lower GI	% Within 62 days	▲ £	100.0%	91.7%	93.3%	100.0%	76.9%	100.0%	100.0%	92.3%	84.6%	69.2%	88.9%	82.4%	78.6%	84.8%	85.0%		89.3%		
	Total > 62 days		0.0	0.5	0.5	0.0	1.5	0.0	0.0	0.5	1.0	2.0	0.5	1.5	1.5	8.5			8.0		
Upper GI	% Within 62 days	▲ £	100.0%	81.8%	0.0%	87.5%	100.0%	100.0%	100.0%	33.3%	88.9%	80.0%	100.0%	86.7%	100.0%	88.5%	85.0%		78.7%		
	Total > 62 days		0.0	1.0	4.0	0.5	0.0	0.0	0.0	1.0	0.5	0.5	0.0	1.0	0.0	3.0			10.0		
Urological	% Within 62 days	▲ £	70.0%	95.7%	100.0%	67.6%	92.7%	59.3%	82.1%	83.3%	81.3%	87.5%	77.4%	90.2%	96.6%	83.9%	85.0%		81.4%		
	Total > 62 days		6.0	0.5	0.0	6.0	1.5	5.5	3.5	3.0	4.5	1.5	3.5	2.0	0.5	25.5			36.5		
Head & Neck	% Within 62 days	▲ £	33.3%	100.0%	80.0%	80.0%	66.7%	66.7%	75.0%	75.0%	42.9%	20.0%	100.0%	83.3%	80.0%	63.2%	85.0%		67.3%		
	Total > 62 days		1.0	0.0	0.5	0.5	0.5	0.5	0.5	0.5	2.0	2.0	0.0	0.5	0.5	7.0			8.0		
Sarcoma	% Within 62 days	▲ £	100.0%			100.0%	66.7%		100.0%		0.0%	100.0%			50.0%	62.5%	85.0%		93.3%		
	Total > 62 days		0.0			0.0	0.5		0.0		0.5	0.0			0.5	1.5			0.5		
Gynaecological	% Within 62 days	▲ £	92.3%	100.0%	85.7%	100.0%	70.0%	83.3%	100.0%	68.8%	55.6%	83.3%	100.0%	94.1%	55.6%	77.0%	85.0%		90.1%		
	Total > 62 days		0.5	0.0	0.5	0.0	1.5	1.0	0.0	2.5	2.0	0.5	0.0	0.5	2.0	10.0			5.0		
Lung	% Within 62 days	▲ £	91.7%	68.2%	77.8%	100.0%	100.0%	73.7%	85.0%	100.0%	72.7%	71.4%	87.5%	66.7%	100.0%	82.3%	85.0%		82.7%		
	Total > 62 days		0.5	3.5	1.0	0.0	0.0	2.5	1.5	0.0	1.5	1.0	0.5	3.0	0.0	10.0			13.0		RC
Haematological	% Within 62 days	▲ £	66.7%	66.7%	100.0%	100.0%	100.0%	66.7%	50.0%	71.4%	100.0%	50.0%	100.0%	85.7%	76.9%	75.4%	85.0%		77.6%		
	Total > 62 days		1.0	1.0	0.0	0.0	0.0	1.0	1.0	1.0	0.0	3.0	0.0	0.5	1.5	8.0			8.5		
Skin	% Within 62 days	▲ £	95.7%	95.7%	100.0%	100.0%	92.5%	93.9%	98.1%	93.9%	93.0%	88.9%	95.2%	98.2%	97.7%	94.9%	85.0%		96.5%		
	Total > 62 days		1.0	1.0	0.0	0.0	1.5	1.0	0.5	1.5	1.5	2.0	1.0	0.5	0.5	10.0			9.5		
Unknown	% Within 62 days	▲ £	100.0%	66.7%	0.0%	50.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	77.8%	85.0%		82.6%		
	Total > 62 days		0.0	0.5	0.5	1.0	1.0	0.0	0.0	1.0	0.0	0.0	1.0	0.0	0.0	3.0			2.0		
All Tumour Sites	% Within 62 days	▲ £	85.8%	89.1%	87.6%	89.3%	88.2%	81.6%	91.4%	87.1%	84.5%	80.6%	89.5%	90.3%	90.6%	87.3%	85.0%		88.4%		
	Total > 62 days		11.0	8.0	7.5	8.5	8.0	12.5	7.0	11.0	13.5	12.5	6.5	9.5	7.0	87.5			107.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £				100.0%					100.0%		100.0%		100.0%	100.0%	85.0%		83.3%		
	Total > 31 days					0.0					0.0		0.0		0.0	0.0			1.0		
Acute Leukaemia	% Within 31 days	▲ £												100.0%			85.0%		100.0%		
	Total > 31 days													0.0					0.0		
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				

TRUST BOARD

Paper No: NHST(18)012
Title of paper: Executive Committee Chairs Report – February 2018
Purpose: To provide assurance to the Trust Board on those matters delegated to the Executive Committee.
Summary: The paper provides a summary of the issues considered by the Executive Committee at the meetings held during January 2018. There were a total 4 Executive Committee meetings held during January 2018. The Executive Committee approved; • The extension of the Radiology Information System contract • Updated Smoke Free policy • Phase 1 of the Pharmacy Business Plan The Executive Committee received assurance reports covering safer staffing, agency and locum usage, appraisal and mandatory training compliance, the Integrated Performance Report (IPR), from the Risk Management Council, the Corporate Risk Register, the Board Assurance Framework, cyber security and the Medway Implementation Programme.
Corporate objectives met or risks addressed: All 2017/18 corporate objectives relating to the quality of services.
Financial implications: The St Helens Shared Care Record Business Case is escalated to the Board for approval, and is an agenda item in the closed part of the Board, due to commercially sensitivity.
Stakeholders: Patients, Patients Representatives, Staff, Non-Executive Directors, Commissioners, Regulators
Recommendation(s): That the report be noted
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 28th February 2018

FEEDBACK FROM THE EXECUTIVE COMMITTEE
JANUARY 2018

1. Introduction

There were 4 Executive Committee meetings in January 2018, and this report provides feedback on the agenda items relating to quality.

2. 4th January 2018

2.1 One Halton Partnership Agreement

The Director of Transformation presented the documents developed by One Halton to establish a partnership Board, which the Trust had been invited to be a member of. The formal agreement to join the One Halton partnership would be taken to the January Trust Board, for approval.

2.2 Learning from Deaths Report

The Medical Director presented the draft learning from deaths report for Q1 and Q2. KH explained the format of the report and how the deaths were allocated to the different categories and selected for review. Some changes to the proposed format were agreed to try and make the information clearer. The data would be reported via the January Trust Public Board meeting as required by the national learning from deaths policy. Subsequent reports would be made quarterly. KH also explained that some changes had been proposed to the Trusts Learning from Deaths Policy, to ensure it aligned with the latest national guidance, and the local processes which had evolved since September.

2.3 Cyber Security

The Director of Informatics updated the Executive Committee regarding the latest cyber security alert regarding computer chip vulnerability. She detailed how the HIS was responding to mitigate risk to the Trust and other stakeholders.

2.4 Radiology Information System (RIS)

The Director of Informatics presented a business case to extend the current RIS. The Trust is part of a consortium with 8 other local providers and collectively there was agreement that the consortium should exercise the option to extend the contract for a further 3 years, on the same terms. The Executive Committee endorsed the proposal.

2.5 Medway Implementation Programme

The Director of Informatics escalated a risk regarding the corporate reporting workstream of the programme, which was behind schedule. Mitigation plans were being developed which would bring the workstream back on track and would be reported in the next monthly status report.

2.6 NHS Improvement – Quarterly Review Meeting(QRM)

The Executive Committee discussed the agenda for the forthcoming QRM with NHSI in order that the Trust could respond to all of the items.

3. 11th January 2018

3.1. Referral Management Systems

Further analysis had been undertaken to understand the impact of the CCG referral management schemes (RMS) on the Trusts elective referrals.

RMS had been introduced at different times by the CCGs, and initially had a significant impact on GP referrals, however over time this appeared to be stabilising. The analysis had broken down referrals from all sources e.g. from A&E, consultant to consultant and had also examined the conversion rates from first outpatient consultation to being listed for a procedure. The pattern of change varied between specialties. When benchmarked the Trust is not an outlier for consultant to consultant referrals. Conversion rates in some specialties had reduced, which was not what was expected, so further analysis was requested for T&O, where the consultants were also being asked about any changes to clinical practice.

The impact of RMS on the Trusts waiting list had so far been minimal, because of the RTT backlog.

3.2 Smoke Free Policy

The Trusts Smoke Free policy has been reviewed and updated. The policy lead is the Director of Nursing, Midwifery and Governance and its scope covers staff, patients and visitors. The revised policy was approved.

3.3 IV Training for Newly Qualified Nurses

The Deputy CEO/Director of HR reported that IV training did not form part of the curriculum for student nurses or part of the preceptorship programme and was a skill that nurses were trained in post registration. The lack of training meant that some nurses felt unprepared for working on some wards, if they had to be moved from their base ward to ensure safe staffing levels. The Trust policy currently stated that IV training would be given 3 – 6 months after qualification. This was currently being reviewed to allow more flexibility for those staff who are confident and able to undertake the training earlier, if they wanted to.

3.4 Francis Action Plan

The Deputy CEO/Director of HR reported that the Francis Action plan had been substantially delivered any outstanding items were covered by the Well Led Framework action plan that had been developed following the self-assessment. The Francis Action Plan was therefore going to be formally closed. One of the issues where further work was required was the Trust approach to “Freedom to Speak Out”, as there were multiple routes in place which staff found confusing. The evidence indicated that Trust staff were

confident in speaking out, but to improve the situation more a coordinated and streamlined approach was needed. The initiatives in place had been developed in response to national policy across Nursing and HR, and they were now developing a single approach.

3.5 Board Assurance Framework (BAF)

The Executive Committee reviewed the BAF and agreed recommendations for changes to reflect the changing political, financial and strategic landscape since the last review in October. These recommendations would be made to the next Trust Board.

3.6 Medway Implementation Programme Update

The Director of Informatics and Director of Finance and Information presented the plans to bring the Business Intelligence Workstream back on track. The Director of Finance gave an assurance that current reporting of activity was not affected and this was accurate.

The Director of Informatics presented the options for the optimal go live date, taking into account the requirements of Operations and Finance with yearend and Easter holidays. The 4 options had been evaluated by a representative team and recommended that the optimal go live date was the weekend of 27th April 2018. The recommendation was agreed.

4. 18th January 2018

4.1 IR35 Review

The Executive Committee undertook a review of staff currently seeking to work outside the IR35 rules.

4.2 Agency Spend

The Deputy CEO/Director of HR presented the position at month 9. The increased spend was reviewed and correlated with the operational pressures the Trust had experienced including increased staff sickness and opening escalation beds. The rates of agency and locum pay and the use of off framework agencies had increased in response to the difficulties in obtaining staff over the Christmas period, to fill rota gaps and maintain safe services. The Premium Payment Scrutiny Council will be examining the services where there was an increase in costs to learn any lessons about what else could have been done, and ensure the additional controls are working.

The Executive Committee also received an update on the recruitment and retention initiatives, including the recruitment of overseas nurses. 57 nurse applicants are currently being processed and a further 12 were being interviewed.

