St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

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

PUBLIC BOARD AGENDA				Paper	Presenter
09:00	1.	Employee of the Month			Chair
09:10	2.	Apologies for Absence			
	3.	Declaration of Interests			
	4.	Minutes of the Previous Meeting held on 26th September 2018		Attached	
		4.1	Correct Record & Matters Arising		
		4.2	Action Log	Attached	
Performance Reports					
09:20	5.	Integrated Performance Report		NHST(18) 87	Nik Khashu
		5.1	Quality Indicators		Sue Redfern
		5.2	Operational Indicators		Rob Cooper
		5.3	Financial Indicators		Nik Khashu
		5.4	Workforce Indicators		Anne-Marie Stretch
Committee Assurance Reports					
09:50	6.	Committee Report – Executive		NHST(18) 88	Ann Marr
10:00	7.	Committee Report – Quality		NHST(18) 89	Val Davies
10:10	8.	Committee Report – Finance & Performance		NHST(18) 90	Jeff Kozer
10:20	9.	Committee Report – Charitable Funds *(incl Annual Accounts & Report)*		NHST(18) 91	Nik Khashu
10:35	10.	Committee Report – Audit		NHST(18) 92	Su Rai
Other Board Reports					
10:40	11.	Strategic & Regulatory Report		NHST(18) 93	Nicola Bunce

10:45	12.	Statement of Compliance with NHS Emergency Preparedness, Resilience and Response (EPRR) Core Standards	NHST(18) 94	Sue Redfern
BREAK				
11:10	13.	WRES Report & Action Plan	NHST(18) 95	Anne-Marie Stretch
11:20	14.	Corporate Risk Register	NHST(18) 96	Nicola Bunce
11:30	15.	Board Assurance Framework	NHST(18) 97	Nicola Bunce
11:40	16.	Learning from Deaths Quarterly Report	NHST(18) 98	Kevin Hardy
11:50	17.	Review of the Meeting		Chair
	18.	Any Other Business		
	19.	Date of Next Meeting – Wednesday 28th November 2018		

Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Board meeting held on Wednesday 26th September 2018 in the Boardroom, Whiston Hospital

PUBLIC BOARD

Chair:	Mr R Fraser	(RF)	Chairman
Members:	Ms A Marr	(AM)	Chief Executive
	Mr D Mahony	(DM)	Non-Executive Director
	Ms S Rai	(SR)	Non-Executive Director
	Mr J Kozer	(JK)	Non-Executive Director
	Mr P Growney	(PG)	Non-Executive Director
	Mrs J Quinn	(JQ)	Associate Non-Executive Director
	Prof K Hardy	(KH)	Medical Director
	Mrs S Redfern	(SRe)	Director of Nursing, Midwifery & Governance
	Mr N Khashu	(NK)	Director of Finance
	Mrs C Walters	(CW)	Director of Informatics
	Mr P Williams	(PW)	Director of Facilities Management/Estates
	Ms N Bunce	(NB)	Director of Corporate Services
	Mr R Cooper	(RC)	Director of Operations & Performance
	Mrs T Hemming	(TH)	Director of Transformation
In Attendance:	Mr G Appleton	(GA)	Chair, St Helens CCG
	Ms J Byrne	(JBy)	Executive Assistant *(Minute Taker)*
	Mrs H Cain	(HC)	Quality Matron – Patient Experience and Governance, Quality Improvement and Clinical Audit *(for Patient Story)*
	Terry Hankin		Deputy Medical Director/Revalidation Officer
	Mrs A Farrell	(AF)	Deputy Director of Operations & Performance *(Observer)*
	Mrs S Kelly	(SK)	*Observer*
Apologies:	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Cllr A Lowe	(AL)	Halton Council *(Co-opted Member)*

1. Welcome & Introductions

RF welcomed attendees to the meeting and invited the new Non-Executive Director, Paul Growney and the new Associate Non-Executive Director, Jean Quinn to introduce themselves to other Board members.

PG grew up in the local area and is passionate about the Trust. He has a background in the charitable sector and in Social Care provision. His interests include community and patient engagement.

JQ is a retired GP with a background in Undergraduate and Postgraduate Medical education. She chaired the Quality & Safety Committee at Wirral University Hospitals NHS Foundation Trust and was a Wirral Councillor involved in Social Care.

2. Patient Story

2.1. LC attended the meeting with her father and HC, Quality Matron to her describe her experience of the Trust's Dermatology Service.

2.2. LC had developed cystic acne three years earlier and despite several visits to the GPs in her surgery and trying the various medications prescribed, the condition grew steadily worse. After 18 months she was referred to the Trust's Dermatology Service and prescribed Roaccutane. LC did not tolerate the initial dose prescribed, which resulted in a very painful, adverse reaction. LC attended A&E to seek help for the inflammation, due to the Dermatology Consultant being on annual leave at the time; however A&E knowledge of the condition was limited. An emergency appointment was made with the Dermatology Consultant on return from leave and the dose was halved, which LC tolerated and had made a significant difference.

2.3. LC had been left with scarring but had been referred to Alder Hey Children's Hospital for skin resurfacing which LC hoped would be completed before her school prom in Jun 2019.

2.4. LC underlined how important it had been for her and how grateful she was that the specialist Consultant had been accessible at short notice for help and advice.

2.5. RF thanked LC for sharing her story with Board members and complimented her on her positive attitude, bravery and maturity in dealing with the condition.

2.6. In response to a query from SR asking what the Trust could have done better, it was acknowledged the referral could have happened more quickly. More recently, a Paediatrician has agreed to work a shift in A&E on a regular basis to help with cases such as this.

2.7. NK added one of the benefits of greater integration with primary care would be quicker, smarter and faster referral for patients such as LC.

2.8. GA suggested the story should be used as a case study to help educate GP's to be able to identify cystic acne.

3. Employee of the Month

3.1. The Employee of the Month Award for August 2018 was presented to Lynn Angell.

3.2. The Employee of the Month Award for September 2018 was presented to Vicky Bannon.

4. Apologies for Absence

Apologies were received from Anne-Marie Stretch.

5. Declaration of Interests

5.1. RF declared that he continued to be the interim Chair of Southport & Ormskirk Hospitals NHS Trust.

6. Minutes of the previous meeting held on 25th July 2018

6.1. Correct Record

The minutes were accepted as a correct record, once the following amendments were made:

6.1.1. In relation to the Apprenticeship Levy, the amount of time apprentices had to spend training was actually 20% rather than 25% (Minute 13.8).

6.2. Action List

6.2.1. Action 1 - Minute 12.4 (30.05.18): *First Stage Complaints – SRe to obtain data to show how the Trust compared to others in the region for next scheduled report* – on agenda (NHST (18)82 Complaints, Claims and Incidents Report). **ACTION CLOSED.**

6.2.2. Action 2 - Minute 5.2.10 (27.06.18): *IPR Operational Figures – reporting of A&E performance* – RC confirmed Type 3 activity undertaken by North West Boroughs Trust on the Trust's behalf would be included in future activity returns and reported in the IPR. **ACTION CLOSED.**

6.2.3. Action 3 - Minute 6.4 (27.06.18): *Monitoring the attendance rate of Marshalls Cross GP Surgery patients* – TH tabled graphs depicting A&E attendance of patients registered with the practice for the previous 12 months, compared to the previous year. TH explained the figures were not completely comparable as the previous data did not include information about patients registered with the ElderCare service, however, the figures demonstrated a 20% decrease in A&E attendances from the practice since the Trust had taken over. **ACTION CLOSED.**

6.2.4. Action 5 - Minute 1.2 (25.07.18): *Reduced TV usage rates for long stay patients* – SRe confirmed she had spoken to Hospedia, the bedside TV, phone and internet service provider, who had confirmed there was a free scheme already in place for long term patients to access TV. She had spoken to Ward Managers to remind them of the importance of contacting Hospedia to do this where patients or their families would benefit. **ACTION CLOSED.**

6.2.5. Action 11 - Minute 16.6 (25.07.18): *KH to bring updated Learning from Deaths quarterly report to September meeting* – on agenda. **ACTION CLOSED.**

6.2.6. All other actions were due in future months.

7. Integrated Performance Report (IPR) – NHST(18)76

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

7.1. Quality Indicators

7.1.1. SRe presented the performance against the key quality indicators.

7.1.2. The Trust was still awaiting the report from the CQC inspection that took place in July and August.

7.1.3. There had been one never event in July, the RCA had been completed and a detailed report would be presented to the Quality Committee.

7.1.4. There had been no MRSA bacteraemia cases in the year to date.

7.1.5. There was 1 C.Diff positive case in August 2018, year to date there had been 11 cases, of which one had been successfully appealed bringing the total to 10. The annual tolerance for 2018/19 was 40.

7.1.6. There were no grade 3 or 4 avoidable pressure ulcers in the year to date.

7.1.7. The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for July was 95.1% and year to date performance was 96.5%.

7.1.8. During the month of July there was 1 inpatient fall resulting in severe harm. The year to date total for all falls was 23.

7.1.9. Venous thromboembolism (VTE) performance for July was 95.10%. Year to date performance is 95.15% against a target of 95%.

7.1.10. Year to date Hospital Standardised Mortality Ratio (HSMR) for (April to March) 2017/18 was 99.1.

7.2. Operational Indicators

7.2.1. RC presented the update on the operational performance.

7.2.2. Performance against the 62-day cancer standard was above the target of 85.0% at 89.5% in month.

7.2.3. The 31-day target was also achieved with 98% performance against a target of 96%.

7.2.4. The 2-week rule compliance had underperformed at 86.5% against a target of 93%. The underperformance was due to a combination of an increase in 2-week wait referral activity, patient rearrangements

and issues related to the migration of the Trust patient administration system. There were action plans in place to recover the position as quickly as possible and to change our internal processes so that patients were given appointments as soon as possible after the referral was received.

7.2.5. A&E performance was 80.4% (type 1), an increase on July's performance of 74.4%. The all type mapped STHK Trust footprint performance for August was 90.5%, an increase on July (87.5%).

7.2.6. Whiston ED ambulance notification to handover time was 11.12 minutes on average for the month of August, against a target of 15 minutes. The Trust was the best performing adult emergency department for ambulance notification to handover times in Cheshire, Merseyside and Greater Manchester.

7.2.7. Following the migration of the Trust patient administration system in April, whilst being successful across the majority of the Trust, the issues within outpatients continued. Actions to address this were ongoing, with a view to return to reporting RTT within Q3.

7.3. **Financial Indicators**

7.3.1. NK presented the update on the financial performance.

7.3.2. At the end of August the Trust reported an overall year to date income and expenditure deficit of £2.4m which was behind plan by £0.6m. The deterioration related to NHSI instructing the Trust to remove £0.6m from the Provider Sustainability Fund due to non-delivery of the 90% A&E target in Q1, despite significant improvements in that quarter. The 2018/19 rules mean that the Trust would not be able to claim this back if performance recovered and was above the trajectory 90% target in future quarters.

7.3.3. Within the year to date position the Trust had utilised £1.5m non-recurrent resources, which was offsetting some of the costs pressures and impacts from Medway as well as under-performance in clinical income.

7.3.4. The Trust continued to deliver above the plan of the CIP target with £4.1m delivered year to date against a plan of £3.7m. The risk on the system transformation schemes had increased in month as a result of NHSI communicating that the PFI support the Trust received would no longer be uplifted for inflation. NK confirmed that not receiving any capital from NHSI to help mitigate winter pressures would increase the financial risk and potential expenditure run rate over winter if there were peaks in activity that outstripped the Trusts bed capacity.

7.3.5. In relation to the A&E target for last year, SR queried whether the target was 90% in quarters 1, 2 and 3 and 95% in March for the all type position. RC confirmed that this was correct.

7.3.6. SR also queried the projected outturn position and increased levels of risk. NK provided assurance that the Finance and Performance Committee reviewed the financial risks and mitigating actions each month and had requested a forecast outturn based on the current risk range be prepared.

7.3.7. SR questioned whether any NHS Provider organisations locally had achieved the A&E target and received the full PSF allocation. NK confirmed that PSF was only available to organisations who had agreed to deliver the NHSI control total. In a general DGH situation with standard type 1 and type 3 activity the A&E 90% trajectory had not been achieved in North Mersey.

7.3.8. NK reported a recent court case won by the NHS which could potentially lead to substantial savings on high cost drugs, which would contribute to the CIP target.

7.3.9. The Trust's cash balances at the end of month 5 were £6.2m, £0.7m behind plan. The Trust was yet to receive over-performance payments from its main commissioners. NHSI and NHSE had confirmed their support of the Trust taking out a temporary loan to cover those costs if necessary. The Trust had written to Finance Directors of the Trusts who were part of the Lead Employer service for Doctors in training requesting regular payment and was currently in discussions with NHSI and Health Education England (HEE) about NHS organisations who had delayed payments for Lead Employer trainees' salary costs.

7.3.10. The financial performance in the month delivered a Use of Resources level of 3.

7.4. **Workforce Indicators**

7.4.1. In AMS' absence, NB presented the update on the workforce indicators.

7.4.2. Absence in August remained static at 4.7% compared to 4.9% in August 2017. Qualified nursing and midwifery sickness (excluding HCA's) was 5.9% (5.4% year to date). ND confirmed that the HR department was undertaking a deep dive to understand the reasons for this spike.

7.4.3. Mandatory training compliance for the core skills framework subjects was 96.7% (target = 85%). Appraisal compliance was 84.3% which was below the target. It was anticipated that incentives to undertake appraisals would increase under the new pay system where incremental progression was linked to appraisal.

8. Committee Report – Executive – NHST(18)77

8.1. AM presented the report to the Board, which summarised Executive Committee meetings held during July and August 2018.

8.2. **Corporate Risk Register**

The Executive Committee had reviewed the Corporate Risk Register and noted that one of the Trust's highest risks concerning staffing on the Department of Medicine for Older People (DMOP) and Frailty had been reduced as a result of a positive targeted recruitment campaign.

8.3. **Medway Patient Administration System**

The Executive Committee was receiving weekly updates on the progress being made to resolve the outpatient booking issues and ensure RTT reporting could resume by the end of Quarter 3, as agreed with NHSI. Changes had been implemented to address issues being experienced by Clinical Directors and the reducing outpatient Did Not Attend (DNA) rates were noted. There were positive improvements to coding speed as a result of the new system.

