St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 31ST JULY 2019
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

AGENDA				Paper	Presenter
09:30	1.	Employee of the Month		Verbal	Chair
09:40	2.	Patient Story		Verbal	
10:00	3.	Apologies for Absence		Verbal	
	4.	Declaration of Interests		Verbal	
	5.	Minutes of the Previous Meeting held on 26th June 2019		Attached	
		5.1	Correct Record & Matters Arising	Verbal	
		5.2	Action Log	Attached	
Performance Reports					
10:10	6.	Integrated Performance Report		NHST(19) 62	Nik Khashu
		6.1	Quality Indicators		Sue Redfern
		6.2	Operational Indicators		Rob Cooper
		6.3	Financial Indicators		Nik Khashu
		6.4	Workforce Indicators		Anne-Marie Stretch
Committee Assurance Reports					
10:30	7.	Committee Report – Executive		NHST(19) 63	Ann Marr
10:40	8.	Committee Report – Quality		NHST(19) 64	Val Davies
10:50	9.	Committee Report – Finance & Performance		NHST(19) 65	Jeff Kozer
BREAK					
Other Board Reports					
11:10	10.	Corporate Risk Register Quarterly Report		NHST(19) 66	Nicola Bunce

11:20	11.	Board Assurance Framework Review	NHST(19) 67	Nicola Bunce
11:30	12.	Learning from Deaths Quarterly Report	NHST(19) 68	Nicola Bunce on behalf of K Hardy
11:40	13.	HR Indicators Report	NHST(19) 69	Anne-Marie Stretch
11:50	14.	NHSE/I Advice: Learning Lessons to Improve our People Practices Report	NHST(19) 70	Anne-Marie Stretch
12:00	15.	Approval of the Workforce Strategy 2019 – 2020	NHST(19) 71	Anne-Marie Stretch
Closing Business				
12:20	16.	Effectiveness of Meeting	Verbal	Chair
	17.	Any Other Business		
	18.	Date of Next Meeting – Wednesday 25th September 2019		

Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Board Meeting held on Wednesday 26th June 2019 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
	Mrs V Davies	(VD)	Non-Executive Director
	Mr J Kozer	(JK)	Non-Executive Director
	Prof K Hardy	(KH)	Medical Director
	Mr R Cooper	(RC)	Director of Operations & Performance
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Mrs S Redfern	(SRe)	Director of Nursing, Midwifery & Governance
	Mr N Khashu	(NK)	Director of Finance
	Mrs C Walters	(CW)	Director of Informatics
	Ms N Bunce	(NB)	Director of Corporate Services
	Dr T Hemming	(TH)	Director of Transformation
In Attendance:	Ms J Byrne	(JBy)	Executive Assistant *(Minute Taker)*
	Ms L Knight	(LK)	Pearl Consultancy *(Associate NED designate -Observer)*
	Mr R Little	(RL)	Regional Account Director, Liaison Group *(Observer)*
	Cllr A Lowe	(AL)	Halton Council *(Co-opted Member)*
	Dr P Williams	(PW)	Assistant Medical Director *(for item NHST(19)60 only)*
Apologies:	Mr P Growney	(PG)	Non-Executive Director
	Mr T Foy	(TF)	St Helens CCG Governing Body Lay Member *(co-opted member)*

1. Employee of the Month

The Employee of the Month Award for June 2019 was presented to Dr Maysara Aziz, Consultant Paediatrician.

2. Apologies for Absence

Apologies were noted as above.

3. Declaration of Interests

3.1. No new interests were declared.

4. Minutes of the previous meeting held on 29th May 2019

4.1. Correct Record

4.1.1. The minutes were accepted as a correct record once minute 12.2 had been updated to explain that 'limited assurance' was the best opinion that could be given for this type of audit.

4.2. Action List

4.2.1. Meeting 24.04.19 (Minute 6.1.9) – CW/JK to meet outside of the Board meeting to discuss the HIS Board – meeting scheduled to follow the Board meeting. **ACTION CLOSED**

4.2.2. Meeting 29.05.19 (Minute 12.5) – SRe to discuss recommendations from a St Helens GP for items to be included in the Shared Care Record with CW outside the Board meeting – Meeting held. **ACTION CLOSED**

4.2.3. Meeting 29.05.19 (Minute 18.2) – AMS to discuss initiatives with local schools regarding career pathways with PG outside the Board meeting – meeting scheduled to discuss. **ACTION CLOSED**

5. Integrated Performance Report (IPR) – NHST(19)51

5.1. The key performance indicators (KPIs) for May were reported to the Board, following in-depth scrutiny of the full IPR at Quality Committee and Finance & Performance Committee meetings.

5.2. Quality Indicators

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

5.2.2. There had been no never events in the month and none year to date.

5.2.3. There had been no MRSA reported in month or year to date (target = 0).

5.2.4. There were 7 C.Diff positive cases reported in May 2019 (4 hospital onset and 3 community onset). Year to date there had been 12 cases (7 hospital onset and 5 community onset) of which 2 community had been successfully appealed and 2 more were subject to appeal. New guidance this financial year required Trusts to include hospital onset and any community cases where patients had been discharged from hospital in the previous 28 days. The annual tolerance for 2019/20 set for the Trust was 48, which was felt to be extremely challenging and continued to be queried by SRe with NHSE/I.