4.3 Breast Reconstruction Services

Further work had been undertaken by the Finance Department to understand the costs of the complex breast reconstruction operations and the coding options as the service currently operates at a loss. It was noted that the Trust was now receiving referrals from all over the north of England as other trusts were no longer offering this service. Capacity within theatres was also limiting the amount of activity that could be undertaken and currently the waiting list was growing. The procedure undoubtedly offered the best outcome for patients, psychologically and physically and was more cost effective than two separate operations, but this was currently not reflected in the tariff. Further work is required.

4.4 Appraisals and Mandatory Training

The Executive Committee reviewed the reported compliance levels across the Trust and noted those areas where performance had dipped during December. Action plans were being put in place to recover the position, and achieve both targets by the end of the year.

4.5 Risk Management Council and Corporate Risk Register (CRR)

The Director of Corporate Services presented the Chairs report from the Risk Management Council, including the CRR report. Further work was required to ensure risks were described accurately and were reported to the relevant director when escalated to the CRR.

4.6 Specialist Nurses

The Director of Nursing, Midwifery and Governance reported that the specialist nurses were supporting the wards during this period of increased demand and escalation. She also reported that 4 NIV Nurses had recently been successfully appointed, which would support the respiratory wards.

4.7 Integrated Performance Report (IPR)

The Executive Committee reviewed the IPR for December.

4.8 Pathology Network

The Director of Operations gave an update on a recent meeting with NHSI and the initiative to develop a networked Pathology Service for Cheshire and Merseyside, as part of the national Lord Carter initiatives to reduce clinical support service costs and increase service sustainability. Of the proposed networks in the North Region, the Cheshire and Merseyside proposals are currently the least advanced.

5. 25th January 2018

5.1 Hospital Charity Review

The Director of Finance and Deputy CEO/Director of HR presented a review of the effectiveness of the Hospital Charity, since the appointment of the Charity Manager, and the plans to develop the charity in 2018/19.

The Director of Finance explained that there were 23 specialist funds, sitting within the charitable fund for which the Board were Trustees.

Proposals for growing the charity and attracting more donations were reviewed, as were the opportunities for a specific appeal. Options for creating a visible charity office on the Whiston site and the return on investment were considered. Further work was needed to review and cost these options.

5.2 Vacancy Dashboard

The Deputy CEO/Director of HR presented the vacancy dashboard. This showed an increase in the number of unfilled nursing posts at the end of December. The pipeline of international nurses was reviewed and also the staff recruited locally who would be taking up post in the coming weeks and months. The Chief Executive emphasised the critical importance of retaining existing staff and initiatives that could be strengthened to support staff during their first 12 months of employment.

5.3 Orthodontics Service

The Director of Operations and Assistant Director of Operations presented that plans for the safe transfer of patients from the Orthodontics Service to other providers. The arrangements for staff affected by the closure of the service were also reviewed, in line with the Trusts organisational change policy, in advance of presentation to the Remuneration Committee on 31st January.

5.4 Pharmacy Business Plan

The Head of Pharmacy attended to present the next phases of the Medicines Management plans to improve clinical pharmacy services to the Trust.
The objective was to increase the clinical pharmacy presence on the wards, particularly in AMU and ward 4A. The proposals were designed to be self-funding, with some transfer of resources from Surgical Care to create more efficient pathways and discharge processes e.g. TTOs and use of patients own drugs. The Executive Committee were supportive of the Pharmacy plans and how they supported releasing more medical capacity. Phase 1 of the plan was approved.

5.5 CQPG Feedback

The Director of Operations provided feedback on the CQPG meeting that had taken place on 16th January. The never event that had occurred in January was discussed, in particular the similarities to the never event that had occurred in November and how this could have been prevented.

5.6 eDischarge

The Medical Director outlined plans to send a summary electronic discharge letter to all GPs within 24 hours of a patients being discharged.

5.7 VTE

The Medical Director had reviewed the options for increasing VTE performance in advance of the implementation of ePrescribing in September 2018. The best clinical and financial option was to continue commissioning additional junior medical staff sessions, for this short intervening period. It was recognised that this may leave a risk to achieving the 95% target at times of operational pressure and high demand.

5.8 Medway Programme Status Report

The Director of Informatics reported that Phase 3 of the implementation programme had been initiated at the Medway Programme Board. This meant that arrangements for staff training were being put in place, and staff would need to be released to attend the training over the next 3 months. The training schedules were flexible and created a role specific training programme to ensure each staff group were familiar with the elements that they needed.

All the other work streams were on track and risks being managed to within acceptable levels.

5.9 St Helens CCG Board to Board Meeting

The Executive discussed the preparation for the forthcoming Board to Board meeting with St Helens CCG.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)013
Title of paper: Committee Report – Audit
Purpose: To feedback to members key issues arising from the Audit Committee.
Summary: The Audit Committee met on 7th February 2018. The following matters were discussed and reviewed: External Audit : • External audit progress report including challenge questions around emerging issues and developments (GT) • The Trust's response to those challenge questions raised above (DoF) • External audit plan (GT) • Annual Report timetable (DoCS) Internal Audit: • Progress/update report on Internal Audit programme including follow-ups of action against previous recommendations (MIAA) Anti-Fraud Services: • Progress/update report against the current anti-fraud plan (MIAA) • Draft work plan for 2018/19 Trust Governance and Assurance: • The Director of Nursing update (DoN). Standing Items: • The audit log (report on current status of audit recommendations) (ADoF) • The losses, compensation and write-offs report for the period 1st April 2017 to 31st December 2017 (ADoF). • Aged debt analysis as at end of December 2017 (ADoF). • Tender and quotation waivers report (ADoF). Any Other Business: • Annual Report on Use of Trust seal (DoCS) • 2016/17 National Reference Cost Index Score (HoCF) Key: GT= Grant Thornton (external auditor) MIAA = Mersey Internal Audit Agency (internal audit and anti-fraud services) DoCS = Director of Corporate Services DoF = Director of Finance DoN = Director of Nursing, Midwifery & Governance

ADoF = Assistant Director of Finance (Financial Services)

HoCF = Head of Corporate Finance

NB. There was no meeting required of the Auditor Panel required on this occasion.

Corporate objectives met or risks addressed: Contributes to the Trust's Governance arrangements

Financial implications: None as a direct consequence of this paper

Stakeholders: The Trust, its staff and all stakeholders

Recommendation(s): For the Board to note.

Presenting officer: Su Rai, NED and Chair of Audit Committee

Date of meeting: 28th February 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)014
Title of paper: Committee report – Quality Committee
Purpose: To summarise the Quality Committee meeting held on 20 February 2018 and escalate issues of concern.

Summary: Key items discussed were:

1. Complaints
    - 14 first stage complaints were received and opened in January 2018; this is the same number as received in December 2017. It is a 66% decrease on January 2017, when 41 complaints were received.
    - At the end of January 2018, there were 41 open first stage complaints (an increase of 2) including 4 overdue (a decrease of 1) compared to December 2017.
    - The Trust responded to 66.7% of first stage complaints within agreed time frames during January 2018, a decrease compared to December 2017 (70.6%), but a substantial improvement on January 2017 (26.7%).
    - The top complaint theme during January 2018 remained as clinical treatment.
    - There were 247 PALS contacts/enquiries during January 2018; an increase of 44% in comparison to December 2017 and an increase of 75% in comparison to the 141 contacts/enquiries in January 2017.
    - The majority (86.3%) of PALS contacts were concerns or complaints resolved locally, as opposed to signposting or dealing with enquiries (13.7%).
    - Lessons learned and actions undertaken were discussed together with the new section relating to Risk Rating complaints as advised by MIAA. There was discussion about what is a 'value judgement at the end of the process' and KH challenged the methodology used and queried whether this should be a severity rating rather than a risk rating. DG asked for a review of the process used to classify complaints.

2. IPR

    A&E performance, infection control, finance & HR targets were discussed. The figures quoted were already out of date due to failing Q3 AED at 89.3%, therefore £850k is to be withheld YTD which creates a risk to the start of Q4.
    - Income and Expenditure was reported in January at a surplus of £6.6m against plan. The STF plan and cash bonuses were discussed and explained to the Committee
    - Agency spend is usually £650m but was £1.1m in January alone; £200k OT, £200K WLI and £200k enhancements for run rate. The impact of this on quality was reflected upon in line with maintaining a safe staffing position.
    - CIPs: Quality Impact Assessment. This is thought to be an important issue for QC and the Board. It was agreed that the process should be reviewed, made robust and there should also be follow up.

3. Fasting Update

    Following the Fasting audit it was agreed that there should be a review of the listing procedure and decisions about fasting to be made early. Policy to be reviewed annually.

4. Medicines Security Audit

    Improved performance. The Committee agreed to amend the policy with regard to 'low risk' medications.

5. Maternity Survey & Action Plan

    Low response rate compared to the National average. Poor overall result. Action Plan

developed to focus on areas requiring improvement. Many improvements already realised.

6. Ante-Natal New Born Screening Update
   Assurance was provided that all actions in the Action Plan are now rated Green with the exception of one which is Amber where the external application of a failsafe system is being developed.

7. Safer staffing
   Overall Trust % staffing fill rates for January 2018 were:
   - RNs on days 92.71%
   - RNs on nights 96.05%
   - Care staff on days 109.24%
   - Care staff on nights 113.49%
   - 13/32 wards had a fill rate of less than 90%
   - 11 adult inpatient wards are below the recommended 3 RN to patient ratio
   - 2 patients experienced severe harm following inpatient falls, one when staffing levels were correct, and one when there was a staffing shortfall

8. Feedback from Councils:
   - Patient Safety Council: Summary page noted.
   - Patient Experience Council: Summary page noted. It was noted in feedback from ED survey the Trust performed about the same as other trusts for majority of indicators, not being rated worse and two areas performing better.
   - Clinical Effectiveness Council – Summary page noted. Ten day turnaround for histopathology results has fallen. Urgent and cancer results prioritised. Histopathology team to attend next meeting.
   - CQPG – Summary page noted, nothing to escalate.
   - Executive Committee – Summary page noted, nothing to escalate.

9. Policies/Documents Approved:
   - Safeguarding Annual Reports
   - Revised Learning from Deaths Policy

10. AOB
    None noted.

Items to be escalated to the Board:
1. Learning from Deaths
2. Quality Impact Assessment of CIPs
3. Fasting prior to surgery
4. Maternity Survey
5. Safeguarding training achieved targets

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 Council note this report.

