St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 31ST JANUARY 2018
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

A G E N D A				Paper	Presenter
09:30	1.	Employee of the Month			Richard Fraser
		1.2	December		
		1.3	January		
09:40	2.	Patient story			Sue Redfern
10:00	3.	Apologies for Absence			Richard Fraser
	4.	Declaration of Interests			
	5.	Minutes of the previous Meeting held on 29th November 2017		Attached	
		5.1	Correct record & Matters Arising		
		5.2	Action list	Attached	
Performance Reports					
10:10	6.	Integrated Performance Report		NHST(18) 001	Nik Khashu
		6.1	Quality Indicators		Sue Redfern
		6.2	Operational indicators		Rob Cooper
		6.3	Financial indicators		Nik Khashu
		6.4	Workforce indicators		Anne-Marie Stretch
Committee Assurance Reports					
10.30	7.	Committee report – Executive		NHST(18) 002	Ann Marr
10:40	8.	Committee Report – Quality		NHST(18) 003	David Graham
10:50	9.	Committee Report – Finance & Performance		NHST(18) 004	Jeff Kozer
BREAK					

Other Board Reports				
11:05	10.	Strategic & regulatory report	NHST(18) 005	Nicola Bunce
11:15	11.	Board Assurance Framework	NHST(18) 006	Nicola Bunce
11:25	12.	Overview of Complaints, Claims & Incidents Q2 2017/18	NHST(18) 007	Sue Redfern
11:35	13.	HR Indicators	NHST(18) 008	Anne-Marie Stretch
11:40	14.	Learning from deaths update and reporting	NHST(18) 009	Kevin Hardy
11:50	15.	One Halton – Approval of Trust membership and agreement to the Memorandum of Understanding and Partnership Board Terms of Reference	NHST(18) 010	Tiffany Hemming
Closing Business				
12:05	16.	Effectiveness of meeting		Richard Fraser
	17.	Any other business		
	18.	Date of next Public Board meeting – Wednesday 28th February 2018		
LUNCH				

Minutes of the St Helens and Knowsley Hospitals NHS Trust Board meeting held on Wednesday, 29th November 2017 in the Boardroom, Whiston Hospital

PUBLIC BOARD

Chair:	Mr R Fraser (RF)	Chairman
Members:	Ms A Marr (AM)	Chief Executive
	Mrs A-M Stretch (AMS)	Deputy Chief Executive/Director of HR
	Mrs C Walters (CW)	Director of Informatics
	Mr D Mahony (DM)	Non-Executive Director
	Mr G Marcall (GM)	Non-Executive Director
	Mr J Kozer (JK)	Non-Executive Director
	Prof K Hardy (KH)	Medical Director
	Ms N Bunce (NB)	Interim Director of Corporate Services
	Mr N Khashu (NK)	Director of Finance
	Mr P Williams (PW)	Director of Facilities Management/Estates
	Mr R Cooper (RC)	Director of Operations & Performance
	Ms S Rai (SR)	Non-Executive Director
	Mrs S Redfern (SRe)	Director of Nursing, Midwifery & Governance
	Dr T Hemming (TH)	Director of Transformation
	Mrs V Davies (VD)	Non-Executive Director
Apologies:	Prof D Graham	Non-Executive Director
	Mr T Foy	St Helens CCG
In Attendance:	Cllr G Philbin (GP)	Halton Council
	Ms J Byrne	Executive Assistant (observing)
	Mrs K Pryde	Executive Assistant (Minutes)
	Mr M Chadwick (MC)	Consultant Surgeon (for item 16)
	Ms A Rosbotham-Williams (ARW)	Assistant Director of Governance (item 2)

1. Employee of the Month

The award for Employee of the Month for October 2017 was presented to Cheryl Anders, Staff Nurse, Ward 5D.

The award for Employee of the Month for November 2017 was presented to David Anwyl, Assistant Director of Operations, Clinical Support Services.

2. Patient Story

ARW accompanied the patient to Board, to share their experiences of the Trust. This story highlighted the importance of effective communication with patients, as there had been delays and lack of information given to the patient at the appropriate time.

On behalf of the Trust, the Chairman apologised to the patient and expressed disappointment that her care had not achieved the five star standards that the

organisation aspires to. An action plan had been developed to address the lessons learnt from this patient's feedback, including reflection on their practice for the individual staff members who had been involved.

3. Apologies for Absence

3.1. Apologies were noted from Professor D Graham and Mr T Foy.

4. Declaration of Interests

4.1. Richard Fraser declared that he continued to hold the position of interim Chair of Southport and Ormskirk Hospitals NHS Trust.

5. Minutes of the previous meeting held on 25th October 2017

5.1. Correct Record and Matters Arising

5.1.1. The minutes were approved as a correct record.

5.2. Matters Arising

5.2.1. None noted.

5.3. Action List

5.3.1. Action 1. Minute 15.6 (27.09.17): WRES Action Plan. The external review will be completed and AMS will present the report and action plan at the January Board.

5.3.2. Action 2. Minute 10.3 (25.10.17): Charitable funds. It was agreed that NK will take a forensic look into funds coming into the Trust and the ROI on the investment made in the charity infrastructure and report back to the Executive Team, before taking formal proposals to the Charitable Funds Committee.

5.3.3. Action 3. Minute 10.5 (25.10.17): Charitable funds. NK will finalise and issue a letter to Directorate Managers to be sent out w/c 4th December, to publicise charitable funds and the purposes for which they can be used.

5.3.4. Action 4. Minute 5.2.5 (25.10.17): Head and neck cancer waits. AM will report back at the January Board. RC to provide a detailed briefing on why the delays occur in order that a letter can be written to Aintree..

6. IPR – NHST(17)097

6.1. Quality Indicators

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

6.1.2. There were no never events in October, but had occurred in the last week, which will be formally reported in November's IPR. The incident involved the misplacement of a nasogastric tube, and is being fully investigated via the 72 hour review process and has been reported to commissioners and the CQC. This brings the number of cases YTD to one.

6.1.3. YTD, there have been two positive blood cultures for MRSA. One is under appeal with PHE (July) and the second case (October) relates to a blood culture contaminant and was not a bacteraemia.

6.1.4. There was 1 C.Diff positive case in October. The total number of positive cases year to date is 20. Two of these cases are still subject to appeal at the December panel.

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

6.1.6. The overall registered nurse/midwife Safer Staffing fill rate for August was 93.5%.

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

6.1.8. VTE performance for September was 93.7%, which is an improvement on August performance but remains below the 95% target. It was agreed that the financial and contractual implications should be reviewed in the Finance and Performance Committee in January

6.1.9. Provisional HSMR (June 2017) is 102.4

6.2. <u>Operational Indicators</u>

6.2.1. RC provided an update on operational performance.

6.2.2. Performance against the 62 day cancer standard was 80.6% in September. Fewer numbers of overall patients in month and an increase in patients with complex pathways resulted in failure to meet the standard. Following a root cause analysis of each patient pathway that breached the standard, clinically led action plans at specialty level have been developed.. RC reported that these action plans had started to have an impact and that performance in October would show an improved position. The YTD position remained ahead of target.

6.2.3. A&E performance in October was 82.1% (type 1) and 88.1% (type 1 & 3). The key actions for continued recovery of this position are being driven forward by the senior leaders across the organisation and wider health system, focusing on both the Emergency Department and the inpatient wards to achieve optimum patient flow. This remains one of the key areas of risk for the Trust, with the

approach of winter. The Board discussed how the additional funding announced in the recent budget would be allocated and how it could be deployed locally to support system resilience.

6.2.4. RTT incomplete performance was achieved in month (93.4%). Specialty level actions to address this continue, including targeted backlog clearance plans.

6.3. Financial Indicators

6.3.1. NK provided an update of the Trust's financial position. For the month of October (month 7), the Trust is reporting an overall Income & Expenditure surplus of £4.908m, which is behind the YTD profiled plan, by £0.214m. Overall Trust income is £215.56m, which is slightly ahead of plan. Clinical income is behind plan by £1.1m, which is offset by an over performance on non-clinical income of £1.5m.

6.3.2. Trust operating expenditure is £196.5m, which exceeded plan by £0.7m. Clinical supplies are £1.0m above plan which is partly offset by the additional non clinical income, and pay is £3.0m higher than plan which is offset by a £3.6m underspend against other costs. Pay control and monitoring is undertaken by the Premium Payments Scrutiny Council, and the level of internal scrutiny on agency and premium payments remains high.

6.3.3. The Trust has delivered £6.5m of CIPs, and is £(1.5)m behind the YTD plan. The successful delivery of the £15.3m CIP target is aligned to the success of the cost control programme.

6.3.4. The Trust continues to plan to deliver theagreed control total of £8.5m, which equates to a £(0.6)m deficit excluding the STF funding of £9.1m.

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

6.3.6. . The board had a robust discussion and debate regarding the YTD and forecast position. It was acknowledged that non-recurrent measures over and above CIPs were being actioned to achieve the reported YTD position. Additional productivity and cost control measures are in place and the Board was encouraged by the month 7 position.

6.4. Workforce Indicators

6.4.1. AMS provided an overview of the Workforce Indicators.

6.4.2. Absence in October increased from 4.3% to 4.8%. YTD absence is 4.3% which is 0.5% below the same point in 2016-17.

6.4.3. Mandatory training compliance has improved slightly in month and continues to exceed the target by 4.1%. Appraisal compliance has improved in month to 78.9% and there is an action plan in place to ensure continued improvement and achievement of the target by year end.

6.4.4. AMS advised the Board that a deep dive into appraisals had taken place at the Workforce Council. A particular problem remained recording of appraisals on ESR and additional support was being provided to managers.

7. Committee report - Executive – NHST(17)098

7.1. AM provided an update to the Board.

7.2. The Executive Committee approved the submission of a bid to provide Community Cardiac/Heart Failure Services for St Helens CCG, a delay in the roll out of e-prescribing, proposals to enable the delivery of NIV on the respiratory wards, a revised policy on document development, and the governance arrangements for oversight of the apprenticeship levy.

7.3. VD enquired about the reported negative feedback received at Marshall Cross Medical Centre and how is being performance managed. AM replied that these were teething problems at the beginning of the interim contract and the practice was being closely monitored by the Executive Committee and the CCG were providing some additional expertise on a temporary basis. The situation had now improved. . TH added that when the Trust took over the medical centre, no clinical staff had transferred and it had taken a little time to secure regular locums, whilst the permanent staff are being recruited. One of the Advanced Nurse Practitioner posts has now been successfully b appointed.. The Friends and Family test feedback for Marshalls Cross has been excellent.

7.4. VD queried when the performance of Marshalls Cross and Community Contracts would be included in the IPR. NB said that the quality indicator performance e.g. falls was now included as part of the overall performance reporting for Newton and Community Continence. Some of the KPIs are still being negotiated with Commissioners and then they will be incorporated within the IPR as a section on the Community Contract.

7.5. The Board acknowledged that there needed to be greater visibility of the performance of these contracts, within the context of the overall performance of the Trust. The Executive Committee were asked to bring forward a proposal..

8. Committee Report – Quality – NHST(17)099

8.1. GM provided feedback from the meeting held on 21st November. Key items discussed were:

8.2. Improvement in complaints. 80.8% 1st stage complaints were responded to in October, within agreed timescales, an increase from 63.6% in September. 100% of complaints were acknowledged within the 3 day target and 60% of complaints related to clinical treatment.

8.3. A&E attendances. The highest number of attendances ever (401) was recorded on 20th November. This is worrying and illustrates the continuing increases in demand being experienced by the Trust

8.4. CQC new Inspection regime presentation. An action plan for how the Trust needs to prepare for the next inspection is being developed, and the Well Led Framework self-assessment and action plan is coming to the January Board meeting.

8.5. CQC A&E escalation plans Checklist – Following a review RC reported that the trust is currently compliant with 16 of the 18 actions identified in Professor Ted Baker's letter, and action plans have now been put in place for the two outstanding issues. A live inspection of the escalation processes will take place in December and a further report presented to the Quality Committee in January.

8.6. Cancer access figures failed in September, but achieved in October. An action plan is in place to continue the improvement.

8.7. The Quality Committee had identified that to overcome the "Monday effect" in A&E performance there was a need to improve discharges at the weekend. This needs a whole system approach including assessment and alternative placement capacity outside the hospital. The Trust is working with its partners and considering options for employing staff who can be deployed flexibly into these settings to support patients leaving hospital. KH added that the NHS Improvement preferred way to spend the recently announced winter money is likely to be on staff to work in the community.

8.8. SR asked if the fasting issue in the report wassomething the Board need to be concerned about. GM said that the audit presented had not addressed the correct issue of patients having to fast for long periods if operations were cancelled or delayed and a further paper was being brought back to the Quality Committee in January.

9. Committee Report – Finance & Performance – NHST(17)100

9.1. DM summarised the report for the Board.

9.2. Items discussed for information:

9.2.1. The committee discussed the forecast outturn and changes to the risk profile after October's improved performance against run rate. The committee discussed actions and mitigations implemented, with particular reference to the STF funding and the Trust's cash flow.

9.2.2.

DM reported to the Board that at F&P a discussion and debate took place around risks to the financial outturn position currently being reported. These included full

achievement of CQUINs, continued adverse impact of HRG4+ against expectations, CIP achievement and management of winter.

9.2.3. F&P recommended to the Board they were encouraged by month 7 financial performance. They recommended that the forecast outturn position should not be formally changed, but it should be reviewed after Q3 given the risks identified and in particular impact of winter for performance and finance.

9.2.4. A&E had delivered an excellent report. Attendances from St Helens have risen, as have ambulances from St Helens. There has been a significant increase in Paediatric attendances.

9.2.5. Specific items to highlight to the Board include: Risk to the Trust's cash flow, due to commercial arrangements with other NHS organisations, particularly the HIS, Payroll and Lead Employer. Other items are temporary loan application and trust financial position.

10. Committee report – Charitable Funds – NHST(17)101

10.1. DM provided an overview of the meeting.

10.2. The committee agreed £5 per patient to be spent on Christmas gifts, plus biscuits/sweets for visitors.

10.3. Andy O'Brien, Directorate Manager, had attended the meeting to make a bid against charitable funds for the balance costs for a Spectralis OCT machine (£91k excl VAT), for the Ophthalmic Department.. The service hadsecured a grant of £58k and wished to use their fund balance for the remainder. This had been approved by the committee, subject to executive agreement about the service development plan.

10.4. The fundraising objectives for 2018 had been discussed.

11. Strategic and Regulatory update report – NHST(17)102

11.1. NB provided an update.

11.2. On 16th November, NHSI published the Q2 performance report for NHS Provider organisations. Reports included:

11.2.1. The sector has seen a 3.4% increase in emergency admissions via type 1 A&E departments compared to the same period last year.

11.2.2. At the end of September, there were around 168,302 delayed discharges across England.

11.2.3. The waiting list for planned care has grown to over 4.1m – the highest since the RTT target was introduced.

11.3. CQC/NHSI consultation on Use of Resources Rating: On 8th November 2017, the CQC and NSHI launched a further consultation on plans to fully

implement the process that both organisations will use to report on how NHS non-specialist acute Trusts use their resources to provide high quality, efficient and sustainable care. The Trust will consider and respond to the consultation, if there are any concerns.

11.4. National appointments – NHSI Chair and NHSE Medical Director. Baroness Dido Harding has been confirmed as the new Chair of NHSI, with effect from 30th October 2017. Professor Stephen Powis has been appointed as the new Medical Director of NHS England. He will replace Sir Bruce Kehoe who retires at the end of December 2017.

11.5. NSHI publication of updated Standard Operating Framework (SOF). Following consultation, NHSI have now published the final version of the updated SOF. A briefing on the proposed changes was included in the September Board report. There have been no material changes to the SOF as a result of the consultation.

12. Research & Development Operational Capability Statement – NHST(17)103

12.1. KH presented the statement which provides the Board with assurance that the Trust is working towards the aims and objectives of the strategy. The Board approved the annual statement.

13. Compliance with the NHS Constitution – NHST(17)104

13.1. NB provided an overview of the report.

13.2. The report is to provide assurance to the Board on the Trust's systems and processes for compliance with the patient, public and staff rights contained within the NHS Constitution.

13.3. The report is reviewed by the Board every two years, unless concerns are raised.

The paper demonstrated that on the basis of the assessment and current knowledge the trust can evidence how it complies with the NHS Constitution and can track each of these rights through its governance systems.

14. Arrangements for 2018/19 Board Meetings – NHST(17)105

14.1. The paper advised Board members of the proposed dates for Trust Board meetings throughout the next financial year, the supporting timetable and scheduled agenda items to discharge all its responsibilities.

14.2. Following discussion regarding agenda items, the schedule was approved by the Board. Each Committee Chair will now be tasked with reviewing and setting the schedule for the committee and council meetings for 2018/19 to ensure assurance can be provided to the Board on the matters covered by their terms of reference.

15. Mid-Year Review of Trust Objectives – NHST(17)106

15.1. AM presented the review to the Board.

15.2. Out of the agreed 27 objectives agreed by the Board in May 2017, 18 are rated green and 9 are amber.

15.3. Following a Board discussion, it was determined that objective 3.2 (implementation of a new midwifery-led care pathway for women having low risk births) should now be green, as this had been fully implemented.

15.4. There were a number of the objectives where risks to achievement remained, even where good progress was being made. .

15.5. VD asked if the Board are confident that the Trust will achieve the planned benefits from taking over the management of adult community nursing services in St Helens. Following further discussion, it was agreed that this should be altered to amber.

16. Guardian of Safe Working Report (STHK) – NHST(17)107

16.1. MC provided an update for the Board.

16.2. The paper pertains only to employees of the Trust under the Terms and Conditions of Service for NHS Doctors and Dentists in training. It covers the subsequent period from the last board report, 30th May – 31st October. Data regarding Lead Employer trainees will be covered by a separate report.

16.3. During the reporting period, a total 57 exception reports have been raised by a total of 15 trainees. The common theme reported is relating to trainees exceeding the working hours set out in their work schedule. In the vast majority of cases, the trainees have stayed past their finish time and received time off in lieu in return.

16.4. The Board discussed the paper at length, including national shortage of junior doctors, exception reporting and assurance received regarding overall safety of working hours in the organisation.

17. Guardian of Safe Working Report (Lead Employer) – NHST(17)108

17.1. MC provided a summary for the Board.

17.2. Response to the survey had been quite poor with only 67% of host organisations responding. Feedback from host organisations shows that the majority of exception reports have been raised by foundation trainees. Afurther period of continuous observation is required to gain a more detailed picture and meaningful data.

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

17.4. On review of the exception reporting data received thus far, the common theme reported is relating to trainees exceeding the working hours set out in their work schedule.

17.5. MC asked the Board to note the report.

18. Effectiveness of meeting

18.1. RF asked TH and GP for their reflections on the effectiveness of the meeting. TH commented that the meeting had kept to time, and she felt there had been constructive challenge and open and honest discussions and identification of actions required.

18.2. GP said it was good to see, from a Halton perspective, that AM is speaking to Dave Sweeney regarding developments to improve DTOCs. GP thought the meeting was open and frank and regarding the patient story, the Trust were not overly defensive and were keen to learn from mistakes..

19. AOB

19.1. NK requested Board approval for the uptake of a temporary loan facility. December is a high risk month, salaries are paid early and NHSI have not paid the STF at Q2 when they said they would. The loan will come with interest, but is the most effective way of managing the cashflow risk. This has been fully debated at the Finance and Performance Committee who have recommended approval of the loan. The temporary loan facility and associated conditions were approved by the Board.

20. Date of next meeting

20.1. The next meeting is scheduled for Wednesday, 31st January 2018 in the Boardroom, Whiston Hospital, commencing at 9.30 am.

Chairman: .....

Date: 31.01.18 .....

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 31ST JANUARY 2018

No	Minute	Action	Lead	Date Due
1.	27.09.17 (15.6)	WRES report. AMS will bring a paper to Board following the external expert input. 11.01.18 External reviewer unwell so items has been postponed until 28th Feb.	AMS	28 Feb 18
2.	25.10.17 (10.3)	Charitable Funds – NK will take a forensic look at funds coming into the Trust and report back to the Executive Team.	NK	31 Jan 18
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.	NK	31 Jan 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.	AM	31 Jan 18
5.	29.11.17 (8.4)	CQC well led presentation: This will be presented at January Board.	NB/SR	31 Jan 18

Paper No: NHST(18)001
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 were no never events in December 2017, 1 year to date (target = 0).

There were no MRSA bacteraemia cases in December 2017 and two cases year to date (target = 0). Of the 2 cases, 1 case is under appeal and 1 was a contaminated specimen.

There were no C.Difficile (CDI) positive cases in December 2017. The total number of confirmed CDI positive cases year to date is 17 (target = 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 December 2017 was 94.4%. YTD performance is 94.0%.