5.2.5. There were no grade 3 or 4 avoidable pressure ulcers reported in April 2019.

5.2.6. The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for May 2019 was 97.9% and year to date was 98.0%.

5.2.7. There had been one fall resulting in severe harm year in April.

5.2.8. Venous thromboembolism (VTE) assessment performance for April was 95.34% against a target of 95%.

5.2.9. Year to date HSMR (April to February) for 2018/19 was 100.6.

5.3. **Operational Indicators**

5.3.1. RC presented the update on the operational performance.

5.3.2. Performance against the 62-day cancer standard in April was 89.6%.

5.3.3. The 31-day cancer target was achieved with 97.4% performance against a target of 96%.

5.3.4. The 2-week cancer standard was not achieved in April with performance of 91.8% against the target of 93%. Further detailed discussion had taken place at the Quality Committee meeting and the issues related to a single speciality because of the lack of breast radiology capacity.

5.3.5. A&E type 1 access performance in May was 71.7%. The all types mapped footprint performance for May was 84.2%. The Trust's highest ever recorded monthly attendance figure of 10,331 had been reported in May 2019.

5.3.6. There had been 3,075 ambulance conveyances in May 2019. Ambulance notification to handover time was 16:29 minutes on average for May, against a target of 15 minutes.

5.3.7. The Trust had been set a 40% reduction target for the average number of super stranded patients (patients with a length of stay of greater than 21 days) by year end 2019/20, which would equate to 92 patients from a baseline figure of 154. The average number in May stood at 135. Teams within the care groups were working to ensure both internal and external pathways were at their optimum. SR observed that a 40% reduction target seemed very ambitious and queried if it was the same for all Trusts. RC confirmed it was a national target, although Trusts were all starting at different baselines and STHK was starting at a low baseline so it was more of a challenge to achieve a further 40% reduction.

5.3.8. NK asked what systems the Trust had in place to maintain patient safety when the A&E department was so busy. SRe explained that there was an established escalation protocol that was enacted in response to different levels of trigger activity, which was based on intentional rounding and put in place increased numbers of staff to ensure the patients were monitored. It was acknowledged that at times of extreme pressure the patient experience did not always meet the

expected standards but SRe was assured that there were robust mechanisms in place to safeguard patient safety.

5.3.9. The RTT performance was achieved in May with 92.9% compliance against a target of 92%. The 6-week diagnostic target was achieved in April with 99.7%, target 99%. There were no 52 week+ waiters.

5.3.10. NK observed that in the main, STHK was still achieving the majority of targets, which was now an exception. RC agreed it was fairly unique; there were some Trusts that were not achieving any of the national access targets. Nearly all organisations were finding the A&E targets challenging, particularly in the Cheshire and Merseyside area, the reasons for which were unclear.

5.3.11. RF believed the high attendance figures underlined the importance of addressing pathways within the Trust to ensure patients received timely treatment in the right place. He looked forward to witnessing a drop in attendance when the Emergency and Urgent Care programme was completed and the new ambulatory care schemes delivered. DM noted daily attendances were heading towards 500 when Type 3 numbers were included. DM had recently had a conversation with a couple in the hospital restaurant who had spoken of the exemplary care they had received in A&E. RC assured Board members the increasing numbers could not affect the commitment of staff.

5.3.12. RF asked RC to pass on the Board's appreciation of how busy the department was and to assure staff members that the Board was working with system partners to try to develop alternative services for patients in community settings.

5.4. **Financial Indicators**

5.4.1. NK presented the update on the financial performance.

5.4.2. The Board had accepted a control total of a £2.6m deficit which, if achieved, would attract Provider Sustainability Funding (PSF) of £6.5m. Key assumptions included full achievement of CQUINS and of £16.1m of CIPS as well as activity and agency spend within capped levels.

5.4.3. At the end of month 2, the Trust had reported a deficit of £1.3m which was in line with agreed plans and assumed full achievement of PSF funding. The Trust had utilised c£1.5m of non-recurrent options to achieve the reported position.

5.4.4. The 2019/20 target for agency spending was £7.6m, which was an increase of £0.3m on 2018/19 cap. Agency expenditure at month 2 was £1.2m which was £0.2m under the planned trajectory.

5.4.5. The Trust was ahead of the CIP target by £0.3m and had CIP plans of £18.5m in year and £20.9m recurrently. The Trust had currently transacted CIP worth 2.9% of the Trust's turnover.

5.4.6. The Finance & Performance Committee had requested a deep dive into non-elective activity as a result of the variation from plan seen in month 2.

5.4.7. NK also reported that the Trust capital programme was fully committed and the Trust was awaiting formal approval of the £4m STP capital following submission of the Business Case to NHSE/I.