Presenting officer: Chair of Council

Date of meeting: 20 February 2018

TRUST BOARD

Paper No: NHST(18)15

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance and Performance Committee, 22nd February 2018

Summary:

Agenda Items

For Information

- Surgical SLR Quarter 2 2017/18 was presented for information.
- CIP Programme Update 2018/19
  - The Trust is utilising the performance and financial metrics within the NHSI Model Hospital and SLR to inform and develop the CIP programme for 2018/19.
  - The methodology was approved by the Committee and a further update on identified schemes will be presented in March.
  - Committee appreciated the challenge of normal CIPs and felt bigger and more transformational CIPs are needed.
- Forecast Outturn 2017/18
  - The Committee discussed the forecast outturn and changes to the risk profile at Month 10, with particular reference to risks associated with the delivery of the CIP programme, STP Funding in Q4 and the Trust's cashflow.
  - Other significant risks remain: Contracting and CQUIN issues, HRG4+impact, Clinical income shortfall against plan and continued operational winter pressures. The Trust is forecasting to achieve the annual plan of £(0.581)m deficit excluding STP, £7.715m including STP and Tranche 1 Winter monies. It was agreed that the Trust will endeavour to do all it can to achieve control total but recognise the very challenging period ahead.
- 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 operational risks associated with the high levels of patients and ambulances attending ED were discussed in detail, as Type 1 performance in January fell to 71.8% and we will continue to escalate the specific issue and activity increases to Commissioners where appropriate.
- Planning Guidance 2018/19
  - The joint Planning Guidance issued by NHSI and NHSE was presented to the Committee and the budget setting will progress in line with the guidance:
    - Control Total changes
    - Expanded role for STP and collaborative approach for Providers and Commissioners adopted for contractual negotiations, including capped expenditure
    - National Growth assumptions
- Budget setting 2018/19
  - NHSI published the planning guidance for 2018/19 in February and NHSI also issued a revised Control Total to the Trust of £(1.828)m deficit which after Provider Sustainability Funding of £12.821m equates to a £10.993m surplus.
  - An indicative budget was reviewed by the Committee, which discussed possible income and cost assumptions in light of the planning guidance.
  - The Committee discussed the adverse impact for the Trust of the CNST impact

(£2.446m increase in 18/19) and the PFI indexation which has not been funded since 2015/16 by NHSE. The paper will be revised in light of the Committee discussion and presented to Trust Board and future Committees.

- CIP Council and Procurement Council
  - The Briefings were accepted.

For Assurance

- Integrated Performance Report Month 10 was reported
  - Discussion took place around operational performance with specific reference to the Trust's Never Event in January, MRSA and C difficile cases year to date, VTE and RTT performance.
  - 62 Cancer performance for January improved again and is now above target at 90.6%
- Finance Report Month 10 2017/18
  - Delivered year to date surplus of £0.63m excluding STF(surplus of £5.7m including STF)
  - This is behind plan by the value of the lost STF relating to Q3 A&E of £0.82m.
  - The Trust has delivered £227.4m of Clinical Income which is broadly in line with plan.
  - The committee discussed the financial impact of operational winter pressures (circa £1m) and the notification from NHSI that the system had failed the A&E target for Q3 and will not be awarded the related STF (£0.8m). This has resulted in the Trust reducing its FOT from £9.474m to £7.715m. Specific risks in achieving outturn were discussed and included the ability to fully recover activity in the remaining months, cost control / CIP risk and STF funding in Q4.
  - The Trust has delivered £9.8m of CIP against a target of £12.4m and this continues to be monitored at a departmental level.
  - The Cash and Capital positions were also discussed.

For Approval

- CTP / PLICs update
  - NHSI wrote to the Trust about the implementation of patient level costing (PLICS) for Acute providers from 2019 and requested participation in the voluntary collection during 2018
  - Participation was approved by the Committee

Actions Agreed

- The committee approved the proposed adoption of the PLICS voluntary collection.
- Review of recently implemented schemes such as GP streaming.
- Priority to develop transformational schemes for CIP Programme 2018/19

Issues to be raised at Board

- ED performance in December & the challenge to try and maintain quality and safety.
- Forecast Outturn for the Trust, including detailed review of risk profile, noting management action taken to date and additional 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: Su Rai Non-Executive Director

Date of meeting: 28th February 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18) 016
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 22nd February 2018.

Summary

Action Log:

- A letter has been sent to fund holders as part of an administrative review of funds.
- The implications of The General Data Protection Regulation (GDPR) are being worked on with involvement from Information Governance.
- Mrs E Titley made a presentation at a meeting of the Executives around her role and presence of the Charity.
- On-going consideration of the Giant Cash Bonanza Lottery the main issue being marketing.

1. Investment portfolio - Mrs J Turner, 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 13th February 2018, presented at the February Charitable Funds Sub-Committee, the share value has increased by £3.6k, and overall the unrealised gain (ie. increase in value since purchase) is £184.7k.

2. Financial position - The Committee reviewed Income and Expenditure since the previous meeting. It was proposed that requests for capital equipment be approved by the Director of Finance before consideration by the Charitable Funds Committee.

3. Fundraising update

   A discussion took place on the best way to inform staff of the role of the Charity Officer and their own role with regards to donations. It was agreed that a "crib sheet" be written that gives all relevant information for types of donations and restrictions etc that could be used by staff and the public. However the overarching message is to communicate with the Charity Officer. The committee were informed of various corporate sponsors and other individual and community fundraising activities.

Corporate objective met or risk addressed: Contributes to the Trust's objectives regarding Finance, Performance, Efficiency and Productivity.
Financial implications: None directly from this report.
Stakeholders: The Trust, its staff and all stakeholders.
Recommendation(s): The Board are asked to note the contents of the report.
Presenting officer: Denis Mahony, Non-Executive Director, and Committee Chair
Date of meeting: 28th February 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)017
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: The report provides a briefing on the key developments and issues of importance since the last Trust Board meeting in January, covering: 1. NHS Improvement (NHSI)/NHS England (NHSE) Joint Planning Guidance; 2. NHSI Oversight of NHS Controlled Providers; 3. Closer working between NHSI and NHSE; 4. Governments response to the Naylor Review; 5. CQC Consultation – Regulation of private healthcare providers.
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, Director of Corporate Services
Date of meeting: 28th February 2018

Strategic and Regulatory Update Report – February 2018

1. NHS Improvement (NHSI)/NHS England (NHSE) Joint Planning Guidance

The Operational Planning Guidance for 2018/19 was published on 2nd February.

This sets out how the additional funding announced in the November 2017 budget will be allocated.

The guidance builds on the two year plans submitted in 2017/18 and requires NHS Providers, Commissioners and STPs to submit coordinated and reconciled plans.

The timetable for submissions is:

Requirement	Submission Date
Draft 2018/19 Operational Plans – finance, workforce, activity, performance	8th March 2018
Agreement and signing any contract variations	23rd March 2018
Final Board approved Operational Plan	30th April 2018

Key Points of the guidance:

- A&E performance recovery trajectory has been extended to March 2019;
- For RTT the waiting list must not grow and the number of 52 week waiters is to be halved by March 2019;
- The Sustainability and Transformation Fund (STF) is being replaced by a Provider Sustainability Fund (PSF) of £2.45 bn and a Commissioner Sustainability Fund (CSF) of £400m to support the system to return to financial balance;
- Accountable Care Systems are now to be known as Integrated Care Systems (ICS);
- The current 8 approved ICS and two shadow ICS areas are required to submit a single integrated Operational Plan;
- The guidance states there will be no additional winter funding in 2018/19 and expected to agree realistic plans for A&E attendances and non-elective activity. Every organisation is required to submit a detailed winter plan (although not by April);
- National tariffs are unchanged. Local systems are encouraged to consider local payment reform, e.g. for ambulatory care pathways;
- The planning templates include no assumptions about lifting the pay cap, although the information submitted will be used to inform the pay negotiations;
- Trusts that accept their control total will be exempt from the majority of contractual fines.

2. NHSI Oversight of NHS Controlled Providers

NHSI has published new guidance extending its regulatory oversight to NHS Controlled Providers. These are wholly owned subsidiaries or joint ventures established by NHS Provider organisations to provide NHS Care. Such legal vehicles are anticipated to be used to establish new care models for Integrated Care Systems.

Following a consultation, NHSI have now confirmed that such NHS Controlled Providers will be required to either hold or comply with the conditions of the Provider Licence as all NHS Foundation Trusts and NHS Trusts are required to do, and will be regulated under the Single Oversight Framework(SOF).

Where an NHS Controlled Provider remains closely linked to an NHS Provider organisation, the regulation and oversight will be risk based, i.e. will not duplicate the scrutiny.

These new requirements come into effect on 1st April 2018.

3. Closer working between NHSI and NHSE

NHSI and NHSE have made moves to support closer working by appointing Non-Executive Directors to each other's Boards. These two individuals David Roberts (NHSE) and Richard Douglas (NHSI) will hold associate non-voting positions and will jointly chair a new NHSE/NHSI Joint Finance Committee.

NHSE and NHSI are also planning to hold two joint Board meetings during 2018, in May and September.

Although legislation would be required to create a single leadership structure for the NHS, it is clear that steps are being taken to achieve closer alignment between NHSE and NHSI.

4. Governments response to the Naylor Review

Sir Robert Naylor undertook a review of NHS Property and Estate which was published in March 2017. The report covered 3 main areas:

- An assessment of the national estates strategy;
- The local delivery of estates management;
- Capital requirements for the NHS estate.

The government published its response to the Naylor review recommendations on 30th January 2018. The key points are:

- NHS estates strategy is currently fragmented and will be overseen by an NHS Property Board. This will incorporate the current functions of NHS Property Services and Community Health Partnerships and will be supported by NHSI;

- Capacity and capability to deliver effective property and asset management needs to be strengthened across the NHS, and there will be a number of new routes to develop NHS Career paths in these fields;

- The Government has announced new capital for the NHS and other measures to enable the retention of capital receipts from land sales and P2 (the next generation of PFI) to help support; service transformation, reducing backlog maintenance and creating affordable homes for NHS staff.

5. CQC Consultation – Regulation of Independent Healthcare Providers

The CQC has launched a consultation to extend its regulatory oversight and inspection powers to independent healthcare providers, e.g. independent GPs and digital doctors, sexual health services and termination of pregnancy services. The consultation will close in June 2018.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)018
Title of paper: Safeguarding Children - Information and Annual Assurance Reports 2016/17
Purpose: To provide the Trust Board with information and assurance that it effectively discharged both its safeguarding children responsibilities during 2016/7.
Summary: The report provides information and assurance for all aspects of safeguarding children during the financial year 2016/7.
Corporate objectives met or risks addressed: Care, Safety, Communication
Financial implications: None
Stakeholders: Trust Board, Commissioners
Recommendation(s): Members are asked to approve the report.
Presenting officer: Sue Redfern, Executive Director of Nursing, Midwifery and Governance, Executive Lead for Safeguarding
Date of meeting: 28th February 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Safeguarding Children

Information and Annual Assurance Report

2016-2017

Completed by: Anne Monteith, Named Nurse Safeguarding Children
Sally Duce, Deputy Director of Nursing and Quality

Contents

1. Introduction 4
2. Assurance of compliance with the Trust's Safeguarding Children Responsibilities 4
2.1 Safeguarding Children Policy 4
2.2 Internal Governance Processes to Safeguard Children 4
2.3 Safer Recruitment including Trust Volunteers 5
2.4 Safeguarding Children Training 5
2.5 Safeguarding Children Policy and Assurance of Compliance 6
2.6 Allegation of Abuse against a Pofessional Policy Activity 6
2.7 Safeguarding Children Supervision Policy 6
2.8 Effective (Multi-agency) Partnership working 6
2.8.1 Serious Case Review (SCR) Involvement 6
2.8.2 Multi-Agency Working 7
2.8.3 Information Sharing 7
2.8.4 Local Safeguarding Children Board (LSCBs) Activity Sharing 7
3. Safeguarding Children Activity and Social Care Referrals 2016-17 7
3.1 Paediatric and Emergency Department Activity 7
3.2 Maternity Safeguarding Activity 8
3.3 Safeguarding Children Incidents 9
4. External Assurance of Effective Processes during 2016 - 17 9
4.1 Safeguarding Children CCG Assurance 9
4.2 Section 11 Audit 9
4.3 CQC Assurance 10
5. Summary of Achievements 2016 – 2017 12
6. Future Developments 13

Safeguarding Children Annual Information and Assurance Board Report 2016-2017

1. Introduction

St Helens & Knowsley Teaching Hospitals NHS Trust (STHK) has a statutory responsibility to safeguarding children and young people at risk from harm across all service areas in accordance with Section 11 of the Children's Act 2004. This activity is closely monitored by the Care Quality Commission (CQC), NHS England and the Clinical Commissioning Groups (CCG) as well as the Local Safeguarding Children Boards (LSCBs). Safeguarding children is everybody's business to help prevent abuse and to act quickly and proportionately to protect children where abuse is suspected whether staff are working directly or indirectly (with children's parents or carers) with children and young people. The purpose of this Annual Report is to provide an overview of safeguarding children activity across the Trust for the last financial year (April 2016 – March 2017) and to provide assurance to the Trust Board.