During the month of November 2017 there were no inpatient falls resulting in moderate or severe harm. YTD total is 12.

Performance for VTE assessment for November 2017 was 95.13%. YTD performance is 93.18% against a target of 95%.

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: 31st January 2018

Operational Performance

Performance against the 62 day cancer standard improved again in month to 90.3%. YTD is 86.8% 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. Unusually the 31 day target was not achieved in month at 94.9%. YTD is 98.3% v target of 96.0%. Following review of the timeline for patients who breached the standard, this related to patients who were unable to attend due to being unwell on the day of appointment.

Increased NEL activity and acuity of patients presenting in ED, resulted in a deterioration in A&E performance, which was 73.1% (type 1) and 85.5% (all types) in month. YTD performance was 80.7% (type 1) and 87.9% (all types) v target of 95.0%. Whilst Intensive support from ECIP was stepped down, the team continue to support the trust with further improvement work related to key actions focusing on both the Emergency Department and the Inpatient wards.

Emergency Department key actions:
1. Standard Operating Procedures in use to ensure consistent delivery of evidence based patient pathways.
2. Appropriate deployment of clinical resources to meet demand.

Inpatient areas:
1. Clinically led board rounds on inpatient wards
2. KPI of expected number of discharges per ward of which 33% to be achieved by midday
3. Senior daily review and escalation for patients who no longer need care in an acute bed, supported by twice weekly discharge planning meetings and monthly executive supported system wide Multi Agency Discharge Events (MADE).

RTT incomplete performance was maintained at (93.2%) in month v target of 92.0%. Specialty level actions to maintain this achievement continue, including ongoing targeted activity recovery and backlog clearance plans.

Financial Performance

Surplus/Deficit - For the month of December 2017 (Month 9) the Trust is reporting an overall Income & Expenditure surplus of £5.9m which is slightly ahead of the YTD profiled plan. Overall Trust Income is £282.6m, which is ahead of plan; Clinical Income is now only just behind plan by £(0.3)m which is offset by an over performance on Non clinical income of £4.97m.

Trust Operating expenditure is £258.5m, which exceeded plan by £4.8m. Clinical Supplies are £1.9m above plan which is partly offset by the additional non clinical income and Pay is £3.1m higher than plan and this is partially offset by a £0.7m underspend against Other Costs. The pay overspend relates to premium payments, agency and bank use. Pay control and monitoring is being reviewed at the Premium Payments Scrutiny Council. The financial position has been supported by the utilisation of non recurrent measures, which is a risk to delivery of the FOT for the year.

Due to winter pressures and for the safety of our patients our elective programme was reduced during December which impacted on our ability to progress with the recovery plan.
The Trust has delivered £8.8m of CIPs and is £(2.1)m behind the YTD plan which is reflected in the Trust's overspend on expenditure. The delivery of the £15.3m CIP target is aligned to the focus on cost control which has been adopted within the operational and support service teams.

The Trust is planning to deliver a surplus of £9.4m, which has increased by £0.9m from the previous month because of Tranche 1 Winter Funding received from NSHI. Our planned surplus equates to a £(0.6)m deficit excluding STF funding of £9.1m.
At the end of December the cash balance was £12.082m, representing approximately 13 days of operating expenses. The Trust has incurred £3.4m of capital expenditure in the nine months to December.

Human Resources

Absence in December has increased to 5.5%. YTD absence is 4.5% against the Q3 target of 4.72%.

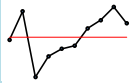
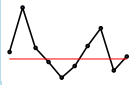
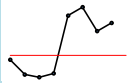
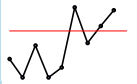
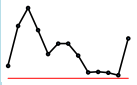
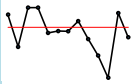
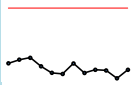
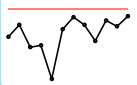
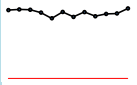
Mandatory training compliance has risen slightly in month and continues to exceed the target by 4.9%. Appraisals have decreased slightly and are now behind the target of 85% by 0.1%.

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

Dec-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

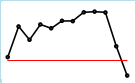
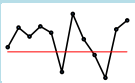
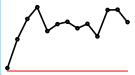
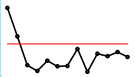
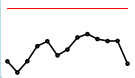
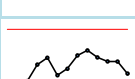
	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 31-37)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Dec-17	2.6%	2.3%	No Target	2.5%		Overall SHMI and HSMR within control limits. Mortality fluctuates month-to-month, but is stable medium-term. Weekend mortality is a noisy metric varying substantially month to month. 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	▲	Mar-17	1.03		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				100.0	97.7		Readmissions have risen in recent months. The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms. High level analysis suggests 'expected' fell sharply from April (and we've put in a ? to HED about this) and observed increased, the latter being dominated by ambulatory care.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	Investigation is underway to understand why 'expected' fell and why readmission of ambulatory patients has increased markedly.	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	Dec-17	3.2%	2.1%	1.0%	1.7%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in LoS, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place. Continued focused management of all patients requiring discharge support. A review of the Trust bed model has resulted in plans to reconfigure some surgical beds to medical by January, thus reducing outliers.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Dec-17	48.1%	48.8%	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	▲	Nov-17	69.9%	69.4%	90.0%	75.7%		eDischarge performance poor - there is insufficient trainee doctor resource to hit this target with existing paper-based systems.		Pending ePR, we are exploring a revised, automated eDischarge solution to address the problem that there are too few trainees to reliably hit the 95% target. Medium-term plan to supplement trainee doctor numbers with advanced nurses is ongoing. The plan is an immediate, automated communication to the GP to alert them to the admission/discharge of their patient, followed by a more detailed discharge summary.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Nov-17	93.1%	89.4%	95.0%	90.0%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Nov-17	99.3%	98.9%	95.0%	99.0%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

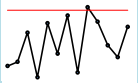
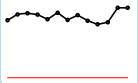
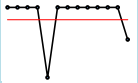
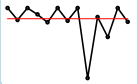
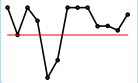
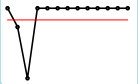
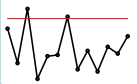
	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Dec-17	96.2%	92.0%	83.0%	94.0%		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	▲£	Dec-17	0	1	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 event reported in November is being developed. Immediate actions implemented including communication to staff and policy review.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Dec-17	99.2%	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	Dec-17	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	▲£	Dec-17	0	2	0	4		Two MRSA cases YTD (1 case under appeal and 1 contaminated specimen). There was 1 C.Difficile (CDI) case in November 2017. 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	▲£	Dec-17	0	17	41	21					SR
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Dec-17	3	16	No Target	17					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Nov-17	0	0	No Contract target	1		No grade 3 or 4 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	▲	Nov-17	0	12	No Contract target	22		No severe harm falls reported in month	Quality and patient safety	Strategic falls actions being implemented as plan .	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲£	Nov-17	95.13%	93.18%	95.0%	93.36%		VTE performance remains suboptimal. The ePrescribing solution implementation has been delayed because of problems with this version of the software and an interim solution is being sort.	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	Oct-17	2	16	No Target	28					
To achieve and maintain CQC registration	Q		Dec-17	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Dec-17	94.4%	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	Dec-17	0	1	No Target	2					

Dec-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 43-51)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Nov-17	95.1%	95.1%	93.0%	95.1%		Two week and 62 day target achieved but the 31 day target was unusually not achieved and review of the timeline for patients who have breeched the standard has highlighted that additional focus needs to be made to patients who fail to attend due to being unwell on day of appointment	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	▲ £	Nov-17	94.9%	98.3%	96.0%	97.9%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Nov-17	90.3%	86.8%	85.0%	88.4%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Dec-17	93.2%	93.2%	92.0%	93.5%		6 specialties are currently failing the 92% incomplete target; General Surgery, ENT, Plastics, T&O, Gynae and Neurosurgery. On going backlog clearance plans continue but similar issues regarding theatre and bed capacity remain. RMS and more recent MCAS primary care services also have compounded the position. However, RMS and MCAS remains unpredictable with short / no notice diverts back to secondary care	As we head into winter and there is an expectation that Surgical Beds will be handed to Medical Care Group. Bed availability to manage the Surgical demand will potentially risk the backlog increasing, causing more incomplete performance failures. Additional risk caused by impact of RMS and MCAS	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. A backlog management plan is in place and alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand. Actions to maintain and improve RTT performance reliant on theatre and bed capacity along with staff availability in collaboration with CCG's in ensuring RMS delivers in a sustainable and manageable way	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Dec-17	100.0%	100.0%	99.0%	100.00%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Dec-17	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Dec-17	0.6%	0.5%	0.8%	0.7%		The cancelled ops target continues to be achieved in December 2017 and YTD. This metric continues to be directly impacted by increases in NEL demand (both surgical and medical patients).	Patient experience and operational effectiveness Poor patient experience	The planned increase in elective surgical activity in St Helens has commenced including increasing GA capacity on Saturdays. Potential to use external theatre and bed capacity continues to be progressed. Continued analysis of the referral drop and impact on RTT underway to include forecast year end position	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Nov-17	100.0%	100.0%	100.0%	100.0%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Dec-17	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Dec-17	73.1%	80.7%	95.0%	76.1%		December 2017 Type 1 performance was 73.1%.	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 (All Types)	F&P	▲	Dec-17	85.5%	87.9%	95.0%	85.1%					
A&E: 12 hour trolley waits	F&P	▲	Dec-17	0	0	0	0					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲£	Dec-17	0	0	0	0		Increased demand for IP capacity has a direct bearing on the ability to maintain this quality indicator.	Patient Experience	Maintained focus and awareness of this issue across 24/7.	RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Dec-17	12	173	No Target	338		% new (Stage 1) complaints resolved in month within agreed timescales continues to improve overall. There has been a notable decrease in the number of new complaints in the last few months.	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	Dec-17	17	224	No Target	293					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Dec-17	70.6%	64.7%	No Target	58.0%					
Friends and Family Test: % recommended - A&E	Q	▲	Dec-17	88.8%	88.2%	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.	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	▲	Dec-17	96.5%	95.7%	90.0%	95.5%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Dec-17	94.9%	98.1%	98.1%	98.5%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Dec-17	97.5%	97.7%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Dec-17	98.8%	96.0%	95.1%	98.7%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Dec-17	100.0%	100.0%	98.6%	93.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Dec-17	94.7%	94.4%	95.0%	94.4%					

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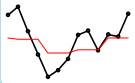
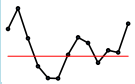
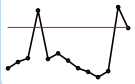
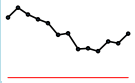
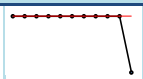
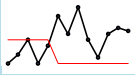
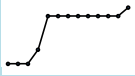
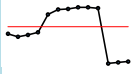
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	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	▲	Dec-17	5.5%	4.5%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.8%		Absence in December has increased to 5.5%. YTD absence has increased by 0.1% to 4.5% however this is 0.3% below the 2016/17 position. Qualified & HCA sickness also increased to 6.6%, 1.3% above the 2017/18 target of 5.3% and 0.7% above 2016/17 outturn	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 January and February, the Absence Support team will support the HR Advisors with WV 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	Dec-17	6.6%	5.4%	5.3%	5.9%					
Staffing: % Staff received appraisals	Q F&P	T	Dec-17	84.9%	84.9%	85.0%	87.4%		Mandatory Training compliance has risen slightly in month and continues to exceed the target by 4.9%. Appraisal has seen a slight decrease to 84.9%.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The Education, Training & Development and Workforce Planning teams continue to work with managers of 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	Dec-17	89.9%	89.9%	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 have been circulated to Managers in the Surgical Care Group.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2	76.1%		No Contract Target						
Staffing: Turnover rate	Q F&P	T	Dec-17	0.7%		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	Dec-17	2.0	2.0	3.0	3.0		The Trust's forecast for year end performance is in line with plan. The Trust has significant contractual agreements with other NHS organisations which may impact on our ability to achieve Better Payment compliance.	Financial	Achievement against the submitted plan and delivery of CIP. Maintaining controls on Trust expenditure and delivering the planned activity while managing the variable costs. Agreeing with Commissioners and NHSE a more advantageous profile for receipt of planned income. Reducing agency expenditure in line with NHSI annual cap.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Dec-17	8,843	8,843	15,315	15,248					
Reported surplus/(deficit) to plan (000's)	F&P	T	Dec-17	5,906	5,906	8,536	4,861					
Cash balances - Number of days to cover operating expenses	F&P	T	Dec-17	13	13	2	2					
Capital spend £ YTD (000's)	F&P	T	Dec-17	6,394	6,394	8,015	3,519					
Financial forecast outturn & performance against plan	F&P	T	Dec-17	9,474	9,474	8,536	4,861					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Dec-17	90.5%	90.5%	95.0%	94.3%					

APPENDIX A

			Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	2017-18 YTD	2017-18 Target	FOT	2016-17	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	100.0%	87.5%	100.0%	96.2%	94.4%	100.0%	84.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%	85.0%		95.2%		
	Total > 62 days		0.0	1.0	0.0	0.5	0.5	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0			6.0		
Lower GI	% Within 62 days	▲ £	58.3%	100.0%	91.7%	93.3%	100.0%	76.9%	100.0%	100.0%	92.3%	84.6%	69.2%	88.9%	82.4%	85.7%	85.0%		89.3%		
	Total > 62 days		2.5	0.0	0.5	0.5	0.0	1.5	0.0	0.0	0.5	1.0	2.0	0.5	1.5	7.0			8.0		
Upper GI	% Within 62 days	▲ £	88.9%	100.0%	81.8%	0.0%	87.5%	100.0%	100.0%	100.0%	33.3%	88.9%	80.0%	100.0%	86.7%	87.0%	85.0%		78.7%		
	Total > 62 days		0.5	0.0	1.0	4.0	0.5	0.0	0.0	0.0	1.0	0.5	0.5	0.0	1.0	3.0			10.0		
Urological	% Within 62 days	▲ £	82.6%	70.0%	95.7%	100.0%	67.6%	92.7%	59.3%	82.1%	83.3%	81.3%	87.5%	77.4%	90.2%	82.6%	85.0%		81.4%		
	Total > 62 days		4.0	6.0	0.5	0.0	6.0	1.5	5.5	3.5	3.0	4.5	1.5	3.5	2.0	25.0			36.5		
Head & Neck	% Within 62 days	▲ £	33.3%	33.3%	100.0%	80.0%	80.0%	66.7%	66.7%	75.0%	75.0%	42.9%	20.0%	50.0%	83.3%	58.8%	85.0%		67.3%		
	Total > 62 days		1.0	1.0	0.0	0.5	0.5	0.5	0.5	0.5	0.5	2.0	2.0	0.5	0.5	7.0			8.0		
Sarcoma	% Within 62 days	▲ £	100.0%	100.0%			100.0%	66.7%		100.0%		0.0%	100.0%			66.7%	85.0%		93.3%		
	Total > 62 days		0.0	0.0			0.0	0.5		0.0		0.5	0.0			1.0			0.5		
Gynaecological	% Within 62 days	▲ £	90.9%	92.3%	100.0%	85.7%	100.0%	70.0%	83.3%	100.0%	68.8%	55.6%	83.3%	100.0%	94.1%	79.5%	85.0%		90.1%		
	Total > 62 days		0.5	0.5	0.0	0.5	0.0	1.5	1.0	0.0	2.5	2.0	0.5	0.0	0.5	8.0			5.0		
Lung	% Within 62 days	▲ £	87.5%	91.7%	68.2%	77.8%	100.0%	100.0%	73.7%	85.0%	100.0%	72.7%	71.4%	87.5%	66.7%	81.0%	85.0%		82.7%		
	Total > 62 days		0.5	0.5	3.5	1.0	0.0	0.0	2.5	1.5	0.0	1.5	1.0	0.5	3.0	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%	75.0%	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	6.5			8.5		
Skin	% Within 62 days	▲ £	97.4%	95.7%	95.7%	100.0%	100.0%	92.5%	93.9%	98.1%	93.9%	93.0%	88.9%	95.2%	98.2%	94.6%	85.0%		96.5%		
	Total > 62 days		0.5	1.0	1.0	0.0	0.0	1.5	1.0	0.5	1.5	1.5	2.0	1.0	0.5	9.5			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%	76.9%	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	3.0			2.0		
All Tumour Sites	% Within 62 days	▲ £	86.6%	85.8%	89.1%	87.6%	89.3%	88.2%	81.6%	91.4%	87.1%	84.5%	80.6%	88.8%	90.3%	86.8%	85.0%		88.4%		
	Total > 62 days		9.5	11.0	8.0	7.5	8.5	8.0	12.5	7.0	11.0	13.5	12.5	7.0	9.5	81.0			107.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £	50.0%				100.0%					100.0%		100.0%		100.0%	85.0%		83.3%		
	Total > 31 days		1.0				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																				

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(18) 002
Title of paper: Committee Report - Executive
Purpose: To provide assurance to the Trust Board on those matters delegated to the Executive Committee.
Summary: The paper covers the Executive Committee meetings that took place between 16th November and 31st December 2017. There were 4 Executive Committee meetings held during this period, with no meetings taking place on 16th or 23rd November due to external events. Also no meeting was scheduled between Christmas and New Year. The Executive Committee approved; • A business case to expand the Pain Management Service • A business case to alter the rates of pay for registered nurses working on the Trust Staff Bank • Measures to enhance cyber security The Executive Committee received assurance reports covering safer staffing, agency usage, Appraisal and Mandatory training compliance, the Corporate Risk Register, Referral Management Schemes, Staff Friends and Family Tests, and the Medway Implementation Programme.
Trust objectives met or risks addressed: All 2017/18 objectives and operational risks managed by the Executive.
Financial implications: None arising directly from this report, requiring Board approval
Stakeholders: Patients, Patients Representatives, Staff, Commissioners, Regulators
Recommendation(s): That the report be noted
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 31st January 2018

EXECUTIVE COMMITTEE ASSURANCE REPORT
OCTOBER 2017

1. Introduction

There were 4 Executive Committee meetings between 16th November and 31st December 2017, and this report provides a summary of the issues addressed and decisions made.

2. 30th November 2017

2.1. Pain Team Business Case

The Executive Committee considered a business case presented by the Surgical Care Group to expand the capacity of the Pain Management Team to match increasing demand. The financial modelling demonstrated that the income from the additional work that could be undertaken would cover the costs, including a contribution to overheads. The appointment of an additional Pain Consultant and supporting staff were approved.

2.2 Referral Management Scheme – Impact Assessment

The impact of the CCG Referral Management Schemes (RMS) on referrals to the Trust and the Referral to Treatment Targets (RTT) is being closely monitored by the Executive. The Trusts main commissioners implemented their RMS at different times during 2016/17. The impact on different specialities is not the same and a more detailed analysis on Trauma and Orthopaedics, ENT and referrals from A&E, is to be undertaken. Further work was also required to monitor the impact on internal and external referrals and the conversion rates from first outpatient appointments to patients listed for surgery.

2.3 CQUIN Report

The report gave an update on 2017/18 CQUIN achievement at Quarter 2 (Q2). All the Acute and Community contract CQUINs had been achieved at Q2. An assessment of the risks to full year achievement of all CQUINs and potential contract penalties was also presented by the Deputy Director of Finance.

2.4 IR35 Report

The Deputy CEO/Director of HR presented a report on the latest position regarding staff who have made cases to be employed outside the IR35 framework.

2.5 Breast Reconstruction Service

Rieka Taghizadeh attended the meeting to discuss the breast reconstruction service. The service provided by the Trust has many patient benefits and excellent outcomes, but the complexity of the approach is not currently recognised in tariff payments. The complex DIEP flap procedures require 3

theatre sessions, so theatre time is also limiting the number of procedures that can be performed. The possibility to developing a health economic business case to present to commissioners was discussed and all income options are to be explored by the Director of Finance.

2.6 Medway Programme Migration Assurance

The Director of Informatics presented the latest independent assurance report on the Medway Implementation programme workstreams. This report covered the data migration process. The independent review had given a high assurance rating for this stage in the migration process, and as expected included a number of recommendations to further improve this work stream. The resulting action plan will be monitored via the Medway Programme Board.

2.7 Cyber Security

The Director of Informatics presented the assessment of the HIS member organisations against the Cyber Security essential criteria for CareCERT re-accreditation. In response a prioritised and phased action plan had been developed with a recommendation that the first phase priority developments be funded by re-directing current resources. This had been discussed at the HIS Board and all the members are in agreement. All the HIS members are interdependent and must move together to achieve the desired level of protection against future cyber security threats.

2.8 Safer Staffing Report

The October Nurse staffing figures were presented and reviewed.

2.9 CQPG Feedback

The Director of Nursing and Midwifery gave feedback on the last CQPG meeting on 17th October. On this occasion there were no new issues that needed escalating to the Executive Committee.

2.10 Strategic Issues

The Chief Executive provided feedback from the Cheshire and Merseyside Cancer Alliance meeting where the location of the Eastern Cancer Hub had been discussed.