5.4.8. The Trust had 3 days of cash available at the month end and continued to meet supplier payment timescales.

5.5. **Workforce Indicators**

5.5.1. AMS presented the update on the workforce indicators.

5.5.2. Mandatory training compliance was 84.9% (target 85%). Appraisal compliance was 86.2% (target = 85%).

5.5.3. Sickness was 4.8% in May, which was 0.1% lower than April 2019, but higher than the target of 4.25%. The results of a deep dive into sickness were due to be presented to the Finance & Performance Committee in July, proposing some bespoke measures around identified areas of sickness within the Trust's control. Board members remained concerned about the high levels of sickness absence and looked forward to exploring what more the Trust could do to support staff to be in work.

5.5.4. Board members noted the report.

6. Committee Report – Executive – NHST(19)52

6.1. AM presented the report summarising the key issues considered by the Executive Committee at meetings held during May 2019.

6.2. The committee approved support for 5 of the current Nurse Practitioner students to continue on to a Registered Nursing apprenticeship course at Edge Hill University. There was a limited window of opportunity for the current learning to be credited as the Nursing and Midwifery Council were changing the nurse training standards in 2020.

6.3. The committee agreed to continue with the temporary additional workforce in Patient Booking Services because of the additional workload resulting from the changes following the implementation of the new Medway Patient Administration System (PAS) and the continuing need to validate waiting lists. Although more efficient solutions were in development, there remained a short term need for additional capacity in the team, so the managers could be freed up to work on developing the solutions.

6.4. The Executive Committee had reviewed the issues raised by senior clinical staff about the implications of the national pension taxation rules and the potential implications for operational capacity if staff decided it was not economic for them to undertake additional activities. The committee agreed that this would have very serious implications for service provision and patient

care, and the Trust would work with the consultant body to explore the implications and possible solutions. It was acknowledged that this issue had now been recognised as a significant risk for the whole NHS and discussions were also taking place nationally with HMRC and Treasury. RF stated that the consequences of the pension tax rules for NHS employees and operational capacity was very serious and needed to be resolved nationally, so that senior staff did not lose out financially for undertaking additional work to achieve national access targets.

6.5. The committee had received an update on discussions with CCGs in relation to full payment of the staff health and wellbeing CQUIN following submission of the quarter 4 evidence. The CCGs were disputing full payment despite the Trust receiving the highest national score for its patient survey.

6.6. The Trust had been notified of the preferred provider for the Halton Urgent Treatment Centre on 7th June; however the announcement was embargoed under procurement regulations to allow a "cooling off" period.

6.7. An evaluation of the benefits and risks of introducing 12 hour shifts for nurses had been undertaken, in response to a number of requests from staff. The benefits of offering flexible working patterns to staff to support recruitment and retention were recognised, alongside the need to provide consistent levels of staffing on wards across all days and shifts. It was acknowledged that 12 hour shifts would not be attractive for all staff. It was agreed that a trial of 12 hour shifts would be undertaken on two wards to assess the implications compared to the shift patterns currently worked by staff.

6.8. SR asked if this would mean staff working longer hours, and AMS explained that staff would work 3 x 12 hour shifts most weeks, to meet their contracted hours. Part of the trial would evaluate the impact on staff health and wellbeing of working longer days.

6.9. Following the publication of the NHS Long Term Plan, and the 2019/20 planning guidance each "place" was required to develop a five year plan which would then feed into the development of STP 10 year plans. The place plans were to be submitted in the summer of 2019 and the STP plans were scheduled to be published in the autumn. National guidance on the content and format of the plans was due to be published. The committee agreed that the Trust needed to be involved in the production of the equivalent plans in all 3 "place" plans for local boroughs. VD asked if each of the CCGs met the criteria in relation to the size of each "place". AM clarified that at the moment it was not clear what would happen to smaller places. NK gave details of the process to develop a Long Term Financial Model (LTFM) for the 5 years of the place based plans, which would aggregate the finances of all NHS organisations contributing to the place. The first iteration of the LTFMs was due to be submitted to the Cheshire and Merseyside Health and Care Partnership (C&M H&CP) in July.

7. Committee Report – Quality – NHST(19)53

7.1. VD presented the Chair's report to the Board, which summarised key issues arising from the Quality Committee meeting held on 18th June and reports from

the Patient Safety, Patient Experience and Clinical Effectiveness Councils.

7.2. VD highlighted to Board members the consistently high level of patient satisfaction with the Trust's services as demonstrated by the Friends and Family Test results.

7.3. The Clinical Effectiveness Council had escalated concerns about the level of Basic Life Support/ Immediate Life Support (BLS/ILS) training compliance to the Quality Committee. This had been discussed by the Executive Committee which had put in place an action plan and would review progress against the agreed improvement trajectory on a weekly basis, until 85% compliance was achieved. A new e-learning package was also being reviewed as it was recognised the Trust needed to make it easier for staff to undertake the training, however competence also required a practical assessment as well as theoretical knowledge.