8.4. **Microbiology Equipment Procurement**

The Executive Committee had reviewed the business case and approved the preferred option to replace outdated and unsupported equipment. The option also allowed flexibility to cope with any future growth either as a Trust or as part of a pathology network.

8.5. **Medical Records Library**

The Executive Committee had approved the proposal to complete the digitisation of medical records by November 2018. The current medical records store would be demolished and the site made available for redevelopment as part of the Trust's strategic long-term estates' plans.

8.6. **Dermatology Service**

Approval had been given for additional staffing to enable the services to respond to increasing demand and to maintain a local service for the population as other providers could not sustain services.

8.7. **Step Down Community Beds**

SR asked about progress in creating additional step down bed capacity to help with winter pressures. AM confirmed that a business case was being presented in the Closed Board meeting.

8.8 Board members noted the report.

9. Committee Report – Quality – NHST(18)78

9.1. VD presented the Chair's report to the Board, which summarised key issues arising from the Quality Committee meeting held on 18th September 2018 and the reports from the Patient Safety, Patient Experience and Clinical

Effectiveness Councils.

9.2. Issues for note by the Trust Board included: a risk that the Trust would not be able to train sufficient staff in PREVENT/WRAP by March 2019, following a change in the national standards, congratulations to the Medicines Management department who had been successful in gaining approval to manufacture aseptic drugs, which would increase the availability of ready-made IV products on wards and collaboration with STP partners.

9.3. Board members noted the report.

10. Committee Report – Finance and Performance – NHST(18)79

10.1. DM presented the Chair's report to the Board as JK had not been able to attend the meeting. The report summarised key issues arising from the Finance and Performance Committee meeting held on 20th September 2018.

10.2. Board members discussed the continuing pressure on A&E performance and noted that the Finance and Performance Committee were now more assured about the plans in place to respond to these pressures. An improving performance trend had been noted.

10.3. KH commented the Trust's performance was seeing a reflection of the national picture.

10.4. The Committee had discussed the risks associated within the Transformational C&M CIP schemes and the increasing risk to the forecast outturn as the CIP delivery expectation stepped up for the last 6 months of the year.

10.5. DM was concerned at the % of admitted patient with a zero LoS and queried why this was increasing. RC clarified that many of these patients were appropriately being treated via an ambulatory pathway following initial assessment, and the Trust was in line with the national trend which showed that one third of all admissions were now zero LoS.

10.6. Board members noted the report and the increasing operational and financial risk.

11. Committee Report – Audit – NHST(18)80

11.1. SR presented key issues arising from the Audit Committee meeting held on Wednesday 1st August 2018.

11.2. SR reported the external audit letter had been agreed by the Committee, with no issues needing to be brought to the attention of Board members. SR reported that the auditors had once again been complimentary about the Trust finance team and the support they received during the annual audit.

11.3. An internal audit report had been presented to the Committee; limited assurance had been given in relation to the signing of Consultant Job

Planning reviews and an action plan had been requested.

11.4. Minor changes to the Corporate Governance Manual had been agreed following the routine annual review and Board members were asked to approve those changes.

11.5. The Board noted the report and approved the changes to the Corporate Governance Manual.

12. Statutory and Regulatory Report – NHST(18)81

12.1. NB presented the report which provides an update on external strategic developments and regulatory requirements.

12.2. Board members noted the proposed Board development programme for 2018/19. RF asked PG and JQ to look at the proposals as they were new to the Board and identify new areas for future Board development.

12.3. Lord Prior of Brampton would take over as Chairman of NHS England from October 2018, when Sir Malcolm Grant's term of office ended. Lord Prior was a former health minister and currently Chair of University College Hospital London.

12.4. Dr Tom Kark QC was to undertake a review of the effectiveness and operation of the Fit and Proper Person Test as it applied in the NHS.

12.5. In relation to the NHS 10 year plan, a number of working groups had been established to consult and develop elements of the plan. The proposed timetable was expected to be published to coincide with the autumn budget in November.

12.6. JQ queried whether GPs were represented on the working groups. NB agreed to circulate details of the NHSE briefing which detailed the working group members.

12.7. NB provided a verbal update on the new Royal Liverpool Hospital development, following the collapse of Carillion. Agreements had now been reached with the PFI Company and Treasury that would enable building work to resume on the near future and it was now predicted that the new hospital would be opened in 2020.

12.8. The Board discussed the impact of the new hospital which was planned to have fewer inpatient beds and might increase the patients choosing to come to STHK.

12.9. JQ believed there should be long-term sustainability plans in relation to beds and wondered how the Trust was ensuring that the demand on hospital services was being fed back nationally. AM responded that the King's Fund and NHS England had undertaken some work to predict the impact of demand on beds but the financial situation meant that there was not a political focus on increasing acute beds at the current time, and emphasis remained on caring for people in out of hospital settings. KH reported that

the collective view of Medical Directors was a need for more beds but not necessarily provided in acute hospitals. NK commented that any additional beds would need to be staffed, and this was also a challenge given the current national workforce shortages.

12.10. Board members noted the content of the report.

13. Quarterly Complaints, Claims and Incidents Report – NHST(18)82

13.1. SRe presented the key points from the complaints, claims and incidents report covering data from Q1 (1st April to 30 June 2018).

13.2. The number of incidents reported had remained fairly steady between Q4 and Q1, but had increased by nearly 10% from the same period last year. There was a slight increase in incidents resulting in harm .

13.3. The number of first stage formal complaints and PALS contacts increased compared to the same quarter last year and the previous quarter. The reasons for this were being analysed to identify any specific areas of concern.

13.4. In relation to a query from DM, SRe highlighted the comparisons with other local Trusts. The table showed that the Trust received less complaints than 4 others trusts in the area, from the peer group of six. This data would be reviewed before being presented to Quality Committee and an update given to Board members.

13.5. SR queried whether a comparison of CNST contributions was an effective KPI for current performance because of the time lag in investigating and settling legal claims. AM was concerned that because several large claims dating back several years had recently been settled the CNST premiums for next year would increase substantially. Modelling of the impact needed to be undertaken and presented to the Finance and Performance Committee on a rolling basis (ACTION).

13.6. SRe reported that a Claims Group involving clinicians had been set up to learn more from claims. Findings would be presented to a future Finance and Performance Committee meeting.

13.7. Chart 8 indicated that the Trust had received the highest number of claims over the past 2 years but paid lower clinical negligence scheme contributions compared to other neighbouring Trusts. SR was asked to provide analysis of the benchmarking data. **Action: SR**

13.8. Board members noted the report.

14. Freedom to Speak Up Self-Assessment and Action Plan - NHST(18)83

14.1. In AMS' absence, NB presented the paper. The Board members discussed the draft self-assessment against the National Guardians Office standards and NHSI toolkit. The Trust did not have a large number of issues raised with its FTSU Guardians, and SR asked how the Board could be assured that

the process was successful. NB stated that there would be regular reports coming to the Board and that two of the Trust Guardians were Board members. AM felt that the greatest assurance came from the national staff survey where the Trust scored very highly on the question "Do you feel able to raise a concern?"

14.2. Board members approved the self-assessment and action plan.

15. Update on CQUIN 1b – Healthy Food for NHS Staff, Visitors and Patients – NHST(18)84

15.1. SR presented the paper, which had also been discussed at Quality Committee.

15.2. VD confirmed that this CQUIN had been reviewed by the Quality Committee in May as part of the Quality Account.

15.3. Substantive changes had been made by the Trust and its external suppliers on healthier food products for staff, visitors and patients, in line with the national CQUIN requirements.

15.4. Board members noted the Trust had successfully delivered all of CQUIN 1b quality standards during 2017/18 and was hoping to secure the full CQUIN payment of £203,042.

15.5. Board members noted the report and the progress that had been made to deliver the CQUIN targets.

16. Medical Revalidation Annual Declaration – NHST(18)85

16.1. KH explained the purpose of the paper was to provide feedback and assurance to Board members that arrangements for Medical Appraisal and Revalidation were operating effectively at the Trust and in accordance with regulations.

16.2. For factual accuracy, it was noted the period covered by the paper was the financial year to 31st March 2018.

16.3. In response to a query from RF, KH confirmed the Trust being Lead Employer for the North West would not change the figures, as only prescribed connections, eg Doctors working in the Trust were reported.

16.4. SR asked how the Trust targeted non-compliance. KH explained because of staff turnover it was highly unlikely that the Trust would ever be able to report 100% compliance, however the responsible officer, Dr Terry Hankin, had a very robust audit process and did follow up all individuals who had not completed the revalidation cycle in the prescribed timescales.

16.5. Dr Hankin joined the meeting.

16.6. Dr Hankin explained the purpose of revalidation was to ensure that Doctors remained fit to practice, and it was not the same as appraisal or job planning.

Both complaints and compliments were included as evidence.

16.7. The Board accepted the report and approved the statement of compliance confirming that the organisation, as a designated body, was compliant with the regulations.

16.8. Dr Hankin left the meeting.

17. Infection Prevention Control Annual Report 2017/18 – NHST(18)86

17.1. SRe explained the Trust was required to produce the annual report on its Infection prevention and control activities, but Board members had received the information contained within it on a monthly basis via the Integrated Performance Report.

17.2. The first part of the report detailed infection prevention performance during 2017/18 and the second part contained the proposed work plan for 2018/19 to reduce the risk of healthcare acquired infections.

17.3. In response to a query from AM, SRe confirmed the RCAs for recent orthopaedics' infections were being undertaken and she would report formally to the next quality committee.

17.4. The Board approved the report.

18. Any Other Business

18.1. KH presented a revised Q4 report, containing the updated key learning points from the previous quarter.

18.2. DM had chaired a recent meeting of the Mortality Surveillance Group and felt that there was still work to be done to embed the learning from deaths processes and ensure lessons were learnt and disseminated to change clinical practice in a timely way.

18.3. KH confirmed that this was all part of the new mortality review process; in fact the recent CQC inspection had focussed on it and highlighted the need for improvement. AM stressed the importance was ensuring a clear governance escalation route from the Mortality Surveillance Group to the Board learning from deaths report.

18.4. SRe asked if the Trust now had sufficient numbers of trained mortality reviewers. KH confirmed that there were currently sufficient numbers to complete the reviews and maintain expertise, but that this was continually being kept under review.

18.5. Board members approved the report.

19. Effectiveness of Meeting

19.1. RF asked those in attendance for feedback.

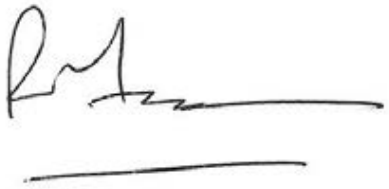
19.2. AF thanked RF for allowing her to observe the meeting. She could compare the meeting with other Board meetings she had attended in previous roles. AF felt the meeting was very well chaired, with a really welcoming atmosphere, particularly for the patient story and members of staff who came in to listen. All the values of the Trust were reinforced. There was a good focus on patient experience throughout the meeting. Every member had contributed and it was good to see the transparency in answering questions. The papers were clear, concise and in a consistent format.

19.3. It was the first time SK had ever attended a Board meeting and she had found it friendly and interesting. She liked that the patient was asked if anything could have been done better as it showed the Trust was striving to improve.

19.4. RF thanked AF and SK for their comments and agreed there was a positive, friendly atmosphere but that this did not prevent challenge or stop members from taking the issues seriously, and he was grateful to all Board members for that.

20. Date of Next Meeting

20.1. The next meeting is scheduled for Wednesday 31st October 2018 in the Boardroom, Level 5, Whiston Hospital, commencing at 09:30 hrs.



Chairman: ……

Date: 31st October 2018 ……

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 31ST OCTOBER 2018

No	Minute	Trust Public Board Action Log	Lead	Date Due
~~1.~~	~~30.05.18 (12.4)~~	~~First Stage Complaints: SRe to obtain data to show how the Trust compared with others in the region, for next scheduled report~~. ACTION CLOSED	~~SRe~~	~~26.09.18~~
~~2.~~	~~27.06.18 (5.2.10)~~	~~IPR – Operational Indicators: AM/RC to meet outside of the Trust Board meeting to discuss the reporting of Type 1/All Types performance figures. To be brought back in September~~. ACTION CLOSED	~~AM/RC~~	~~26.09.18~~
~~3.~~	~~27.06.18 (6.4)~~	~~Re preventing A&E attendances, TH agreed to monitor the attendance rate from the Marshalls Cross Practice to evaluate the impact of the new service model. Verbal update planned for September~~. ACTION CLOSED	~~TH~~	~~26.09.18~~
~~4.~~	~~25.07.18 (1.2)~~	~~SRe to report back to Board members on why Laura Lambert had not been offered a discounted price for television access as she had been a long stay patient and pass on the feedback in relation to the privacy of diaries being incorporated into patient notes~~. ACTION CLOSED	~~SRe~~	~~26.09.18~~
5.	25.07.18 (10.6)	SRe to develop a QWR "You Said, We Did" quarterly report to Board for members to understand whether issues raised at QWRs had been resolved, to be reported to Quality Committee.	SRe	31.10.18
6.	25.07.18 (11.5)	KH to review Learning from Deaths policy in light of the Working with Families Guidance and consider the appropriate controls to provide assurance and update the Trust Policy.	KH	~~30.11.18~~ Revised to 30.01.19
7.	25.07.18 (12.7)	AMS to include employee relations' cases time to resolve KPIs in future HR Indicators reports.	AMS	30.01.19
8.	~~25.07.18 (13.11)~~	~~AMS to prepare a briefing for RF on the concerns about the apprenticeship levy to discuss at the next NHSI Chairs meeting on 18.10.18~~. ACTION CLOSED	~~AMS~~	~~For NHSI Chairs' mtg~~
9.	25.07.18 (15.5)	The Executive to develop an integration strategy to support the Trust Strategy 2018 to 2021.	NB	30.01.19
~~10.~~	~~25.07.18 (16.6)~~	~~KH to bring updated Learning from Deaths quarterly report to September Board meeting~~. ACTION CLOSED	~~KH~~	~~26.09.18~~
~~11.~~	~~26.09.18 (12.6)~~	~~NB to investigate how GPs are represented on the 10 Year Plan working groups and report back. Information circulated following the September Board meeting~~. ACTION CLOSED	~~NB~~	~~31.10.18~~
~~12.~~	~~26.09.18 (12.7)~~	~~NB to circulate a briefing outlining the priorities of different NHS leaders over the next 3 years. Done~~. ACTION CLOSED.	~~NB~~	~~31.10.18~~
13.	26.09.18 (13.7)	Quarterly Complaints, Claims and Incidents Report Chart 8 indicated that the Trust had received the highest number of claims over the past 2 years but paid lower clinical negligence scheme contributions compared to other neighbouring Trust's. SR was asked to provide analysis of the benchmarking data.	SRe	28.11.18
14.	26.09.18 (17.3)	SRe to report the RCA for Orthopaedics infections to a future Quality Committee meeting.	SRe	28.11.18

INTEGRATED PERFORMANCE REPORT

Paper No: b l {¢ómyúyт
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.