3. 7th December 2017

3.1 Staff Friends and Family Test (FFT)

The Deputy CEO/Director of HR reported on the latest staff FFT which had surveyed the staff in the Medical Care Group. The response rate was low, but not different from the average for this type of survey. The approval rating (staff who would recommend StHK as a place to work) was 74%, which was the 2nd highest of acute Trusts in Cheshire and Merseyside and 4th of all Trusts.

An action plan to improve the results is being developed.

3.2 eRostering

The Deputy CEO/Director of HR reported on the progress of the roll out of eRostering and some of the operational issues being encountered, many of which will be resolved when SAFEcare is implemented. Options for reducing the administration required by nurses are to be developed.

3.3 Staffing deep dive

The Director of Nursing and Midwifery presented a paper providing in depth analysis of the ward staffing and the number of shifts filled compared to planned on each ward. The staff allocation and backfill procedures are to be reviewed to try and ensure the most appropriate utilisation of available staff.

3.4 Marshalls Cross

The Director of Transformation provided an update on the implementation of the substantive contract to deliver the primary care services from Marshalls Cross Medical Centre, once the caretaker contract ends on 31st January 2018.

3.5 A&E Delivery Board Chair

The CEO confirmed that from immediate effect she would be chairing the Mid Mersey A&E Delivery Board.

4. 14th December 2017

4.1 Report from the Risk Management Council (RMC)

The Interim Director of Corporate Services presented the chairs report from the RMC, which gave an overview of all the risks currently on the Trusts risk register and those scoring 15 or above that had been escalated to the Corporate Risk Register (CRR). No new risks had been escalated to the CRR during November.

4.2 Medway Programme Update

The Director of Informatics presented the monthly update on the Medway implementation programme. Stage 2 of the plan is on track and the stage 3 plan has now been approved by the Programme Board. The reporting workstream is delayed and a mitigation plan is being developed by Informatics, Corporate Information and System C to ensure that it is completed by the revised completion date. Some of the current operational processes, that are managed outside of the existing PAS e.g. Active Monitoring Patients are being migrated to Medway and all the records audited.

A business case and options appraisal on the optimum go live date is also to be developed, taking account of Easter and School Holidays, the financial year end and external activity reporting schedules. This will be presented in early January.

4.3 IT System Security Update

To protect against potential data breach risks all the Trusts IT systems are in the process of being reviewed. The Director of Informatics gave an update on the progress in identifying all the systems and agreeing the Information Asset Owners (IAO) and Information Asset Administrator (IAA) for every system. All the IAO and IAA's are now being trained to understand their responsibilities and duties in keeping systems and information safe and secure.

Additional controls have been put in place to ensure that any new or replacement IT system must be purchased via procurement and signed off by the Senior Information Risk Owner (SIRO) who is the Director of Informatics, on behalf of the Trust.

4.4 St Helens Community Contract Outcome Measures

The Director of Operations and Interim Director of Corporate Services presented a paper detailing the progress in developing and agreeing with St Helens CCG the contract outcome measures.

The challenge was to identify outcome measures that could be solely linked to the impact of the contract and changes to the way services were being delivered. The discussions were productive and all parties were working together to identify ways of demonstrating the added benefit from the new contract.

Good progress was being made in transforming the services to deliver against the contract service specifications, with both District Nurses and Community Matrons now operating within the St Helens Cares agreed localities. All of the services had been able to recruit more staff and the additional Clinical Leadership that the CCG had sought was in place.

The contract KPIs have been finalised for each service and will be reported on a monthly basis and the quality and CQUIN outcomes are now reported via the Trusts standard reporting systems.

The Director of Transformation will present plans for future transformation of the services in January.

4.5 IPR

The Executive Committee reviewed the draft IPR.

Issues identified for further action or in depth review were the recent Maternity Patient Survey Results, MSSA bacteraemia trends, BCG vaccination target, eDischarge, and level 2 safeguarding training rates, readmission rates and cancelled operations.

4.6 Strategic Issues

The CEO reported on the meeting with St Helens Cares about the creation of a single lead provider contract. The aim was to have this in place by October 2018.

5. 21st December 2017

5.1 Agency Use

The Deputy CEO/Director of HR presented the month 8 report on agency usage to secure a range of clinical staff. The in-month expenditure had increased compared to October, but the overall position remained on course to deliver the planned expenditure of £9.3m. The largest proportion of the expenditure continued to be on Consultant Medical staff.

5.2 Nurse Bank Pay

The Deputy CEO/Director of HR presented a paper outlining proposals to bring bank staff payments for registered nurses in line with practices at other Trusts. The proposals has been scrutinised by the Premium Payments Council. The recommendation was that the Trust increase the pay rate to be comparable with the substantive grade and a standard rate of enhancements for all unsocial hours, which would help attract staff to work on the bank and reduce the requirements for agency staff. The proposal was agreed and its impact would be reviewed in 6 months.

5.3 Mandatory Training and Appraisal

The Deputy CEO/Director of HR reported on the latest reported position which showed an improvement in all areas.

The hard work of the operational team in making this improvement was recognised.

5.4 CQPG

The Director of Operations reported back from the November CQPG meeting

5.5 Ambulance Attendances

The Director of Operations raised concerns about the increasing number of ambulances attending the Trust, which was the highest in the North West. A lot of activity appeared to be coming from other areas and a “divert and

deflection" report had been requested from NWAS, to gain a better understanding of the reasons for this.

5.6 Strategic Issues

The CEO reported from the A&E Delivery Board Conference Call with NHS Improvement, that the cancellation of all elective activity was being considered as a way of responding to winter pressures in January. The implications for Trust RTT performance and income had been discussed.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18) 003

Title of paper: Committee Report – Quality Committee

Purpose: To summarise the Quality Committee meeting held on 23rd January 2018 and escalate issues of concern.

Summary: Key items discussed were:

1. Complaints. Performance for December & Q3.

   - 13 1st stage complaints were received and opened in December 2017, a decrease from 18 received in November 2017 and 22 received in December 2016.
   - 46 1st stage complaints were received and opened in Quarter 3, a decrease of 38.7% compared to the previous quarter

   The committee acknowledged and commended the sustained improvement in performance and processes of the complaints department. It was agreed that there must now be a development of "lessons learned".

2. IPR. The IPR for January was presented in which A&E performance, infection control, finance & HR targets were discussed. Ash Bassi highlighted, and the Committee commended, the additional hard work from Trust staff to support ED pressures at this difficult time. Whilst the performance is under target, the trust remains one of the best in the North West; patient safety remains the key issue.

   A never event relating to a misplaced nasogastric tube was reported in January 2018. The RCA panel has already identified that this was due to a misinterpretation of a chest X-ray and immediate actions have been put in place, including additional training for staff. Only staff who have been appropriately trained can review the check X-ray.

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

   - RNs on days 93.36%
   - RNs on nights 96.72%
   - Care staff on days 106.89%
   - Care staff on nights 112.78%

   However, 13/32 wards have percentage fill rates less than 90%.

   Shelford Acuity Audit. Overall staffing levels are correct; however two wards may require an increase in RN funded posts. There will be a repeat audit in February.

4. CQC action plan. 55 out of 57 CQC actions have now been completed. Final actions will be completed by the end of this financial year.

5. Mortality Surveillance Review. This requires further development. There is a lack of engagement and a need for clarity as to what is required. Once this is achieved the emphasis should then be learning from deaths.

6. A&E Escalation update following live inspection. ARW carried out an on-site assessment in ED on 15th January. The findings were consistent with the self-assessment for the majority of areas. At the time of the visit, a number of staff (including new staff) identified the need for increased levels of leadership support. This has been fed back to the Director of Operations.

7. Feedback from Councils/Committees:

- Patient Safety Council – Nothing significant to escalate
- Patient Experience Council – The results from the Maternity Survey were disappointing. A report will be presented to the Quality Committee in February and an update will be given at the February Trust Board.
- Clinical Effectiveness Council – All effectiveness KPI's are being reviewed.
- CQPG Meeting - No issues to escalate.
- Executive Committee - No issues to escalate
- Workforce Council – No issues to escalate

Summary of items to be escalated to the Board

- Complaints. Overall improvement.
- IPR. A&E pressures and targets. New never event.
- Mortality Surveillance review process.
- Maternity Survey.

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

Financial implications: None directly from this report.

Stakeholders: Patients, the public, staff and commissioners

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

Presenting officer: David Graham, Non-Executive Director

Date of meeting: 31st January 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18) 004

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance and Performance Committee, 25th January 2018

Summary:

Agenda Items

For Information

- Trustwide SLR Quarter 2 2017/18 was presented for information.

- Forecast Outturn 2017/18
  - The Committee discussed the forecast outturn and changes to the risk profile at Quarter 3. The committee discussed the additional winter monies notified in a letter from NHSI in December which awarded the Trust £938k to improve the FOT to £9.474m; the risks to the FOT, with particular reference to the Elective programme cancellation, STP Funding and the Trust's cashflow.
  - Other significant risks remain: contracting and CQUIN issues, HRG4+impact, Clinical income shortfall against plan, operational winter pressures and CIP delivery. The Trust is still forecasting to achieve the annual plan of £(0.581)m deficit excluding STP, £9.474m 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 Q4 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, given that Type 1 performance in December fell to 73.1% and we will continue to escalate to Commissioners where appropriate.
- Budget setting 2018/19
  - NHSI are yet to publish the planning guidance for 2018/19 and so an indicative budget was reviewed by the Committee, which discussed possible income and cost assumptions in light of the missing guidance. The paper will be revised in light of the Committee discussion and presented to Trust Board and future Committees.
- NHSI STF Comms re £ for £
  - The NHSI guidance on the STF Year end incentive scheme was noted.
- CIP Council
  - The briefing was accepted.

For Assurance

- Integrated Performance Report Month 9 was reported
  - Discussion took place around operational performance with specific reference to the Trust's MRSA and C difficile cases year to date, VTE and RTT performance.
  - 62 Cancer performance for December improved again and is now above target at 86.6%.

- Finance Report Month 9 2017/18
  - Delivered year to date surplus of £5.9m, which is slightly better than the planned surplus. As at December, the Trust has delivered £227.4m of Clinical Income

which is broadly in line with plan.
    - Specific risks in achieving outturn were discussed and included the ability to fully recover activity in the remaining months, exposure to tariff change, cost control / CIP risk and STF funding.
    - NHSE elective cancellation programme was implemented in December as a consequence of escalating winter pressures and has been extended to the end of January; this will have a significant impact on Trust activity and PbR income.
    - The Trust has delivered £8.8m of CIP against a target of £10.9m and this continues to be monitored at a departmental level.
    - The Cash and Capital position was also discussed.
- MUST Steering Group
    - Improved performance in December due to implementation of electronic system, replacing manual process

For Approval

- CIP programme 18/19
    - 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 further updates on identified schemes will be presented in February and March

Actions Agreed

- The committee approved the proposed approach to the CIP Programme for 2018/19.

Issues to be raised at Board

- ED performance in December & the challenge to try and maintain quality and safety.
- CIP performance and importance of clinical engagement in development and delivery
- Trust Financial position, YTD and Forecast 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: Jeff Kozer Non-Executive Director
Date of meeting: 31st January 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(18) 005
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 November, covering: 1. NHS Improvement (NHSI) Updated Guidance on Special Measures; 2. NHS Improvement Updated Guidance for Trusts undertaking significant transactions, including mergers and acquisitions; 3. National Workforce Strategy – Facing the Facts, Shaping the Future; 4. Cabinet Re-shuffle; 5. 2018/19 Planning Guidance.
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: 31st January 2018

Strategic and Regulatory Update Report – January 2018

1. NHS Improvement (NHSI) Updated Guidance on Special Measures.

On 20th December 2017 NHSI published updated guidance specifically for those Trusts placed into special measures for quality reasons. The guidance was developed with the Care Quality Commission (CQC). Parallel guidance for Trusts in special measures for financial reasons is also to be published in the near future.

The key points of the guidance are summarised below;

A Trust may be placed in special measures for quality reasons when it is rated by the CQC as 'inadequate' in the well-led domain (i.e. there are concerns that the organisation's leadership is unable to make sufficient improvements in a reasonable timeframe without extra support) and 'inadequate' in one or more of the other domains (safe, effective, caring and responsive).

In these circumstances the Chief Inspector of Hospitals, will recommend to NHSI that the Trust is placed in special measures for quality reasons. If NHSI accept the recommendation the Trust will also be placed in segment 4 of NHSI's Single Oversight Framework for NHS providers.

NHSI will develop an appropriate package of support, taking into account the evidence CQC provides alongside relevant evidence including Trust finances and operational performance. The special measures support package will include the issues that directly led to the Trust going into special measures but could cover other challenges too. A Trust may therefore be subject to interventions relating to its finances when it has gone into special measures for quality reasons, and vice versa.

Typically, Trusts will be subject to the following interventions;

- *NHSI will appoint an improvement director who will act on its behalf to provide assurance of the Trust's approach to improving performance.*
- *NHSI will also appoint one or more appropriate partner or "buddy" organisations to provide support in improvement.*
- *NHSI will review the capability of the Trust's leadership.*

NHSI and CQC will work closely together during the period that the Trust remains in special measures. The expectation is that CQC will re-inspect the Trust within 12 months of the start of special measures.

NHSI will only take a Trust out of special measures for quality reasons following a recommendation from the Chief Inspector of Hospitals. The Chief Inspector will recommend that a Trust can come out of special measures if the quality of care is showing sufficient signs of improvement, even if it is not yet 'good', and if the Trust leadership is robust enough to ensure that the Trust will sustain the improvements and make further improvements. NHS Improvement must also be confident that improvements will be sustained.

Sufficient improvement is when:

- *all inadequate ratings across the five key questions at Trust level, together with the overall Trust rating, have improved to at least 'requires improvement'*
- *no core service remains inadequate overall*
- *for multi-site Trusts, no core service remains inadequate, or – exceptionally – one or more core services remain inadequate but there is significant evidence of an ongoing trajectory of improvement across the organisation.*

If a Trust is removed from special measures, for quality but remains in special measures for finance it will continued to be assessed as segment 4 by NHSI.

2. NHSI Updated Guidance for Trusts undertaking significant transactions, including mergers and acquisitions.

The guidance provides a single framework for organisational transactions (mergers and acquisitions) undertaken by NHS Trusts and Foundation Trusts ('Trusts'), and non-organisational transactions (significant capital investments, joint ventures and private finance initiatives – PFIs).

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.

Transactions covered by the guidance are;

I. Any material transaction where ratio of the gross assets, income or consideration attributable to the transaction exceeds 10% of the Trust's gross assets, income or total capital respectively.
II. Any transaction that could be reviewed by the Competition and Markets Authority (under the Enterprise Act 2002).
III. Any statutory transaction covered by the National Health Service Act 2006 (NHS Act 2006) unless otherwise stated):

– Merger – Acquisition

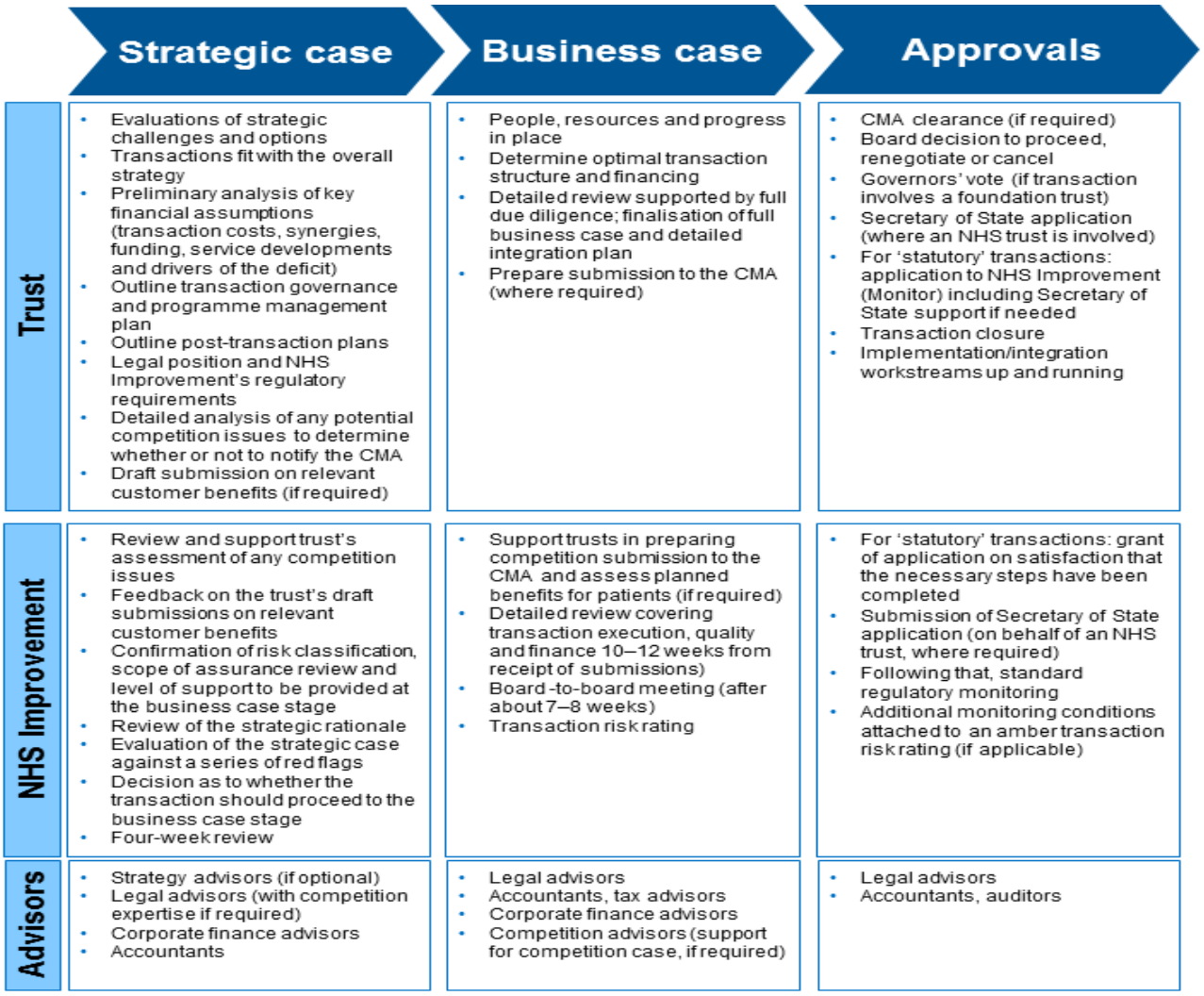
– Three-way merger or acquisition

– Dissolution of an NHS Trust and transfer of assets

– Dissolution of a Foundation trust

– Commercial transfer

Overview of the Standard Transaction Review Framework



The guidance suggests that the minimum timeframe for this process to be completed would be 16 months.

3. National Workforce Strategy – Facing the Facts, Shaping the Future.

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.

Specific proposals include:

- Targeted retention schemes to encourage staff to continue working in healthcare, including support for local NHS organisations on how to improve retention rates, an expansion of the nursing Return to Practice scheme and

efforts to encourage European nationals to stay by ensuring a streamlined, user-friendly service for obtaining settled status

- Improvements to medical training and how junior doctors are supported in their careers, with a greater emphasis on producing more doctors in areas where there are the biggest shortfalls, including general practice and psychiatry, and ongoing efforts to improve the working practices of doctors in training, such as improving access to training opportunities and better communication around rotations and shift patterns
- A far-reaching technology review across England looking at how advances in genomics, pharmaceuticals, artificial intelligence and robotics will change the roles and functions of clinical staff over the next two decades and what this will mean for future skills and training needs – this will build on existing schemes to improve the digital skills of the healthcare workforce, including the planned launch of the Digital Academy in January 2018
- Making the NHS a more inclusive, 'family-friendly' employer – the strategy also acknowledges the changing shape and expectations of the NHS workforce, with more people wanting flexible working practices to enable them to balance work and family life. It concludes that NHS organisations will need to develop an employment offer that remains attractive for all staff.

The draft strategy also looks at the major workforce plans for the Five Year Forward View priorities: cancer; mental health; maternity; primary and community care; and urgent and emergency care.

4. Cabinet Re-shuffle.

In the recent Cabinet re-shuffle Jeremy Hunt remained as Secretary of State for Heath with an expanded brief to also cover Social Care.

The Health and Social Care Ministerial Team also saw a number of changes, with Stephen Barclay MP and Caroline Dinenage MP appointed as Ministers of State.

The Parliamentary Under-secretaries for State are Lord O'Shaughnessy, Steve Brine MP and Jackie Doyle-Price MP.

The briefs of each member of the team, including the expanded responsibility for Social Care have not yet been announced.

Jonathan Ashworth MP remains the shadow Secretary of State for Health.