7.4. With regard to the Freedom to Speak Up report, SR asked whether numbers were in line with previous years. SRe explained it was a relatively new national initiative so benchmarking was not widely available. AMS felt the Board should be assured by the increase in numbers of concerns being raised, as this indicated staff were comfortable in using the process and it indicated the Trust was being successful in nurturing an open and supportive culture where staff felt they could speak up.

7.5. SR asked if the 5 additional concerns that had not been reported to the Guardians Office had been resolved internally. SRe confirmed the 5 issues had all been responded to via other routes as they had not fulfilled the Freedom to Speak Up criteria of speaking up about issues of patient care, quality or safety, eg one of the concerns was a question relating to hospital signage.

7.6. RF agreed that the important issue for the Board was that staff had a mechanism they were "happy" to use to raise any concerns. There were various mediums available to both patients and staff, eg Twitter, Ask Ann, Freedom to Speak Up, team talks and Quality Ward Rounds, to make it as easy as possible for people to raise a concern via the medium they felt most comfortable with.

7.7. The paper was noted.

8. Committee Report – Finance & Performance – NHST(19)54

8.1. JK presented the Chair's report to the Board which summarised key issues arising from the Finance & Performance Committee meeting held on 20th June.

8.2. JK was assured by the attendance of 4 clinicians at the meeting and felt it demonstrated good clinical engagement and the commitment to improvement.

8.3. As mentioned in minute 6.9, committee members had been briefed on the requirement to develop a local Long Term Financial Model (LTFM) to support the C&M H&CP consolidated system position.

8.4. NK had briefed the Committee that NHSE/I had indicated there may be additional Provider Sustainability Fund (PSF) distributed to Trusts following

submission of 2018/19 accounts. He also detailed the pressures on the national capital budget and the steps that NHSE/I are proposing to reduce capital expenditure during 2019/20.

8.5. Committee members had reviewed the Integrated Performance Report (IPR) and once again focused on sickness, as per minute 5.5.3.

8.6. The committee had received a report on the process being followed for the 2019 National Cost Collection exercise, and were assured that the appropriate internal systems, processes and staffing were in place for the Trust to complete the data collection, and authorised the Director of Finance to sign off the final submission. It was anticipated the new nationally mandated system which had replaced reference costs would provide much richer data comparisons of patient level spending.

8.7. Committee discussed the A&E performance and activity in detail and the options to increase capacity for winter 2019/20, including the potential for a modular ward to increase bed capacity. Activity against plan was reviewed and further analysis requested so the committee could understand the changes in activity patterns.

8.8. The committee also received an update on the delivery of the CIP programme and scrutinised the Surgical Care Group CIP plans and the effectiveness of the Quality Impact Assessment Process.

8.9. The paper was noted.

9. Committee Report – Charitable Funds – NHST(19)55

9.1. NK briefed the Board in PG's absence, on the main issues discussed and decisions made at the meeting on 20th June.

9.2. The committee reviewed a number of proposals to increase fundraising and access to funds.

9.3. The committee noted the investments portfolio performance and reviewed the income and expenditure position.

9.4. The future Fundraising strategy was discussed and members noted the Charity Abseil earlier in the year had raised circa £16k.

9.5. The report was noted.

10. Strategic & Regulatory Report – NHST(19)56

10.1. NB updated Board members on external strategic developments that could impact the future direction of the organisation and all regulatory requirements to comply with governance good practice.

10.2. The interim NHS People Plan had been published on 3rd June. This would inform the Trust's revised Workforce Strategy, which was due to be presented at the July Board meeting. The interim plan focused on 5 main themes to tackle to national workforce shortages. Board members noted the plan could

not be finalised until after the NHS spending review scheduled for autumn 2019.

10.3. NHS Accountability Framework 2019/20 – the Government published its mandate on 22nd May and reflected the closer working between NHS England and NHS Improvement, and the establishment of an NHS Assembly to oversee the delivery of the NHS Long Term Plan.

10.4. Mental Capacity Amendment Act 2019 – the Act gained Royal assent on 16th May 2019. The aim of the act was to strengthen protection and rights for vulnerable adults who lacked mental capacity, particularly by improving the safeguards for approving a deprivation of liberty. The changes were not likely to come into effect until 2020, but would have substantial and operational implications for the Trust. VD informed Board members that the Quality Committee had asked for a report which was due to be presented at the Safeguarding Committee.

10.5. Board members noted NHSE/I's published Q4 performance report for NHS Providers and the national performance against key access targets.

10.6. NK drew Board members' attention to the action in Appendix 1 relating to expanding the NHS Graduate Management Training Scheme from 200 to 500 participants and confirmed 3 trainees would be joining the Trust in September 2019.

10.7. The report was noted.

11. Informatics Report & Strategy Update – NHST(19)57

57 - Informatics presentation.pptx

11.1. CW presented a report detailing progress to date against the 2017-2020 Informatics Strategy, highlighting achievements and an overview of planned developments for the year ahead.