Safeguarding Children arrangements include:

- Robust internal governance processes to safeguard children including an Executive lead, a Named Doctor, Named Nurse and Named Midwife in post;
- Safer recruitment;
- Training of all staff as appropriate for role;
- Policies for safeguarding children and allegations of abuse against a professional;
- Effective supervision arrangements;
- Working in partnership with other agencies.

2. Assurance of compliance with the Trust's Safeguarding Children Responsibilities

2.1 Safeguarding Children Policy

The Trust Safeguarding Children Policy is available on the Trust Intranet for all staff to access and contains individual Standard Operating Procedures to cover many areas of safeguarding and child protection. The Policy was reviewed and minor amendments made in 2016 to reflect the revised Working Together to Safeguard Children Statutory Guidance 2015.

2.2 Internal Governance Processes to Safeguard Children

The Executive Director of Nursing, Midwifery and Governance is the Executive lead with overall responsibility for Safeguarding. There was a change in the structure of the Safeguarding team in 2016 when the Head of Safeguarding post was replaced with a substantive Named Professional post to lead on the Safeguarding adult agenda. The Safeguarding Children team consists of a Named Nurse, Doctor and Midwife supported by specialist nurse and midwife. The Named Nurse and Named Professional now report directly to the Deputy Director of Nursing.

The Trust's Safeguarding Children (SC) Steering Group, which reports to the Patient Safety Council, has responsibility for ensuring the Safeguarding children agenda is achieved. The group was established in September 2009 with representatives from all service areas within the Trust and met four times during 2016-17 to review the overarching Safeguarding Children work plan which ensures that the Trust has a clear oversight of the agenda, the work it is undertaking and progress being made. The Patient Safety Council reports into the Trust's Quality Committee which is a sub-group of the Trust Board. In addition to this, a quarterly Safeguarding Children report containing commissioner feedback from the CCG's Safeguarding Designated Professionals is reviewed at the joint commissioner and Trust's Clinical Quality Performance Group.

2.3 Safer Recruitment including Trust Volunteers

The Trust complies with the NHS Recruitment Standards. The Human Resources IT TRAC Recruitment system supports this, ensuring every step required to recruit safely is complied with prior to start date. Appointment to the Trust's volunteer service, during 2015, was also moved to the TRAC system to ensure the same robust standards apply to the voluntary workforce. Work is on-going with the Roman Catholic Human Resources Manager to ensure sharing of employment details for the chaplaincy assistants and RC volunteers working in the Trust through the Service Level Agreement.

2.4 Safeguarding Children Training

The Trust's Safeguarding Children Training Strategy and Training Needs Analysis sets out which staff groups are to receive which of the 3 levels of Safeguarding Children training according to their role, as set out in the Intercollegiate Safeguarding Children training standards, last updated in 2015. This update has resulted in a substantial broadening of the staff groups requiring 'Level 2' training to all Trust clinical staff.

Level 1 training is delivered as part of the Trust's Induction Programme for all new starters and during 2016-17, annually (clinical staff) or bi annually (non-clinical staff) within the Trust's mandatory training for all staff. This is a face to face session delivered by a member of the Trust's Safeguarding Team. This training is combined with the vulnerable adults' awareness training. Attendees receive additional safeguarding children information in a Level 1 reader distributed following mandatory and induction training by email.

Level 2 Safeguarding Children training is delivered via a workbook and assessment that is completed by individual staff members every 3 years.

Level 3 training is delivered internally by the Named Nurse Safeguarding Children as one full day course every 3 years. Level 3 specialist training is accessed via the LSCB every 3 years. This is a 2 day 'Working Together to Safeguard Children' Course provided as part of their multi-agency training programme and is accessed only by staff who are involved in care planning and case management of children subject to child protection procedures.

Safeguarding Compliance figures as of the end of March 2017 are listed below against a target of 90%:

- Level 1 96%
- Level 2 74%
- Level 3 74%

2.5 Safeguarding Children Policy and Assurance of Compliance

Evidence of compliance with the policy and Trust Safeguarding procedures was provided by the completion of three quarterly audits of health records in Paediatrics and the Emergency Department to review compliance with safeguarding processes. The findings in these audits were of a consistently high standard, therefore a decision was made to review the audit programme and carry out thematic audits.

In March 2017 an audit of referrals to Children's Social Care was completed. This focussed on the quality of information and processing of referral forms, most areas reviewed evidenced 100% compliance. There is a plan to repeat the audit in November 2017.

2.6 Allegation of Abuse against a Pofessional Policy Activity

In addition to employing STHK staff, the Trust is also lead employer to over 3500 doctors in training covered by this Allegations policy. It incorporates the process for making referrals to the Local Authority Designated Officer (LADO) when an allegation is made against a member of staff involving children. During the reporting period, the Safeguarding Team and the Human Resources (HR) department were involved with 4 LADO referrals, all Trust employees. One referral was made by the Named Nurse Safeguarding; the three remaining cases were referred by police and Children's Social Care. Three cases were closed with no further action following investigations by police and / or social care. The fourth case remains ongoing; the staff member is currently suspended pending the completion of Legal Proceedings in the Family Court.

STHK also has in place a HR/ Lead Employer / Safeguarding group which meet on a bi-monthly basis to review cases that are subject to LADO referral as well as any other cases involving an allegation or complaint requiring a joint approach.

2.7 Safeguarding Children Supervision Policy

Supervision activity is monitored through the Trust's KPIs. 100% compliance was achieved for staff directly involved with the case management of children made subject to safeguarding procedures.

2.8 Effective (Multi-agency) Partnership working

2.8.1 Serious Case Review (SCR) Involvement

A SCR should take place if abuse or neglect is known, or suspected, to have been involved and a child has died or has been seriously harmed and there is cause for concern about how organisations or professionals worked together to safeguard the child A SCR should also be considered if a child dies in custody or by suspected suicide. During 2016 / 2017 the Trust were involved with one SCR commissioned by St Helens LSCB. This followed the death of a young baby secondary to possible overlay with additional concerns relating to alcohol use and mental health issues. An initial internal review of the case highlighted some lessons to be learnt in respect of the Maternity Department, actions were immediately put in place to address issues identified. These actions are monitored in a Trust SCR Action Plan via the Safeguarding Steering Group. Further actions are likely to be identified following publication of the SCR independent report.

There was one Practice Learning Review commissioned by Knowsley LSCB, the LSCB felt that there were some key points of leaning identified but did not feel a SCR was required. This followed the death of a neonate, whose mother had concealed the pregnancy. There was one action for the Maternity Unit to compile a SOP for the management of concealed pregnancy, which has been drafted and is awaiting ratification.

2.8.2 Multi-Agency Working

There is significant involvement from the paediatric and maternity departments with multi agency planning for children and unborns with identified needs, ranging from early help to child protection cases. Meeting attendance is monitored through the KPIs and cases are reviewed regularly at the Children's Safeguarding Steering Group. There were some areas of non-compliance for attendance at meetings (target 90%); however the actual numbers were very small. These incidents have been reviewed by the Safeguarding Team and where necessary action taken to improve compliance, this included working with the Local Authority to ensure meeting invitations were sent to a central point to ensure acknowledgement and monitoring by the Safeguarding Team.

2.8.3 Information Sharing

Effective information sharing between agencies is essential for effective identification of need, assessment and provision of relevant services for children. Early sharing of information is the key to providing effective early help where there are emerging problems or concerns. Sharing information can also be essential for protecting a child who is at risk of neglect or abuse. Serious Case Reviews (SCRs) continue to highlight information sharing as an area of concern when reviewing child deaths.

STHK has a dedicated Paediatric Liaison Team which ensures information in relation to attendances for all children and young people up to the age of 18 are shared with relevant community practitioners, including school nurses and health visitors, as well as social workers when indicated. The team also processes information from the maternity department when a safeguarding cause for concern has been raised and across the trust when adults present and concerns are raised in relation to their children.

2.8.4 Local Safeguarding Children Board (LSCBs) Activity Sharing

The Trust is an active partner at the three Local Safeguarding Children Boards (LSCBs) in St Helens, Halton and Knowsley with representation at several sub groups. The minutes from each of the Boards are provided to the Trust's Children Safeguarding Steering Group. The Trust also has representation and contributes when appropriate to LSCB multi agency audits.

3. Safeguarding Children Activity and Social Care Referrals 2016-17

3.1 Paediatric and Emergency Department Activity

The table below is the number of attendances where a safeguarding concern was noted for a child and information shared with the Trust's Safeguarding Children Team for the last 3 years. These attendances vary from low levels of concern e.g. notification of a child with current or historical social care involvement, to a child who is thought to

have suffered significant harm e.g. attended with a non-accidental injury, who require an immediate social care referral. The numbers continue to increase year on year.

Year	No of attendances with recorded safeguarding concern
2013/2014	1251
2014/2015	1560
2015/2016	1641
2016/2017	1860

The table below is the number of actual referrals made to Children's Social Care

Year	No of referrals to Children's Social Care
2013/2014	98
2014/2015	84
2015/2016	101
2016/2017	115

A large percentage of safeguarding activity is generated by children and young people attending with mental health problems, such as low mood, self-harm and attempted suicide. The Trust has a clear self-harm pathway, which covers all aspects of mental health and ensures these young people are assessed by both the paediatric medical team and the CAMHS Assessment and Response Team (CART, an in-reach service provided by 5 Borough Partnership Trust)). This pathway complies with current NICE guidelines and was shared across a regional mental health network, and highlighted as good practice. The table below represents the number of attendances for young people with mental health problems.

St Helens LSCB recognises the significance of mental health problems in adults and children across the borough, and as part of the LSCB action plan there is much work being undertaken to highlight areas of concern and improve support services. There is Trust representation at the St Helens Mental Health working group, chaired by the Assistant Director Integrated Children's Health.

The numbers of young people attending the Trust with associated mental health problems is recorded in the table below.

Year	No of attenders with mental health problems
2013/2014	419
2014/2015	454
2015/2016	528
2016/2017	481

3.2 Maternity Safeguarding Activity

When a safeguarding concern is noted in the Maternity Department a "Cause for Concern Form" is completed by a member of the midwifery team in relation to mental health, drug and alcohol misuse, domestic abuse or anything else that may affect a mother's ability to care for the baby without additional support or monitoring. This is shared with the Safeguarding Specialist Midwife, GP, Health Visitor and if necessary

Children's Social Care and actions and plans implemented accordingly to maintain the new-born's safety.

The table below represents the number of Cause for Concerns initiated during the last 4 years. There has been a notable increase since 2013 /2014.

Year	No of Cause for Concern Forms initiated
2013/2014	645
2014/2015	961
2015/2016	1109
2016/2017	1190

3.3 Safeguarding Children Incidents

There have been no significant incidents relating to Safeguarding Children in 2016/2017 which required an internal review, RCA or SIRI.