5. 2018/19 Planning Guidance

At the time of writing the 2018/19 planning guidance has 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.

ENDS

Trust Board

Paper No: NHST(18) 006

Title of paper: Board Assurance Framework (BAF)

Purpose: For the Executive Committee to review the BAF and agree proposed changes to be recommended to the Trust Board.

Summary:

The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its strategic plans and long term objectives.

In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in October 2017.

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

Key to proposed changes:

~~Score through~~ = proposed deletions

Blue Text = proposed additions

Red = overdue actions

Recommended changes

The wording of risk 2 should be altered to reflect wider system working and Place Based Care developments - ***Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners***

In light of the pressures being faced by the NHS and the winter escalation plans that are in place the score of risk 3 - Sustained failure to maintain operational performance/deliver contracts should be increased to 20.

Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to assure the delivery of its strategic objectives.

Financial implications: None arising directly from this report.

Stakeholders: NHSI, CQC, Commissioners.

Recommendation(s): To review and approve the proposed changes to the BAF.

Presenting officer: Nicola Bunce, Director of Corporate Services.

Date of meeting: 31st January 2018

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

Alignment of Trust 2017/18 Objectives and Long Term Strategic Aims

2017/18 Trust Objectives	Strategic Aims					
	We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes	We will be the hospital of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will be a sustainable and efficient organisation
Five star patient care – Care	■		■			
Five star patient care – Safety	■	■	■			
Five star patient care – Pathways		■	■	■		
Five star patient care – Communication		■		■	■	■
Five star patient care – Systems	■	■				
Organisational culture and supporting our workforce					■	■
Operational performance	■			■		
Financial performance, efficiency and productivity	■					■
Strategic Plans		■		■		■

Risk Scoring Matrix

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

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

Risk 1 – Systemic failures in the quality of care	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause: • Failure to deliver the Clinical and Quality standards and targets • Failure to deliver CQUIN element of contracts • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting Effects: • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage Impact: • Harm to patients • Loss of reputation • Loss of contracts/market share	5x4= 20	• Quality metrics and clinical outcomes data • Safety thermometer • Quality Ward Rounds • Complaints and claims • Incident reporting and investigation • Quality Governance structure • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with lead CCG • NHSI Single Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC Action Plan • Medicines Optimisation Strategy	To Board; • IPR • Patient Stories • Quality Board Rounds • Quality Committee and its Councils • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Staff Survey • Friends and Family scores • Nursing Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit • National Inpatient Survey Other; • National clinical audits • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Inspection Report • Learning Lessons League • IG Toolkit results • Model Hospital benchmarking	5 x2 = 10	Quarterly publication of avoidable deaths data (Jan 2018)	Full Implementation of the midwifery led care pathway for women having low risk births (November 2017) Plans to achieve 30% of discharges by midday Improvement plans for Falls, Infection Control and Pressure Ulcers in 2017/18 Recovery plan for VTE ahead of IT solution (November 2017)	~~Delivery of the remaining CQC (Should do) Actions (September 2017)~~ Complete the final CQC "should do" action on EOL care, with local system partners – March 2018 Implementation plans for the four key 7-day service standards in 2017/18 – March 2018 Implementation of Stroke Service integration with WHH – phase 2 planned completion in 2017/18 Improve F&F response rates (March 2018) Benefits realisation from the delivery of the St Helens community services contract - March 2018	5 x 1 = 5	KH/ SR

Risk 2 ~~– Failure to agree a sustainable financial plan with commissioners~~ **Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners**	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to deliver strategic financial plans and two year operational plan, including the agreed control total • Failure to control costs • Failure to implement transformational change at sufficient pace • Failure to continue to secure national PFI support • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • Failure to respond to new models of care (FYFV) Effects; • Failure to meet statutory duties • NHSI Segmentation Status increases Impact; • Unable to deliver viable services • Loss of market share • External intervention	5 x 5 = 25	• Two year Operational Plan and STP financial Modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 3 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review) • Contract monitoring and reporting • Activity planning and profiling • IPR • ~~NHSI monthly monitoring submissions~~ • NHSI annual provider Licence Declarations • PMO capacity to support delivery of CIP and service transformation • Signed Contracts with all Commissioners • Premium/agency payments approval and monitoring processes • Internal audit programme	To Board; • Finance and Performance Committee • Annual financial plan • Monthly finance report • IPR • Statement of Internal Control • Annual Accounts • Audit Committee • External Audit Reports Inc. VFM assessment • SLM Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports • Annual audit programme • STF Targets and Control Total Other; • NHSI monthly reporting • Contract Monitoring Board • NHSI Review Meetings • Use of Resources reviews • Contract Review Boards with Commissioners	5 x 4 =20	Agree a shared health economy financial and sustainability strategy/control total Develop 2017 - 19 detailed CIP plans Establish a benchmarking and reference cost group 2017/18 financial recovery plan Assessment of the impact of national winter escalation plans on the 2017/18 financial plan (February 2018)	Develop capacity and demand modelling and a consistent approach to service development proposals approval Foster positive working relationships with health economy partners to help create a joint vision for the future of health services Prompt payment of lead employer invoices by other NHS organisations to maintain cash balances (October 2017)	Develop a detailed STP implementation plan with C&M partners in line with the priorities outlined in the Next Steps FYFV plan Secure maximum SFT funding 2017/8 and 2018/19. Development of clear plans for the Trusts response to ACS/O development plans in St Helens, Halton and Knowsley, including legal form and risk/benefit analysis (February 2018)	4 x3 = 12	NK

Risk 3 - Sustained failure to maintain operational performance/deliver contracts	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to deliver against national performance targets (ED, RTT, Cancer etc) • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting Effects; • Reduced patient experience • Poor quality and timeliness of care leading to poorer outcomes • Failure of KPIs and self-certification returns • Increases in staff workload/stress Impact; • Potential patient harm • Loss of reputation • Loss of market share/contracts • External intervention • Loss of STF funding • Increases in staff sickness rates	4 x 4 = 16	• NHS Constitutional Standards • Care group activity profiles and work plans • System Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • A&E Delivery Board Membership ~~Membership of CCG System Resilience Groups~~ • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events re DTOC patients	To Board; • Finance and Performance Committee • IPR • System Resilience Plan • Annual Operational Plan • Data Quality audits Other; • Contract review meetings/CQPG • NHSI monitoring and escalation returns/sit reps • CCG CEO Meetings • CQC System Reviews e.g. Halton	4 x 4 = 16 4 x 5= 20	~~Surgical Care Group activity and RTT recovery plan (November 2017)~~ ~~Approved winter plan for the local system (November 2017)~~ ~~Approval of the A&E capital scheme to create a GPAU and expansion of GP streaming (November 2017)~~ Improvement plans for 62 day cancer target, where this is not consistently achieved in every month. Theatre productivity improvement plan monitoring.	Long term health economy emergency access resilience and urgent care services plans re NEL admissions and DTOC	Improvement Event Action Plans and Internal Improvement strategy – on going Work with NHSI and ECIP for practical intensive support to achieve 4-hour trajectory – March 2018 ~~Review of bed usage and allocation's to achieve maximum throughput to safeguard both RTT and emergency access and throughput performance (September 2017)~~ Recruitment of additional HCA's to support packages of care (January 2018) Full Implementation of the new frailty pathways for all CCGs – March 2018 Impact and recovery assessment of winter pressures on elective activity and RTT – March 2018	4 x 3 = 12	RC

Risk 4 - Failure to protect the reputation of the Trust	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Good Rating • Failure to report correct or timely information Effect; • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff • Increased external scrutiny/review • Delay in FT application timetable Impact; • Reduced financial viability and sustainability • Reduced service safety and sustainability • Reduced operational performance • Increased intervention	4 x 4 = 16	• Communication and Engagement Strategy • Communications and Engagement Action Plan • Workforce, Recruitment and Retention Strategy • Publicity and marketing activity • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports	To Board; • Quality Committee • Workforce Council • Audit Committee • Charitable funds committee • Communications and Engagement Strategy • IPR • Staff Survey • Complaints reports • Friends and Family • Staff F&F Test • PLACE Survey • National Cancer Survey • Referral Analysis Reports • Market Share Reports • CQC national patient surveys • CQC Inspection ratings • Annual assessment of compliance against the CQC fundamental standards • Compliance review against the NHS Constitution Other; • Health Watch • CQC • NHSI Segmentation Rating	4 x 3 = 12	Regular media activity reports , including social media, to the Board/Committee	Action plan to improve understanding of patients and carers' views – April 2018 WRES Action Plan for 2017/18 (January 2018)	New Trust intranet to be developed and launched - July 2017 Achievement of 90% complaints response times target for 2017/18 – March 2018 Staff engagement and leadership strategy review (January 2018) Hospital Charity effectiveness and ROI review – January 2018 Maternity Patient Survey Action Plan Implementation – March 2018	4 x 2 = 8	AMS

Risk 5 – Failure to work effectively with stakeholders	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Different priorities and strategic agendas of multiple commissioners • Unable to create or sustain partnerships • Competition amongst providers • Complex health economy • Poor staff engagement • Poor community engagement • Poor patient and public involvement Effect; • Lack of whole system strategic planning • Inability to secure support for IBP/LTFM • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff Impact; • Unable to reach agreement on collaborations to secure sustainable services • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff • Failure to win new contracts • Increase in complaints and claims	4 x 4 = 16	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCC/ Workforce Council • Patient and Public Engagement and Involvement Strategy • CCG CEO Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • CCG Board to Board Meetings • St Helens Cares Peoples Board • Involvement in Halton and Knowsley ACS development • CCG Representative attending StHK Board meetings • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Merseyside and Cheshire Sustainability and Transformation Planning governance structure • Acute Alliance LDS Exec to Exec working • StHK Hospitals Charity annual objectives	To Board; • Quality Committee • Charitable Funds Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports from external events • NHSI Review Meetings • Quality Account • Review of digital media trends • Monitoring of and responses to NHS Choices comments and ratings • Participation in the C&M STP leadership and programme boards • Partnership working with NWB NHSFT to deliver the St Helens Community Nursing Contract	4 x 3 = 12	Annual programme of engagement events with key stakeholders to obtain feedback and inform strategic planning	C&M STP performance and accountability framework ratings and reports	~~C&M STP shared implementation plans and accountability structures - to meet the requirements of Next Steps for the FYFV~~ St Helens Cares Single Provider – October 2018 Agree membership of the One Halton Partnership – January 2018	4 x2 = 8	AMS

Risk 6 - Failure to attract and retain staff with the skills required to deliver high quality services	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment Effect; • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff Impact; • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	5x4 = 20	• Team Brief • Staff Newsletter • Mandatory training • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCC/Workforce Council • Francis Report Action Plan • Education and Development Plan • HR Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews • Workforce KPIs • Recruitment and Retention Strategy action plan • Nurse development programmes • Agency caps and usage reporting • LWEG/LETB membership • Speak out safely policy • ACE Behavioural standards	To Board; • Quality Committee • Workforce Council • Finance and Performance Committee • Premium Payments Scrutiny Council • IPR - HR Indicators • Staff Survey • Monthly Nurse safer staffing reports • Workforce plans aligned to strategic plan • Monitoring of bank, agency and locum spending • Monthly monitoring of vacancy rates and staff turnover • Staff F&FT snapshots • WRES report and action plan • Quality Ward Rounds Other • Annual workforce plans • HR benchmarking • Nurse staffing benchmarking	5x4= 20		Specific strategies to overcome recruitment hotspots e.g. Oversees recruitment ~~RMO cover for St Helens in line with strategic site development plans and changing nature of patients~~ Plans to optimise opportunities from the apprenticeship levy to create new roles and qualifications to address skills and capacity gaps	Complete E-Rostering roll out to all Medical Staff (December 2017) ~~Specialist nurses to dedicate time to research and training - January 2017~~ ~~Departmental Development and Succession Plans - March 2017~~ Development of a C&M collaborative staff bank - March 2018 Plans to maximise the ROI from the apprenticeship levy – June 2018 Annual review of Departmental OD plans – June 2018	4 x 2 = 8	AMS

Risk 7 - Major and sustained failure of essential assets or infrastructure	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire Effect; • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric o equipment • Increase in complaints Impact; • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 4 = 16	• New Hospitals / Vinci Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • Capital programme • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups	To Board; • Finance and Performance Committee • Finance Report • Capital Programme • Audit Committee • I.P.R. Other; • Major Incident Plan • Business Continuity Plans • ERIC Returns • PLACE Audits • Model Hospital • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee, to capture: ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance	4 x 2 = 8	The estates strategy will need to be continually refreshed as the configuration of clinical, clinical support and back-office functions across a wider footprint develops. Development of strategic estate options for cancer services, urgent care and surgical care are being developed	To dovetail into the C&M STP 5-year forward view programme. Maximise the potential from the GP Streaming investment to improve the A&E department flows. (Deed of Variation being finalised. Tender imminent with construction work to commence as soon as possible)	~~Membership of the St Helens Strategic Estates Group~~ ~~Membership of the NHS C&M Estates Enabling Group and Corporate Services Programme Board~~	4 x 2 = 8	PW

Risk 8 - Major and sustained failure of essential IT systems	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage • Lack of effective risk sharing with HIS shared service partners Effect; • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Inability to record activity and duplication due to reliance on back up paper or manual systems. • Loss of data or patient related information Impact; • Reduced quality or safety of services • Increased costs • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	~~4x4=16~~ ~~4x5=20~~	• HIS Management Board and Accountability Framework • Procurement Framework • Health Informatics Strategy • HIS performance framework and KPIs • HIS customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plan • Disaster Recovery Policy • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • Availability and capacity management framework	To Board; • HIS Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • Executive committee • Risk Management Council • Information Security Assurance Group • Health Informatics Service Operations Board • Programme/Project Boards • Information Governance Steering Group Other; • Internal/External Audit Programme • Information Governance Toolkit Submissions • Information Security Dashboard • External Accreditation – CareCert, Cyber Essentials, External Penetration Test • Service Level Agreements • NHS IT Health Check (CareCert) • HIS Strategy	~~4x2=8~~ ~~4x4=20~~	Annual Financial plan agreed with all partners Cyber Security Business Case approval Infrastructure Replacement Programme to be agreed Corporate Governance Structure established Staff Development Plan Technical Development Annual Audit Assurance Report	ISO27001 Cyber Essentials Plus NHS IT Health Check (CareCert) Annual Service Delivery Assurance Report Service Improvement Plans Communications Strategy Digital Maturity Assessment Independent systems review	ISO27001 (Q4 19/20) Cyber Essentials Plus (Q4 18/19) CareCert Accreditation (Q2 18/19) Cyber Security Strategy (Q4 18/19) Delivery of PAS Replacement programme (Q1 18/19)	4x2=8	CW

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18) 007

Title of paper: Overview of Complaints, Claims & Incidents Q2 2017/18

Purpose:

The purpose of this paper is to present an overview of incidents, complaints, PALS and claims activity and performance during Quarter 2 (Q2) 2017-18 to identify if there are any key themes or trends that need further investigation and to provide the Board with assurance that there are systems and processes in place to report and manage these issues.

Summary for 1st July 2017 to 30th September 2017 (Quarter 2):

Incidents

- 3722 incidents were reported in Q2
  - Increase of 434 (13.2%) from Q1
  - Increase of 336 (9.9%) increase from Q2 2016-17
- 3023 patient incidents were reported in Q2
  - Increase of 333 (12.4%) from Q1
  - Increase of 241 (8.7%) from Q2 2016-17
- The rate of patient incidents per 1,000 bed days in Q2 was 50.4
  - Increase of 11.8% from the Q1 (45.1 per 1000 bed days)
  - Increase of 10.6% increase from Q2 in 2016-17 (45.6 per 1000 bed days)
- 49 moderate/severe and death patient harms in Q2
  - Decrease of 5 (9.3%) from Q1
  - Decrease of 14 (22.2%) from Q2 2016-17
- The rate of incidents affecting patients and resulting in moderate harm or above per 1,000 bed days was 0.8
  - Decrease of 9.8% from the Q1 (0.9 per 1000 bed days)
  - Decrease of 20.8% from Q2 in 2016-17 (1.0 per 1000 bed days)
- 12 incidents in Q2 were StEIS reportable
- This increase in the numbers of reported incidents and the decrease in incidents reporting harm to patients, is an indicator of a strong organisational safety culture

Complaints

- 75 1st stage complaints were received and opened in Q2; an increase of 22 (42%) compared to Q1 and an increase of 7% from the 70 received in Q2 2016-17.
- Clinical treatment was the primary cause of complaints in Q2.
- This has been the highest cause of complaints for the previous five quarters.

PALS

- There were 581 PALS contacts in Q2, a 25% increase of 116 contacts compared to the Q1 and 34 more than Q2 2016-17 (547).
- Communication remains the main reason for enquiries to PALS

Clinical Negligence Claims

- 25 new clinical negligence claims have been received in Q2, a 14% decrease from the 29 received in Q1, but a 47% increase from the 17 received in Q2 2016-17

Activity

Activity has risen during the quarter (see below), which may have contributed to the increase in incidents, complaints and PALS contacts, specifically the increase in A&E attendances and the increase in waiting times during this period may have had an impact on the number of PALS contacts

	+/- compared to Q1 2017-18	**+/- compared to Q2 2016-17**
Spells including well babies	-0.3%	2.3%
Outpatient Attendances (Seen)	3.7%	1.3%
A&E Attendances (Type 1)	5.3%	7.9%

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

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

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

Recommendation(s): Members are asked to review the report and consider if there are any issues that need to be referred to the Quality Committee for further investigation.

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

Date of meeting: 31st January 2018

1. Introduction

The Trust uses the same Datix system to record reported incidents, complaints, PALS enquiries and claims. This allows the Trust to link any related occurrences.

This report highlights if there are any trends and the learning derived from incident reporting, complaints, claims and PALS enquiries received by the Trust. The information includes all reported incidents, complaints, PALS and litigation (claims and inquests).

The data included in this report covers Q2 2017-18, 1st July to 30th September 2017.

1.1 Governance of Complaints, Incidents and Claims

The Quality Committee receives a monthly report on complaints management, with a more detailed report submitted monthly to the Patient Experience Council. The Patient Safety Council receives a monthly report on incidents and a quarterly report relating to claims. Each of these Councils provides a chair's report, with escalation of any areas of concern, to the Quality Committee. The Claims Governance Group meets monthly and reviews any potential new claims, high value claims and lessons learnt as a result of claims. A chair's report is submitted monthly to the Risk Management Council, which reports to the Executive Committee.

1.2 Reasons and Themes

The table below compares the reasons for incidents, complaints, PALS contacts and claims for all reported during Q2, to identify if there are any common themes that can be identified.

Table 1: Top five themes from reported incidents, complaints, PALS and claims

Incidents	No.	Complaints	No.	PALS	No.	New clinical negligence claims	No.
Accident that may result in a personal injury	967	Clinical Treatment	31	Communications	118	For all specialities failure to diagnose or delay in diagnosis	7
Implementation of care or ongoing monitoring	562	Admissions and Discharges (excl. delayed discharge re care package)	9	Admissions and Discharges (excl. delayed discharge re care package)	101	Fail/delay Treatment	3
Medication	379	Values and Behaviours (Staff)	6	Clinical Treatment	67	Failure to recognise complication of treatment	3
Access, Appointment, Admission, Transfer	355	Communications	5	Access to Treatment or Drugs	46	Failure to warn (informed consent)	2
Clinical Assessment	335	Patient Care/	6	Patient Care/	46	Delay in	1

Incidents	No.	Complaints	No.	PALS	No.	New clinical negligence claims	No.
(Investigations, Images and lab tests)		Nursing Care		Nursing Care		performing an operation	
				Appointments	46		

Note: The chart above should be used as guidance only as the claims received often fall into more than one category, for example there may have been negligent performance of a surgical procedure followed by a fall on the ward, or failure to diagnose a condition with general unhappiness regarding the care received. The categories used for reporting are indicated by external bodies, for example the clinical negligence ones are set by NHS Resolution and the complaints codes are used to report the KO41 via NHS Digital as required by the Department of Health.

Rank	Theme	No reported in period
1st	Clinical care	2455
2nd	Access/admission/discharge issues	511
3rd	Communication and records	6
4th	Attitude/behaviour/competence	123

The top category in each of the 4 areas has been consistent for the last five quarters and the other reasons for each area have also remained in the top five, except for claims, where there is some fluctuation due to the small numbers, for example there were two claims relating to inappropriate treatment in Q1, but not in Q2.

From this analysis it can be seen that the most common theme across all areas is clinical care, followed by access/admission/discharge issues. This analysis will be repeated each quarter to see if the profile changes over time.

2. Incidents

There were 3721 incidents reported by staff during this period, with 12 incidents reported to StEIS and 52 categorised as moderate, severe harm or death.