During April the Trust implemented a new Patient Administration System which has impacted on the timeliness of some indicators.

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 has been 1 never events year to date (target = 0).

There have been no MRSA bacteraemia cases year to date (target = 0).

There were 2 C.Difficile (CDI) positive cases in August 2018. YTD there have been 13 cases . The annual tolerance for CDI for 18-19 is 40.

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 September 2018 was 94.5%. YTD performance is 96.2%.

During the month of August 2018 there was 1 fall resulting in severe harm , which occurred in an inpatient area.

Performance for VTE assessment for August 2018 was 98.47%. YTD performance is 95.81% against a target of 95%.

YTD HSMR (April to May) for 2018-19 is 90.8

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 18/19 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: oмăű hŎűƨōŜ₪ нлму

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (August 2018) at 88.9%. The 31 day target was also achieved with 97.7% performance against a target of 96%. 2 week rule compliance has underperformed at 87% against a target of 93.0%. This underperformance is due to a combination of an increase in 2 week wait referral activity and patient rearrangements.

Accident and Emergency type 1 performance for September was 79.2%. The all type mapped STHK Trust footprint performance was 89.7%.Type 1 attendances for September 18 were 9,202, a reduction of 105 on August 18. An executive led urgent and emergency care summit took place on September 12th, which brought together senior clinical and managerial leaders from across the organisation, with the purpose of formulating a plan to improve 4 hour performance; five workstreams have been developed, which will be governed through the Urgent and Emergency Care Council

Whiston ED ambulance notification to handover time was 10 mins on average for the month of September (target 15 mins) and total turnaround average turnaround time of 30 minutes (target 30 minutes). The Trust was the best performing adult emergency department, for ambulance notification to handover times in Merseyside and Cheshire and Greater Manchester

In line with the national expectation to reduce the number of Super Stranded patients (patients with a length of stay of greater than 21 days) by 25%, the trust has now achieved a 15% reduction against this target, which is a further improvement on the previous months position.

Following migration of the Trust patient administration system in April, whilst being successful across the majority of the Trust, the issues within outpatients continue. This has resulted in a continued inability to accurately report RTT performance. The actions to address this situation are ongoing, with a view to return to reporting RTT within Q3.

Financial Performance

At the end of M6 StHK has reported a deficit of £2.1m which is £0.6m adverse variance to agreed plans. The reason for the variance is the NHSI instruction to remove Q1 PSF relating to A&E performance. The Trust has also been advised (at the QRM on 17th October) that as part of M7 reporting the Q2 A&E PSF of £769k will also need to be removed. During the discussion at QRM NHSI have agreed to review the system-wide mapping for a potential year-to-date adjustment.

Within the YTD position the Trust has utilised £2.7m non-recurrent resources, this is offsetting some of the cost pressures and impacts from Medway as well as under performance in Clinical Income. The non-recurrent nature of this benefit will need to be considered when agreeing future year plans as these benefits will not be available going forward.

The Trust continues to deliver above the YTD CIP target with £5.2m delivered against a plan of £4.9m. Whilst there are plans and ideas for delivery of the full £19m CIPs, a significant proportion are deemed currently as high risk.
The Trust cash balances at the end of M6 were £3.2m. The Trust is yet to receive over performance payments from one of its main commissioners relating to Q1. The Trust now employs 9,000 trainee Doctors for 5 HEE areas across the country as part of its Carter at scale innovations. If provider organisations fail to pay their invoices in time this puts significant strain on the Trust cash balances. The Trust now shares the non-compliant organisations with regulators to assist in obtaining payment.

As a result of the challenges within the external element of the CIP the forecast outturn position will be challenging. The forecast outturn will be reviewed with the F&P committee during Q3.

The financial performance in the month delivers a Use of Resources level of 3.

Human Resources

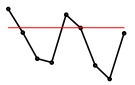
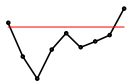
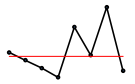
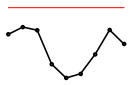
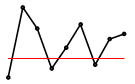
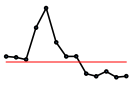
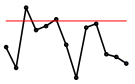
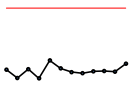
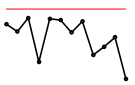
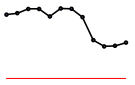
In September overall absence again remained static at 4.7% and exceeds the Q2 target of 4.35%. Qualified & HCA sickness has also remained static in month at 5.9%. YTD performance has increased to 5.5% against the target of 5.3%.
Mandatory Training compliance is 96% (target = 85%). Appraisal compliance is 82% (target = 85%).

The following key applies to the Integrated Performance Report:

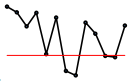
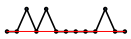
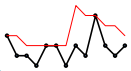
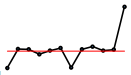
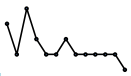
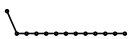
▲ = 2018-19 Contract Indicator
▲£ = 2018-19 Contract Indicator with financial penalty
● = 2018-19 CQUIN indicator
T = Trust internal target
UOR = Use of Resources

Sep-18

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

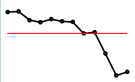
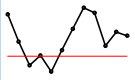
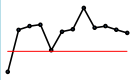
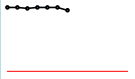
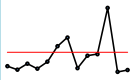
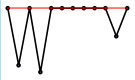
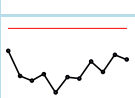
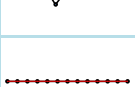
	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 31-37)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Sep-18	2.0%	2.0%	No Target	2.4%		SHMI improvement has been sustained. SHMI lags behind HSMR nationally. HSMR is dramatically improved and currently substantially better than English average. Crude mortality has also fallen.	Patient Safety and Clinical Effectiveness	Continue measures to improve clinical effectiveness and reduce unwarranted variation.	KH
Mortality: SHMI (Information Centre)	Q	▲	Mar-18	1.02		1.00						
Mortality: HSMR (HED)	Q	▲	May-18	98.3	90.8	100.0	99.1					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	May-18	107.4	101.3	100.0	95.8					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Apr-18	96.5	96.5	100.0	101.2		The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms. Readmissions have risen nationally in the last 2 years. It was suggested that ambulatory readmissions might have been a result of inappropriate coding of elective returns - audit has shown that this is not the case	Patient experience, operational effectiveness and financial penalty for deterioration in performance	The Trust is conducting an internal analysis of emergency readmissions and taking part in a district audit with CCG partners.	KH
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	May-18	92.2	93.6	100.0	90.6		Sustained reductions in NEL LOS are assurance that Trust patient flow 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	May-18	108.9	108.0	100.0	99.2					
% Medical Outliers	F&P	T	Sep-18	0.1%	0.4%	1.0%	2.3%		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 reconfiguration of some surgical beds to medical thus significantly reducing outliers to almost zero through recent months	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Sep-18	32.3%	38.6%	52.5%	48.7%		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. Targeted senior manager support to ensure patients are listed and transferred out of ICU in a timely manner	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Aug-18	71.7%	69.6%	90.0%	69.5%		eDischarge performance poor - there is insufficient trainee doctor resource to hit this target with existing paper-based systems.		Pending ePR, we have devised an automated eDischarge notification which will be computer generated and send within 24 hours. Thereafter a full discharge summary will be sent within 14 days. We're seeking CCG approval at CQPG before implementation.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Aug-18	80.3%	86.9%	95.0%	89.5%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Aug-18	97.2%	97.5%	95.0%	99.1%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

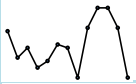
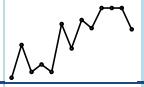
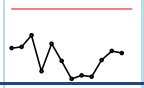
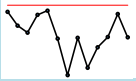
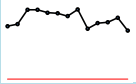
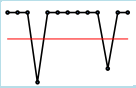
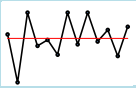
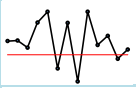
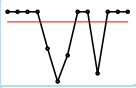
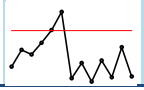
	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Sep-18	90.0%	85.2%	83.0%	90.3%		Target is being achieved YTD. With effect from April 2017, STHK is also treating patients from the Warrington Area.	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Following previous months deterioration, plans for improvement have resulted in achievement against the target	RC
PATIENT SAFETY (appendices pages 39-42)												
Number of never events	Q	▲£	Sep-18	0	1	0	2		A patient incident reported from Whiston theatres met Never event criteria in July 2018.	Quality and patient safety	Immediate actions implemented and formal RCA underway. The National safety standards for invasive procedures will provide further mitigation against future never events.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Sep-18	98.6%	98.9%	98.9%	98.9%		Achieving standard YTD	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	Sep-18	0	0	0	0		The trust continues to have no inpatient prescribing errors which cause serious harm. Trust has moved from being a historic low reporter of prescribing errors to a higher reporter - which is good.	Quality and patient safety	Intensive work on-going to reduce medication errors and maintain no serious harm.	KH
Number of hospital acquired MRSA	Q F&P	▲£	Sep-18	0	0	0	2		Internal RCAs on-going with more recent cases of C. Difficile.	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	▲£	Sep-18	2	13	40	19					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Sep-18	2	18	No Target	22					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Aug-18	0	0	No Contract target	0		No grade 3 or 4 avoidable pressure ulcers YTD	Quality and patient safety	The Trust provides ongoing tissue viability training for all nursing staff including bank staff . New pressure ulcer reduction actions being implemented.	SR
Number of falls resulting in severe harm or death	Q	▲	Aug-18	1	4	No Contract target	22		1 severe harm fall reported in August 2018 (ward 5B)	Quality and patient safety	RCA is currently being undertaken. Falls action plan progressing and monitored through Strategic Falls Group. New initiatives and awareness session programmes planned.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲£	Aug-18	98.47%	95.81%	95.0%	93.67%		VTE performance monitored since implementation of Medway. The ePrescribing solution will be implemented imminently.	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	Sep-18	1	11	No Target	31					
To achieve and maintain CQC registration	Q		Sep-18	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Sep-18	94.5%	96.2%	No Target	93.9%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety		SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Sep-18	0	0	No Target	1					

Sep-18

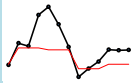
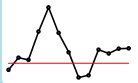
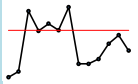
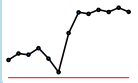
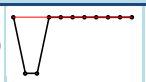
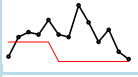
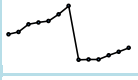
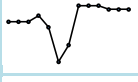
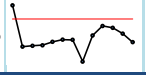
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	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	▲ £	Aug-18	87.0%	89.7%	93.0%	95.0%		31 and 62 day targets achieved YTD. Underperformance against the 2ww target in July due to a combination of an increase in 2 week wait referral activity, patient rearrangements and issues related to the migration of the Trust patient administration system.	Quality and patient experience	1. All DMs tasked to produce action plans by specialty 2. Consultant radiologist recruitment efforts intensified 3. Focus group being established to address skin 2WW capacity challenges. 4. Shared working between B&P and Dermatology to address capacity shortage	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Aug-18	97.7%	98.4%	96.0%	97.7%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Aug-18	88.9%	90.5%	85.0%	87.4%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	May-18	93.7%	93.7%	92.0%	94.0%		The level of scrutiny and validation of PTL reports required post go live with Medway, has lead to an inability to accurately report RTT performance within the required timescales to report the monthly position. On going backlog clearance plans continue with good effect but similar issues regarding theatre and bed capacity remain. RMS and more recent MCAS primary care services also have compounded the position. However, RMS and MCAS remains unpredictable with short / no notice diverts back to secondary care	Surgical Beds have now been converted to Medical bed capacity. Bed availability to manage the Surgical demand could result in backlog increasing. Additional risk also 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	▲	Mar-18	100.0%		99.0%	100.0%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	May-18	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Sep-18	0.6%	0.8%	0.8%	0.6%		Achievement of cancelled ops target for August. One patient breached the 28 day re-list target in July due to the procedure being deemed to be more complex than anticipated.	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.	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Aug-18	100.0%	99.4%	100.0%	99.4%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Sep-18	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Sep-18	79.2%	76.1%	95.0%	78.2%		Accident and Emergency type 1 performance was 79.2%, a decrease on Augusts performance of 80.4%. The all type mapped STHK Trust footprint performance for September, was 89.7% a reduction on August 18 (90.5%) Type 1 attendances for September 18 were 9,202, a reduction of 105 on August 18. An executive led urgent and emergency care summit took place on September 12th, which brought together senior clinical and managerial leaders from across the organisation, with the purpose of formulating a plan to improve 4 hour performance; five workstreams have been developed, which will be governed through the Urgent and Emergency Care Council. Whiston ED ambulance notification to handover time was 10 mins on average for the month of September (target 15 mins) and total turnaround average turnaround time of 30 minutes (target 30 minutes). The Trust was the best performing adult emergency department, for ambulance notification to handover times in Merseyside and Cheshire and Greater Manchester	Patient experience, quality and patient safety	The urgent and emergency care transformation plan has several interconnected work streams designed to improve overall 4 hour access performance. Emergency Department/Front Door processes in place including 'walk in' streaming, Stretcher Triage streaming and internal departmental efficiencies and exit from ED. GP streaming in place as per NHSE recommendations. Flow through the Hospital Continuation of use of the SAFER Care Bundle to increase hospital discharges before midday to 33% and standardisation of daily Red to Green board rounds and afternoon huddles. Twice weekly discharge tracking meetings to manage medically optimised and DTOC escalation. Monthly Executive Multi-Agency Discharge Events (MADE) continue across the whole system to remove barriers and blocks that prevent patients with complex needs being discharged safely from hospital. Following 6a ECIP event and system resilience planning, commenced daily AMU/ED huddles and Community Matron in reach which is proving beneficial. Frailty in-reach to ED commenced. 1pm Frailty/ED/SpR safety huddle in place.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Sep-18	89.7%	88.3%	95.0%						
A&E: 12 hour trolley waits	F&P	▲	Sep-18	0	0	0	0		In line with the national expectation to reduce the number of Super Stranded patients (patients with a length of stay of greater than 21 days) by 25%, the trust has achieved a 15% reduction against this target. This is a further improvement on last months position (13%) Work has continued to maintain low numbers of 'good to go' patients as well as ensuring effective MDT management of clinically unwell patients.			