11.2. RF observed that the Trust's main priority for the Trust was to improve care for patients in hospital and in the community and take pressure off ED, and technology enabled us to do this. He felt the Trust had taken some bold decisions with its partners, and although there were still issues to resolve the direction of travel was very encouraging. He congratulated the team and asked CW to pass on the Board's thanks for all their hard work, in delivering this ambitious agenda.

11.3. The report was noted.

12. Approval of the Clinical Quality Strategy 2019 to 2022 – NHST(19)58

12.1. KH presented the revised Clinical Quality Strategy to Board members, which had been reviewed at April's Strategy Board meeting. It included the changes agreed by the Board to ensure the strategy remained fit for purpose, and new measures to assess progress, with delivery.

12.2. The strategy was approved.

13. Fit & Proper Persons Chair's Report – NHST(19)59

13.1. RF introduced the annual Board level Fit and Proper Persons Tests (FPPT) that had been undertaken for all directors. RF had reviewed all the declarations and searches and was in a position to make the declaration that there were no concerns about any Board member's "fitness" for the role and the Trust remained compliant with CQC regulation 5.

13.2. RF thanked members for their participation in this important process.

13.3. The report was noted.

14. 7-Day Services Board Assurance Framework NHST(19)60

14.1. PW joined the meeting and explained the aim of the 7-Day Hospital Services Programme was to ensure that patients requiring emergency admission received high-quality, consistent care every day of the week through early, consistent senior decision-making and provision of other urgent services. Ten clinical standards (CS) had been developed, of which 4 'priority standards' were reported to both the Trust Board and NHSE on a 6-monthly basis. This process was now based on a self-assessment, following the audit of a random sample of case notes, which was presented to the Trust Board to provide assurance.

14.2. In relation to CS2 - time to first consultant review, the audit showed that 73% of patients admitted on a weekday and 78% of patients admitted at the weekend were seen within 14 hours, against the target of 90%. This was an improvement and PW detailed some of the further actions that had been put in place to improve further. DM commented on the significant proportion of the "fails" just outside of the 14 hour timeframe, which was the opportunity to improve.

14.3. SR queried if there was any evidence to suggest that patients who had not been reviewed within 14 hours had come to harm. PW confirmed he had discussed this with the Patient Safety team and there were no incidents on Datix to suggest the delay had contributed to patient harm.

14.4. SR asked how patients had been selected for the audit. PW confirmed information analysts had taken a week's data in April based on the sample size stipulated by NHSI.

14.5. PW confirmed the Trust was currently meeting two other priority standards, ie CS5 - access to diagnostic tests and CS6 - access to consultant-directed interventions.

14.6. In relation to CS8 - ongoing daily review by consultant, the audit showed an improvement in weekday performance (88%) but a slight decrease in weekend performance (80%). PW confirmed there were daily consultant rounds and he suspected there were patients who had been included during a board round review but it hadn't been documented, therefore he was working with the team

to ensure these were evidenced.

14.7. DM asked whether there were any good local benchmarks. PW explained since the process had changed league tables were not published, however he would ask for feedback when he submitted the report to NHSE.

14.8. The report was noted and Board members were assured by the plans in place to further improve Trust performance against standards.

15. NHS Resolution: Maternity Incentive Scheme (Year 2) Board Declaration – NHST(19)61

15.1. SRe presented the report which detailed the progress that had been made towards achieving the 10 mandated safety criteria. Six standards were already met and there were action plans in place which would mean the remaining four actions could be achieved by the deadline of 8th August.

15.2. Board members noted the paper and agreed that the Quality Committee would receive a further update in July and if assured the Executive Committee would be delegated to approve the final declaration, there being no Board or Quality Committee meetings in August.

16. Effectiveness of Meeting

16.1. RF asked Lisa Knight for her observations. She believed it was clear that everyone worked well together outside the meeting, which she supposed was related to the work of the Board committees. RF asked if LK could perceive an executive/non-executive split, LK confirmed maybe a little, but not with a detrimental effect and challenge was appropriate. RF thanked LK for her comments.

16.2. RF asked KL for patient feedback, as his wife had recently given birth to daughter, Ellie, in the Trust's maternity unit. KL confirmed it had been a very positive experience and they had found the midwives to be really helpful, friendly and supportive.

17. Any Other Business

RF informed Board members that Dr John Matthews, ED Consultant, had successfully delivered a baby when a spectator went into labour during a Pink Concert at Liverpool FC's Anfield Stadium the previous evening. This had been widely reported in the media.

18. Date of Next Meeting

The next meeting will be held on Wednesday 31st July 2019 at 09:30 hrs in the Executive Boardroom, Level 5, Whiston Hospital, L35 5DR.