Charts 1 and 2 below show the Trust's incident reporting activity from Q 1 2016-17 to Q2 2017-18. This shows an increase in incident reporting but a downward trend in levels of significant harm resulting from the incidents. This indicates an improving culture of reporting.

Chart 1: total incidents reported

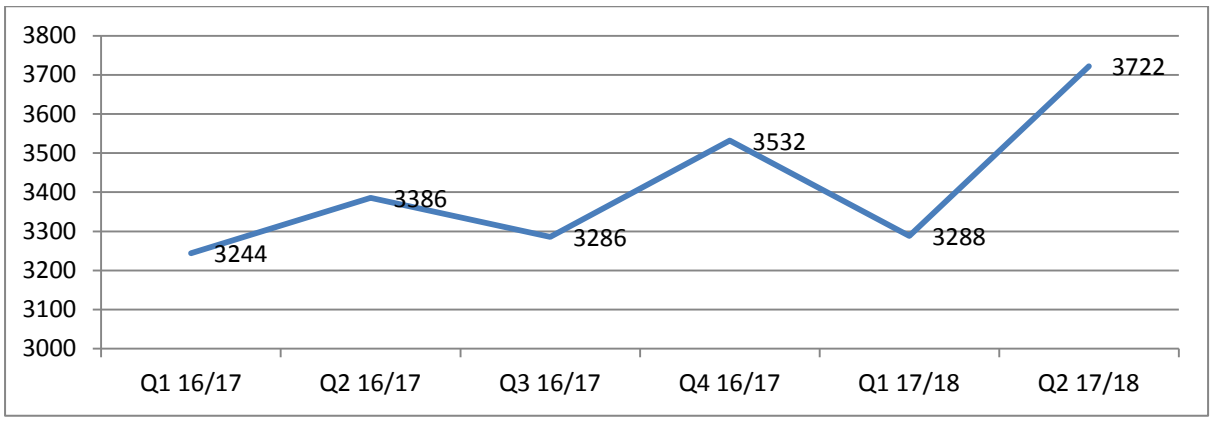
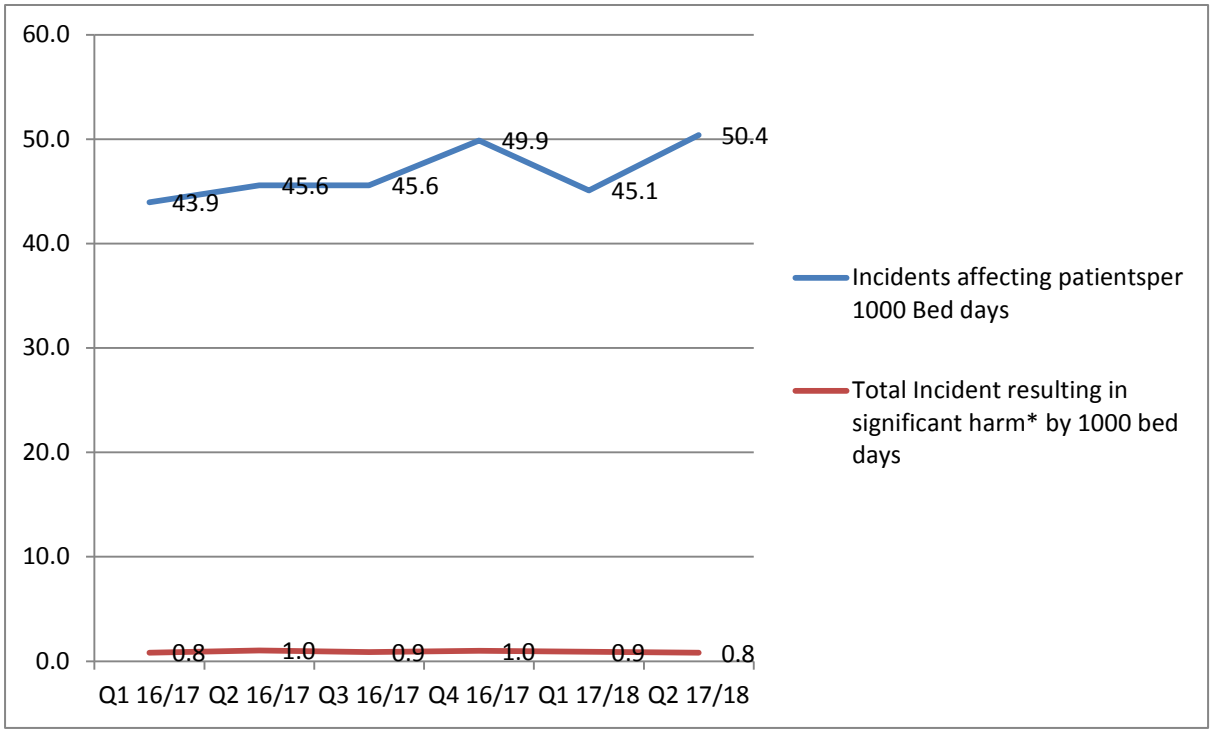


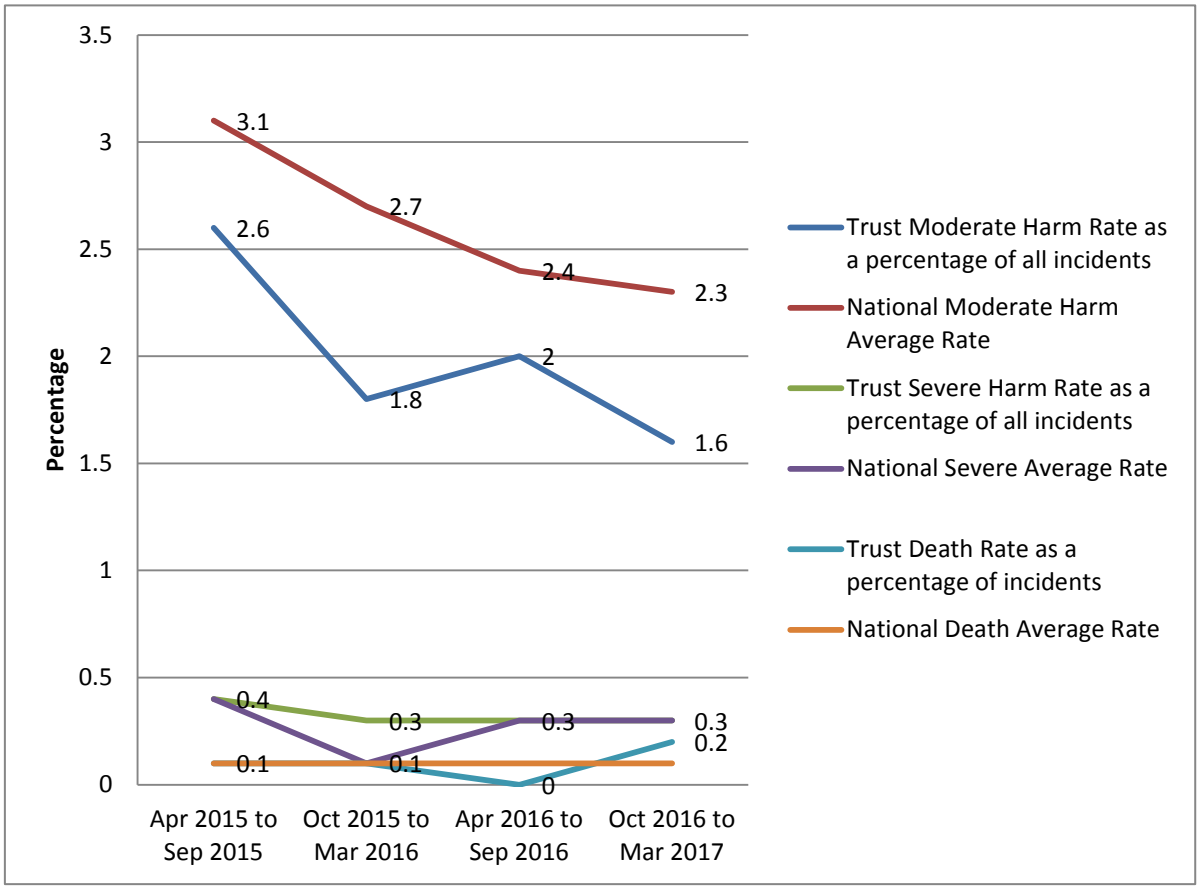
Chart 2: Incidents affecting patients per 1000 bed days



*significant harm = incident resulting in moderate / severe harm or death

Chart 3: Comparison of Trust's rates (as per NRLS data) of moderate harm and above against national rates (April 2015 – March 2017)

Chart 3 shows the most recent data provided by NHS England comparing patient safety incidents reported to the National Reporting and Learning System (NRLS) by the Trust to the national average. The Trust's rates of moderate harm are consistently below the national average, although rates for severe or death vary in comparison due to the relatively small numbers.



2.1. Thematic analysis of incidents reported to StEIS* in Q2 2017-18

In Q2 the Trust reported 12 incidents to StEIS.

*Only those incidents outlined in the Serious Incident Reporting Framework are reported on StEIS. These include any incident where the Trust causes severe harm or death, IG breaches, allegations of abuse and a number of other categories.

Table 2: incidents reported to StEIS in Q2 2017-18

Incident category	Number
Slips, Trips & Falls	5
Abuse/alleged abuse of adult patient by staff	2
Sub-optimal care of the deteriorating patient	2
Confidential information leak/information governance breach	1
Treatment Delay	1
Medication Incident	1

2.2. Actions taken as a result of serious incidents

A root cause analysis investigation is undertaken of each serious incident, with recommendations and an action plan produced to reduce the risk of a reoccurrence.

Examples of the actions taken include:

- Monthly audits of falls care

- Improved guidance for referral to specialist fall nurses
- A review of management of oxygen and implementation of improved guidance
- All professional staff have been made aware of their profession obligations in terms of record keeping via Team Brief
- Simulation training for paediatric resuscitation now includes PACE (probe, alert, challenge and emergency) training, which is a method of graded assertiveness to allow staff to communicate and direct with clarity in a crisis situation
- The emergency medicines handbook has been updated
- The surgical on call team are now using the e-handover system for patients referred from ED

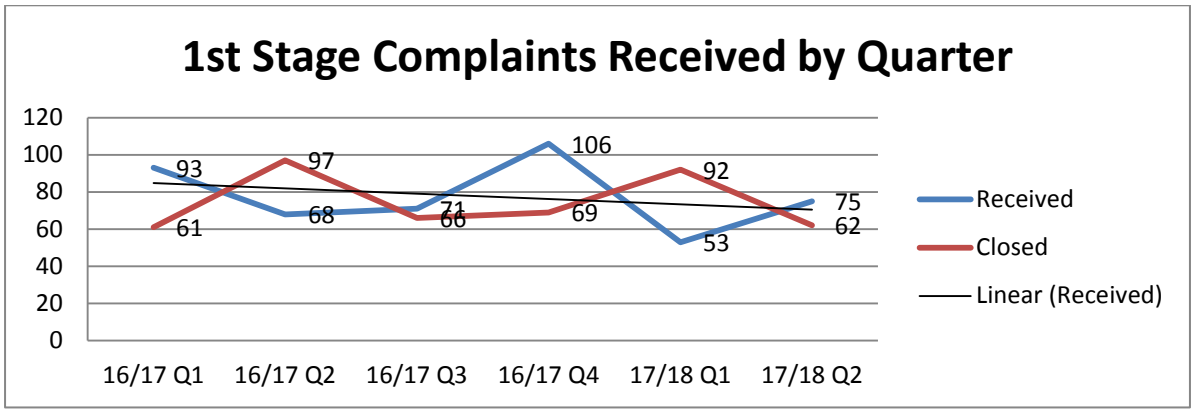
Lessons learnt from incidents are shared via the bi-monthly safety bulletin included in Team Brief, via the Ward Manager and Matrons' meetings, as well as through each Care Group governance meetings.

3. Complaints

75 1st stage complaints were received and opened in Q2; an increase of 22 (42%) compared to Q1the previous quarter.

The chart below contains 1st stage complaints (written and verbal) received by quarter, since April 2016. This shows a slight reduction in the overall number of complaints received in the last six quarters.

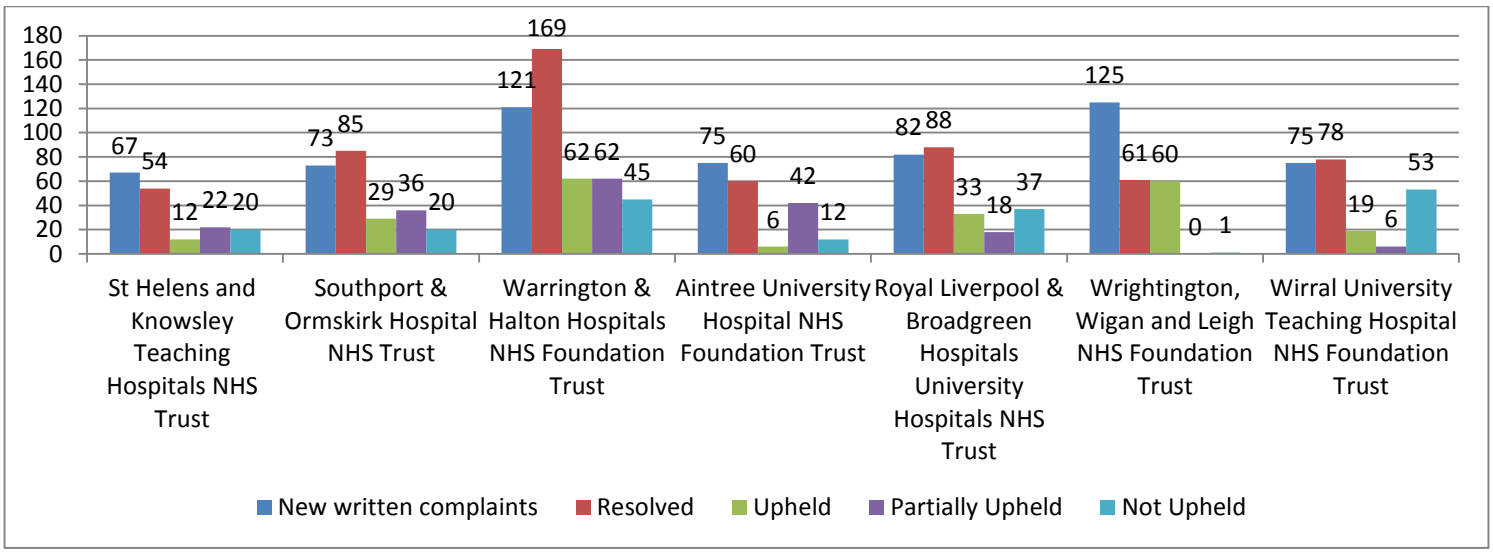
Chart 3: complaints received by each quarter from Q1 2016-17



3.1. Complaints – local and national comparison

NHS Digital collates details of Trust written complaints (which are a sub set of all the complaints received and recorded) via a quarterly return (KO41a). The chart below shows a comparison with neighbouring Trusts.

Chart 4: Comparison of number of written 1st stage complaints received and resolved in quarter 2 2017-18



Note: The resolved complaints will not necessarily have been received in the same quarter

The Q2 figures indicate that the Trust has received less written complaints than other local trusts; as well as upholding fewer complaints as a proportion of the total resolved than local other trusts.

3.2. Actions taken as a result of complaints

Each complaint response includes any learning that has been identified and the necessary actions for each area. A summary of lessons learnt and actions taken from incidents and complaints across the Trust is shared at the monthly Matron and Ward Manager meetings for onward cascade to each department/ward. In addition, complaints are a standing agenda item on the Care Group and ward governance meetings' agenda to ensure that lessons are learnt from complaints and to embed any actions taken to improve the quality of patient care. Actions taken in Q2 include:

- Audit undertaken to confirm compliance with policy for identifying patients
- Reiteration of Trust ACE behavioural standards
- Staff reminded of their obligations in respect of keeping family members informed if patients are moved to another hospital
- Purchase of ward supply of banana boards to help patients transfer from bed to chair independently
- Email sent to all RNs with copy of medication policy to ensure staff are fully aware of the required standard
- Reminders to staff about the importance of clear accurate documentation including all discussions with family
- 'Butterfly' poster has been implemented for end of life patients to ensure staff are aware of their additional needs
- All urology medical staff to check the waiting list timeframe with the Admissions Department prior to providing patients with an estimated time for surgery to provide a realistic expectation of timescales

4. PALS

There were 581 PALS contacts/enquiries during Quarter 2 2017-18. This represents a 25% increase compared to Q1 2017-18 (465 contacts/enquiries received and 34 more than the same quarter in the previous year).

The main themes for PALS contacts are shown in table 1 and remain generally consistent, other than "access to treatment or drugs" which has not featured in the top five in the last five quarters. This will be monitored going forward. Of the 581 PALS enquiries received, 35 became complaints, a conversion rate of 6%.

5. Legal Services

5.1. Clinical negligence claims

The Trust received 25 new claims in Q2, representing a small decrease compared to the 29 new claims in Q1. However, it is a 47% increase compared to the equivalent period in 2016-17 when 17 new claims were received. Fifteen of the new claims were received by the Surgical Care Group and ten by the Medical Care Group.

5.2. Actions taken as a result of claims

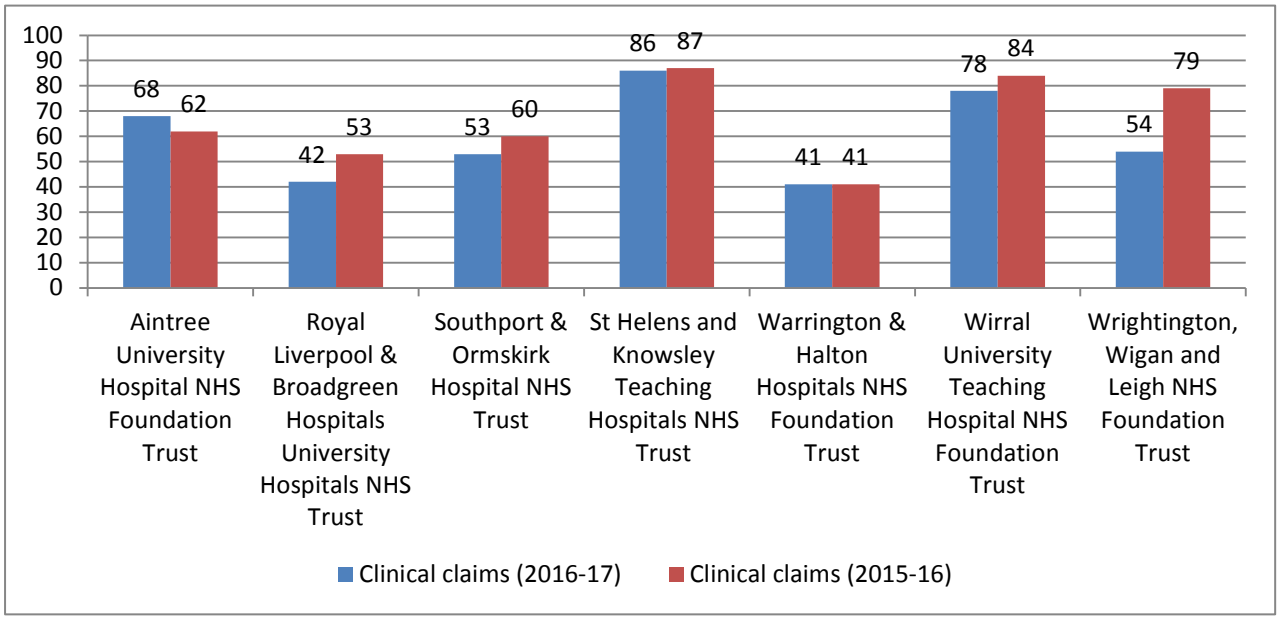
Learning is identified following each claim and improvements are undertaken to prevent a repeat of the incident. The following are examples of changes made as a result of claims:

- New risk assessment pack introduced by Falls Specialists
- New falls patient care plan introduced
- Pressure pad alarms introduced for patients with high risk of falls
- Urinary incontinence management training provided for junior doctors

5.3. Benchmarking data for claims

Quarterly benchmarking data is not available for NHS Trusts. However, NHS Resolution does produce annual figures for claims notified in previous financial years.

Chart 5: Comparison of number of clinical negligence claims received in 2015-16 and 2016-17 for local trusts



The number of claims is broadly similar to Wirral University Teaching Hospital NHS Foundation Trust, which is of a similar size and provides many of the same services as StHK, including maternity services. The Trust received 8 obstetric claims in 2015-16 and 5 in 2016-17.

5.4. Inquests

The Trust, via the Legal Department, proactively manages inquests where the coroner is considering a verdict other than natural causes and where the Trust has some direct involvement with the deceased. In many cases there are lessons to be learned and a corporate witness from the Trust is required to attend to inform the Coroner of these lessons and what actions have been subsequently taken to prevent recurrence.