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Sep-18	0	0	0	0		Increased demand for IP capacity has a direct bearing on the ability to maintain this quality indicator.	Patient Experience	Maintained focus and awareness of this issue across 24/7.	RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Sep-18	9	126	No Target	224		% new (Stage 1) complaints resolved in month within agreed timescales continues to improve overall although there was a dip in September. There has been a decrease in the number of new complaints received in the last month.	Patient experience	The Complaints Team continue to improve the timeliness of responses, with 100% of first stage complaints responded to within agreed timescales for the last three months.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Sep-18	18	110	No Target	270					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Sep-18	88.9%	95.5%	No Target	67.0%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Aug-18	21	16	No Target	20		In August 2018 the average number of DTOCS (patients delayed over 72 hours) was 21.		Tracking meetings happen with LA/CCG and wards twice weekly to ensure the numbers of DTOCs are maintained below 20.	RC
Average number of Stranded patients per day (7+ days LoS)	Q	T	Sep-18	298	312 *Jun-Sep							
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Sep-18	113	119 *Jun-Sep							
Friends and Family Test: % recommended - A&E	Q	▲	Sep-18	86.1%	85.7%	90.0%	87.5%		The YTD recommendation rates remain below target for A&E, maternity (postnatal community) and outpatients, but are above target for in-patients, antenatal, birth and postnatal ward maternity services. Outpatients have seen an overall dip in recommendation rates from March 2018.	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. The Patient Experience Manager continues to work with leads in each area where performance is below target, to identify specific themes for improvement, which are then displayed as 'you said, we did' posters. Easy to use guides have been issued to each ward for completion of the You said we did posters. The posters are distributed centrally to ensure that each ward has up-to-date posters. Significantly negative comments are followed up with the contributor if contact details are provided to try and resolve immediate issues.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Sep-18	94.6%	95.4%	90.0%	95.8%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Sep-18	100.0%	98.9%	98.1%	98.5%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Sep-18	98.9%	98.3%	98.1%	97.9%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Sep-18	95.7%	95.7%	95.1%	96.6%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Sep-18	100.0%	97.4%	98.6%	98.1%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Sep-18	93.8%	94.0%	95.0%	94.5%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 53-60)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Sep-18	4.7%	4.5%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.7%		In September overall absence again remained static at 4.7%. This exceeds the Q2 target of 4.35% and is higher than this time last year. Qualified & HCA sickness has also remained static in month at 5.9%. YTD performance however has increased to 5.5% against the target of 5.3%.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	The Absence Support team continue to support the HR Advisors with welfare visits and stages to ensure timely action is taken and staff and managers are supported during this very busy period. The Stress Advisor has also been planning/ completing visits with hotspot areas, in conjunction with HRBP's to support workforce wellbeing. HRBP's are undertaking deep dives into hotspot areas to inform further action including help from Stress Advisor, OD plans.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Sep-18	5.9%	5.5%	5.3%	5.7%					
Staffing: % Staff received appraisals	Q F&P	T	Sep-18	82.0%	82.0%	85.0%	88.4%		Mandatory Training compliance exceeds the target by 11%. Appraisal compliance is below the target by 3%.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The Education, Training & Development and Workforce Planning teams continue to work with managers to ensure on-going maintenance of compliance for Mandatory Training & to improve the rate of compliance for Appraisals with non-compliance being reviewed by the Trusts Executive Committee on a monthly basis and also at department level finance & performance meetings.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Sep-18	96.0%	96.0%	85.0%	92.5%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q1	93.4%		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.	Findings from the Q1 survey have been shared with Survey Champions in Medical Care Group following the publication of the results in July. The Q2 survey in Surgical Care has closed and we are currently awaiting the results .	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q1	81.3%		No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Sep-18	0.8%		No Target			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. The Trust is undertaking a project with NHSE regarding retention of Nurses and this is part of our wider retention strategy and action plan for 2018/19 for the Trust.	AMS
FINANCE & EFFICIENCY (appendices pages 61-66)												
UORR - Overall Rating	F&P UOR	T	Sep-18	3.0	3.0	3.0	3.0		At the end of September (M6) the Trust is reporting an overall YTD I&E deficit of £2.1m which is behind plan by £0.6m The Trust is currently forecasting delivery of the plan. During Q3 the Trust will review the forecast to identify the respective risk and mitigations in delivering the Control Total. Better payment compliance is currently not being achieved on invoice numbers but is being achieved on value.	Delivery of Control Total	Weekly update to be provided to DoF on current progress of internal schemes. Divisions to report progress at Finance & Performance Committee. Executives to engage external stakeholders regarding progress of transformational programmes that will assist in delivering the Cost Improvement Programme. The approval of invoices within the Trust is impacting compliance. The Finance department will continue to work with areas of the Trust that need to improve.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Sep-18	5,242	5,242	19,000	12,325					
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Sep-18	(2,144)	(2,144)	10,993	5,001					
Cash balances - Number of days to cover operating expenses	F&P	T	Sep-18	3	3	2	12					
Capital spend £ YTD (000's)	F&P	T	Sep-18	2,146	2,146	9,516	9,180					
Financial forecast outturn & performance against plan	F&P	T	Sep-18	10,416	10,416	10,993	5,001					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Sep-18	91.0%	91.0%	95.0%	91.4%					

APPENDIX A

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

			Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	2018-19 YTD	2017-18 Target	FOT	2017-18	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	95.7%	88.0%	97.0%	85.0%		97.0%		
	Total > 62 days		0.0	0.0	0.0	0.0	0.0	0.0	2.5	0.0	0.0	0.0	0.0	0.5	1.5	2.0			3.5		
Lower GI	% Within 62 days	▲ £	84.6%	69.2%	88.9%	82.4%	78.6%	80.0%	91.7%	75.0%	100.0%	76.5%	100.0%	100.0%	92.3%	92.4%	85.0%		84.0%		
	Total > 62 days		1.0	2.0	0.5	1.5	1.5	2.0	0.5	1.5	0.0	2.0	0.0	0.0	0.5	2.5			12.5		
Upper GI	% Within 62 days	▲ £	88.9%	80.0%	100.0%	86.7%	100.0%	100.0%	63.6%	100.0%	80.0%	80.0%	80.0%	66.7%	62.5%	75.0%	85.0%		87.2%		
	Total > 62 days		0.5	0.5	0.0	1.0	0.0	0.0	2.0	0.0	1.0	1.0	0.5	0.5	1.5	4.5			5.0		
Urological	% Within 62 days	▲ £	81.3%	87.5%	77.4%	90.2%	96.6%	60.9%	96.8%	86.2%	93.8%	90.0%	78.8%	82.1%	97.0%	87.1%	85.0%		82.5%		
	Total > 62 days		4.5	1.5	3.5	2.0	0.5	9.0	0.5	2.0	1.0	2.0	3.5	5.0	0.5	12.0			37.0		
Head & Neck	% Within 62 days	▲ £	42.9%	20.0%	100.0%	83.3%	80.0%	33.3%	66.7%	100.0%	50.0%	66.7%	33.3%	57.1%	42.9%	48.0%	85.0%		64.6%		
	Total > 62 days		2.0	2.0	0.0	0.5	0.5	1.0	0.5	0.0	0.5	0.5	2.0	1.5	2.0	6.5			8.5		
Sarcoma	% Within 62 days	▲ £	0.0%	100.0%			50.0%	33.3%	100.0%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	94.1%	85.0%		66.7%		
	Total > 62 days		0.5	0.0			0.5	1.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.5			2.5		
Gynaecological	% Within 62 days	▲ £	55.6%	83.3%	100.0%	94.1%	55.6%	90.9%	66.7%	77.8%	87.5%	72.7%	50.0%	100.0%	72.7%	77.8%	85.0%		78.2%		
	Total > 62 days		2.0	0.5	0.0	0.5	2.0	0.5	0.5	1.0	0.5	1.5	0.5	0.0	1.5	4.0			12.0		
Lung	% Within 62 days	▲ £	72.7%	71.4%	87.5%	66.7%	100.0%	80.0%	100.0%	100.0%	87.0%	95.8%	88.9%	100.0%	100.0%	93.8%	85.0%		84.7%		
	Total > 62 days		1.5	1.0	0.5	3.0	0.0	1.5	0.0	0.0	1.5	0.5	0.5	0.0	0.0	2.5			11.5		RC
Haematological	% Within 62 days	▲ £	100.0%	50.0%	100.0%	85.7%	76.9%	100.0%	88.9%	83.3%	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	85.0%		80.6%		
	Total > 62 days		0.0	3.0	0.0	0.5	1.5	0.0	0.5	1.0	0.0	0.0	0.0	0.0	1.0	0.0			9.5		
Skin	% Within 62 days	▲ £	93.0%	88.9%	95.2%	98.2%	97.7%	100.0%	95.5%	92.5%	100.0%	91.4%	97.7%	93.8%	98.1%	95.9%	85.0%		95.2%		
	Total > 62 days		1.5	2.0	1.0	0.5	0.5	0.0	1.0	2.0	0.0	2.5	0.5	1.5	0.5	5.0			13.0		
Unknown	% Within 62 days	▲ £	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%		75.0%	100.0%	100.0%		100.0%	75.0%	92.9%	85.0%		78.4%		
	Total > 62 days		0.0	0.0	1.0	0.0	0.0	0.0		1.0	0.0	0.0	0.0	0.0	0.5	0.5			4.0		
All Tumour Sites	% Within 62 days	▲ £	84.5%	80.6%	89.5%	90.3%	90.6%	85.2%	89.1%	89.6%	94.2%	89.9%	90.3%	89.5%	88.9%	90.5%	85.0%		87.4%		
	Total > 62 days		13.5	12.5	6.5	9.5	7.0	15.0	8.0	8.5	4.5	10.0	8.0	9.0	9.5	41.0			119.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £	100.0%		100.0%		100.0%	100.0%					100.0%	100.0%	100.0%	100.0%	85.0%		100.0%		
	Total > 31 days		0.0		0.0		0.0	0.0					0.0	0.0	0.0	0.0			0.0		
Acute Leukaemia	% Within 31 days	▲ £				100.0%						100.0%			0.0%	50.0%	85.0%		100.0%		
	Total > 31 days					0.0						0.0			1.0	1.0			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)088

Title of paper: Executive Committee Chair's Report – October 2018

Purpose: To provide assurance to the Trust Board on those matters delegated to the Executive Committee.

Summary:

The paper provides a summary of the issues considered by the Executive Committee at the meetings held during September 2018.

There were a total of 4 Executive Committee meetings held during this period.

The Executive Committee agreed:

- The Cold Decontamination business case for referral to the Trust Board for approval
- The options appraisal for the future of Outpatient pharmacy dispensing
- SafeCare acuity monitoring module roll out to all wards by December 2018
- A business case to recruit additional staff for the urology service in response to increased demand.

The Executive Committee received the regular assurance reports covering; the Integrated Performance Report, agency and locum staff usage, appraisal and mandatory training compliance, the Risk Management Council and Corporate Risk Register. There was also a weekly progress report on the action taken to resolve the Medway PAS implementation issues.

There were no specific issues that required escalation to the Board.

Trust objectives met or risks addressed: All 2018/19 Trust objectives.

Financial implications: None arising directly from this report.

Stakeholders: Patients, Patients Representatives, Staff, Commissioners, Regulators

Recommendation(s): That the report be noted

Presenting officer: Ann Marr, Chief Executive

Date of meeting: 31st October 2018

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE
September 2018

1. Introduction

There were 4 Executive Committee meetings in September 2018.

2. 6th September 2018

2.1 Bank and Agency Report

The Deputy CEO/Director of Human Resources presented a report detailing the Trust's agency and locum staff utilisation to month 4. Although agency usage had decreased and use of internal bank staff increased the overall spend on bank and agency had not materially reduced. Further executive scrutiny of bank and agency staff requests and additional monitoring and controls were agreed.

2.2 Cold Decontamination Business Case

The Director of Estates and Facilities presented the business case and detailed the preferred option. The case was supported and subsequently presented and approved at the Trust Board in September.

2.3 Pharmacy Strategy

The Director of Operations and Performance presented options for the future provision of outpatient pharmacy dispensing services for the Trust, in line with the national Carter efficiency recommendations. There were national procurement frameworks in place and it was agreed that these should be explored.

2.4 CQUIN Update

The Director of Finance presented an update on CQUIN achievement for 2017/18 and the agreement of CQUINs for 2018/19 which had not yet been finalised, due to national changes. Achievement of the Trust financial plan for the year assumed that all potential CQUIN income would be secured.

2.5 SafeCare Roll Out – Up date

The first phase of the SafeCare roll out had now been completed on 4 wards. This had gone well, was producing useful information to support staffing decisions and staff had found the system easy to use. Roll out to the remainder of wards by December was agreed. This will then provide "real time" staffing and patient acuity information across all inpatient areas.

2.6 Local Consultant Excellence Awards

The Deputy CEO/Director of Human Resources briefed the Executive Committee on the changes to the national scheme and the implications for the Trust.

2.7 Weekly Medway Update Report

The Director of Informatics and Director of Operations and Performance reported that the system supplier had recently completed an intensive system support visit, and a joint action plan was being developed with the Trust. It was noted that it would still be some time before the RTT position would be fully validated and reported and that this remained a risk.

2.8 STP Technology Bids

The Director of Informatics reported that joint bids were being developed with local CCGs and Warrington and Halton NHSFT against the available funding to support integrated care.

2.9 Trust Board Agenda

The Director of Corporate Services presented the draft Trust Board agenda for September for review.

2.10 Halton Urgent Care Centre Procurement

The Director of Operations and Performance had attended the bidder information day, relating to the proposed re-procurement of the Widnes and Runcorn urgent care centres.