4. External Assurance of Effective Processes during 2016 - 17

4.1 Safeguarding Children CCG Assurance

The Trust's safeguarding children systems and processes are monitored externally by achieving key performance indicator requirements which are submitted monthly in the Trust's Integrated Performance Report and quarterly to the CCGs designated nurses who commission children's safeguarding. Due to a change in the CCG allocation of Designated Nurses, STHK now submit KPIs and are monitored by St Helens CCG who provide assurance to Halton and Knowsley CCG. The quarterly submissions in 2016/2017 provided reasonable assurance in all areas except for Safeguarding Training Compliance, for which a recovery action plan has been implemented.

4.2 Section 11 Audit

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

An online Section 11 audit is completed and submitted to the LSCBs which includes self-assessment and the submission of supporting information to evidence compliance in the following areas:

- A clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children;

- A senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements;

- A culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services;

- Arrangements which set out clearly the processes for sharing information, with other professionals and with the Local Safeguarding Children Board (LSCB);

- A designated professional lead (or, for health provider organisations, named professionals) for safeguarding. Their role is to support other professionals in their agencies to recognise the needs of children, including responding to possible abuse or neglect. Designated professional roles should always be explicitly defined in job descriptions. Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively;

- Safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check;

- Appropriate supervision and support for staff, including undertaking safeguarding training;

- Employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role;

- Staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare; and

- All professionals should have regular reviews of their own practice to ensure they improve over time.

- Clear policies in line with those from the LSCB for dealing with allegations against people who work with children.

In December 2016 the Named Nurse Safeguarding and Deputy Director of Nursing attended the St Helens LSCB Section 11 Scrutiny policy. Significant assurance was accepted by the panel in all areas with the only recommendation to improve processes to evidence that the Trust listens and responds to children.

4.3 CQC Assurance

In November 2016 CQC carried out a "Review of Children looked after and safeguarding in Knowsley."

The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.

The focus was on the experiences of looked after children and children and their families who receive safeguarding services.

The review focussed on:

- The role of healthcare providers and commissioners;

- The role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews;

- The contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services;

- Whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2015.

The aim of the review was to follow the Child's Journey, recording their experience of health services within the following domains:

- Early help;
- Child in Need;
- Child protection;
- Looked after Children.

The Trust review was carried out by two CQC inspectors who visited the Emergency Department, Paediatric and Maternity Unit. The review within paediatrics was much less intense than that in the other two areas, with the greater focus evident within Maternity Services.

There were some areas of good practice noted within the Trust which included:

- Children and young people access emergency care via a bright and welcoming dedicated paediatric emergency department (ED) with its own entrance. Consideration of care pathways means that contact with adult patients is minimised and a child-friendly culture is maintained which includes separate waiting/play areas for younger children and teenagers;

- Staff in ED are identifying, risk assessing and signposting young people to relevant local support services when they attend ED following substance or alcohol misuse. A substance misuse screening tool is completed which aids ED staff in their decision making around how they can most effectively instigate early help and support for vulnerable young people;

- Children and young people under the age of 18 years who attend ED at Whiston hospital following an episode of deliberate self-harm follow an established NICE compliant pathway which means that they are fast tracked through the ED and are routinely admitted to the paediatric ward to await a CAMHS assessment. The ward has dedicated cubicles which have been adapted and risk assessed to ensure children and young people who are considered to be at continued high risk of self-harm are admitted to a safe environment;

- The paediatric liaison function is well embedded in the ED at Whiston hospital. The paediatric liaison team screens the records of all children and young people up to the age of 18 years following an attendance at the ED. This ensures a good level of

oversight and a review of the assessment, treatment and outcomes for children and young people;

- Women living in Knowsley have good access to maternity services at Whiston hospital with most antenatal care being provided in clinics held within the local community or at the hospital. Midwives have a flexible approach to engaging women with antenatal care and although antenatal home visits are not routine practice, midwives will conduct home visits when this is more appropriate or necessary to ensure the wellbeing of a pregnant woman;

- Pregnant women and the maternity workforce at Whiston hospital are supported by a small specialist team of midwives for vulnerable women which includes mental health, substance misuse, public health and young parent specialist midwives. The specialist midwives take case holding responsibility for high risk complex cases, and are available to advise and support midwifery colleagues with lower risk cases;

- Support for women with perinatal mental health difficulties is available in Knowsley. Although there are no joint clinics held by maternity and the adult mental health services, a bi monthly multi-disciplinary meeting ensures that practitioners involved in a pregnant woman's care are updated and can plan their care accordingly. The specialist midwife for mental health attends relevant meetings held by the mental health team, who we were informed are supportive in providing robust mental health care plans for pregnant women and in supporting women and maternity staff during labour and the immediate postnatal period.

The report and recommendations were published on the CQC website in January 2017, and an action plan implemented by Knowsley CCG which contained the required actions for each provider organisation included in the inspection. There were a total of 22 recommendations for STHK, 4 of which required a multi-agency response with 5 Boroughs NHS Trust.

The majority of the actions are process driven and require amendments to current safeguarding procedures with implementation of relevant training and audit of compliance.

There are some actions with financial implications, the most significant being the construction and staffing of a dedicated reception area within the Paediatric Emergency Department.

The action plan is reviewed regularly by the Safeguarding Team to ensure that identified actions are progressing appropriately within the recommended time scales.

5. Summary of Achievements 2016 – 2017

- Reasonable assurance has been received from the CCG in relation to Safeguarding Children KPI compliance.

- The Knowsley CCG CQC report highlighted good practice in relation to safeguarding children practice and processes, with some positive patient feedback noted.

- Actions in relation the above report have been progressed.

- The Safeguarding Team has continued to actively participate at the LSCB activity in the three main local areas.

6. Future Developments

- The Trust Safeguarding will endeavour to maintain KPI compliance.

- There will be a focus on improving and sustaining Safeguarding Children training compliance.

- Safeguarding Audit will continue with the completion of individual audits completed in maternity, paediatrics and the sexual health service to monitor compliance to trust process.

- There will be a focus on emerging themes in safeguarding, particularly Harmful Sexual Behaviour (HSB). The Safeguarding Children Policy will be amended to reflect processes required to support children and families in this area.

ENDS

St Helens and Knowsley Teaching Hospitals
NHS Trust

TRUST BOARD

Paper No: NHST(18) 018
Title of paper: Safeguarding Adults Annual Information and Assurance Report 2016/17
Purpose: To provide the Trust Board with information and assurance that it effectively discharged its safeguarding adults' responsibilities during 2016/7
Summary: The report provides information and assurance for all aspects of safeguarding adults during the financial year 2016/7
Corporate objectives met or risks addressed: Care, Safety, Communication
Financial implications: None
Stakeholders: Trust Board, Commissioners
Recommendation(s): Members are asked to approve the report
Presenting officer: Sue Redfern, Executive Director of Nursing, Midwifery and Governance, Executive Lead for Safeguarding
Date of meeting: 28th February 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Safeguarding Adults

Annual Information and Assurance Report

2016-2017

Completed by:
Natalie Hendry – Named Professional Safeguarding Adults
Sally Duce – Deputy Director – Nursing and Quality

Contents

Introduction 4

SECTION 1: SAFEGUARDING ADULTS 4

1. Assurance of compliance with the Trust's Safeguarding Adults Responsibilities 4

1.1 Safeguarding Adults Policy 4

1.2 Internal Governance Processes to Safeguard Adults 4

1.3 Safer Recruitment including Trust Volunteers 5

1.4 Safeguarding Adults Training 5

1.5 Prevent Training 6

1.6 Safeguarding Adults Policy and Assurance of Compliance 6

1.7 Allegations of Abuse against a Professional Policy Activity 6

1.8 Effective (Multi-agency) Partnership Working 6

1.8.1. Safeguarding Adult Review (SAR) Involvement 6

1.8.2. Multi-agency working 7

1.8.3. Information Sharing 7

1.9 Safeguarding Adults Activity 7

1.10 Safeguarding Adults Incidents 8

1.11 External Assurance of Effective Processes during 2016/17 8

1.11.1. Safeguarding Adult Commissioner Assurance 8

1.12 Summary of Achievements 2016/2017 8

1.13 Future Developments 8

SECTION 2: Supporting Adults with Additional Needs 9

Overview 9

2.1 Mental Capacity Act 9

2.2 Deprivation of Liberty Safeguards 9

2.3 Learning Disability 10

2.4 Mental Health Liaison 11

2.5 Patients with Interpretation and Translation Needs 11

2.6 Summary of Achievements 2016/2017 12

2.7 Future Developments 12

Safeguarding Adults Annual Information and Assurance Report 2016-2017

Introduction

St Helens & Knowsley Teaching Hospitals NHS Trust has a statutory responsibility to safeguarding adults at risk from harm across all service areas in accordance with the Care Act 2014. This activity is closely monitored by the Care Quality Commission (CQC), NHS England and the Clinical Commissioning Groups (CCG) as well as the Local Safeguarding Adult Boards (LSABs). It is everybody's business to help prevent abuse and to act quickly and proportionately to protect adults where abuse is suspected. The purpose of this Annual Report is to provide an overview of safeguarding adult activity across the Trust for the last financial year (April 2016 – March 2017) and to provide assurance to the Trust Board.

Safeguarding Adult arrangements include:

- Robust internal governance processes to safeguard adults at risk including an executive lead, Named Professional and Specialist Staff in post;
- Safer recruitment;
- Training of all staff as appropriate for role;
- Policies for safeguarding adults and managing allegations of abuse against a professional;
- Effective supervision arrangements;
- Working in partnership with other agencies.

This report combines adult safeguarding activity with the Trust's wider remit of supporting adults with additional needs. The report details achievements in both areas and lays out our plans for the coming year.

This report is in two sections:

- **Section 1** details the work undertaken around the formal safeguarding process.
- **Section 2** details the work around supporting adults who have additional needs.

SECTION 1: SAFEGUARDING ADULTS

1. Assurance of compliance with the Trust's Safeguarding Adults Responsibilities

1.1 Safeguarding Adults Policy

The Trust's Safeguarding Adults Policy is available on the Trust Intranet for all staff to access and contains Standard Operating Procedures to cover all areas of safeguarding adults. The Policy was reviewed and amended in 2015 to reflect the introduction of the Care Act 2014. The policy is due for review in 2018.

1.2 Internal Governance Processes to Safeguard Adults

The Executive Director of Nursing, Midwifery and Governance is the Executive lead responsible for Safeguarding. There was a change in the structure of the Safeguarding team in 2016, when the Head of Safeguarding post was replaced with a substantive Named Professional post to lead on the Safeguarding adult

agenda. The Safeguarding Adults team consists of a Named Professional supported by specialist nurses and administrators. The Named Nurse for Safeguarding Children and Named Professional for Safeguarding Adults now report directly to the Deputy Director of Nursing.

The Trust's Safeguarding Adults Steering Group, which reports to the Patient Safety Council, has responsibility for ensuring the Safeguarding adults agenda is achieved. The group was established in September 2009 with representatives from all service areas within the Trust and met four times during 2016-17 to review the overarching work plan which ensures that the Trust has a clear oversight of the agenda, the work it is undertaking and progress being made. The Patient Safety Council reports into the Trust's Quality Committee, which is a sub-group of the Trust Board. In addition to this, a quarterly Safeguarding adult report containing commissioner feedback from the CCG's Safeguarding Designated Professionals is reviewed at the joint commissioner and Trust's Clinical Quality Performance Group.