In Q2 four inquests were opened, which is broadly consistent with the pattern across the year. Datix shows that of these four, one had previously been reported as an incident and one investigated as a complaint.

In Q2 there were no inquests held relating to St Helens and Knowsley Teaching Hospitals NHS Trust.

6. Conclusion

In Q 2 2017-18, the number of incidents reported increased compared to Q1, however the number of moderate and severe harms fell. Complaints and PALS increased, and claims decreased. During this period there was a slight increase in activity undertaken by the Trust compared to Q1, which may in part have led to an increase in reported incidents,.

The primary causes for incidents, complaints and clinical negligence claims throughout Quarter 2 2017-18 were clinical, in comparison; the primary reason for PALS concerns

has been communication. However, complaints often include multiple reasons for a complaint and communication is often the secondary cause of complaint.

ENDS

TRUST BOARD

Paper No: NHST(18) 008
Subject: HR/Workforce Strategy & Workforce Indicators Report
Purpose: To provide assurance to the Board of the Trust's achievement of workforce indicators that supports the achievement of the Trust's Corporate Objectives specifically to developing organisation culture and supporting our workforce.
Summary: The Trust is committed to developing the organisational culture and supporting our workforce. This paper summarises achievements/progress to date.
Corporate Objective met or risk addressed: Developing organisation culture and supporting our workforce
Financial Implications: N/A
Stakeholders: Staff, Managers, Staff Side Colleagues and Patients
Recommendation(s): The Trust Board is requested to accept the report and to note the areas of achievement/progress against corporate objectives.
Presenting Director: Anne-Marie Stretch, Deputy CEO/Director of HR
Board date: 31st January 2018

HR/Workforce Strategy & Workforce Indicators Report

1.0 Purpose of the Paper

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

2.0 Recruitment & Retention

Like all other NHS organisations, the Trust faces workforce challenges relating to recruitment. National reports state that there are in excess of 87,964 advertised vacancy full-time equivalents within NHS England. Our specific Trust challenges reflect the national picture i.e. shortages in:

- Qualified nursing specifically general ward nursing
- Consultants in dermatology, radiology, histopathology, stroke, care of the elderly, acute medicine and emergency medicine.
- Doctors in training in paediatrics, obstetrics and gynaecology, general surgery and emergency medicine
- Biomedical scientists, specifically Blood sciences

The Trust currently has 57 band 5 ward vacancies.

The Trust is currently recruiting to 16 consultant vacancies (a number of which are covered by temporary staff).

Reasons for the shortages in qualified nursing stem from the implications of the Francis Report following the Mid Staffordshire NHS FT public inquiry, which prompted the debate and subsequent nurse to bed ratio for hospitals. Medical staff workforce planning is undertaken at national level and is notoriously difficult due to the length of time to train up to Consultant level and the continued sub specialisation of care.

The Trust has a Recruitment Strategy which includes the utilisation of international recruitment, the establishment of the Trust 'brand' via social media as an employer of choice, the optimisation of online and other media advertisement along with open days/ nursing campaigns to address the on-going national shortage of doctors, nurse and other staff. The HR and Nursing directorate are working collaboratively to explore the use of nurse associates, surgical first assistants and apprentice nurses.

The Trust continues to takes steps in progressing with the reservist agenda together with the Director of Transformation in the delivery of a bespoke recruitment campaign targeted at medical and nursing veterans resettling out of HM Armed Forces, to fill suitable existing gaps within the Trust. A Veterans Insight Day is scheduled for March 2018 following the Trust pledge to support the Step Into Health campaign.

A couple of specific medical staff success stories are:

By forging links with an English speaking overseas university the Trust (Brno University in the Czech Republic) has had great success in the last 2 years in recruiting up to 12 newly qualified doctors to undertake a two year contract with the Trust. Predominantly supporting medicine and surgery posts at Foundation year 1 and 2 level, this programme continues to support the Trust with the on-going national shortage of doctors, including gaps in Deanery training posts. The Trust will be recruiting again in Brno this year.

The Medical Training Initiative (MTI) is a mutually beneficial scheme run by each Royal College that provides non-training grade doctors from overseas with the opportunity to work and train in the UK. The scheme is underpinned by the Diploma in UK Medical Practice which all MTI candidates are expected to achieve. We have successfully recruited, using the MTI scheme and the British Association of Physicians of Indian Origin (BAPIO) training scheme, 3 senior fellows in paediatrics, 2 Specialty doctors in emergency medicine and 1 specialty doctor in radiology.

2.1 Overseas Nurse Recruitment

The problem of demand for qualified nursing far outstripping supply is well documented and covered comprehensively in the media with the UK supply pipeline being particularly inadequate. In 2017 Health Education England made the decision to introduce tuition fees for degree nursing programmes therefore opening a free market for whoever wished to train to be a nurse. Indications are that whilst the number of applications to nurse degree programmes have dropped, the number of applications still exceeds the places available on the courses. The duration of the degree nurse course is 3 years so the service will not see the outputs of this policy change until 2020.

Recognising the limitations to the UK supply, in August 2015 the Trust made 122 offers to qualified nurses in India. However, like many Trusts, the many hurdles faced by the Indian nurses themselves to secure registration on the NMC register and the UK immigration requirements, has resulted in only 15 of the 122 actually taking up employment in the Trust. A significant issue is the requirement to pass the International English Language Test System (IELTS). This has proven a significant barrier to Indian nurses being able to meet NMC language requirements. However, there is positive news. On the 1st November 2017 the NMC made changes to its language testing requirements. Nurses who qualified outside of the UK can now demonstrate language competence by passing the Occupational English Language Test (OET) as an alternative to IELTS. The OET is tailored to healthcare settings and is therefore considered more relevant.

In addition, nurses who qualified outside of the European Economic Area (EEA) do not need to complete a language test if they can provide evidence that they recently completed a pre-registration nursing qualification which taught and examined in English, or that they have registered and practised for a minimum of one year in a country where English is the first and native language and a successful pass in an English language test was required for registration.

The NMC is continuing to seek an understanding as to what other evidence it might accept as standalone evidence of language competence for overseas applicants. More details of this review should be made available at the next NMC Council meeting at the end of January 2018.

Global Learners Programme

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

The Trust has 51 candidates in progress via the Global Learners Programme who are expected to join the Trust throughout 2018. An attrition rate is expected due to a number of the learners failing to meet the immigration/NMC requirements or changing their mind about the programme. The Trust is working hard with every individual to guide them through the process.

Health Education England (North) have committed to providing the Trust with a further cohort of between 10-20 candidates bi-monthly who have already passed their International English Language Test System (IELTS), and are targeting candidates who meet the new NMC criteria across the world including the Caribbean and Africa. The Global Learners Programme has a visit to India and the Philippines planned for January 2018 to identify further potential recruits to the programme.

A pastoral care program is in place to support the internationally recruited nurses in a smooth transition to life in the UK and work in the NHS. This includes airport collection, settlement into accommodation, food hamper, a tour of the hospitals, local area, Liverpool City centre and arrangement of bank account, doctors and dentist. The feedback from the internationally recruited nurses regarding the support received from the Trust has been positive.

2.2 Retention

Given the recruitment challenges, particularly for qualified nurses and medical staff, it is absolutely critical that the Trust retains staff in these shortage groups. In December 2017 Ruth May, Executive Director of Nursing, NHS Improvement urged Trusts to ask three questions?

1. Do we know why our staff want to leave and why our staff leave?
2. What mechanisms do we have to engage and empower staff to drive their ideas forward?
3. How can we be sure that staff are aware of and can benefit from our retention initiative?

There are so many aspects to giving staff a good experience and this paper covers many of them. The key areas of focus need to be:

- Culture – being a positive and enjoyable place to work
- Feeling valued and recognised
- Consistent approach to flexible working
- Flexible retirement
- Education and training
- Reward and recognition
- Role rotational placements

- Continuous professional development opportunities
- Coaching and mentorship
- Being able to make changes/improvements
- Understanding their part in delivering the Trust's objectives

In light of the NHS Employer's guidance, the Trust's Recruitment and Retention Strategy will be reviewed.

Staff Friends and Family Test

On a quarterly basis the Trust is required to ask staff if they would recommend the Trust as a place to work. In October, the Trust received the results of its Quarter 2 Staff Friends and Family Test (SFFT), which was undertaken across the Surgical Care Group during September.

Although the overall response rate was low (10%), this is in line with Acute Trusts both locally and nationally. The results are however very positive, with 76% of respondents recommending the Trust as a place to work, making the Trust the best Acute Trust in Cheshire and Merseyside. This is well above the national average.
Compared to the previous year's results for the Surgical Care Group, there has been an increase in the percentage of staff recommending the Trust as a place to work. Up from 69% to 76%.

According to both 2016/2017 and 2017/2018 survey results, staff's overall attitude and the general work environment are the top reasons which recommend the Trust as a good place to work.

Staff Turnover Rates

Turnover rate is currently 10.98% for the period January 2017 to December 2017 compared to the national average of c.17%. The Acute sector average is 16.05% and across the North West this is 15.49%.

Staff Group	St Helens & Knowsley	Merseyside Trust A	Merseyside Trust B
Add Prof Scientific and Technic	**9.58%**	**11.64%**	**6.31%**
Additional Clinical Services	**8.91%**	**7.67%**	**9.03%**
Administrative and Clerical	**11.18%**	**10.60%**	**7.79%**
Allied Health Professionals	**11.87%**	**5.00%**	**7.92%**
Estates and Ancillary	**5.90%**	**4.58%**	**10.10%**
Healthcare Scientists	**8.58%**	**9.20%**	**8.41%**
Medical and Dental	**16.34%**	**12.21%**	**14.29%**
Nursing and Midwifery Registered	**12.05%**	**8.37%**	**12.85%**
Trust Total	10.98%	11.48%	12.76%

2.3 EU Citizens after Brexit

In December 2017 the Home Office wrote to all Trusts following the agreement at the European Council that EU citizens living lawfully in the UK before the UK's exit from the EU will be able to stay. The deal will respect the rights that individuals are exercising and the benefits they currently have. All EU citizens will need to apply to obtain settled status with this process commencing during the second half of 2018 and will remain open for at least two years after the UK leaves the EU. Whilst the Trust only employs a small number of staff affected (197) we will be writing to them to keep them informed of the developments.

3.0 Temporary Staffing

As a consequence of the on-going workforce challenge there is the continuing need to fill posts on a temporary basis by using bank, agency and/or locum workers. Whilst vacancies are not the only reason for this usage, they do remain the principle reason for usage and as such there is a premium financial cost for the use of agency staff. The Trust's agency expenditure is detailed in the Finance Report and reported regularly to several key Trust Committees and Trust Board. The Trust has an agency cap set by NHSI of £7.2m for 17/18. The Trust's planned spend is £9.3m and year to date spend is £6.89m. The Trust continues, as per NHSI rules, to report agency spend; fill rate and framework compliance to the NHSI on a weekly basis. A monthly report is discussed at the Executive Committee and a Premium Payments Scrutiny Council has been established to review all premium payments including agency, overtime and additional activity costs. Scrutiny is given to the volume of agency usage but also the hourly/commission rate to ensure the Trust is getting the best value for money.

As an alternative to costly agency staff, the recruitment campaigns for healthcare assistants and qualified nurses to join the Trust Nurse Bank are on-going. The most recent Bank healthcare assistant advert received 200 applications, and interviews have been conducted in January 2018. In addition, a bank recruitment campaign targeting internal staff had over 100 employees join in the first two weeks of its go live, 52 qualified nurses, 9 medical staff and 32 healthcare assistants. There have been further successes with the growth of our social media presence making use of Facebook groups and plans are underway to roll out a STHK recruitment Twitter account to further engage with our temporary workforce.

3.1 Collaborative Bank Project

Building on the need to avoid costly agency spend, the collaborative bank project development seeks to support the optimisation of workforce capacity across Trusts within Cheshire & Merseyside through having one bank of staff who can move easily between Trusts.

The project aims to have tested the proposed system by the end of the financial year. In addition to the work required on rostering systems, other workstreams include the alignment of temporary staffing pay rates. An event is taking place on 29th January 2018 for all Directors of Finance, Nursing, Human Resources and Medical Directors to explore this further.

The Trust is host to the Cheshire & Merseyside Collaborative Bank project which has been established to enable the efficient sharing of high quality bank staff across organisations

within Cheshire & Merseyside, decrease spend on agency staff and support the improvement of quality of care and experience for patients. NHS Improvement have set targets for all Trusts to establish medical banks and develop collaborative banks by the end of the financial year.

3.2 Workforce Streamlining

The Trust is actively engaging with the Workforce Streamlining North West programme. The programme supports the delivery of Carter at Scale within HR services through the removal of unwarranted variation and duplication in workforce processes and improving productivity and efficiency.

The programme is now in year two of a three year programme and this year Trusts across Cheshire and Merseyside are working together to develop efficiencies in recruitment processes, aligning mandatory training requirements in order to avoid unnecessary repetition, duplication and lost time on transfers and recruitment of staff and Occupational Health processes in order to improve the time taken to recruit and decrease costs of duplicated health checks across organisations.

4.0 Health Roster (E-Rostering)

Given the workforce challenges it is imperative that our human resources are utilised as efficiently as possible. Health Roster Nursing is the most commonly used e-rostering system in the NHS. The electronic system aids to automate roster creation by integrating with our payroll and temporary workforce systems. Implementation of the system is on-going and there are now 74 clinical areas live with Health Roster across the Trust. The Trust is working towards full implementation across Clinical Support Services and Administration and Clerical areas in 2017/18. The Trust is on target to deliver all junior doctor and non-training grade medical workforce implementation by summer 2018. The Trust has also used this system for the Consultant workforce to record their annual leave and study leave; this was implemented in December 2017. The effective use of e-rostering is monitored against 5 national key performance indicators. The most recent data shows that the Trust compares favourably nationally with e rostering performance. Further work is needed to meet the 8 week notice of rotas being issued (currently at 7.3 weeks).

4.1 E-Rota

E-rota is the medics part of the Allocate Health roster has been used since August 2016 to test compliance of junior doctor rotas under both the 2002 and 2016 contracts, and to calculate the pay elements for those on the 2016 contract. E-rota also provides the exception reporting functionality for doctors on the 2016 contract. The Trust successfully implemented the software for junior doctors in GP practices/ Public Health in order for them to be able to raise exception reports in August 2017.

5.0 Improving the Health and Well Being of our Workforce

Part of our retention strategy includes ensuring that our staff are looked after from a health perspective. Throughout 2017/18 there have been a number of Well Being activities to encourage staff to improve their well-being. In September there was the annual HWWB Open Day, the footfall for this event was around 600 staff from all over the Trust, similar events took place at both St Helens and Alex Park. Staff were made aware of Health Work and Well Being provision, areas such as stress and back care were targeted. During the

summer months there were skin safety events. The Know Your Numbers Campaign whereby staff were offered a free blood pressure check was well attended. The Trust took part in the NHS Games and were runners up in both the netball and rounder's competitions. Staff at both St Helens and Knowsley and Southport and Ormskirk supported National Nurses Day.

5.1 Flu Vaccination programme

The flu vaccination programme was launched on 29th September 2017 at the Health Work and Well Being Open Day. The national CQUIN target is for 75% of front line staff to be vaccinated. In October 2017 NHSI recommended that staff need to be offered a flu vaccine. The Trust has achieved this via pay slips, staff have also been asked to complete a form indicating that the current position for STHK is 86.2% which compares favourably with local and national rates. There has been recent media coverage calling for mandatory flu vaccination for front line staff and the Trust will continue to monitor any further guidance on this point.

5.2 Safe Efficient Quality Occupational Health Service (SEQOHS)

The five year re-accreditation for SEQOHS took place on 24th January 2018 and we were successfully reaccredited. SEQOHS is an integral part of the Health Work and Well Being Service which ensures that standards are being maintained. Two external assessors attended HWWB for a full day to audit the Service. Evidence of the SEQOHS standards had already been uploaded via the web tool and submitted for them to assess. The information from the standards includes; Business Probity, Information Governance, People, Facilities and Equipment, Relationships with Purchasers and Relationships with Workers. It will take approximately a month to receive formal confirmation that the re-accreditation has been successful.

5.3 Service Level Agreements (SLAs)

Due to the increase in the demands from Lead Employer within Health Work and Well Being, SLAs have been set up to carry out duties due to the geographical spread of trainees. A Hub and spoke model has been established with St Helens and Knowsley being the hub. In West Midlands there are four spokes, in East of England three and East Midlands two. There was a meeting in Nottingham in November to look at pathways for trainees focussing on Pre-Employment and Management Referrals.

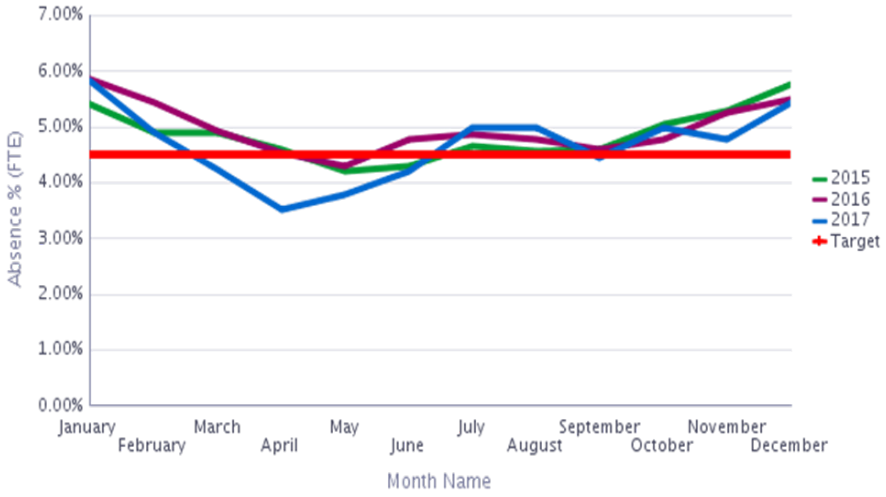
6.0 Attendance Management

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

The benchmarking data below shows that the Trust's sickness absence for the period January to December 2017, the Trust being fairly consistent with two similar organisations within Cheshire and Merseyside. The North West sickness absence is 4.7% and Acute sector average is 4.4% The top reasons for absence remain consistent across the NHS i.e. stress, musculoskeletal, colds and flu.

Benchmarking of Cumulative Absence January 2017 to December 2017			
Staff Group	**St Helens and Knowsley**	**Merseyside Trust A**	**Merseyside Trust B**
Add Prof Scientific and Technic	4.32%	4.44%	3.93%
Additional Clinical Services	7.09%	7.12%	6.96%
Administrative and Clerical	3.85%	3.82%	4.30%
Allied Health Professionals	2.71%	2.89%	2.74%
Estates and Ancillary	7.20%	10.69%	8.00%
Healthcare Scientists	2.68%	2.76%	3.88%
Medical and Dental	1.31%	1.87%	1.03%
Nursing and Midwifery Registered	4.76%	5.62%	5.31%
Trust Total	**4.68%**	**5.08%**	**4.65%**

Trust Trend Summary



	2015	2016	2017
January	5.40%	5.85%	5.83%
February	4.91%	5.45%	4.90%
March	4.90%	4.94%	4.23%
April	4.59%	4.55%	3.51%
May	4.21%	4.30%	3.78%
June	4.30%	4.79%	4.19%
July	4.67%	4.87%	4.95%
August	4.55%	4.79%	4.95%
September	4.59%	4.61%	4.46%
October	5.05%	4.77%	4.98%
November	5.29%	5.27%	4.78%
December	5.77%	5.50%	5.42%

The Trust had a good start to the new financial year with regards to absence. However the expected increase in the winter months has occurred but 2017 is an improved position on previous years. The Absence Support Team continues to be a value asset to the Trust by supporting managers with their application of the policy and ensuring the procedure and toolkit are adhered to. This includes ward audits regarding compliance with the policy and on-going training for managers.

6.1 Application of the Attendance Management Policy

The Attendance management policy distinguishes between those staff who have an underlying medical condition (levels) and those who do not (stages). If staff hit a series of 'triggers' relating to absence then their contract of employment can be terminated. This usually occurs at level 3 but the policy does allow for further targets for improvement if required.

There are currently 557 individuals on various 'Stages' of the Attendance Management procedure, this type of short-term absence refers to situations when a person is absent from work on a frequent basis where there is no single underlying medical reason connecting sickness absences and have hit one of the 'triggers' as laid down in the policy. There are four stages in total, three being potential dismissal and four being appeal. There are 316 employees currently on various 'Levels' of the policy. This process is used to managed individuals who are absent due to an underlying medical condition confirmed by HWWB that causes an unacceptable level of attendance. There are four levels, three being potential dismissal and four being appeal.