3. 13th September 2018

3.1. Risk Management Council (RMC) and Corporate Risk Register (CRR) Report

The Director of Corporate Services presented the Chair's report from the RMC and the Executive Committee reviewed the risks that had been escalated to the CRR during August.

3.2 Integrated Performance Report (IPR)

The Director of Finance presented the IPR for August and the Executive Committee reviewed performance across all the KPIs. In particular the issues in achieving the cancer access targets for complex multi trust pathways and the actions that had been put in place were reviewed.

3.3 New NHSI Rules for Agency and Locum Payments

The Deputy CEO/Director of Human Resources briefed the Committee on the new rules that had been announced by NHSI which reduced the agency cap and the requirement for the Chief Executives approval of all breaches. Although the Trust only had a small number of breaches they were often in critical posts and specialities which would have a significant service impact if not filled.

3.4 Medway Weekly Update

Progress had been made with the PTL validation process, but this was not yet complete and the system was still recording new patients in the same way, but configuration changes had now been agreed which would stop this. Patients who

had been waiting longest were the priority for validation to ensure that they were seen within 18 weeks. Capacity and the ability to undertake the back log activity before the end of the financial year was also discussed and the Director of Operations confirmed that each speciality was developing plans for how this would be achieved. The importance of getting to a position where the true referral rates and accurate waiting list could be reported was reiterated.

3.5 Board Development Programme

The Director of Corporate Services presented a paper outlining proposals for the Board development programme for the coming 12 months.

3.6 Phase 2 – Stroke Developments

The Director of Finance reported on progress in implementing the next phase of the Mid-Mersey stroke service changes, which had been planned for 1st October 2018. There remained some financial issues that needed to be resolved between Warrington and Halton Hospitals NHSFT and Warrington CCG, but StHK had made all the necessary preparations and was able to take all the acute stroke patients as soon as these issues had been resolved.

3.7 St Helens Reminisce Festival

The Director of Operations and Performance provided a briefing on the festival that had taken place the previous weekend and the number of seriously ill people who had attended A&E. There were reflections on whether this should have been declared a major incident and how the Trust could work more closely with the Local Authority to be better prepared for future events on this scale.

4. 20th September 2018

4.1 Urology Service Business Case

Members of the Urology Service management team attended the Committee to present the business cases requesting funding for additional staff to respond to increasing demand. The Director of Operations explained that an additional Consultant and Specialist Nurse posts would help to improve two week urgent cancer referral waiting times, allow further sub-specialisation and also reduce reliance on waiting list initiatives. The Executive Committee approved the business case as the investment would result in clinical improvements and a positive financial contribution.

4.2 Mandatory Training and Appraisals

The Deputy CEO/Director of Human Resources presented the monthly performance report for mandatory training and appraisals by Director.

4.3 Bank and Agency Report

The Deputy CEO/Director of Human Resources presented the month 5 bank and agency usage report, including analysis of agency cap breaches. There had been an increase in the number of shifts requested but a higher proportion had been

filled from the Trusts own bank. Additional information was requested for future reports to enable further analysis and strengthen assurance regarding the financial controls.

4.4 Medway Weekly Report

The Director of Operations reported on the continuing referral validation processes and that system re-configurations had been developed and were being tested that would resolve the issues going forward.

4.5 Executive Committee Time Out – 4th October

The Director of Corporate Services presented the draft agenda for the half day Executive time out and amendments were agreed to ensure best use of the time.

4.6 Audit of Coding Information

The Director of Finance reported on a recent audit of the information in patient case notes that was used to inform clinical coding and ensure the acuity and complexity of patients was accurately recorded. The Executive Committee agreed that the company should be asked to continue this process on a rolling basis for a period of 12 months.

5. 27th September 2018

5.1 General Medical Council – National Trainee Survey Results

The Deputy CEO/ Director of Human Resources presented a summary of the results nationally and for the Trust. The survey had been completed by over 40,000 Doctors in training in England and 209 of the 211 working at the Trust. The Trust reflected the North West and National picture, which was a reported decline in satisfaction following the introduction of the new Junior Doctors contract in 2016.

An action plan was being developed in response to the survey which included consideration of the increased role of advanced nurses to work alongside Doctors in Training and the adoption of Hospital at Night, so there was more support 24 hours a day. The impact of HEE trainee allocations compared to the demand experienced by the Trust was also acknowledged.

5.2 Orthodontics Service – lessons learnt

The Deputy CEO/Director of Human Resources presented a paper that summarised the 6 year process to withdraw from the provision of orthodontics services by the Trust and the lessons learnt from dealing with specialist commissioning, local CCGs and other service providers.

5.3 Medway PAS Weekly Update

The Director of Operations reported that system fixes had now been tested and were being implemented. Referral information for GP referrals only was presented to gain an understanding of underlying activity trends and the capacity that would be needed to cope with the backlog. The analysis showed that comparing average

GP referrals per day showed an increase of 8.7% from April – August 2018, compared to the same period in 2017. The longest waiters continue to be prioritised and the Trust had no 52 week breaches. The Trust continued to keep its regulators informed.

5.4 Digital Maturity Investment Plan

The Director of Informatics presented the proposed 5 year investment programme to deliver the; Trust's digital strategy, ensure IT infrastructure would be fit for purpose and meet the national digital maturity standards. The programme was accepted in principle but would be subject to the annual capital budget and planning processes.

5.5 Letters to Primary Care – outside the local COIN

The Director of Informatics reported on the progress in ensuring that electronic correspondence could be sent in a timely and secure way to practices in Liverpool and other CCGs who were not part of the Trust's normal catchment population. This had now been tested and was due to go live by the end of October 2018.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)89

Title of paper: Committee Report – Quality Committee Chair's Report

Purpose: To summarise the meeting papers from the 23 October 2018 and escalate issues of concern.

Summary:

QC(18)131 Learning from Deaths: The report highlighted improvements which are being made to the Learning from Deaths process following the recent CQC inspection. Most of the Actions are now complete with the exception of actions 1 & 11 which remain challenging and more work is required before these can be signed off.

QC(18)124 Complaints Update: 64 first stage complaints were received and opened in Q2; 1 more than Q1. 12 second stage complaints were opened in Q2, 4 more than the previous quarter. The Trust responded to 96.3% of 1st stage complaints in the agreed timescales in Q2 an increase compared to 94.4% in Q1. Clinical treatment remained the primary cause for complaint with patient/nursing care being the second.

QC(18)125 IPR: the main issues to be noted from the IPR are as follows:

- The CQC draft report is currently out for managers to perform factual accuracy checks. The deadline for submission is Friday 26 October.
- 1 never event has been reported, against a target of 0
- No MRSA bacteraemia cases, against a target of 0
- 2 C.Difficile positive cases reported against a tolerance of 40. YTD there have been 13 cases
- No Grade 3/4 Pressure Ulcers reported.
- Safer Staffing fill rate was 94.5%. YTD performance is 96.2%.
- There was 1 inpatient fall resulting in severe harm which occurred in an inpatient area.
- VTE assessment was 98.47%, YTD performance is 95.81% against a target of 95%.
- Year to date HSMR for 2018-19 is 90.8%.

QC(18)126 Safer Staffing: M6 has seen a decrease of RN overall fill rate by 2.52% and an increase in Care staff fill rate by 1.35%.

QC(18)129 Continuity of Carer Update: The report confirmed that the STHK Maternity Service is achieving satisfactory progress towards achieving the target of 20% of women using the service are able to access a continuity of carer pathway.

QC(18)127 ILS Non-Compliance for RNs: The Immediate Life Support and Basic Life Support Compliance report highlighted that the current training compliance is sub-optimal against the standard agreed by the Trust Resuscitation Group. AMS confirmed this will be discussed at the next review of Mandatory Training.

QC(18)130 Freedom to Speak Up Report: The report highlighted the Q1-Q2 position regarding Trust cases, self-assessment and internal actions being progressed in line with the National Guardians office guidance

QC(18)132 WRES Action Plan Quarterly Update: Report confirms the 3 Workforce Equality Diversity and Inclusion Strategy and 3 year Programme Plan was approved at WFC in July 2018 with delegated authority to Quality Committee. Many of the actions detailed in the plan indicate a completion date within the first 12 months.

Feedback from Councils/Committees:
QC(18)133 Patient Safety Council: The summary page was noted. There were no issues to escalate.

QC(18)134 Patient Experience Council: The summary page was noted. Positive feedback was noted from HealthWatch following a recent end of life event.

QC(18)135 Clinical Effectiveness Council: The summary page was noted. The following were identified for escalation:

- Respiratory: Audit staff/research nurse support required for Best Practice Tariff/Quality audit requirement.
- Obs & Gynae: Review of MBRRACE UK data. JK provided an update re MBRRACE as the lead and confirmed anomalies are being monitored by the Head of Midwifery.
- Rheumatology: Staff stress is a concern due to workload and problems with appointments system.
- Medicines reconciliation: Compliance is poor in surgery. Pharmacist in post 10 September for Ward 4A which is helping to improve compliance.
- Medway: raised in both Respiratory and Rheumatology presentations as a problem.

QC(18)136 CQPG: The summary page was noted and the following highlighted:

- DIEP Breast reconstruction: Due to the current tariff the Trust will experience financial losses associated with delivering this service. The Trust on advice from NHSI is commencing its work with Commissioners to discuss a locally priced tariff. Commissioners will add this service to the agenda of the next Collaborative Commissioning Forum (CCF).
- The Healthy Eating CQUIN was not achieved which resulted in financial loss to Trust.

QC(18)137 Mortality Surveillance Group: The report was noted and feedback on the layout given. Chair confirmed recurrent themes would be a welcome addition and queried whether the dates in the action plan were feasible; it was decided to extend them to January 2019.

Policies/Documents for Approval: There were no items presented for approval.

Policies/Documents for Approval by Councils: None received.

Items to be brought to the attention of the Board:

- ILS non-compliance

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: Chair of Committee

Date of meeting: 31 October 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)90

Title of paper: Committee Report – Finance & Performance

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

Summary:

Agenda Items

For Information

- Contract KPI's & CQUIN
  - The Committee discussed the financial penalties incurred by the Trust so far, these are within the plans set by the Trust at the beginning of the year.
  - The CQUIN schemes were also discussed and it was noted that there is little flexibility with the CCG to negotiate a local variations. The schemes are monitored monthly by the Director Nursing and any risks to delivery are highlighted within the monthly finance report.

- Forecast Outturn
  - The forecast outturn position was presented taking the Committee through the current run rate and underlying financial position of the Trust. A projected forecast for Q3 & Q4 was also presented with potential mitigations to help towards delivery of each quarter.
  - Discussion focussed around the productivity achieved during 2018/19 and how this could be improved for the remainder of the year and sustained into future activity plans.
  - The committee felt that there is a significant risk to achieving the £1.8m deficit outturn position. Recovering the operational impacts of Medway in Q1/Q2 and STP level CIPs were the drivers. There was also concern around the possible impact of winter pressures given no funding allocations but are in a better position than last year.
  - The committee was encouraged that there were ideas to bridge the recurrent issues of not achieving outturn. More work on this was required once planning guidance from regulators was issued.
  - The committee wished to consider again the outturn position at the November meeting.

- Briefings were accepted from:
  - CIP Council
  - Procurement Steering Council

For Assurance

- A&E Performance
  - The Committee reviewed the presentation from the ADO for Urgent Care on the current performance.
  - It was noted that ambulance handover time was the best in the north west

region and the committee wish to thank all involved in that achievement.
    - The ADO highlighted the work streams which has been implemented within the department, the Committee requested a timeline be added to each action for future presentations with expected improvements in performance.
    - The pathways from the GP within A&E into Acute services were discussed, the committee felt referrals should align to attending an external GP, and the ADO will investigate the current process.

- Integrated Performance Report Month 6
    - Discussion took place around operational performance. There had been no grade 3 or 4 avoidable pressure ulcers YTD and no MRSA bacteraemia cases YTD.
    - The committee noted that there have been 13 C-Difficile cases YTD, with a tolerance of 40 for the year.
    - There was concern on the performance of 2 week cancer waits as it only achieved 87% against a target of 96%.

- Finance Report Month 6 2018/19
    - The month 6 financial position was presented to the committee showing a £2.1m deficit position with includes all PSF funding for Q2. It was noted that following the QRM meeting with NHSI Q2 A&E PSF funding will need to be removed during the next reporting period. During the discussion at QRM NHSI have agreed to review the system-wide mapping to ensure all walk in centre activity is mapped appropriately. The impact of Q1 and Q2 A&E PSF being clawed back is c£1.2m

    - The following elements were reviewed and discussed:
        - Cash of £3.2m, with cash balances challenging as a result of delays in payments from NHS organisations.
        - Capital spend of £2.1m with plans in place for full allocation.
        - The financial position was supported by £2.7m non-recurrent support which will be affecting the underlying position.
        - UoR of 3 which was in line with plans.
    - CIP is above plan by £0.3m with green schemes now representing 2.5% of total income, which is higher than the national planning assumptions.

- CIP Programme update
    - The committee noted the improvement in green rated schemes with £10.322m now delivered. This is an increase from M5 by £0.682m.

- CIP Programme update – MCG
    - The Care Group presented their position with £3.5m of their £5.2m target already achieved which equates to 70%.
    - The Committee reviewed the proposals that the Care Group had identified to deliver the remainder of their CIP target and were assured that progress is being made.

For Approval

- Temporary Loan Facility
    - The paper highlighted the increasingly challenging cash position both from the timing of PSF payments and the additional cash requirement from lead employer contracts. The paper requested the Committee to recommend the Board taking out a loan with the expectation of repayment following receipt of PSF funding.
    - The Committee agreed to recommend to the Board the taking out of a loan.

Risks noted

- Inclusion of PSF within financial position for A&E performance for Q2
- CIP profile and step up in delivery from Q3 onwards
- Non-recurrent measures utilised within financial position YTD and limited scope going forward.
- A&E performance
- Achievement of Q3 and Q4 given risks on winter and its impact.

Items to be raised at Board

- Underperformance of 2 week cancer rule compliance.
- Trusts performance relating to ambulance handover times, we are the best performing adult emergency department in the North West region.
- Cash risk as a result in delays to payments from other NHS organisations (Lead Employer)
- Risk to achievement of our planned outturn position, changes to the Trust's forecast position will need to follow the NHSI protocols.
- Recommendation to take out the temporary loan facility.