Chairman: ……

31st July 2019

Date: ……

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 31ST JULY 2019

No	Date of Meeting (Minute)	Action	Lead	Date Due
~~1.~~	~~25.07.18 (12.7)~~	~~AMS to include employee relations' cases time to resolve KPIs in future HR Indicators reports.~~ **On Agenda. ACTION CLOSED.**	~~AMS~~	~~30.01.19~~ ~~31.07.19~~
2.	30.01.19 (14.9)	AMS/SRe to review the exit interviews process to ensure it is comprehensive and lessons are being learnt to improve retention.	AMS/SRe	31.07.19
~~3.~~	~~24.04.19 (6.1.9)~~	~~CW/JK to meet outside of the Board meeting to discuss the HIS Board. CW/JK to meet after Board meeting~~. **ACTION CLOSED.**	~~CW~~	~~-~~
~~4.~~	~~24.04.19 (12.2)~~	~~NB to add a comparison of previous year to Corporate Risk Register for benchmarking purposes to the next quarterly report.~~ **On Agenda. ACTION CLOSED.**	~~NB~~	~~31.07.19~~
~~5.~~	~~29.05.19 (12.5)~~	~~SRe to discuss recommendations from a St Helens CCG GP for items to be included on the Shared Care Record with CW outside of the Board meeting~~. **ACTION CLOSED**	~~SRe/CW~~	~~-~~
~~6.~~	~~29.05.19 (18.2)~~	~~AMS to discuss initiatives with local schools regarding career pathways with PG outside the Board meeting. Meeting has been scheduled~~. **ACTION CLOSED**	~~AMS~~	~~-~~

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: NHST(19)62
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

The CQC rated the Trust as **outstanding** overall following its inspection in July/August 2018. The caring and well-led domains were rated as **outstanding**, with safety, responsive and effective rated as **good.**

There were no Never Events in June 2019. (YTD =0)

There were no cases of MRSA in June 2019 (YTD=0)

There were 8 C.Difficile (CDI) positive cases reported in June 2019 (5 hospital onset and 3 community onset). YTD there have been 18 cases (12 hospital onset and 6 community onset). The annual tolerance for CDI for 2019-20 is 48. The new guidance now requires us to include hospital onset and any community cases that have been discharged from hospital in the previous 28 days.

There were no grade 3 or 4 avoidable pressure ulcers in May 2019. (YTD = 0).

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for June 2019 was 98.5%. YTD rate is 98.2%.

During the month of May 2019, there was 1 fall resulting in severe harm , which occurred in A&E. (YTD Severe harm fall=2)

Performance for VTE assessment for May 2019 was 95.32% against a target of 95%. (YTD = 95.33%)

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 19/20 financial outturn will have implications for the finances of the Trust
Stakeholders: Trust Board, Finance Committee , Commissioners, CQC, TDA, patients.
Recommendation: To note performance for assurance
Presenting Officer: N Khashu
Date of Meeting: 31st July 2019

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (May 2019) at 87.6%. YTD 88.6%. The 31 day target was achieved with 97.2% performance in month and YTD 97.3% against a target of 96%. The 2 week rule target was not achieved with 87.3% in month and 89.5% YTD against a target of 93.0%.

Accident and Emergency Type 1 performance for June 2019 was 64.4% and YTD 69.2%. The all type mapped STHK Trust footprint performance was 81.5% in month and 83.2% YTD. The Trust received 9914 Type 1 attendances in June 2019. Year to date growth in ED attendances is 4.6% up on 2018/19

Five improvement work streams (streaming, emergency department delivery, assessment areas, inpatient flow and ward daily discharges) are actively working on improving patient flow and are being governed through the Urgent and Emergency Care Council which meets monthly and is chaired by CEO.

Whiston ED had the highest number of ambulances conveyances in Cheshire and Merseyside and Greater Manchester in June 2019 with 2886 conveyances. Ambulance notification to handover time was not achieved with 21.27 mins/seconds on average (target 15 mins).

The Trust has been set a 40% reduction target in the number of super stranded patients (length of stay 21day+) by year end 2019/20. Working from the baseline figure of 154, a 40% reduction would equate to 92 patients. The average number in June stands at 130. Medical and Surgical clinical /managerial teams and all CCG and local authority partners are actively engaged in the achievement of the reduction in super stranded. Progress and actions to address are monitored daily.

The 18 week referral to treatment target (RTT) was achieved in June 2019 with 93.3% compliance (Target 92%). The 6 week diagnostic target was achieved in June with 99.4% (Target 99%). There were no 52+ week waiters.

Financial Performance

At the March 2019 Board the Trust agreed to accept the issued Control Total of a £2.6m deficit excluding the Provider Sustainability Fund (PSF). This allowed the Trust to access £6.5m of PSF assuming the planned deficit is achieved.
Key assumptions within the plan include:-
- Full achievement of CQUINs
- Activity within planned levels
- Achievement of CIPs (£16.1m)
- Agency spend within cap levels

Surplus/Deficit - At the end of M3 StHK has reported a deficit of £2.3m which is in line with agreed plans and assumes full achievement of this years PSF funding. The Trust has utilised c£1.5m of non-recurrent options to achieve the reported deficit. The Trust is forecasting to have a surplus of £3.9m including PSF funding.