1.3 Safer Recruitment including Trust Volunteers

The Trust complies with the NHS Recruitment Standards. The Human Resources IT TRAC Recruitment system supports this, ensuring every step required to recruit safely is complied with prior to start date. Appointment to the Trust's volunteer service, during 2015, was also moved to the TRAC system to ensure the same robust standards apply to the voluntary workforce. Work is on-going with the Roman Catholic Human Resources Manager to ensure sharing of employment details for the chaplaincy assistants and RC volunteers working in the Trust through the Service Level Agreement.

1.4 Safeguarding Adults Training

The Trust's Safeguarding Adults Training Strategy and Training Needs Analysis sets out which staff groups are to achieve which of the 3 levels of Safeguarding Adults training according to their role.

Level 1 training is delivered as part of the Trust's Induction Programme for all new starters and during 2016-17, annually (clinical staff) or bi annually (non-clinical staff) within the Trust's mandatory training for all staff. This is a face to face session delivered by a member of the Trust's Safeguarding Team. This training is combined with the safeguarding children's' awareness training.

Level 2 Safeguarding Adults training is delivered via a workbook and assessment that is completed by individual staff members every 3 years.

Level 3 training is delivered internally by the Safeguarding Adults Specialist Nurses as one full day course every 3 years.

Level 4 is for highly specialist staff and is delivered externally.

Safeguarding Compliance figures as of the end of March 2017 are listed below against a target of 90%.

- Level 1 96%
- Level 2 66%
- Level 3 78%

- Level 4 100%

1.5 Prevent Training

Prevent is part of the UK's counter terrorism strategy and is firmly embedded into safeguarding practice.

The Trust has a Prevent Training needs analysis and strategy and staff are assigned a training level according to job role.

Level 1+2 training is delivered to all staff as part of induction and mandatory training. It is also included in all safeguarding training (adults and children).

Level 3 training is a face to face session delivered by a Home Office approved facilitator (Trust staff have been trained to deliver).

Prevent Compliance figures as of the end of March 2017 are listed below against a target of 85% (to be achieved by end of March 2018).

- Level 1+2 96%
- Level 3 37%

1.6 Safeguarding Adults Policy and Assurance of Compliance

Evidence of compliance with the policy and Trust Safeguarding procedures was provided by the completion of quarterly audits of health records across all services to review compliance with safeguarding processes. The audits have highlighted areas for improvements and have generated an action plan.

1.7 Allegations of Abuse against a Professional Policy Activity

In addition to employing STHK staff, the Trust is also lead employer to over 3500 doctors in training covered by this policy. There was 1 case of alleged abuse against an adult by an agency nurse whilst employed at the Trust. This was reported to the nursing agency and the Named Professional Safeguarding Adults provided the co-ordination to the local authority.

1.8 Effective (Multi-agency) Partnership Working

1.8.1. Safeguarding Adult Review (SAR) Involvement

A Safeguarding Adults Review (SAR) is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is not to apportion blame. It is to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

They are commissioned when:

- There is reasonable cause for concern about how Safeguarding Adults Board members or other agencies providing services, worked together to safeguard an adult; and

- The adult has died and the Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died); or

- The adult is still alive and the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect.

During 2016 / 2017 the Trust were involved with one SAR commissioned by Knowsley SAB (dating back to an incident in 2014). This was a completed report and was at the action plan stage and the Trust contributed to the finalising of this action plan. The Trust was involved in 2 reviews which were not identified as meeting the criteria for a SAR, but that the LSAB felt that some learning could be achieved. All actions are monitored in a Trust SCR/SAR Action Plan via the Safeguarding Steering Group.

1.8.2. Multi-agency working

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

The safeguarding adult's team participate in every strategy discussion and meeting relating to a patient that we are involved in, we achieved 100% compliance with the KPI around attendance at multi-agency meetings for adults at risk.

1.8.3. Information Sharing

Effective information sharing between agencies is essential for effective identification of need, assessment and provision of relevant services for adults at risk. Early sharing of information is the key to providing effective early help where there are emerging problems or concerns. Sharing information can also be essential for protecting an adult at risk. Safeguarding Adult Reviews (SARs) continue to highlight information sharing as an area of concern when reviewing deaths and serious harm to adults at risk.

The safeguarding adult's team work alongside partner agencies to ensure that information about adults at risk is shared in a proportionate and timely manner.

1.9 Safeguarding Adults Activity

The Safeguarding Adults Team provides support and advice to all Trust staff who have concerns about an adult at risk. This activity is called a contact. A referral is when the contact generates a formal safeguarding referral to the local authority. The data shows a high level of contacts between areas of the Trust and the Trust's Adult Safeguarding Team which is viewed as being very positive. The data also shows a number that are formally referred to the local authority.

Table 1 below shows comparison of Contacts and Referrals to Adult Social Care in each quarter of 2016/2017

Quarter	Contact	Referral
1	216	50
2	232	49
3	227	49
4	261	51

Table 2 below shows comparison of Contacts and Referrals for 2012-2017

Period	Total Contacts	Total Referrals
April 2012- March 2013	458	206
April 2013- March 2014	510	194
April 2014- March 2015	798	177
April 2015- March 2016	961	241
April 2016- March 2017	936	199

1.10 Safeguarding Adults Incidents

There have been no significant incidents relating to Safeguarding Adults in 2016 / 2017 which required an internal review, RCA or SIRI.

1.11 External Assurance of Effective Processes during 2016/17

1.11.1. Safeguarding Adult Commissioner Assurance

The Trust's safeguarding adult systems and processes are monitored externally by achieving key performance indicator requirements which are submitted monthly in the Trust's Integrated Performance Report and quarterly to the CCGs designated nurses who commission adult safeguarding. Due to a change in the CCG allocation of Designated Nurses, STHK now submit KPIs and are monitored by St Helens CCG who provide assurance to Halton and Knowsley CCG. The quarterly submissions in 2016/2017 provided reasonable assurance in all areas except for Safeguarding Training Compliance, for which a recovery action plan has been implemented.

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

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

1.12 Summary of Achievements 2016/2017

- Reasonable assurance has been received from the CCG in relation to Safeguarding Adult KPI compliance.
- The principles of the Care Act 2014 have been firmly embedded into practice.
- The Safeguarding Team has continued to actively participate at the LSAB activity in the three main local areas.

1.13 Future Developments

- The Trust Safeguarding will endeavour to maintain KPI compliance.
- There will be a focus on improving and sustaining Safeguarding Adult training compliance.
- Safeguarding Audit will continue to monitor compliance to trust process.
- There will be a focus on emerging themes in adult safeguarding, particularly around the newer forms of harm such as modern slavery and self-neglect.

SECTION 2: Supporting Adults with Additional Needs

Overview

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

The safeguarding adult's team provides support to all staff in the Trust in relation to supporting patients with additional needs who have increased vulnerabilities such as:

- Mental Capacity challenges;
- Deprivation of Liberty Safeguards;
- Learning Disability;
- Mental Health;
- Interpretation and Translation Needs.

2.1 Mental Capacity Act

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

The Trust Mental Capacity Act Steering Group has met six times in 2016/17 and includes regular representation from local Supervisory Authorities.

The Trust has audit adherence to the Mental Capacity Act 2005 Policy on a quarterly basis. This audit is showing increased awareness and a greater adherence to the administration side of the process.

The Trust's MCA Training Strategy is embedded within the overall Safeguarding Adults Training Strategy which details the competences expected of staff and compliance was monitored through the Key Performance Indicator throughout 2016/17.

2.2 Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) were introduced as an addendum to the Mental Capacity Act 2005. This process involves the Trust identifying patients who lack capacity and need restrictions to be put into place to ensure their safety. This requires the Trust, as the 'managing authority', to request an authorisation from the patient's supervisory authority, a role which transferred to the local authority in April 2013. A series of assessments of the patient's needs are then undertaken to determine the patient's best interests.

In March 2014 the Supreme Court handed down its judgements relating to two DoLS cases, one known as Cheshire West, which has effectively lowered the threshold for a

deprivations and increasing the likelihood that authorisations will need to be made by the Acute Trust.

The training plan covers DoLS and the information about the implications of the Supreme Court Judgements has been included in the training offer.

Table 3 provides a detailed record of the Trust DoLS activity in 2016/17 demonstrating the significant increase in applications and authorisations resulting from the amended definition.

Year	DoLS Applications
2012/13	13
2013/14	12
2014/15	69
2015/16	190
2016/17	191

Whilst the number of applications has increased **Table 4** details the outcome of the applications. A high number of patients subject to an Urgent authorisation are discharged prior to the completion of the assessment.

Table 4 Data 2016/17

	Authorised	Unauthorised	D/C prior to assessment	Awaiting Outcome	Total
St Helens	29	27	25	0	81
Knowsley	11	13	13	0	37
Halton	12	11	9	0	32
Liverpool	3	13	13	0	29
Out of Area	5	2	5	0	12
Total	60	66	65	0	191

2.3 Learning Disability

The Trust Learning Disability Steering Group meets quarterly and was held 4 times during this reporting period. The group continues to be the Trust's vehicle for improving the access and experience of patients with a learning disability to the Trust.

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

The Safeguarding Team over the last year has had **131** patients referred to it for support with reasonable adjustments and for multi-agency liaison support.

The Safeguarding Adult Team audits the range of reasonable adjustments made to the patient journey and takes place quarterly. The audit outcomes demonstrate improving awareness and quality in our work with adults who have a learning disability.

The Safeguarding Adult team continues to be an active partner in multi-agency work to support people with learning disabilities and their carers and actively participates in the Learning Disability Forum in Knowsley and St Helens.

The Safeguarding Adults Team is working alongside partner agencies to develop action plans following the publishing the MAZARS report 'Death by Indifference' and will ensure that any learning is embedded into practice.

2.4 Mental Health Liaison

The Trust has a fully commissioned Acute Adult Mental Health Liaison Team based in the Emergency Department, working 24/7, undertaking assessments both in the Emergency Department and across all inpatient areas. This service is run by North West Boroughs Healthcare NHS Foundation Trust.

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

The Safeguarding Adult Team is an active member of the multi-agency Mental Health Steering Group held monthly in the Emergency Department.

2.5 Patients with Interpretation and Translation Needs

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

Activity for Foreign Language Interpretation has shown an increase of 63% over this period. For BSL interpretation the number is fairly even

Table 6 - Interpreter Activity

Period	Foreign Language	British Sign Language
2013/14	482	171
2014/15	665	203
2015/16	1093	284
2016/17	1732	240

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

2.6 Summary of Achievements 2016/2017

- Reasonable assurance has been received from the CCG in relation to Safeguarding Adult KPI compliance.
- The Safeguarding Team has continued to actively participate at the LSAB activity in the three main local areas.
- Audit shows that positive support has been provided to adults with additional needs which has led to improved patient experience.