Corporate objectives met or risks addressed: Finance and Performance duties
Financial implications: None as a direct consequence of this paper
Stakeholders: Trust Board Members
Recommendation(s): Members are asked to note the contents of the report
Presenting officer: Jeff Kozer, Non-Executive Director
Date of meeting: 31st October 2018

TRUST BOARD

Paper No: NHST(18)91

Title of paper: Committee Report – Charitable Funds Committee

Purpose: To brief the Board on the main issues discussed and decisions made at the Committee meeting on 25th October 2018.

Summary

1. Action Log
   Discussions are still ongoing around:
   - the physical presence of the Charity within the hospital
   - Giant Cash Bonanza Lottery

   Action is to be taken to implement the administrative review of charitable funds and the education of staff with regards to charitable donations.

2. Financial position - The Committee noted the level of investments and recent income and expenditure. It was also noted that some of the investment portfolio may need to be redeemed in the near future because of increased expenditure.

3. Approval of expenditure - a presentation was given by Dr Abbas Badawi for funding from the Cardio-Respiratory Fund, to purchase an Innosight Ultrasound Scanner System. The system will allow a more accurate pleural ultrasound, enable exportation of images to PACS, improving the accuracy of scans and enhancing the quality of the existing service within the Respiratory Dept. The committee agreed to the purchase.

   Agreement was given to fund attendance at the International Radiology Conference in Chicago by Gill Navis, Lead Sonographer, from the Radiology Training Fund.

   No one was in attendance at the meeting to promote the case for a Specular Microscope for Ophthalmology. The decision was deferred until the next meeting by which time either the proposers have made their case to Mr N Khashu, Director of Finance, previously, or attend the meeting.

4. Fundraising update
   - Mrs E Titley, Charity Manager, gave details of fundraising activities that are going to be held regularly, for example, the abseil, Pink Friday, Lilac Centre walk
   - The committee was also briefed on various ways that donations/funds are being sought. One example was getting £3.5k from Tesco in the form of new toys for the paediatric department

5. Any other business –
    - The Annual Accounts and Report 2017-18 were approved by the Committee on behalf of the Trustee (ie the Trust Board) after the independent examiner's report done by Grant Thornton, external auditors.
    - Christmas monies – the Committee agreed £5.00 per patient to be spent on Christmas gifts, plus biscuits/sweets for visitors.
    - Eric Phipps, IT Network and Security Manager, emailed a request to use the charity status in order to purchase a Cyber Security tool which is free if purchased through a registered charity. The tool is called Nessus (also known as a vulnerability scanner) and will allow IT to find and fix problems and potential weaknesses with devices on the network, providing a more secure IT infrastructure. This was agreed.

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

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff and all stakeholders.

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

Presenting officer: Nikhil Khashu, Director of Finance

Date of meeting: 31st October 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)92

Title of paper: Committee Report – Audit

Purpose: To feedback to members key issues arising from the Audit Committee.

Summary: The Audit Committee met on 17th October 2018.

The following matters were discussed and reviewed:

External Audit :

- External audit update report (GT)
- Trust Response to Emerging Issues and Developments Questions raised in above report (DoF)

Internal Audit:

- Internal audit progress report (MIAA)

Anti-Fraud Services:

- Anti-Fraud progress report (MIAA)

Trust Governance and Assurance:

- The Director of Nursing update including update from Quality Committee (DoN).

Standing Items:

- The audit log (report on current status of audit recommendations) (ADoF)
- The losses, compensation and write-offs report for the period 1st April 2018 to 30th September 2018 (ADoF).
- Aged debt analysis as at end of September 2018 (ADoF).
- Tender and quotation waivers report (ADoF).

Other:

- Update for the Audit Committee including action plan regarding recent Consultant Job Planning review categorised as limited assurance (HR)

Key:

GT= Grant Thornton (external auditor)

MIAA = Mersey Internal Audit Agency (internal audit and anti-fraud services)

DoF = Director of Finance

DoN = Director of Nursing, Midwifery & Governance

ADoF = Assistant Director of Finance (Financial Services)

HR = HR representative

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

Corporate objectives met or risks addressed: Contributes to the Trust's Governance arrangements
Financial implications: None as a direct consequence of this paper
Stakeholders: The Trust, its staff and all stakeholders
Recommendation(s): For the Board to note.
Presenting officer: Su Rai, NED and Chair of Audit Committee
Date of meeting: 31st October 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)93
Title of paper: Strategic and Regulatory Update Report – October 2018
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 policy and regulatory developments including; 1. Planning Guidance 2019/20 and payment reform proposals 2. UK Corporate Governance Code 3. CQC State of Care Report 2017/18 4. Brexit preparations
Trust 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 H&SCP, Commissioners, Regulators
Recommendation(s): The Board is asked to approve the Board development programme and note the other items.
Presenting officer: Nicola Bunce, Director of Corporate Services
Date of meeting: 31st October 2018

Strategic and Regulatory Update Report – October 2018

1. Planning Guidance 2019/20 and payment reform proposals

Following the announcement of a five year budget settlement for the NHS, NHS Improvement and NHS England (NHSI/E) have issued initial guidance setting out the proposed planning process.

The proposed NHS annual 3.4% real terms growth between 2019/20 and 2023/24 needs to be supported by credible long term plans developed by local health systems to deliver the NHS 10 year plan that is due to be published in November/December 2018.

NHSI/E are developing a new policy framework, which will include clinically led reviews, the development of a new financial architecture and different approaches to workforce and physical capacity planning. The new plans must also:

- improve productivity and efficiency
- eliminate provider deficits
- reduce unwarranted variation in quality of care
- incentivise systems to work together to redesign patient care
- improve how demand is managed
- make better use of capital investment

There is an outline planning timetable (appendix 1) which balances 1 year and five year planning, with 1 year plans for 2019/20 to be developed by individual organisations, which will then be aggregated at STP level and accompanied by a "local system operational plan narrative".

STPs are then also being asked to produce detailed 5 year plans by summer 2019.

In addition payment reforms are being proposed from 2019/20, which include:

- a blended payment approach for urgent and emergency care
- removal of marginal rate tariffs for emergency care and emergency re-admissions
- changes to the Market Forces Factor(MFF)
- the introduction of centralised procurement
- a move away from organisational control totals and the Provider and Commissioner Sustainability Funds (PSF and CSF)
- reducing the value of CQUIN to offset core prices and also focussing on a smaller number of indicators
- Aligning the Quality Premium payments to strategic priorities

All Boards/Governing Bodies have been asked to ensure they plan adequate time to work with their local health system partners and for review and sign off of the annual and 5 year plans.

2. UK Corporate Governance Code

The Financial Reporting Council (FRC) has published the new UK Corporate Governance Code (the code) which comes into force from 1 January 2019. The code is of interest as a benchmark of good corporate governance and because NHS guidance on best practice governance for NHS Boards and the requirements of annual governance statements have historically been updated in line with the Code.

The key changes set out in the new code are:

Workforce and stakeholders: There is a new provision to promote greater Board engagement with the workforce to understand their views. The code asks Boards to describe how they have considered the interests of stakeholders when performing their duty to promote the success of the organisation.

Culture: The new code places greater emphasis on the need for Boards to create a culture which aligns the organisation's values with strategy. Importantly the code asks Boards to assess how the Board leads in generating and preserving value over the long-term, as well as achieving short term benefits.

Succession and diversity: The code emphasises the need for Boards to have the right mix of skills and experience to ensure constructive challenge and to promote diversity. It stresses the need to refresh boards and for robust succession planning. It also asks that meaningful consideration is given to the length of term that chairs remain in post, so that a clear division of power exists between chair and chief executive.

Remuneration: The new code emphasises that remuneration committees should take into account workforce remuneration and related policies when setting director remuneration.

These changes will be factored into the Trusts own annual effectiveness review process for the Trust Board and Board Committees.

3. CQC State of Care Report 2017/18

CQC have published a second state of care report bringing together their conclusions from inspections of a range of health and social care providers in 2017/18 and the 20 system reviews that were undertaken. The main conclusions from the report were:

Most people in England receive a good quality of care. Ratings showed that quality overall has been largely maintained from last year. But quality and access to care are not consistent, and people's overall experiences of care are varied. Services for many people with multiple or complex needs were not joined up.

Access – In 2018, access to care varies from place to place across the country. Some people cannot access the services they need, or their only reasonable access is to providers with poor services. In two years, the number of older people living with an unmet care need has risen by almost 20%, to nearly one in seven older people. Friends and family carers must often fill the gap, but three quarters of carers had received no support or a day's break in the previous 12 months.

More than 40% of GP practices now provide access outside of their normal hours, but the general practice workforce is increasingly stretched, and there was wide variation in the proportion of patients in local areas that were satisfied with the appointment times they were given.

In the NHS, the number of patients waiting to start treatment in hospital 18 weeks after being referred rose by 55% from 2011 to 2018.

Quality – The overall quality of care in the major health and care sectors has improved slightly. More than nine out of 10 (91%) of GP practices and 79% of adult social care services were rated as good at 31 July 2018. More than half (60%) of NHS hospital core services and 70% of NHS mental health core services were rated as good at that date.

Our ratings show that, around one in six adult social care services and one in five NHS mental health core services needed to improve, and one in 100 was rated as inadequate. Almost a third of NHS acute core services were rated as requires improvement and three in 100 were rated as inadequate.

The safety of people who use health and social care services remains our biggest concern. There were improvements in safety in adult social care services and among GP practices. But while there were also small safety improvements in NHS acute hospitals, too many need to do better, with 40% of core services rated as requires improvement and 3% rated as inadequate. NHS mental health service also need to improve substantially, with 37% of core services rated as requires improvement and 2% as inadequate.

Workforce– Workforce problems have a direct impact on people's care. Getting the right workforce is crucial in ensuring services can improve and provide high-quality, person-centred care. Each sector has its own workforce challenges, and many are struggling to recruit, retain and develop their staff to meet the needs of the people they care for.

Recruiting and retaining newly qualified GPs is a problem in a profession where there is already an ageing workforce.

In adult social care, the highest vacancy rates in all regions in 2017/18 were for the regulated professions that include registered nurses, allied health professionals and social workers. Vacancy and turnover rates for all staff groups are generally higher in domiciliary care agencies than in care homes.

In our review of children and young people's mental health services, low staffing levels were the most common reason for delays in children and young people receiving care.

Demand and capacity – Demand is rising inexorably, not only from an ageing population but from the increasing number of people living with complex, chronic or multiple conditions, such as diabetes, cancer, heart disease and dementia. Demand for urgent and emergency care services continued to rise in 2017/18, with more attendances at emergency departments than ever.

The capacity of adult social care provision continues to be very constrained: the number of care home beds dropped very slightly in the year, but what was noticeable were the wide differences across the country.

Providers face the challenge of funding the right capacity to meet people's needs. Services need to plan – together – to meet the predicted needs of their local populations, as well as planning for extremes of demand, such as sickness during winter and the impact this has on the system.

Funding and commissioning – Care providers need to be able to plan provision of services for populations with the right resources, so good funding and commissioning structures and decision-making should be in place to help boost the ability of health and social care services to improve. Funding challenges of recent years are well known, and in June 2018 the government announced an extra £20.5 billion there is no similar long-term funding solution for adult social care.

4. Brexit preparations

The Department of Health and Social Care (DHSC) has formally requested all NHS organisations to undertake a formal self-assessment of the risk to critical equipment and supplies in the event of a "no deal" Brexit. The "at risk" contracts and proposed mitigation plans have to be submitted to the DHSC by 30th November 2018. The procurement teams in the Trust are working with colleagues across Cheshire and Merseyside to produce a coordinated response from the local health system that avoids multiple requests for the same information from common suppliers.

The risk of a "no deal" Brexit has been added to the Corporate Risk Register.

Appendix 1

Outline timetable for planning	Date
NHS Long Term Plan published	Late November / early December 2018
Publication of 2019/20 operational planning guidance including the revised financial framework	Early December 2018
Operational planning	
Publication of • CCG allocations for 5 years • Near final 2019/20 prices • Technical guidance and templates • 2019/20 standard contract consultation and dispute resolution guidance • 2019/20 CQUIN guidance • Control totals for 2019/20	Mid December 2018
2019/20 Initial plan submission – activity and efficiency focussed with headlines in other areas	14 January 2019
2019/20 National Tariff section 118 consultation starts	17 January 2019
Draft 2019/20 organisation operating plans	12 February 2019
Aggregate system 2019/20 operating plan submissions and system operational plan narrative	19 February 2019
2019/20 NHS standard contract published	22 February 2019
2019/20 contract / plan alignment submission	5 March 2019
2019/20 national tariff published	11 March 2019
Deadline for 2019/20 contract signature	21 March 2019
Organisation Board / Governing body approval of 2019/20 budgets	By 29 March
Final 2019/20 organisation operating plan submission	4 April 2019
Aggregated 2019/20 system operating plan submissions and system operational plan narrative	11 April 2019
Strategic planning	
Capital funding announcements	Spending Review 2019
Systems to submit 5-year plans signed off by all organisations	Summer 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)94

Subject: Statement of Compliance with NHS Emergency Preparedness, Resilience and Response (EPRR) Core Standards

Purpose: To present to Board members the annual assessment and statement of compliance and action plan.

Summary:

The Trust is required to complete an annual self-assessment to provide assurance of compliance with the national EPRR core standards for acute hospitals to the Department of Health. The Accountable Officer (Director of Nursing, Midwifery & Governance) for the Trust must sign the Statement of Compliance form and present it to the Board and then submit it to Cheshire & Merseyside NHS England resilience team. EPRR must also form part of the Trust's annual report and report to the public on the website.

The self-assessment core standards template (see appendix A) consists of 64 questions (applicable to the Trust) on Major Incident preparedness and business continuity including questions on HAZMAT/CBRN preparedness.

There are an additional 8 'deep dive' questions on command and control that do not affect the overall score, with which the Trust is fully compliant.

The Trust is 'fully compliant' with 59 questions and 'partially compliant' with 5 questions (see attached).

Last year the Trust achieved 98.4% compliance and was rated as 'fully compliant'. This year's audit shows that the Trust is 'substantially compliant' at 92.19%, due to the addition of new assessment criteria rather than any deterioration.

The statement and action plan have been reviewed by the Risk Management Council and are recommended to the Board.