An additional £0.5m relating to 2018/19 PSF has been allocated to the Trust following the redistribution of funds that were unachieved by other organisations. This has been included in our YTD and Forecast position but excluded as a technical adjustment so there is no benefit in this financial year as per guidance from NSHi.

The annual target for agency is £7.6m which is an increase of £0.3 on 2018/19 cap. Agency expenditure at month 3 is £1.9 which is £0.2m under our planned trajectory.

At month 3 the Trust is ahead of the CIP target of £1.5m by £0.6m and has plans to the value of £20.5m in year and £23.6m recurrently. The Trust has currently transacted CIP worth 2.9% of the Trusts turnover which is 1.8% greater than the 1.1% included within national planning assumptions.

Human Resources

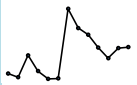
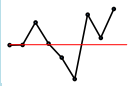
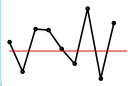
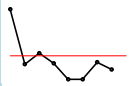
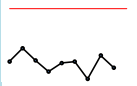
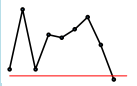
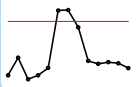
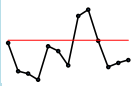
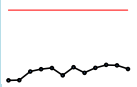
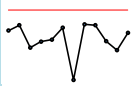
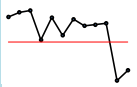
In June, sickness was 4.9% which has increased slightly (0.1%) since last month. It is 0.65% higher than Q1 target of 4.25%. Qualified & HCA sickness remains higher than target by 0.4%. All qualified Nursing & Midwifery sickness achieved Q1 target this month (4.2%).
Mandatory Training compliance is 82.2% (target = 85%). Appraisal compliance is 84.8% (target = 85%).

The following key applies to the Integrated Performance Report:

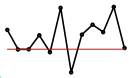
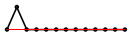
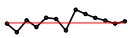
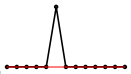
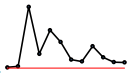
▲ = 2019-20 Contract Indicator
▲£ = 2019-20 Contract Indicator with financial penalty
● = 2019-20 CQUIN indicator
T = Trust internal target
UOR = Use of Resources

Jun-19

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

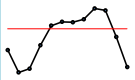
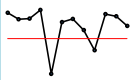
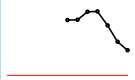
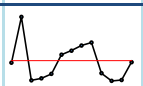
	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 31-37)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Jun-19	2.3%	2.3%	No Target	2.2%		SHMI (governments preferred measure) stable and consistently better than NW average. HSMR rose across Winter. Weekend admission mortality is a noisy metric.	Patient Safety and Clinical Effectiveness	The Board has commissioned an external review of Winter HSMR to complement internal work examining the rise, the causes and remedial action. Documentation of comorbidities (which artificially increases HSMR) is still below expected - actions to correct this will further improve standardised mortality measures.	KH
Mortality: SHMI (Information Centre)	Q	▲	Dec-18	1.00		1.00						
Mortality: HSMR (HED)	Q	▲	Feb-19	117.6		100.0	100.6					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Feb-19	124.5		100.0	105.4					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Jan-19	98.4		100.0	99.5		The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	The Trust continues to work internally and with healthcare partners to minimise unnecessary readmissions.	KH
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Feb-19	88.4		100.0	90.3		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. This includes robust management of delayed patients and scrutiny of superstranded patients.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Feb-19	98.5		100.0	112.3					
% Medical Outliers	F&P	T	Jun-19	0.2%	0.3%	1.0%	0.5%		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. There are currently no medical outliers.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Jun-19	42.4%	40.8%	52.5%	45.7%		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	▲	May-19	72.6%	73.1%	90.0%	71.3%		eDischarge performance remains poor. Inpatient performance is stable and is not expected to improve until new (pending) electronic solutions are implemented. Outpatient performance requires investigation is improving as Medway issues are addressed.		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.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	May-19	86.1%	82.8%	95.0%	85.0%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	May-19	93.4%	93.1%	95.0%	96.3%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