7.0 Organisational Change Workforce Transformation & Change Update

The HR Advisory Team continue to support and manage a wide range of organisational change and workforce transformation projects involving multi-disciplinary services across the Trust. A number of which are in response to the Trust being successful in tendering for numerous services, particularly in Community i.e. Tissue Viability, CCP Nurses and Marshall's Cross Medical Practice. Internal organisational change programmes for Medical Care include, anti-coagulation and stroke nurse specialist restructure, diabetes nurse specialist on-call consultation, therapy 7 day working redesign, and Phase 2 of the Stroke ward conversion continues. In Surgical Care, the Community and Vulnerability Midwifery review is underway and plans for the introduction of a maternity led unit continue.
The Trust also continues to consult with Orthodontic staff in relation to the closure of St Helens Orthodontic Service at the end of this financial year. The Theatre recovery consultation continues regarding the on-call out of hours rota. In January 2017, it was announced that the national rollout of HPV (virology test) as the primary screen in place of cytology screening is scheduled to be implemented in the NHS cervical screening programme by April 2019. The changes to service delivery for cervical cytology at the Trust will reduce the screening workload by approximately 80%. The team will be required to continue delivering a quality cervical screening service for the next eighteen months as a minimum. The Trust continues to consult with the affected staff together with staff side colleagues. Staff have been consulted with since this announcement and are deemed "At Risk" and will be managed in accordance with the organisational change policy. Histopathology TUPE into the Trust involving one Consultant is near conclusion and the Payroll department are midway into their restructure. Consultation and recruitment continues across a number of management structures to ensure the Trust is able to be responsive to external demands and strategic priorities.

8.0 Employee Relations

The HR Advisory Team facilitate the management employee relations cases across the care groups for all staff groups. There are increasing cases involving external agencies such as safeguarding and police resulting in lengthy and complex investigations and regional union representative involvement. The team are currently managing a wide range of employee relations cases, including investigation, grievances and mediation. .

	Investigations (including fast track)	Disciplinary meetings planned	Grievances	Mediations	Capability	Suspension/ASOS	Tribunals
Total	**28**	**4**	**3**	**8**	**11**	**8**	**Nil**

9.0 Equality, Diversity & Inclusion

The Trust continues to make progress with the Equality Delivery System (EDS2) and the Workforce Race Equality Standard (WRES) for 2017/18. These are national documents promoting the equality, diversity and inclusion agenda. Action requires involvement from essential stakeholder groups such as the Equality & Diversity Steering Group, noting that the Trust is required to demonstrate continuous improvement in closing the gaps in experience and opportunity between our White and BME workforce. An external Equality and Diversity expert will be supporting the Trust in formulating the 2017/18 action plan and will also review our current Equality & Diversity workforce agenda thus ensuring our action plan reflects best practice. The action plan will be shared at Trust Board in the forthcoming months.

NHS England and NHS Equality and Diversity Council continue to consult and engage with NHS Organisations regarding the new Workforce Disability Equality Standard (WDES). It is proposed the WDES is mandated from April 2018. The Trust will be consulting with key stakeholders in preparing our 2018/19 action plan.

In addition to the WRES, the WDES is a set of specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used by the relevant organisations to develop a local action plan, and enable them to demonstrate progress against the indicators of disability equality. Like the WRES, on which the WDES is in part modelled, it will also allow us to identify good practice and compare performance regionally and by type of Trust. The first WDES reports will be published in August 2019 based on 2018/19 financial year.

10.0 Workforce Planning & Information Team

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

10.1 Workforce Planning – Staff in Post

Since April 2017, the figure for staff in post increased overall by 118.48 wte. Increases in Nursing & Midwery staff account for the 3.74 wte of the increase. There are currently c.87.04 wte of staff currently on maternity leave.

Whole Time Equivalent by Staff Groups	Month		
Staff Group	Apr-17	Dec-17	Difference
Add Prof Scientific and Technic	152.29	168.59	16.31
Additional Clinical Services	959.73	953.59	-6.14
Administrative and Clerical	996.36	1,064.94	68.58
Allied Health Professionals	234.80	249.58	14.78
Estates and Ancillary	292.74	298.21	5.47
Healthcare Scientists	186.18	182.81	-3.37
Medical and Dental	400.09	419.20	19.11
Nursing and Midwifery Registered	1,397.73	1,401.46	3.74
Grand Total	**4619.898**	**4738.377**	**118.48**

10.2 Retirement Age

Given the workforce challenges it is imperitive that the Trust can offer flexibility to those staff who wish to retire. The retire and return option offered under the NHS Pension Scheme is proving popular. The table below shows the numbers of staff who could retire. The number of qualified nurses who could potentially retire is of concern and discussions regarding flexible retirement options are encouraged, as is the promotion of the various NHS Pension Scheme options.

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

11.0 Developing our Workforce

11.1 Mandatory Training and Risk Management.

The Trust has been leading on the Training Streamlining Programme for the Cheshire & Mersey region and has been reviewing its current provision for both Mandatory Training and Induction of new staff. The aim of the programme is to align training requirements across the region and to reduce the time committed to face to face training and repetition of unnecessary training on entry into the organisation. Under this Programme and subject

to nationally agreed refresher periods for NHS Core Skills Framework subjects, the Trust refresher periods will be amended for the Core Skills Subjects to align with the national refresher periods and partner NHS organisations in the Northwest Region. This will mean a shift to 36 months for most subjects.

Following a national upgrade to the ESR portal on 17th July 2017, continuing problems with the revised e-learning platform are being experienced by existing Trust users and other users nationally. These are impacting on the effective Trust-wide roll out of e-learning solutions via Trust technology and personal devices. The issue relates to an ESR system specification requirement that is currently being investigated by the Workforce Planning and IT team, with a resolution expected to allow the Trust to carry out a structured pilot of the system in February, prior to a roll out to all staff groups during March.

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

11.2 Appraisal Training

Appraisal compliance has improved dramatically following collaboration between the Workforce Planning (ESR) Team, Education, Training & Development Team and Service Managers. This focussed piece of work has resulted in compliance which is at the 85% target. Compliance will continue to be closely monitored to ensure levels are maintained. November 2017 brought the introduction of the new Appraisal e-form for use by staff in Agenda for Change Bands 1-9. The Appraisal e-form has been developed to encourage quality conversations that are meaningful, relevant and valuable. Enabling staff to be the best they can be when fulfilling their roles. Feedback from managers using the new e-form is extremely positive and is considered to be both reducing the time taken to complete an appraisal and ensuring a more robust, structured approach. The Education, Training and Development Team, are providing on-going support to Appraisers and Managers with the Trust, through the new management development module `Appraisal Refresher`. During the reporting period, 47 attended the management development module 'Facilitating High Quality Appraisal and Career Development Conversations'. In the same period 3 attended the new management development module `Appraisal Refresher`.

11.3 Apprenticeships Status in December 2017

Effective use of the Apprenticeship Levy remains a high priority for the Education, Training and Development Team. Working with Service Managers and colleagues in the Corporate Nursing Team, the Apprenticeship Coordinator is liaising with a range of providers including universities to develop opportunities for staff to meet service development and Continuing Professional Development needs.

Following the removal of HEE funding for Biomedical Science Degrees, in collaboration with Liverpool John Moores University, the team have been able to transfer 9 Biomedical Scientists onto the Healthcare Science Practitioner Degree Apprenticeship to ensure continuation of studies.

Following the launch of the initial cohort of 3 Assistant Practitioners onto the Nurse Degree Apprenticeship with the Open University in September 2017, additional cohorts are now planned to commence in February and March 2018 with Edge Hill University. These Cohorts of 17 learners in total will comprise a mix of Assistant Practitioners and HCAs. A robust selection process will be undertaken in March 2018 jointly by the Nursing

Directorate and University to select the learners for these 2 cohorts and this will commit £459,000 of the Trust Levy. Further cohorts are planned to address the shortfall in qualified nurses and will be the subject of a future business case to the Trust Executive Committee.

Functional skills are fully funded and a pre-requisite of Apprenticeship registration. If a member of staff does not already hold qualifications in Maths and English, the Trust is able to support them to meet this requirement to hold GCSE Level Maths and English at Grade C or above. For those staff not holding this qualification we are offering the equivalent Functional Skills at Level 2. These programmes in Maths, English and ICT are delivered on site and are free at the point of access for our staff.

28 members of staff are continuing to complete apprenticeships through the pre-levy apprenticeship frameworks. 54 members of staff are registered to complete apprenticeships. A further 23 expressions of interest have been received and are awaiting approval by the Trust's Executive Committee. This is to ensure that support for apprenticeships are targeted to areas of need.

12.0 Organisational Development - Cultural Surveys

Education, Training & Development are continuing to support and administer cultural and 'pulse' surveys across a number of operational services. Cultural surveys provide a comprehensive picture of the culture within a service and provide detailed information used to establish appropriate interventions, such as focus groups, individual/ team coaching, HR interventions and service redesign to address any issues that are highlighted. Cultural Surveys are a key tool in the Organisational Development planning process

In the reporting period, cultural surveys have taken place within Maternity and Frailty, with arrangements to provide feedback confirmed shortly. An additional cultural survey has been launched targeting the medical workforce (non-training grades) within the Medical Care Group

Pulse Surveys are used to measure the impact of any planned interventions following a full cultural survey. These are much shorter surveys comprising of just a few key questions designed to identify where progress is being made and where further work may be necessary.

13.0 Leadership Coaching

The Trust continues to support a coaching culture through the delivery of a rolling coaching programme to c.40 leaders within the Trust at Bands 8b and above. As part of the development programme, all managers at Bands 8b and above are assigned an experienced coach to support them in effectively developing and managing their teams and service

14.0 Core Management & Leadership Development

The Education, Training & Development Team deliver a range of internal Management & Leadership Development modules to ensure our managers have the necessary skills and knowledge to effectively deliver their roles. The current modules comprise of the following:

- Effective Management Practice
- Person Centred Communication
- Effective Team Working
- Facilitating High Quality Appraisal and Career Development Conversations
- Coaching Skills
- Appraisal Refresher

The modules are offered, both as a "stand-alone" option, or as an end to end programme dependant on the needs of the individual. During the reporting period, 96 managers attended one or more of the modules. Feedback from attendees is positive with many saying the programme has improved the way they deliver their role.

Development opportunities for senior managers and clinicians are accessed through the NHS Leadership Academy, with recent nominations to the 'Nye Bevan', 'stepping up' and 'Ready Now' programmes.

15.0 Payroll Services

STHK Payroll Services currently process circa 40,000 payslips a month to 25 monthly payroll clients and 3 weekly clients across Cheshire and Merseyside, East of England, West Midlands and East Midlands. The Payroll service catalogue includes end to end payroll processing, pensions, expenses and salary sacrifice.

From 1st February 2018, payroll services will also be provided to Mersey Care NHS Foundation Trust, with an increase of circa 6,500 payslips per month.

Recent key achievements have included:

- The full implementation of e-expenses for the Trust and Lead Employer Trainees
- Phased implementation of ESR Employee Self-Service including e-payslips to the Trust
- The full implementation of ESR Employee Self-Service including e-payslips for Lead Employer Trainees
- The full implementation of auto enrolment for the Trust and all clients
- The implementation of a weekly payroll to support the Trust's aim of reducing agency spend
- The increase of number of payslips processed
- Significant assurance from MIAA audits

16.0 Lead Employer Arrangements

The Trust is now the Lead Employer to c 5,300 junior doctors in training. In July 2017 the Lead Employer service was also commissioned by Health Education England (HEE) to deliver a HR Advisory telephone service until March 2018 to GP Practices in the Humber and Yorkshire region where lead employer arrangements do not currently exist, to support the implementation of the new 2016 Junior Doctors contract. The Trust is

expecting the contracts will be extended until HEE decide what model they wish to have in the future and for any procurement process to be followed.

NHS Employers have asked the Trust to host a newly formed Guardians of Safe Working Network for the North West.

Health Education North West advised the Trust in December 2017 that they will cease to fund the lead employer arrangements in the North West. Consultation with all Trusts in the North West has been undertaken with the continuation of the lead employer model being the favoured option. Host organisations will need to fund the model going forward and it is likely that a procurement exercise to identify lead employer(s) will take place during the next 3 months. Lead employer arrangements for GP trainees remain unchanged.

17.0 HR Governance

HR Governance is an internal oversight of the management of workforce and employment related risks ensuring that they are effectively managed to enable the delivery of the workforce strategy. The HR Governance Steering Group has been developed to provide assurance to Workforce Council that governance is managed within the Directorate and also to give assurance regarding the HR Directorate's readiness for the proposed new General Data Protection Regulation (GDPR) and the management of contracted services.

18.0 Recommendations

The Trust Board is requested to accept the report, noting the areas of achievement/progress against corporate objectives.

Anne-Marie Stretch
Deputy Chief Executive and Director of HR
January 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18) 009
Title of paper: Learning from deaths update and reporting
Purpose: To provide assurance to the board that the Trust is seeking to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.
Summary: The paper details the data to Q3 on deaths, including the method for sharing and learning, in accordance with the Learning from Deaths Policy.
Corporate objectives met or risks addressed: To deliver safe care
Financial implications: None as a direct consequence of this paper.
Stakeholders: Patients, the public, patient representatives, commissioners, regulators
Recommendation(s): 1. The board is asssured that the Trust can respond appropriately and learn lessons from unexpected deaths.
Presenting officer: Professor Kevin Hardy, Medical Director
Date of meeting: 31st January 2018

STHK Learning From Deaths Board Report

	Deaths in Scope [1]	Specified Groups									
		LD Deaths	SMI Deaths [2]	Child Deaths	Neonatal Deaths & Stillbirths	Maternal Deaths	CQC Alert Deaths	Diagnosis Group [3] Deaths	SIRI Deaths	Concern [4] Deaths	**Total [5]**
Apr-17	121	0	1	0	3	0	0	10	0	3	**17**
May-17	133	1	0	0	3	0	0	11	1	2	**17**
Jun-17	132	0	0	0	2	0	0	9	1	0	**12**
Jul-17	143	1	1	0	0	0	0	12	1	1	**16**
Aug-17	130	2	2	0	2	0	0	8	0	1	**14**
Sep-17	150	1	3	0	5	0	0	11	1	1	**22**
Total	**809**	**5**	**7**	**0**	**15**	**0**	**0**	**61**	**4**	**8**	**98**

	Specified groups			Non Specified Deaths Sample % Reviewed
	Total [5]	Reviewed	% Reviewed	
Apr-17	17	17	100.0%	28.8%
May-17	17	17	100.0%	31.9%
Jun-17	12	12	100.0%	26.7%
Jul-17	16	16	100.0%	26.8%
Aug-17	14	14	100.0%	31.9%
Sep-17	22	21	95.5%	18.0%
Total	**98**	**97**	**99.0%**	**27.1%**

	% of deaths		
	where no concerns	where significant doubt about whether or not, problems in care delivery/service provision contributed to death – refer to multi professional review	where balance of probability is that death may have resulted from problems in care delivery/service provision - refer to SIRI Investigation
Apr-17	97.6%	2.4%	0.0%
May-17	85.4%	14.6%	0.0%
Jun-17	97.6%	2.4%	0.0%
Jul-17	84.8%	13.0%	2.2%
Aug-17	88.9%	11.1%	0.0%
Sep-17	93.9%	6.1%	0.0%
Total	**91.0%**	**8.6%**	**0.4%**

[1] This includes all inpatient deaths at STHK and all stillbirths. If a patient was transferred and died at another provider then they are out of the scope of this data - even if the cause of death relates to care at STHK.

[2] For the purpose of this report SMI is defined as DOLs or patients under the Mental Health Act during the spell

[3] Diagnosis groups under internal monitoring

[4] Any death associated with a complaint, PALs or an expression of concern by a member of staff

[5] If a patient is attributed to more than one specified group, the Total will only count each patient once

Learning & Sharing 2017/Q1 & Q2

2017/Q2 Key Priorities

(1) Monitor (check, action, repeat) blood gases in COPD

(2) If you can't get IV access, escalate to a senior immediately

Assurance

Sharing: (Current Q-1) Board (mins) ☐, Quality Committee (mins) ☐, F&P (mins) ☐, CEC (mins) ☐, PSC (mins) ☐, PEC (mins) ☐, MCG Governance (mins) ☐, SCG Governance (mins) ☐, Grand Rounds (mins) ☐, ED Teaching (record) ☐, FY Teaching (record) ☐, Team Brief (record) ☐, Intranet Message Board (record) ☐, Global Email (record) ☐, Directorate meetings (mins) ☐. List any policies/procedures or guidelines changed:

_____

_____

Effectiveness: (Current Q-2) Audit of DATIX ☐, SIRIs ☐, Complaints ☐, PALS ☐, Litigation ☐, Mortality Reviews for evidence of failure to deliver these priorities ☐.

Comments:

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(18) 010
Title of paper: One Halton - Partnership (Vision, MOU, TOR)
Purpose: To present the proposals to create a One Halton Partnership and seek the Boards formal approval of the Trust's membership.
Summary: 1. One Halton is seeking closer partnership working of all providers and commissioners within the borough, in order to improve the resident/patient experience and ensure appropriate use of resources. 2. A vision document, Memorandum of Understanding and Terms of Reference have been produced by One Halton (appendices 1,2 & 3) to set out the principles of new ways of working by all member organisations. These documents are attached and the Boards/Governing Bodies of all the proposed member organisations are being requested to formally endorse these. 3. One Halton Partnership recognises that, at this stage, although there is a new governance structure being formed to deliver the aspirations of the One Halton vision, these cannot replace the statutory accountabilities of the individual partner organisations. One Halton Partnership Board will seek to make recommendations to be adopted or endorsed by each partner organisation.
Corporate objective met or risk addressed: To work in partnership to improve health outcomes
Financial implications: None as a direct consequence of this paper
Stakeholders: Halton borough residents, Halton CCG, Halton Council, C&M Health and Social Care Partnership, Regulators.
Recommendation(s): It is recommended that the Trust Board; 1. Endorse the vision, MOU and TOR documents for the One Halton Partnership 2. Approve the participation of the Trust participating as a member of the Partnership Board.
Presenting officer: Tiffany Hemming, Director of Transformation
Meeting date: 31st January 2018

NHS
Halton
Clinical Commissioning Group

One Halton Accountable Care Strategic Vision

One System, One Plan, One Halton

Version 9.1 LTG (November 2017)

Contents

Background and Introduction

The Health and Social Care Act 2012 placed a statutory duty on the NHS and local authorities to promote and enable integrated care, further reinforced by the Care Act 2014. A raft of policy initiatives and incentives have been implemented to support greater integration and partnerships including the Better Care Fund, a national pioneer programme and, most recently, actions to support the vision for the NHS in England described in the Five Year Forward View. The new care models proposed in the Five Year Forward View are particularly aimed at overcoming barriers between hospital and community services. They are aligned with the wider policy direction of organising care in the community around the needs of service users, shifting the focus from episodic and acute care to whole life care, expanding preventative support that encourages "self-care", independence and wellbeing.

In 2014/15 Halton as a borough started its journey towards an integrated model of care with a shared vison across health and social care.

Our Strategic Vision

To improve the general health and wellbeing of the people of Halton, working together to provide the right level of treatment close to home, so that everyone in the borough can live longer, healthier and happier lives.

We are building from the strong legacy and foundation of **One System, One Plan, One Halton**.

Our **values** are based on strong partnerships; Collaboration (engagement & participation), System leadership (values based approach) Strong relationships, shared goals and an agreed set of outcomes.

Ultimate responsibility for the implementation of One Halton lies with the Halton Health & Wellbeing Board, however, in order to deliver our vision and priorities we need everyone who lives and works in Halton to take an active role. We are passionate about improving the health and wellbeing of people living in Halton. Local residents, statutory, voluntary, community and commercial organisations all have an important role to play in achieving this goal.

The One Halton Health and Wellbeing Strategy sets the framework for the commissioning of health and wellbeing services in Halton with a particular emphasis on “self-care” prevention and early intervention. It does not replace existing strategies, commissioning plans and programmes, but influences them.

Integration is key to our strategic approach with all partners working together to deliver:

joint commissioning, culture change through community development, training for all staff in how to deliver health messages so every contact counts, development of multi-disciplinary teams and joint advocacy and policy work.

A governance structure for One Halton will oversee the development and delivery of our priorities. Specific groups will be responsible for the development of an action plan setting out what all stakeholders will do to deliver the outcomes we want. They will use a life course approach and ensure each action plan includes action to maximise "self-care" prevention and early intervention, provide high quality treatment and care based on need close to home where this is possible and supports people in both the short and long term.

Transformation

Partners across Halton are developing new models of integrated working, based around the two towns of Runcorn & Widnes .These two towns will for this document be referred to as ***Service Delivery Footprints (SDFs).***

The SDFs are effectively a “functional geography” that can help us better plan and deliver our local services. SDF footprints are natural communities that are big enough to base services on but small enough to be sensitive to the populations needs. This work builds on the successful early implementation of hubs either side of the river, with integrated community services such as community nursing, social care in practice, wellbeing practitioners and the development of a single operating model.