Corporate Objectives met:

We will meet and sustain national and local performance standards.

Financial Implications: N/A

Stakeholders: Staff, patients, EPRR partner agencies (NHS England, PHE, CCGs, other local NHS Trusts, emergency services, local councils, utility network providers, transport authorities, voluntary agencies with an emergency role).

Recommendation(s):

That the Trust Board approves the Statement of Compliance and supporting action plan.

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

Committee date: 31st October 2018

Emergency Planning Response and Resilience (EPRR) Core Standards Assurance 2018-19

Introduction

The Trust is required to complete an annual self-assessment to provide assurance of compliance with the national EPRR core standards for acute hospitals to the Department of Health. The Accountable Officer (Director of Nursing, Midwifery and Governance) for the Trust must sign the Statement of Compliance form and present it to the Board and then submit it to Cheshire & Merseyside NHS England resilience team. EPRR must also form part of the Trust's annual report and report to the public on the website.

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Actions arising from 2018/19 assurance process

See Appendix 1.

Reasons for 'partial compliance'

- Question 9 - on collaborative working requires the new CSU officers representing CCGs to be invited to future Major Incident Planning Group Meetings and Trust training and exercises (as either players or observers).
- Questions 20 & 21 - regarding live evacuation and regular lockdown exercising are new additions to this year's core standards.
- Question 28 - now specifically requires executives and key senior managers/ directors to attend strategic and tactical multi-agency command & control (MAGIC) courses run by Merseyside Local Resilience Forum.
- Question 40 - refers to mandatory attendance at the Local Health Resilience Partnership (LHRP) strategic level meetings (now 3 x per year rather than 4). The organisation's Accountable Officer regularly attends the Local Health Resilience Partnership meetings. The difficulty has always been that Executive LHRP meetings are scheduled at the same time as Trust Board, however, in future an assistant director can attend, but every effort must be made to ensure senior level attendance at these meetings by an officer who has authority to commit resources and sign off strategic level agreements.

Conclusion

The Board is requested to note and approve the results of the audit and the commitment to the action plan and the on-going delivery of the EPRR programme.

Jayne Heaney
Head of Emergency Management

ENDS

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Time scale	Comments (including organisational evidence)
1	Governance	Appointed AEO	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Fully compliant				
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Fully compliant				
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board.	Fully compliant				
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan	Fully compliant				
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Fully compliant				
6 7	Governance Duty to risk assess	Continuous improvement process Risk assessment	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	Fully compliant				
			The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	Fully compliant				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Fully compliant				
9 11 12	Duty to maintain plans Duty to maintain plans Duty to maintain plans	Collaborative planning Critical incident Major incident	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements	Partially compliant	Further work with LHRP partners NHS England and CSU on collaborative planning and exercising.	Jayne Heaney	Apr-19	invitation to MIPG and exercise planning review
			In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				
			In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				
15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				
16	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				
17	Duty to maintain plans	Mass Countermeasures	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				
18	Duty to maintain plans	Mass Casualty - surge	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Time scale	Comments (including organisational evidence)
19 **20**	**Duty to maintain plans** **Duty to maintain plans**	**Mass Casualty - patient identification** **Shelter and evacuation**	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				
			In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Practical evacuation exercise of a ward to be scheduled in Summer 2019	Steve Byrne, Fire Advisor	Aug-19	Exercise Proposal to be discussed at Major incident Planning Group meeting in February 2019 and planning group and meetings appointed. Multi agency exercise involving Fire and Ambulance Service and NHS England and local CCG
21 **22**	**Duty to maintain plans** **Duty to maintain plans**	**Lockdown** **Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Practical Lockdown exercise involving rolling internal lockdown to be scheduled Autumn 2019	Dyan Clegg, Dep Director Estates Manageme nt	Oct-19	Exercise Proposal to be discussed at Major Incident Planning Group meeting in February 2019 and planning group and meetings appointed. Joint multi agency exercise with the Trust, Vinci (PfI provider) , Medirest (soft FM provider) and Merseyside Police
			In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				
23	**Duty to maintain plans**	**Excess death planning**	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements. A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				
24	**Command and control**	**On call mechanism**		Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	Fully compliant				
25	**Command and control**	**Trained on call staff**	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement	Fully compliant				
26 **27** **28** **30**	**Training and exercising** **Training and exercising** **Training and exercising** **Response**	**EPRR Training** **EPRR exercising and testing programme** **Strategic and tactical responder training** **Incident Co-ordination Centre (ICC)**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Fully compliant				
			The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning	Fully compliant				
			Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff	Partially compliant	Senior / Exec to attend MAGIC courses for 2019/20			
			The organisation has a pre-identified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards	Fully compliant				
31 **32** **33**	**Response** **Response** **Response**	**Access to planning arrangements** **Management of business continuity incidents** **Loggist**	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies	Fully compliant				
			The organisations incident response arrangements encompass the management of business continuity incidents.	Y	• Business Continuity Response plans	Fully compliant				
			The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for accessing and utilising loggists • Training records	Fully compliant				
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising	Fully compliant				
35	**Response**	**Access to 'Clinical Guidance for Major Incidents'**	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies	Fully compliant				
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	Guidance is available to appropriate staff either electronically or hard copies	Fully compliant				
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Fully compliant				

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38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Fully compliant				
39 40 41	Warning and informing Cooperation Cooperation	Media strategy LRHP attendance LRF / BRF attendance	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'	Fully compliant				
			The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	Y	• Minutes of meetings	Partially compliant	Assistant Director nominated to ensure future full attendance at Strategic Level	Rajesh Karimbath	future LHRP meetings	
			The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented	Fully compliant				
42 46	Cooperation Cooperation	Mutual aid arrangements Information sharing	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Fully compliant				
			The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Fully compliant				
47	Business Continuity	BC policy statement	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Fully compliant				
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles	Fully compliant				
49 50 51 52 53	Business Continuity Business Continuity Business Continuity Business Continuity Business Continuity	Business Impact Assessment Data Protection and Security Toolkit Business Continuity Plans BCMS monitoring and evaluation BC audit	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.	Fully compliant				
			Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	Fully compliant				
			The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Fully compliant				
			The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers	Fully compliant				
			The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	Fully compliant				
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	Fully compliant				
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework	Fully compliant				
56	CBRN	Telephony advice for CBRN exposure	Staff have access to telephone advice for managing patients involved in CBRN exposure incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Fully compliant				
57	CBRN	HAZMAT / CBRN planning arrangement	There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex).	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Fully compliant				
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	Fully compliant				
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 /7	Fully compliant				
• Stakeholders • Provider/supplier business continuity arrangements										
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident- guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Completed equipment inventories; including completion date	Fully compliant				
61	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Y	Completed equipment inventories; including completion date	Fully compliant				

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Time scale	Comments (including organisational evidence)
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	Record of equipment checks, including date completed and by whom.	Fully compliant				
63	CBRN	Equipment PPM	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other equipment	Y	Completed PPM, including date completed, and by whom	Fully compliant				
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy	Fully compliant				
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT / CBRN Decontamination training lead is appropriately trained to deliver HAZMAT / CBRN training	Y	Maintenance of CPD records	Fully compliant				
66	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what- will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Fully compliant				
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	Maintenance of CPD records	Fully compliant				
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what- will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	Fully compliant				
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) 24 / 7.	Y		Fully compliant				

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)95
Subject: Workforce Equality, Diversity & Inclusion quarterly update incorporating the Workforce Race Equality Standard (WRES) Annual Update 2018
Purpose: To provide Assurance to the Trust Board that the Equality, Diversity & Inclusion and Workforce Race Equality Standard (WRES) is being monitored on a quarterly basis by the Quality Committee.
Summary: The Workforce Equality, Diversity & Inclusion Strategy and 3 year Programme Plan was approved at Workforce Council in July 2018 with the delegated authority of the Quality Committee. The Trust Board received the annual WRES and Action Plan in August 2018. The Quality Committee received their first quarterly update on the 23rd October 2018.
Corporate Objective met or risk addressed: Developing organisational culture and supporting our workforce
Financial Implications: Funding will be required for the training elements for the action plan. A business case will be presented to the Trusts Executive Committee by the end of Q3.
Stakeholders: Staff, managers, the Trust Board, patients, potential applicants.
Recommendation(s): The Trust Board are asked to note the assurance provided by the Quality Committee and that the ED&I action plan is on progress
Presenting Director: Anne-Marie Stretch, Deputy CEO & Director of Human Resources
Trust Board Date: 31st October 2018

Trust Board

Equality, Diversity & Inclusion Strategy Update

This paper advises the Trust Board that Quality Committee received the first quarterly update on progress made against key actions contained within the Workforce Equality, Diversity & Inclusion 3 year programme of work at the Quality Committee on the 23rd October 2018. An integral component of the action plan is the requirement to undertake the annual Workforce Race Equality Standard (WRES) and incorporate any actions into the wider programme of work. The Quality Committee also received a quarterly update on the annual WRES action plan for 2018/19 following the provision of WRES to the Trust Board in August 2018.

The Trusts 3 year Workforce Equality, Diversity and Inclusion Strategy 2018 – 2021 was approved by Workforce Council in July 2018 on behalf of the Quality Committee. It is supported by a 3 year Programme Action Plan that incorporates in one place, all the actions that the Trust has committed to such as in the:

- Equality Delivery System 2 (EDS2),
- Workforce Race Equality Standard (WRES),
- The forthcoming Workforce Disability Equality Standard (WDES),
- Gender Pay Gap

The Workforce Council monitors the detailed implementation of the action plan and receives quarterly progress reports from the Equality, Diversity & Inclusion Steering Group. The Trusts Non-Executive Director workforce and E,D&I champion is also engaged in the assurance process to the Board on the national standards and action plans.

To date good progress is being made against the ambitious programme of work. The Quality Committee will receive the next quarterly update in February following the Workforce Councils report in January 2019.

The Trust Board are requested to note that the Trust has been invited to take part in a GMC commissioned research programme to better understand why statically more BME doctors are subject to disciplinary or grievance procedures than white staff. This work will be led by Roger Kline, Research Fellow from Middlesex University and the author of “Snowy White Peaks of the NHS”. The Trusts Divisional Medical Directors are also conducting similar research as part of a Leader Academy, clinical leadership programme. The learning and any action required will be built into the E, D&I action plan and we will share our learning collaboratively.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)96

Title of paper: Corporate Risk Register– October 2018.

Purpose: To inform the Board of the risks that have currently been escalated to the Corporate Risk Register (CRR) from the Care Groups via the Trusts risk management systems.

Summary:

The CRR is reported to the Board to provide assurance that the Trust is operating an effective risk management system, and that risks identified and raised by front line services can be escalated to the Executive if they are graded as high or extreme risks. The risk management process is overseen by the Risk Management Council (RMC), which reports to the Executive Committee providing assurance , that all risks;

- Have been identified and reported
- Have been scored in accordance with the Trusts risk grading matrix.
- Any risks initially rated as high or extreme or increasing to high /extreme have been agreed with and reviewed by the appropriate Executive Director
- Are regularly reviewed
- Have an identified target risk score, which captures the level of risk appetite and has a mitigation plan that will realistically bring the risk to the target level

This report covers the risks reported and reviewed in September 2018 and is a snap shot, rather than a summary of the quarter.

The report shows;

- The total number of risks on the risk register is 789 (of which 9 had not been scored)
- 43% (335) of the Trusts risks are rated as Moderate or High.
- There are 11 high/extreme risks that are escalated to the CRR.

The spread of risks across the organisation is;

- 2 in the Medical Care Group
- 1 in the Surgical Care Group
- 3 in Clinical Support Care Group
- 5 in Corporate Services
- 0 in Marshalls Cross Primary Care Services

The risk categories of the CRR risks are;

- 5 x Patient Care
- 2 x Money
- 2 x Governance

• 2 x Staff
Corporate objectives met or risks addressed: The Trust has in place effective systems and processes to identify manage and escalate risks to the delivery of high quality patient care.
Financial implications: None directly from this report.
Stakeholders: Staff, Patients, Commissioners, Regulators.
Recommendation(s): The Trust Board 1. Notes the risk profile of the Trust and the risks that have been escalated to the CRR
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 31st October 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE RISK REGISTER REPORT – OCTOBER 2018

1. Purpose

The purpose of this report is to provide an overview of the Trust's risks, and those risks which score 15 or above which have been escalated to the Executive Committee and added to the Corporate Risk Register (CRR) – Appendix 1. This report is based on information extracted from the DATIX system for September 2018.

2. Risk Register Summary for the Reporting Period

This table provides a high level overview of the "turnover" in the risk profile of the Trust in the previous 3 months.