2.7 Future Developments

- The Trust Safeguarding will endeavour to maintain KPI compliance.
- There will be a focus on improving and sustaining Safeguarding Adult training compliance.
- Safeguarding Audit will continue to monitor compliance to trust process.
- The Safeguarding Adult Team will continue to update the Trust on changes in legislation and national guidance for adults with additional needs and will update Policy and training in line with such developments.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)019
Subject: WRES External Review and Action Plan
Purpose: To provide an update further to September's Board meeting in relation to the Trust's performance, benchmarking against local, national and acute Trusts. Actions are also included within this paper associated with the results and associated links to the Equality Delivery System 2 (EDS2).
Summary: Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS provider organisations. The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. In April 2015, after engaging and consulting with key stakeholders including other NHS organisations across England, the WRES was mandated. WRES has been part of the NHS standard contract, starting in 2015/16 and included in the 2016/17 NHS standard contract. To provide an update further to September's Board meeting in relation to the Trust's performance, benchmarking against local, national and acute Trusts. Actions are also included within this paper associated with the results. The report complements the standard WRES reporting template that has been provided to all NHS organisations by NHS England and will be completed for publication after this Board meeting.
Corporate Objective met or risk addressed: Developing organisational culture and supporting our workforce
Financial Implications: N/A
Stakeholders: Staff, Managers, Executive Board, Patients.
Recommendation(s): The Trust Board are requested to accept the updated report and action plan.
Presenting Director: Anne-Marie Stretch, Deputy CEO & Director of Human Resources
Board Date: 28th February 2018

Introduction

This paper provides further details in relation to Indicator 1 of the Trust's WRES regarding the disaggregation of bandings across clinical and non-clinical bandings as requested at September's Board meeting. The report also provides comparison with previous and local, national and acute Trust data to put the Trust data into perspective. An external Equality and Diversity expert has reviewed our results and supported the Trust in formulating the action plan in line with best practice.

As reported in September to the Trust Board, there are a total of nine indicators that make up the WRES split across Workforce, Staff Survey and Board Representation. Appendix 1 provides an overview of all WRES indicators.

The paper also includes linkages to the Equality Delivery System, referred to in this paper as EDS2. The Equality Delivery System (EDS) was commissioned by the national Equality and Diversity Council in 2010 and launched in July 2011. It is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010.

The EDS was reviewed and refreshed after engagement with key stakeholders in 2013 and EDS2 was launched in November 2013. EDS2 is more streamlined and simpler to use compared with the original EDS. It is aligned to NHS England's commitment to an inclusive NHS that is fair and accessible to all.

The main purpose of the EDS2 was, and remains, to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS2, NHS organisations can also be helped to deliver on the Public Sector Equality Duty. The WRES and EDS2 are complementary but distinct. The data and analysis for the WRES indicators will assist organisations when implementing EDS2.

WRES Indicator 1: Percentage of staff in each of the AfC Bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.

Links to EDS2 3.1: *Fair NHS recruitment and selection processes lead to a more representative workforce at all levels*

VSM is defined as 'Chief Executive', 'Finance Director', 'Other Executive Director', 'Board Level Director', 'Clinical Director - Medical', 'Medical Director', 'Director of Nursing', 'Director of Public Health'

In the context of the WRES, White staff comprises White British, White Irish and White Other (Ethnicity codes A, B, C) whereas BME staff comprises all other categories.

At September Board, the following information was provided in relation to Indicator 1 2017 results:

Data for reporting year 2017	Data for previous year 2016
Overall Staff Workforce BME: 7.87%	Overall Staff Workforce BME: 7.54%
Non-Clinical BME: 0.67% (10/1471)	Non-Clinical BME: 0.84% (12/1435)
Clinical BME: 10.6% (403/3768)	Clinical BME: 10.23% (375/3664)

It was requested at September's meeting that disaggregation of the banding data in the table above was required. Table 1 overleaf provides an overview of the Trust's 2017 data.

Clinical / Non-Clinical	Banding	% BME	% White	% Null	%Not Stated/ Not Given
Clinical	Band 1	0.0%	100.0%	0.0%	0.0%
	Band 2	2.3%	96.8%	0.1%	0.8%
	Band 3	4.3%	94.3%	0.5%	1.0%
	Band 4	0.9%	99.1%	0.0%	0.0%
	Band 5	14.0%	85.7%	0.0%	0.4%
	Band 6	4.7%	93.9%	0.0%	1.4%
	Band 7	3.1%	95.9%	0.0%	1.0%
	Band 8a	4.0%	94.1%	0.0%	2.0%
	Band 8b	0.0%	100.0%	0.0%	0.0%
	Band 8c	12.5%	87.5%	0.0%	0.0%
	Band 8d	0.0%	100.0%	0.0%	0.0%
	Band 9	0.0%	100.0%	0.0%	0.0%
	Medical & Dental	42.7%	57.3%	0.0%	0.0%
Non Clinical	Apprentice	0.0%	100.0%	0.0%	0.0%
	Band 1	0.4%	99.6%	0.0%	0.0%
	Band 2	1.0%	98.3%	0.0%	0.7%
	Band 3	0.4%	99.1%	0.0%	0.4%
	Band 4	0.4%	99.6%	0.0%	0.0%
	Band 5	0.0%	100.0%	0.0%	0.0%
	Band 6	1.4%	98.6%	0.0%	0.0%
	Band 7	0.0%	100.0%	0.0%	0.0%
	Band 8a	3.4%	96.6%	0.0%	0.0%
	Band 8b	0.0%	100.0%	0.0%	0.0%
	Band 8c	0.0%	100.0%	0.0%	0.0%
	Band 8d	0.0%	100.0%	0.0%	0.0%
	Band 9	0.0%	100.0%	0.0%	0.0%
	VSM	12.5%	87.5%	0.0%	0.0%

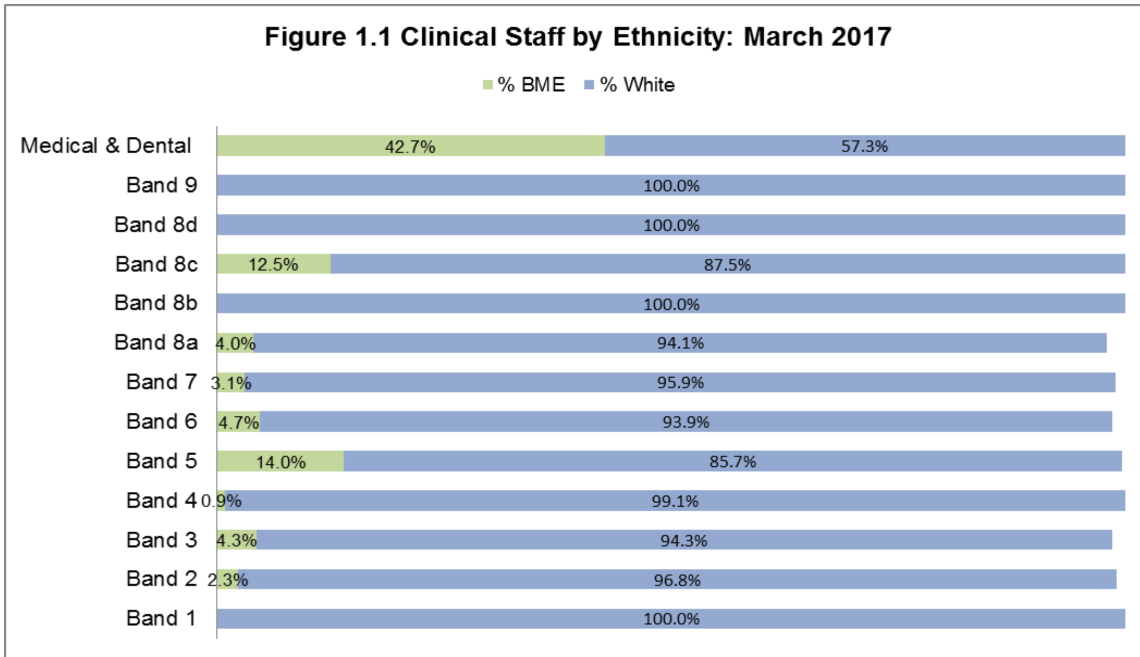
Table 1

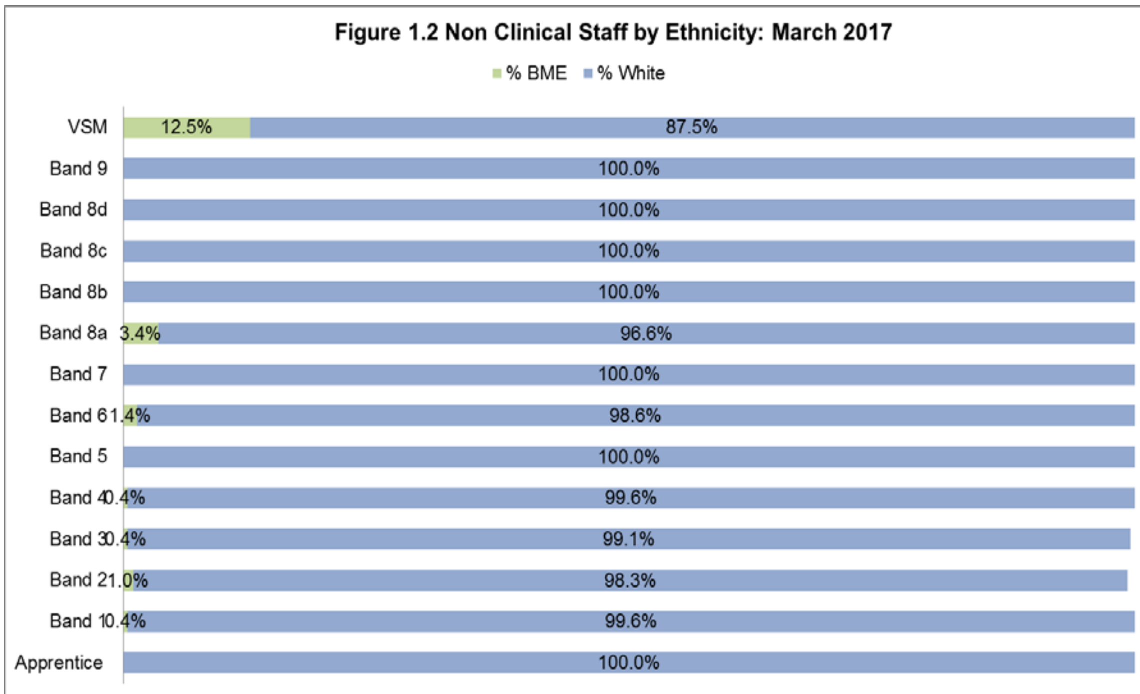
Table 1 shows that in the Trust, there are differences in spread of BME staff across many pay grades. Bands 1, 8b, 8d and 9 have nil BME staff identified within the clinical bandings. Bands 5, 7 and 8b & above excluding VSM within non-clinical bandings has nil BME staff identified.

This mirrors the NHS nationally, where the more senior the pay grade, the less likely it will be filled by BME staff. In bands 8-9 and VSM the proportion of BME staff is substantially lower than it is in the NHS workforce as a whole. (NHS Digital, 2016)

The Trust's data requires further analysis across care groups, job role and ethnic origin is required to identify particular roles/areas/ ethnic origins that are underrepresented, this will be included within the action plan.

Figures 1.1 & 1.2 summarises the Trusts data for clinical and non-clinical ethnicity as at 31st March 2017.





Note that Null and Not Stated/Not Given data has been excluded from these figures

.

Action 1: Analyse the data provided in Table 1 further by care group, job role and disaggregation by ethnic origin to identify any trends or gaps.

Action 2: To include a positive statement supporting applications from BME applicants on appropriate all advertisements. To also seek alternative advertisement methods via regional BME networks to capture a wider audience.

Action 3: Develop positive employee case studies of BME staff across ethnic origins to profile career progression success stories and encourage existing managers and individuals as well as attracting potential staff to apply for vacancies.