Our ambition is for these SDFs to connect a number of services including community health services, GP surgeries, adult social care, housing, schools, children’s services and others. This is about creating integrated working that takes joint responsibility, working with residents, using new conversations, scaling our early intervention work to prevent reactive and unplanned cost, and knowing the assets of the community. services will work together in multi-disciplinary teams to offer early intervention and, if necessary, intensive support to families and individuals who are dealing with issues including mental health; debt; drug and alcohol misuse; domestic abuse; worklessness and long term health conditions.

Some of the potential wider integration could incorporate (but not exclusively):

- Integrated Community Services (including Community Nursing, Therapies and Adult Social Care)
- Primary care out of hospital services (Extended access/Out of hours)
- Mental Health
- Public Health Based Interventions
- Wellbeing
- Health Improvement teams
- Start Well, Live Well, Age Well
- Primary School Alignment
- Housing
- CCG Primary Care Commissioning and Improvement Capacity
- Consultant Outpatient Transitions (Tiers 3 & 4)
- Early Intervention and Prevention Services
- Improving Healthy Lifestyles
- National Probation Service
- Cheshire Fire and Rescue Services
- Alcohol and Drug Treatment Services
- Community Link Workers
- Children's centres
- Nursing and Residential Care
- Admiral (Dementia) nurses


PHARMACY

Design principles and objectives

We will;

- Manage demand for services by promoting self-care independence and prevention;
- Enable health and social care service integration wherever possible and appropriate;
- Design services around users and not organisations;
- Incentivise providers to work together to meet the needs of the whole person;
- Treat people in the home and community for as long as it is appropriate and possible;
- Reduce dependence on oversubscribed and expensive specialist resources such as emergency services, non-elective admissions and care homes;
- Manage length of stay in hospitals, avoid delays to discharge and prevent readmissions where possible;
- Allow system efficiencies to be realised – duplication and over supply is eliminated while "cost shift" from one service line or organisation to another is avoided;
- Create the climate for staff from different professional backgrounds to work together in a positive, open and trusting multi-disciplinary climate;
- Allow every member of staff to be trained in having new conversations with residents that focus on assets rather than need; and
- Make full use of digital technology, including development of a joined-up electronic record

An asset based approach is at the heart of One Halton, enabling staff to have a different conversation with patients and residents to promote self-care and independence and improved links to positive opportunities within the community to improve health and wellbeing.

Scope

NHS Halton Clinical Commissioning Group (HCCG), Halton Borough Council, Bridgewater Community Healthcare NHS Foundation Trust, North West Boroughs Healthcare NHS Foundation Trust, St Helens and Knowsley Teaching Hospitals NHS Trust, Warrington & Halton Hospital NHS Foundation Trust (WHHFT) and local GP federations have come together to develop a One Halton Accountable Care System model for Halton.

In the **first instance** the model will be formed around 2 GP service delivery footprints (SDFs) across Runcorn and Widnes and the integration of health and social care services.

In the **medium to long term** there is an ambition to extend this to integrate with public health and a wider set of public, voluntary and community services, such as leisure, housing and others.

In the **long term** there will be a badgeless provision of services with integration across organisational boundaries, increased investment in community based services and a sustainable primary care.

The approach is place based, based on SDFs using registered GP lists and a whole population budget to deliver a range of services against an agreed set of outcomes.

The scope of the One Halton Programme is to develop the vehicle to support both commissioner and provider integration to deliver a set of improvement outcomes delivering health and social care services across a whole population.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Goals

Through this process we will deliver a set of key goals for the health and wellbeing system in Halton;

Goal 1

Services should enable people to take more responsibility for their own health and wellbeing

Goal 2

People should stay well in their own homes and communities as far as possible

Goal 3

When complex care is required it should be timely and appropriate

Prioritisation

It is our desire to change or 'transform' health and social care to make sure the people of Halton get the right care and support, the right way, when and where they need it.

To help us achieve this, we've identified the six themes prioritised within our **One Halton Health & Wellbeing Strategy**:

Our priorities for 2017-2022:

1. **Children and Young People**: improved levels of early child development
2. **Generally Well**: increased levels of physical activity, healthy eating and reduction in harm from alcohol
3. **Long-term Conditions**: reduction in levels of heart disease and stroke
4. **Mental Health**: improved prevention, early detection and treatment
5. **Cancer**: reduced level of premature death
6. **Older People**: improved quality of life

Our priorities contribute to our shared outcomes:

- More Halton children do well at school by reaching a good level of development educationally, socially and emotionally
- Healthy fit workforce to drive economic prosperity with fewer people suffering long term conditions from the age of 50
- More people will be supported to stay well and live independently for as long as possible
- People lead full, active lives using a wide range of facilities within local communities including good quality housing, parks, arts and cultural facilities, leisure services and safe cycling routes
- Reduced demand on services, improved quality and access
- More efficient use of financial resources

Our Commitments

Through signing up to deliver this One Halton Accountable Care Vision we are jointly:

- Taking ownership of where we are now. We all recognise progress has been made but that there is more work to do
- Being responsible for delivering on the agreed priorities and actions set out within our plans
- Making a commitment to make things better. For us to be successful all partners in Halton need to play their part including our local people
- Being accountable for developing systems that deliver more joined up approaches to delivering services

Strong leadership

Leadership is critical in the context of developing integrated systems and services. Stakeholders have different agendas and levels of understanding. A locally tailored leadership programme, supported by management is an essential component of One Halton.

Through our leadership we will talk to staff, ensure they understand the change and are motivated to change at both a strategic level and operational level. We are committed to work across all agencies with all staff and our population to collaboratively transform services for the future.

Integrated Strategic Commissioning

There is recognition that there are constraints that apply nationally and limit the flexibility in relation to local commissioning arrangements. Commissioning arrangements sit within NHS Halton ~~CCG~~ and Halton Borough Council. We will embrace learning from areas that have progressed in this area and take the opportunities that have arisen.

We will commit to and where permitted to, develop an integrated strategic commissioning function that will develop an alliance contracting model in line with our vision of “one system, one budget, one plan”.

Provider Partnerships (Alliance)

Providers are often constrained by contractual, legal and statutory constraints. Providers will need to work together to identify and agree who is best placed to deliver the best treatment and care for our population. They will need to agree a set of working principles that align with the national and local agendas.

Financial Resilience

Development and implementation of the detailed proposals will need to be completed from within existing expertise within partner organisations supported by the One Halton Programme Board.

In order to commission integrated services NHS Halton ~~CCG~~ and Halton Borough Council will be responsible for the commissioning budget allocation and the alignment of this to any decisions on pooling financial budgets. Proposals for pooled budgets will need to take into account that “health population” is funded by GP registered lists and LA funding by geographical population.

Partners will need to ensure any future integrated arrangements have robust financial accountability and governance. Estimates of the financial benefits of integration are constrained by the limited nature of the current evidence base.

Co-Located Service Provision (where appropriate)

Providers and commissioners will need to work together to build a community based service provision that supports patients, clinicians and multi-disciplinary workforce. Co-location of service provision should be the ultimate goal in the medium to long term. In the short term consideration of the constraints of existing building stock will need to be considered.

Governance

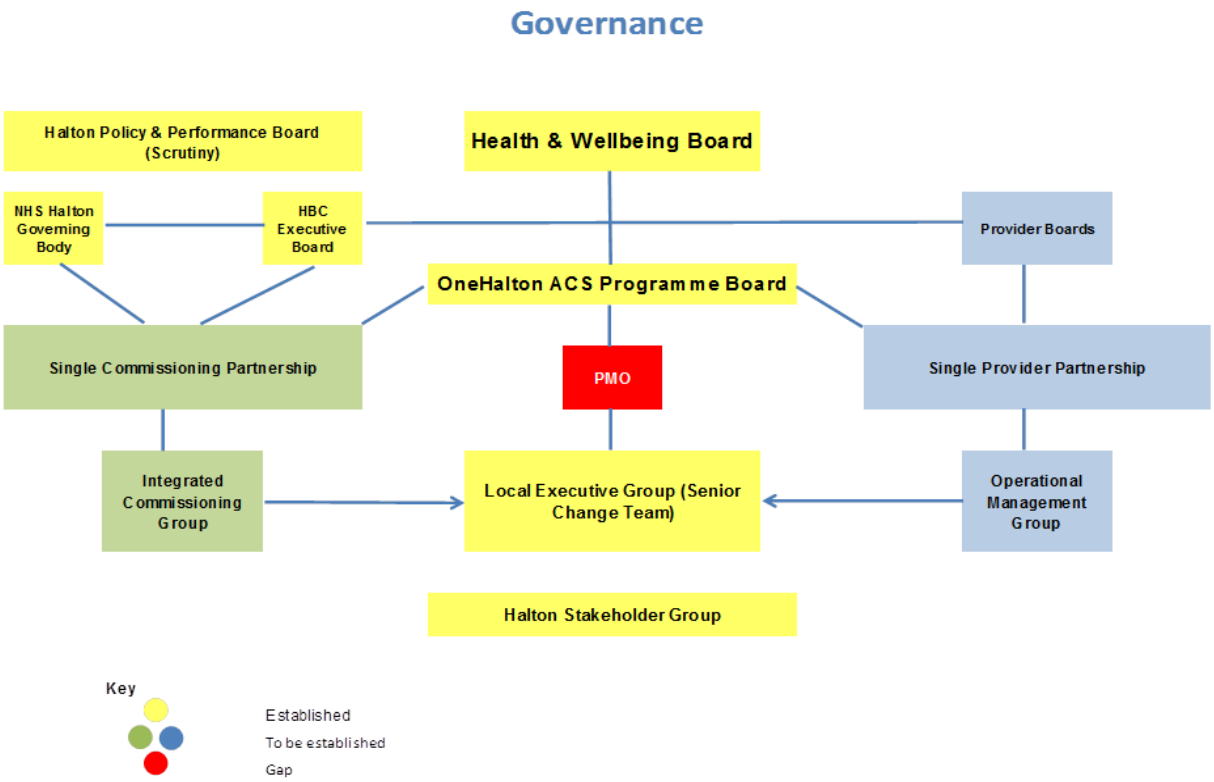
The integration of Health and Social Care in Halton will require the involvement of different commissioning and provider organisations, from both the statutory and non-statutory sector, working together in new ways.

Poor governance arrangements are one of the most frequently cited organisational barriers to successful integration so it will be vitally important to the success of this programme that robust governance arrangements are in place to oversee the delivery and evaluation of this complex work programme.

The following strategic groups and Boards will ensure effective governance of the programme:

- Halton Health and Wellbeing Board
- Halton Policy & Performance Board (Scrutiny)
- NHS Halton Governing Body
- Halton Borough Council Executive Board
- One Halton Accountable Care System Programme Board
- One Halton Single Commissioning Partnership
- One Halton Single Providers Partnership
- Local Executive group
- Halton Stakeholders group
- Engagement & Involvement of Population

Each agreed work stream will have a separate project group that will report into the One Halton Programme Management Office (PMO) reporting to the One Halton ACS Programme Board. Terms of reference and memorandum of understanding for the One Halton ACS Programme Board is attached in appendix 1. Each group will develop its own work plan to achieve the stated outcomes. Part of this work will involve engaging service users and residents in the co-production of new approaches. Project leads will also ensure alignment of activity with existing enabling programmes/groups.



Project implementation plans will be created which will form the basis of the monitoring process. This will be updated by the One Halton PMO as the project progresses, and referenced by the highlight reports. Regular reporting will be via a monthly highlight report, and will be produced by the programme/scheme lead to show actual and projected progress against plan.

The report will be submitted to the One Halton ACS Programme Board on a bi-monthly basis.

Project planning and control

The overall control of the project will be in line with Prince 2 methodology and adopts the “manage by exception” approach.

The Senior Responsible Officer (SRO) will have oversight of the whole programme and will be held to account by the Chief Executive Officer of Halton Borough Council and the Interim Chief Officer of NHS Halton CCG. The programme manager (when appointed) will carry out day-to-day management of the project within the delegations of authority.

Members of the project Team will raise or review project issues/changes/risks at the monthly project meetings. Project issues and risks will be reviewed and assessed for impact against the project timescales, cost and quality.

Programme approach

- Current services have been reviewed and evaluated against a number of criteria to establish which services should be in scope for the first phase of implementation.
- Phase 1 identifies the core services within the initial scope.
- Work is already progressing on these programs to redesign care pathways and integrate services from the bottom up.

Benefits & Outcomes

People will be supported to live longer healthier lives.
People with health and/ or social care needs will know how to navigate the health and social care system;
People with health and/or social care needs will be able to access the right information at the right time and will be able to access the support they need;
People will have an increased understanding of the benefits of wellbeing and will utilise local community resources to put this into practice;
People in local communities will have a range of locally grown support mechanisms such as carer led support groups, patient led self-management groups for long term conditions;
Through social prescribing GPs will support people to get to the right support and avoid more expensive and often unnecessary interventions;
Integrated teams will work closely with GP practices and will envelop individuals and work closely with provider services including local community and voluntary sector services;
People with long term conditions will have the ability to hold their own personalised care records and use Personal Budgets and Personal Health Budgets to manage their own care;
People with long term conditions and those defined at risk will have the ability to see and share their health and social care records;
People will be able to have repairs, adaptations and improvements made to their homes quickly and within timescales acceptable to them;
Carers will be supported to have a life outside of caring and will be supported in their caring role;
There will be improved access to services (parity of esteem) for all patients/clients, including children and young people, with mental health issues. Mental health conditions will be treated and assessed on a par with physical conditions;

Over time we will create a flexible workforce that can deliver more than one service for the benefit of patients and carers and the health and social care system;
We will manage demand for unplanned, emergency and urgent care services across the Borough where people choose the right place first time every time.
We will have greater control of our local pound and annual spend.
There will be Improved Value for Money through identifying cross-organisational efficiencies and economies of scale
Maintain financial resilience & sustainability of the Halton Health and Social Care System


OneHalton
Working better together
Welcome to OneHalton

NHS
Halton
Clinical Commissioning Group

OneHalton
Working better together

One Halton Accountable Care System Board

Draft Memorandum of Understanding

The signatories to this MoU have come together to improve health and wellbeing services for local people and to encourage self-health.

In doing so we are committed to:

- Improving health and wellbeing outcomes for local people
- Collaboration between health and social care services, providing accessible high quality services to local people
- Developing new ways to prevent and better detect illness
- Reducing the levels of demand on hospital, acute care and healthcare services generally
- Delivering service closer to home and within local communities

Our Commitment

We agree to the following principles in the development of an integrated health and social care eco system in Halton Borough:

1. We agree that an integrated system of health and social care is the best way to ensure optimum health, wellbeing and care outcomes for our population and to ensure collective financial sustainability.

2. We agree that the Halton Health & Wellbeing Strategy provides the focus for our work together and sets out our vision to work together to reform health and social care services to improve the health outcomes of our residents and reduce health inequalities, as quickly as possible,.

3. We agree the One Halton ACS Board will provide a focal point for prevention and early intervention, proactively identifying potential future demand and shifting the focus from unplanned and reactive services to planned and targeted interventions.

4. We agree to put patients and residents at the heart of what we do.

5. We agree to put General Practice and other community practitioners at the centre of our care model.

6. We agree to design and plan services around functional geographical footprints with populations of 30,000 to 50,000 based on registered patient lists.

7. We agree to design services for users and not our organisational needs.

8. The Commissioners agree to deliver a single approach to commissioning health, wellbeing and care services in order to transform services and improve outcomes. This will enable collaboration integrated working and include the development of pooled budgets.

9. We agree that we will consider the options available to us, and select the best delivery model for the integrated care system in Halton, but not withstanding this, we will continue to integrate our services on the ground, at pace, using the existing options available to us to do so.

10. We acknowledge that creating a Locality Care Partnership will not resolve the significant budget challenges facing all organisations but it will go some way to reducing it and it will be necessary to continue to work closely together with all stakeholders to manage the deficit around health and social care

<u>Asset Based Approach</u>

11. We agree in an asset based approach to the design and delivery of our integrated services including:
    a) A commitment that staff delivering services in Halton will be trained and updated in having new conversations with residents that focus on assets rather than need.

    b) Managerial arrangements within our organisations create the climate for staff from different professional backgrounds to work together in a positive, open and trusting climate

    c) That people are supported to be in control of their own lives

    d) That services are co-ordinated in a place, in a way, that is informed by a deep understanding of the community assets and capability in that place to support residents to be connected to their community and each other.

    e) That service administration is organised in agreed functional geographical footprints, allowing alignment with key service providers organised on the same footprint.

    f) That the partnership encourages its workforce to be positive, courageous and accountable in the way they deliver their services to the public.

    g) That our partnership embraces positive risk taking and permission based working, with the workforce liberated to demonstrate innovation and creativity on a daily basis.

Governance

12. We agree to working together to reform health and social care services to improve health outcomes for residents, as quickly as possible, and enable system wide change to develop transparent, robust and inclusive governance structures.

13. The key principles of our governance arrangements will be:

a) The objective of providing governance arrangements which aim to provide streamlined decision making; excellent co-ordination of services for the residents of Halton; mutual co-operation; partnering arrangements, and added value to the way we deliver our services.
b) An acknowledgement that the arrangement does not affect the sovereignty of any party and the exercise and accountability of their statutory functions.
c) A commitment to open and transparent working and proper scrutiny and challenge of the work of the One Halton Accountable Care Services Board and any party to the joint working arrangements.
d) A commitment to ensure that any decisions, proposals, actions whether agreed or considered at the One Halton ACS Board carry with them an obligation for the representative at the One Halton ACS board to report these to their own constituent bodies, and seek agreement if required through the appropriate governance route.

14. We agree that the governance arrangements will be kept under regular review and be revised from time to time to reflect the changing status of the integrated care delivery vehicle.

15. We agree that any decision affecting the statutory duties of an organisation will be referred through that organisation's governing processes.

16. We agree to provide mutual assurance to the constituent bodies and that the minutes of the One Halton ACS board will be circulated to the Boards of the constituent bodies.

Resources

17. We agree to the formation of the One Halton ACS PMO to manage the implementation of our work programme, with a commitment to seek resources and expertise from partner organisations, as appropriate, to support our integration journey.

18. We agree to use the assets and resources available to us within our organisations, such as buildings, IM&T and other infrastructure to support the adoption and enablement of integrated working arrangements.

19. We agree to work together to transform our collective workforce to ensure we have the right skills, capabilities and resources to deliver sustainable integrated working arrangements across health and social care now and in the future.

One Halton Accountable Care Programme Board

Terms of Reference

The *One Halton* Accountable Care Programme Board (One Halton ACPB) is a forum for development and partnership working. It is not a decision making body but will seek delegated decision-making responsibilities from Joint Committee status at a later stage. For any strategic and/or significant decision-making, Programme Board members will be expected to make recommendations to appropriate bodies and committees.

Overall Objective
To secure, via partnership working, the provision of system leadership and meaningful engagement in the development of the *One Halton* Accountable Care System. This aims to secure sustainable, high quality services which meet patient needs and optimise the health of the borough, delivering organisational sustainability.

Membership (to be confirmed)
Chief Executives / Chairs / Clinical Executive Officers from the following organisations:-

- Independent Chair
- NHS Halton Clinical Commissioning Group
- Halton Borough Council
- GP Health Connect
- Widnes Highfield Health Ltd
- St Helens & Knowsley Teaching Hospitals
- Warrington & Halton Hospital NHS Foundation Trust
- Bridgewater Community Healthcare NHS Foundation Trust
- North West Boroughs Partnership NHS Foundation Trust
- Halton & St Helens Voluntary and Community Action
- Halton Housing Trust
- Halton 3rd sector consortium (rota basis)

Key Tasks

- To ensure effective leadership in the *One Halton* AC Programme, ensuring SMART plans for future service models and that are ambitious, sustainable and achievable;

- To make recommendations for actions as appropriate to Halton Health & Wellbeing board but not to take decisions which are binding on other organisations;

- To ensure alignment between the *One Halton AC* Programme and the plans for each organisation, highlighting any tensions or interdependencies, and agreeing with all how these should be resolved;

- To ensure key staff from each constituent organisation are enabled to participate in the Programme work streams;

- To review the results of the programme at the end of Phase 1, and to advise on how these are taken forward;

- Develop and deliver a strategic vision for Halton with an agreed set of co produced outcomes;

- Support the development of a shadow integrated commissioner and local delivery partnership by 2018.

Reporting Arrangements
The *One Halton* AC Programme Board will meet on a bi-monthly basis. Standard progress reports will be produced for presentation to all relevant committees to ensure consistency of message.

It will be accountable to the Halton Health and Well Being Board

Administrative Support
NHS Halton CCG

Review Date
November 2017