RISK REGISTER	Current Reporting Period 02.10.2018	Previous Reporting Period 03.09.18	Previous Reporting Period 02.08.18
Number of new risks reported	44	38	50
Number of risks closed or removed	35	8	67
Number of increased risk scores	1	5	4
Number of decreased risk scores	3	6	6
Number of risks overdue for review	121	102	61
Total Number of Datix risks	**789**	**780***	**752**

**Includes 9 new risks not yet scored/approved*

3. Trust Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
53	**64**	**25**	**135**	**14**	**154**	**54**	**121**	**40**	**109**	**1**	**7**	**3**	**0**
142 = 18.2			**303 = 38.8%**			**324 = 41.5%**				**11 = 1.41%**			

The risk profile for each of the Trust's Care Groups and for the collective Corporate Services are:

3.1. Surgical Care Group

255 risks reported 32.7% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
4	**21**	**9**	43	3	54	21	57	15	27	**0**	**1**	**0**	**0**
34 = 13.3%			**100 = 39.2%**			**120 = 47.1%**				**1 = 0.39%**			

3.2. Medical Care Group

208 risks reported 26.7% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
25	**26**	**3**	**43**	**2**	**34**	**7**	**25**	**15**	**26**	**0**	**1**	**1**	**0**
54 = 26.0%			**79 = 38.0%**			**73 = 35.1%**				**2 = 0.96%**			

3.3. Clinical Support Care Group

61 risks reported 7.82% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
6	**5**	**1**	**6**	**0**	**8**	**6**	**6**	**4**	**16**	**1**	**2**	**0**	**0**
12 = 19.7%			**14 = 23.0%**			**32 = 52.5%**				**3 = 4.92%**			

3.4. Corporate (Finance, Health Informatics/Health Records, Facilities, Nursing/Governance/Quality & Risk, HR and Medicine Management)

237 risks reported 30.4% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
18	**11**	**12**	**42**	**8**	**55**	**18**	**31**	**2**	**35**	**0**	**3**	**2**	**0**
41 = 17.3%			**105 = 44.3%**			**86 = 36.3%**				**5 = 2.11%**			

The highest proportion of the Trust's risks continues to be identified in the Corporate Care Group. The split of the risks across the corporate departments is:

	High	Moderate	Low	Very low	Total
Health Informatics/ Health Records	1	16	3	0	20
Facilities (Medirest/TWFM)	0	2	12	7	21
Nursing, Governance, Quality & Risk	0	18	13	7	38
Finance	1	3	16	14	34
Medicines Management	0	21	48	8	77
Human Resource	3	26	13	5	47
Total	5	86	105	41	237

3.5. Marshals Cross GP Surgery

19 risks reported 2.44% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
0	**1**	**0**	**1**	**1**	**3**	**2**	**2**	**4**	**5**	**0**	**0**	**0**	**0**
1 = 5.2%			**5 = 26.3%**			**13 = 68.4%**				**0 = 0%**			

Appendix 1 - Corporate Risk Register – October 2018

KEY	Medicine		Surgical		Clinical Support		Corporate	

New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Target Risk Score I x L	Action plan in place
Governance	222	Risk of failure to ensure delivery of national performance targets	4 x 4 = 16	4 x 4 = 16	24/04/2017 Rob Cooper	4 x 2 = 8	Action plan in place
Governance	1772	Risk of Malicious Cyber Attack	3 x 4 = 12	3 x 5= 15	09/11/2016 Christine Walters	3 x 3 = 9	Action plan in place
Money	1555	Risk of not receiving apprenticeship levy payments for Lead Employer Doctors in Training.	3 x 5 = 15	3 x 5 = 15	01/04/2016 Anne-Marie Stretch	3 x 4 = 12	Action plan in place
Money	1152	Risk to the quality of care, contract delivery and finance due to increased use of bank and agency	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	4 x 3 = 8	Action plan in place
Patient Care	1569	Risk to consultant recruitment for Clinical Support Services, due to national staff shortages	5 x 2 = 10	5 x 3 = 15	17/11/2016 Anne-Marie Stretch	5 x 2 = 10	Action plan in place
Patient Care	1080	Risk to patient safety risk and operational effectiveness if staffing levels are below establishment on wards 2B &2C	4 x 5 = 20	4 x 5 = 20	15/08/2017 Sue Redfern	4 x 1 = 4	Action plan in place
Staff	762	Risk that if the Trust cannot recruit sufficient staff to fill approved vacancies then there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	4 x 2 = 8	Action plan in place
Patient Care	2080	Risk of avoidable harm to A&E patients being cared for in the corridor at times of escalation when there is insufficient bed capacity	5 x 4 = 20	5 x 4 = 20	27/12/17 Rob Cooper	5 x 2 = 10	Action plan in place
Patient Care	2283	Risk that replacement biochemistry blood analysers cannot be procured by December	4 x 4 = 16	4 x 4 = 16	11/05/18 Rob Cooper	4 x 2 = 8	Action plan in place
Staff	2370	Consultant vacancies in Critical Care	4 x 4 = 16	4 x 4 = 16	21/08/18 Kevin Hardy	4 x 2 = 8	Action plan in place
Patient Care	2502	Impact of Brexit “no deal” on the supply of medical consumables and devices	4 x 4 = 16	4 x 4 = 16	21/09/18 Nik Khashu	4 x 2 = 8	Action plan in place

ENDS

TRUST BOARD

Paper No: NHST(18)97

Title of paper: Review of the Board Assurance Framework (BAF) – October 2018

Purpose: For the Board to review the BAF and agree any changes.

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 statutory duties, 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 July 2018.

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 Board, in accordance with the agreed level of risk appetite.

Key to proposed changes:

~~Score through~~ = proposed deletions

Blue Text = proposed additions

Red = overdue actions

Recommended changes

The target risk scores for risks 2 and 6 should be adjusted so that the impact score is consistent across the initial, current and target scores with the likelihood being altered by the controls and actions being undertaken to mitigate the risks.

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

Financial implications: None arising directly from this report.

Stakeholders: NHSI, CQC, Commissioners.

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

Presenting officer: Nicola Bunce, Director of Corporate Services.

Date of meeting: 31th October 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 Aims					
		We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes for the population	We will be the hospital of choice for patients	We will respond to local health needs	We will attract and develop careing highly skilled staff	We will work in partnership to create sustainable and efficient health systems
1	Systemic failures in the quality of care	✓		✓	✓	✓	✓
2	Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	✓		✓		✓	✓
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 2018/19 Objectives and Long Term Strategic Aims

2018/18 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 for the population	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 work in partnership to create sustainable and efficient health systems
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	5 x 4= 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 routine annual PIR return • Medicines Optimisation Strategy • Learning from deaths policy	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 Insight and Inspection Report • Learning Lessons League • IG Toolkit results • Model Hospital benchmarking	5 x 2 = 10	Routine reporting of quality and performance of community and primary care services delivered by the Trust	Plans to achieve 30% of discharges by midday Improvement plans for Falls, Infection Control and Pressure Ulcers in 2018/19 Embedding and sharing lessons learnt from never events, inquests and mortality reviews	Implementation plans for the four key 7-day service standards by 2020 Implementation of Stroke Service integration with WHH – phase 2 planned completion in 2018/19 Targeted improvement work to increase FFT response rates (March 2019) Implementation of NEWS2 (March 2019)	5 x 1 = 5	KH/ SR

Risk 2 –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) • Failure to secure sufficient capital to support additional equipment/bed capacity 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 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/R Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports • Annual audit programme • PSF Targets and Control Total • CQUIN Implementation Other; • NHSI monthly reporting • Contract Monitoring Board • NHSI Review Meetings • Use of Resources reviews • Contract Review Boards with Commissioners • St Helens Cares Peoples Board	5 x 4 =20	Develop 2018 - 19 detailed CIP plans and strengthen QIA monitoring to mitigate additional risk Establish a benchmarking and reference cost group Transformational CIP contribution to the overall CIP target	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 Cash flow and prompt payment of invoices from other NHS providers	Develop a detailed Health and Care Partnership implementation plan with C&M partners in line with the priorities outlined in the Next Steps FYFV plan Secure maximum PSF funding in 2018/19 to achieve control total. Agree payment mechanisms to support the development of an Integrated care system for St Helens (October 2018) Seek all possible sources of capital funding including national bids to support capacity planning	5 x 2= 10	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, and Cancer etc.) • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand 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 PSF 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 • System Urgent Care Delivery Board Membership • 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 • Community services contract review meetings • NHSI monitoring and escalation returns/sit reps • CCG CEO Meetings • CQC System Reviews e.g. Halton, Liverpool	4 x 5= 20	Theatre productivity improvement plan monitoring.	Long term health economy emergency access resilience and urgent care services plans re NEL admissions and DTOC Health economy winter resilience plan for 2018/19 which identifies additional capacity requirements - Sept 2018 Achieve target to reduce bed occupancy to 92% in 2018/19 Action plan to achieve BAU operational functionality for out-patients and Patient booking services following introduction of new Medway PAS (December 2018 as agreed with NHSI)	~~Improvement Event Action Plans and Internal Improvement strategy – on going~~ Urgent and Emergency Care Summit improvement programme – March 2019 Delivery of the ECIP concordat 5 key targets for 2018/19 Full Implementation of the new frailty pathways for Knowsley and Halton CCGs following the allocation of transition funding and the successful introduction in St Helens (March 2019) Action Plan to reduce super stranded patients by 25% - December 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 • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR	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 Executive Committee Development of a new Patient Experience Strategy	Action plan to improve understanding of patients and carers' views (January 2019)	Update Trust internet site Delivery of the Well Led Action Plan – on going ~~Preparation for new style CQC inspection scheduled for July/August 2018~~ ~~Develop a new Trust staff engagement and leadership strategy (September 18)~~	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 ICS development • CCG Representative attending StHK Board meetings • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Merseyside and Cheshire Health and Care Partnership governance structure • 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 • Membership of the St Helens Peoples Board • Collaborative working with Halton and Knowsley CCGs to develop plans for Integrated care systems in these Boroughs • Achievement of the integrated working CQUIN • Annual staff engagement events programme	4 x 3 = 12	Annual programme of engagement events with key stakeholders to obtain feedback and inform strategic planning	C&M Health and Care Partnership performance and accountability framework ratings and reports	St Helens Cares - development of financial and governance models – Now planned for April 2019 Participation in One Halton Programme Board Continue working with Knowsley to support the development of place based integrated care plans	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	5 x 4 = 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 • FTSU Self-Assessment and action plan Other • Annual workforce plans • HR benchmarking • Nurse staffing benchmarking • C&M HR Work Stream	5 x 4 = 20		Specific strategies to overcome recruitment hotspots e.g. International recruitment and working closely with HEE's 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 Trainee Medical Staff (revised to August 2018)~~ Development of a C&M collaborative staff bank – Revised to March 2019 Maximise the benefits of the apprenticeship levy – December 2018 Implementation of the NHSI Recruitment and Retention Framework and evaluation of the return on investment (March 2019) Develop workforce strategy in relation to new roles e.g. Nurse Associates to maximise potential – September 2019	5 x 2 = 10	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 • Membership of the C&M 5-year forward view programme strategic estates workstream	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	Development of a 10 year strategic estates development plan to support the Trusts service development and integration strategies.	Maximise the potential from the GP Streaming investment to improve the A&E department flows.	~~Options appraisal for additional community based bed capacity to support the Winter Plan (September 2018)~~ Delivery of additional car parking capacity to improve patient and staff experience (Revised to November 2018)	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; • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure. 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 • Lack of digital maturity. • Loss of data or patient related information Impact; • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 5= 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	To Board; • ~~HIS~~ Board Reports • IM&T Strategy delivery and benefits realisation plan reports (5YFV) • Audit Committee • Executive committee • Risk Management Council • Information Security Assurance Group • Health Informatics Service Operations Board • Health Informatics Strategy Board • Programme/Project Boards • Information Governance Steering Group Other; • Annual financial plan agreed with partners • Internal/External Audit Programme • Data security protection Toolkit Submissions • Information asset owner framework • Information Security Dashboard • External sources of assurance – CareCert, Cyber Essentials, External Penetration Test	4 x 4= 20	Annual Cyber Security Business Case approval Annual Infrastructure Replacement Programme to be agreed Annual Corporate Governance Structure review Staff Development Plan Technical Development Annual programme of audit	ISO27001 Cyber Essentials Plus Service Improvement Plans Communications Strategy Digital Maturity Assessment	ISO27001 (August 2020) Cyber Essentials Plus (January 19) Cyber Security Strategy (revised to November 2018) Benefits realisation programme following PAS replacement (March 2019) Penetration Test (December 2018) Information asset owner/administrator work programme (Tier 1 systems) (December 2018) Information security management framework (December 2018) Five year Forward View Plan (December 2018)	4 x 2 = 8	CW

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)98
Title of paper: Learning from Deaths Quarterly Report 2018/19 Q1
Purpose: To describe mortality reviews that have taken place in both specified and non-specified groups; to provide assurance that all specified groups have been reviewed for deaths, and key learning disseminated throughout the Trust.
Summary: Data is given for Quarter 1 2018/19 and key learning described
Corporate objectives met or risks addressed: 5 star patient care: Care, Safety, Communication
Financial implications: None
Stakeholders: Trust patients and relatives, clinicians, Trust Board, Commissioners
Recommendation(s): To approve the report
Presenting officer: Prof Kevin Hardy, Medical Director
Date of meeting: 31st October 2018

STHK Learning From Deaths Board Report

		Specified Groups										
	Deaths in Scope [1]	Learning Difficulties Death	Severe Mental Illness Death [2]	Child Death	Neonatal Death or Stillbirth	Maternal Death	CQC Alert Death	Diagnosis Group Death [3]	Post-Op Death	SIRI Death	Concern Death [4]	Total [5]
Apr-18	114	2	1	0	2	0	0	4	10	0	4	23
May-18	133	3	0	0	0	0	0	5	5	0	2	15
Jun-18	118	1	0	0	0	0	0	2	6	0	5	14
Grand Total	365	6	1	0	2	0	0	11	21	0	11	52

	Specified Groups			Non-Specified Groups		
	Total [5]	Reviewed	% Reviewed	Total	Reviewed	% Reviewed (Target 25%)
Apr-18	23	23	100.0%	91	23	25.3%
May-18	15	15	100.0%	118	30	25.4%
Jun-18	14	14	100.0%	104	27	26.0%
Grand Total	52	52	100.0%	313	80	25.6%

	% of Reviews with RAG Rating [6]		
	Total RAG Reviewed	Total Reviewed	% RAG Reviewed
Apr-18	41	46	89.1%
May-18	42	45	93.3%
Jun-18	40	41	97.6%
Grand Total	123	132	93.2%

	Outcome of RAG Reviewed 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	Grand Total
Apr-18	39	0	2	41
May-18	41	1	0	42
Jun-18	37	3	0	40
Grand Total	117	4	2	123

	Outcome % of RAG Reviewed 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	95.1%	0.0%	4.9%
May-17	97.6%	2.4%	0.0%
Jun-17	92.5%	7.5%	0.0%
Grand Total	95.1%	3.3%	1.6%

[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

[6] Some nationally specified review processes don't include RAG rating.

Learning & Sharing 2018/Q1

2018/Q1 Key Priorities

(1) Where there is concern that a patient is at risk of falling out of bed, a low rise bed must be used. Bedrails are likely to introduce more risk and should never be used as a form of restraint;

(2) If a patient has a suspected hip fracture, the plain XR is normal, but the patient cannot mobilise, request a CT scan within 24 hours. After a normal CT scan if the patient can still not mobilise, please ask the responsible consultant to speak to a Radiologist to discuss MRI scan.

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 mail (record) ■, Directorate meetings (mins) ☐. List any policies/procedures or guidelines changed:

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Effectiveness: (Current Q-1) Audit of DATIX ☐, SIRIs ☐, Complaints ☐, PALS ☐, Litigation ☐, Mortality Reviews for evidence of failure to deliver these priorities ☐.