Workforce Disability Equality Standard (WDES)

Building on the existing WRES, NHS England has agreed with the NHS Equality and Diversity Council to mandate a Workforce Disability Equality Standard (WDES) via the NHS Standard Contract in England from April 2018, following a preparatory year from April 2017. The Trust will therefore be required to assess whether disabled staff face discrimination from 2018 in addition to the WRES. The Trust has participated in the consultation of WDES.

Based on the Trusts 2016-2017 workforce equality monitoring data, The Trust has high numbers of the workforce choosing not to disclose equality data i.e.:

- Disability 21.7%
- Religion 33.16%
- Sexual orientation 32.54%

Action 4: In preparation for the introduction of WDES together with ongoing performance monitoring against the WRES, The Trust workforce will be encouraged to update all their data (including equality data on ESR self-serve) via the online ESR Portal. Communication to staff regarding, who has access to this information, why do we need it and what do we do with it will be provided.

Workforce Planning and Human Resources will lead on this and monitor progress via the ESR Steering Group and Equality & Diversity Steering Group.

This will also ensure the data in Indicator 1 for the WRES 2018 is as accurate as possible.

WRES Indicator 2: Relative likelihood of BME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts.

Links to EDS2 3.1: *Fair NHS recruitment and selection processes lead to a more representative workforce at all levels*

The table below provides the results for 2017 alongside the previous year and national, regional and acute averages.

- The higher the result the more positive it is.

STHK 2017	1.35 times greater
STHK 2016	1.26 times greater
National Average 2016	1.57 times greater
North Average 2016	1.3 times greater
Acute Trust Average 2016	1.5 times greater

The figures indicate a slight improvement in the past year. The Trust is performing above the north average, but below acute and national.

Nationally findings have shown that, overall, BME staff tend to be more qualified than white staff yet have less demonstrable formal workplace experience. There is therefore recommendation that organisations look at how more informal experience is better recognised during the recruitment process (such as work shadowing, work experience and including such activities in personal specification requests.

Action 5: Review Equality & Diversity training provision across the Trust and introduce e-learning where appropriate to ensure staff are provided with an understanding of the Equality Act, protected characteristics and signposting to further literature but also more in-depth training for those staff involved in recruitment and selection training and equality impact assessments.

Action 6: Recognise the benefits of informal experience during the recruitment process and amend person specifications as appropriate.

WRES Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Indicator Guidance Note: this is calculated by cases entering the formal disciplinary process as measured by entry into a formal disciplinary investigation. This refers to staff who have entered a formal investigation as prescribed by the local disciplinary process. Any occasional cases where disciplinary action is not preceded by an investigation should also be included in this definition. Staff who have been subject to an investigation, but for whom no further action was taken should be counted.

Links to EDS2 3.6: *Staff report positive experiences of their membership of the workforce.*

The table below provides the results for 2017 alongside the previous year and national, regional and acute averages.

- The higher the result the more negative it is.

STHK 2017	3.68 times greater

STHK 2016	3.79 times greater
National Average 2016	1.56 times greater
North Average 2016	1.4 times greater
Acute Trust Average 2016	1.4 times greater

Data shows that BME staff are 3.68 times greater to enter the formal disciplinary process when compared with white staff, although this indicator has improved slightly for The Trust since last year, there is however further work to be done on this issue.

The table below shows The Trust Staff Satisfaction Survey 2016 results compared to other acute Trusts on each of the sub-dimensions of staff engagement. The Trust score of 3.96 was the highest (best) 20% when compared with all acute Trusts, an improvement from 3.92 in 2015 and above the national average of 3.81.

Action 7: The introduction of the Employee Relations Tracker System in January 2018, will ensure accurate data collection and verification rather than the current system of an excel spreadsheet.

Action 8: Further analysis of factors such as location, role, band, reason for disciplinary of all and BME staff to identify any trends or information gaps.
Unconscious bias literature has been circulated throughout the Trust previously however embedding this further is required in various methods.
The HR Business Partners will undertake case file reviews with managers to ensure cases require formal investigation or should be dealt with informally and/or subject to learning/improvement approach in addition to ensuring the correct policies are used to address performance issues.

WRES Indicator 4: Relative likelihood of BME staff accessing non-mandatory training and Continuing Personal Development compared to White staff.

Links to EDS 3.3: *Training and development opportunities are taken up and positively evaluated by all staff*

The table below provides the results for 2017 alongside the previous year and national, regional and acute averages.

- The higher the result the more positive it is.

STHK 2017	0.97 times greater
STHK 2016	0.41 times greater
National Average 2016	1.10 times greater

North Average 2016	1.1 times greater
Acute Trust Average 2016	1.2 times greater

In 2017, the Trust's results are lower than the national, north and acute averages but it has increased from last year's results. Further investigation is required to identify the breadth of training that is offered and captured as well as the 'take up' rate of training by BME staff compared to White staff.

Action 9: The Oracle Learning Management (OLM) is the training administration module of the Electronic Staff Records (ESR). This can be utilised to undertake further analysis and categorisation of non-mandatory training and Continuing Personal Development (CPD) accessed by BME staff and undertake comparative analysis across BME and white staff.

WRES Indicators 5-8: relate to Staff Survey findings.

National NHS Staff Survey indicators For each of the four staff survey indicators, compare the outcomes of the responses for white and BME staff	
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Links to: EDS2 3.4: *When at work, staff are free from abuse, harassment, bullying and violence from any source.*

Links to: EDS2 3.6: *Staff report positive experiences of their membership of the workforce.*

The extract table below from the Trust 2016 staff survey findings provides an overview of the results and comparison with 2015. Responses to the 2016 staff survey break down as follows and detailed in Table 2.

- 93% (622) of respondents – White
- 7% (49) of respondents – BME.

			Your Trust in 2016	Average (median) for acute trusts	Your Trust in 2015
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	24%	27%	22%
		BME	26%	26%	32%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	17%	24%	20%
		BME	13%	27%	28%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	92%	88%	93%
		BME	81%	76%	75%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	3%	6%	6%
		BME	13%	14%	12%

Table 2

Indicator 5 (KF 25) (Lower score = better) showed a decrease for BME staff from 32% to 26% but an increase for White staff from 22% to 24%. Both results were either lower than or equal to the average for Acute Trusts.

Indicator 6 (KF26) (Lower score = better) showed a decrease for White staff from 20% to 17% and a considerable decrease for BME from 28% to 13%. Both results were considerably lower than the average for Acute Trusts.

Indicator 7 (KF21) (Higher score = better) showed a slight decrease for White staff from 93% to 92% but a considerable positive increase for BME staff from 75% to 81%. Both results were higher than the average for Acute Trusts.

Indicator 8 (Q17b) (Lower score = better) showed a decrease for White staff from 6% to 3% but a slight increase for BME staff from 12% to 13%. Both results were lower than the average for Acute Trusts.

Action 10: Assess what the Trust currently promotes and has clearly displayed as the Trust's message to the public regarding harassment or bullying of staff via the Promoting Personal Safety Group.

Action 11: Interrogate available data further to undertake useful cross analysis for example, how do numbers of formal bullying & harassment based issues compare with the staff survey results.

Action 12: Include these four questions to reflect these Indicators within newly revised Appraisal documentation to capture a wider workforce audience and provide an opportunity for further discussion regarding how incidents are reported, and to whom. Promote the Freedom to Speak Up mechanism in place across the Trust. Appendix 2 is an extract from the newly revised appraisal paperwork.

<u>WRES Indicator 9</u>: Percentage difference between the organisations' Board voting membership and its overall workforce.

Links to EDS2 3.1: *Fair NHS recruitment and selection processes lead to a more representative workforce at all levels.*

The table below provides the results for 2017 alongside the previous year and national, regional and acute averages.

STHK 2017	18.18%
STHK 2016	18.18%
National Average 2016	7.1%
North Average 2016	5.5%
Acute Trust Average 2016	6.7%

As of 31st March 2017, the Trust had a BME workforce of 7.87%. 18.18% of voting members on the Board are identified as being from a BME background.

Data based upon the WRES returns for 193 NHS trusts, it was found that nationally:

- 43.5% (84) of trusts reported having no BME board members
- 37.3% (72) of trusts reported having one BME board member
- 10.9% (21) of trusts reported having two BME board members
- 4.7% (9) of trusts reported having three BME board members
- 2.6% (5) of trusts reported having four BME board members
- 1.0% (2) of trusts reported having five BME board members

Action 13: Appoint Non Executive to Equality, Diversity and Inclusion Steering Group to ensure the Board are fully engaged with and updated regarding the Equality, Diversity and Inclusion agenda.

Appendix 1: The Workforce Race Equality Standard Indicators

<table>
<tr><td colspan="2">Workforce indicators
For each of these four workforce Indicators, <u>compare the data for white and BME staff</u></td></tr>
<tr><td>1.</td><td>Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by:
• Non-Clinical staff
• Clinical staff - of which
- Non-Medical staff
- Medical and Dental staff

Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of Medical and Dental staff, which are based upon grade codes.</td></tr>
<tr><td>2.</td><td>Relative likelihood of staff being appointed from shortlisting across all posts

Note: This refers to both external and internal posts</td></tr>
<tr><td>3.</td><td>Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

Note: This indicator will be based on data from a two year rolling average of the current year and the previous year.</td></tr>
<tr><td>4.</td><td>Relative likelihood of staff accessing non-mandatory training and CPD</td></tr>
<tr><td colspan="2">National NHS Staff Survey indicators (or equivalent)
For each of the four staff survey indicators, <u>compare the outcomes of the responses for white and BME staff</u></td></tr>
<tr><td>5.</td><td>KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td></tr>
<tr><td>6.</td><td>KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td></tr>
<tr><td>7.</td><td>KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion</td></tr>
<tr><td>8.</td><td>Q17. In the last 12 months have you personally experienced discrimination at work from any of the following?
b) Manager/team leader or other colleagues</td></tr>
<tr><td colspan="2">Board representation indicator
For this indicator, compare the difference for white and BME staff</td></tr>
<tr><td>9.</td><td>Percentage difference between the organisations’ Board membership and its overall workforce disaggregated:
• By voting membership of the Board
• By executive membership of the Board

Note: this is an amended version of the previous definition of Indicator 9</td></tr>
</table>

Appendix 2: Section 2 Extract from Appraisal e-form launched in November 2017

During the last 12 months…							
I have raised concerns about harassment, bullying or abuse from patients, relatives or the public	No Yes N/A	I have raised concerns about harassment, bullying or abuse from staff	No Yes N/A	I have personally raised concerns about discrimination at work from another member of staff	No Yes N/A	I believe the Trust provides equal opportunities for career progression or promotion	No Yes

Summary of discussion… I have concerns which are affecting my workplace experience?		☐ YES. Continue completing this section	☐ NO. Move onto SECTIC
I know how to raise concerns	Yes I am now aware	I am aware of how to access the Speak Out Safely Guardians	Yes I am now aware
I am aware of how to access the Speak In Confidence anonymous online system? For more information please click here	Yes I am now aware	I have already shared my concerns with either my Line/Departmental Manager and/or Speak Out Safely Guardian and/or reported via the Speak In Confidence system and plans are in place to remove / reduce my concerns	Yes No N/A
Today we have discussed development opportunities and agreed actions to address my concerns. These will be included as personal objectives within my Personal Development Plan (PDP).	Yes No N/A	Today we have discussed the practicalities and agreed actions of when and how to address my concerns	Yes No N/A