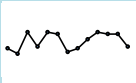
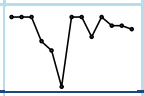
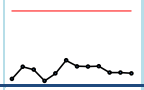
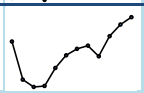
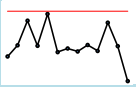
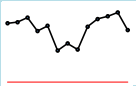
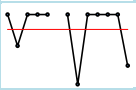
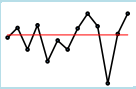
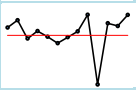
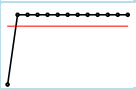
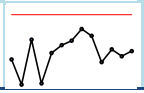
	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Jun-19	95.0%	90.3%	83.0%	85.7%		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	Continued achievement.	RC
PATIENT SAFETY (appendices pages 39-42)												
Number of never events	Q	▲£	Jun-19	0	0	0	1		No never events reported YTD	Quality and patient safety	Safer surgery actions and checks in place to minimise the likelihood of never events.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Jun-19	99.0%	99.0%	98.9%	99.1%		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	Jun-19	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	▲£	Jun-19	0	0	0	1		YTD there have been 20 C Diff cases, of which 2 have been successfully appealed, leaving 18 cases. Internal RCAs on-going with more recent cases of C. Difficile.	Quality and patient safety	The objective (i.e. target) for cases of CDI set for our Trust in 2019-20 by NHS Improvement (NHSI) is no more than 48 cases. From April 2019 onwards, the Trust's objective will include community onset healthcare associated: cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks. All CDI cases are subject to an Exec RCA review	SR
Number of hospital onset and community onset C Diff	Q F&P	▲£	Jun-19	8	18	48						
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Jun-19	5	11	No Target	31					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	May-19	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	▲	May-19	1	2	No Contract target	18		Fall resulting in severe harm reported from ED	Quality and patient safety	RCA is currently being undertaken. Bespoke improvement work in areas being undertaken.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲£	May-19	95.32%	95.33%	95.0%	95.94%		VTE performance monitored since implementation of Medway and newly introduced ePMA. An electronic solution is in the IT pipeline. Performance remains above target.	Quality and patient safety	Every effort is being made to supplement routine reviews with additional activity to improve performance pending electronic solution.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Apr-19	3	3	No Target	26					
To achieve and maintain CQC registration	Q		Jun-19	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards. Trust rated as outstanding following the 2018 inspection.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Jun-19	98.5%	98.2%	No Target	96.5%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	Safe Care Allocate has been implemented across all inpatient wards. All wards are receiving support to ensure consistency in scoring patients. Recruitment into posts remains a priority area.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Jun-19	0	0	No Target	0					

Jun-19

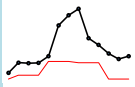
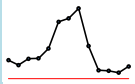
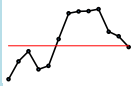
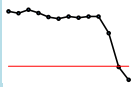
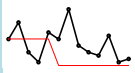
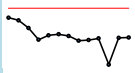
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	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	▲ £	May-19	87.3%	89.5%	93.0%	92.2%		2 week performance below standard with increasing pressures on Breast Service and the ability to provide 1 stop service. 31 day Target achieved in month. 62 Day target met but pressures remain with Consultant workforce constraints. Radiological capacity in Breast and Dermatology patient rearrangements contributed to the performance.	Quality and patient experience	1. All DMs producing speciality level action plans to provide 2 week capacity 2. Capacity demand review on going at speciality level 3. Eastern sector hub negotiations ongoing	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	May-19	97.2%	97.3%	96.0%	98.1%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	May-19	87.6%	88.6%	85.0%	88.3%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Jun-19	93.3%	93.3%	92.0%	92.4%			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	▲	Jun-19	99.4%	99.5%	99.0%	99.9%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Jun-19	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Jun-19	0.8%	0.6%	0.8%	0.8%		There was one breach of the 28 day re-list target in January due to difficulties in communicating with the patient.	Patient experience and operational effectiveness Poor patient experience	Proactive system in place to monitor, manage and prevent cancelled operations within the care group. Lessons learned from the 28 day re-list patient in January have been feedback to the relevant departments for learning and reflection.	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	May-19	100.0%	100.0%	100.0%	99.5%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Jun-19	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Jun-19	64.4%	69.2%	95.0%	74.3%		Accident and Emergency Type 1 performance for June 2019 was 64.4% and YTD 69.2%. The all type mapped STHK Trust footprint performance was 81.5% in month and 83.2% YTD. The Trust received 9914 Type 1 attendances in June 2019. Year to date growth in ED attendances is 4.6% up on 2018/19 Five improvement work streams (streaming, emergency department delivery, assessment areas, inpatient flow and ward daily discharges) are actively working on improving patient flow and are being governed through the Urgent and Emergency Care Council which meets monthly and is chaired by CEO. Whiston ED had the highest number of ambulances conveyances in Cheshire and Merseyside and Greater Manchester in June 2019 with 2886 conveyances. Ambulance notification to handover time was not achieved with 21.27 mins/seconds on average (target 15 mins).	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 New and refreshed workstreams aimed at improving discharges before midday also supported by a media campaign #HomeForLunch. Daily 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. Continue with daily AMU/ED huddles which is proving beneficial. Frailty in-reach to ED commenced. COPD pilot in place from December continues with benefits realised of avoiding admission.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Jun-19	81.5%	83.2%	95.0%	87.1%					
A&E: 12 hour trolley waits	F&P	▲	Jun-19	0	0	0	0					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Jun-19	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	Jun-19	25	73	No Target	266		% new (Stage 1) complaints resolved in month within agreed timescales continues to remain above the 90% target.	Patient experience	The Complaints Team continue to work hard to respond to complaints within agreed timescales and to proactively monitor each complaint that is likely to exceed this. The backlog of overdue complaints continues to remain extremely low. To increase performance, weekly remainders are sent to Care Groups regarding complaint responses due a fortnight before to ensure improved performance is maintained.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Jun-19	18	68	No Target	241					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Jun-19	94.4%	95.6%	No Target	92.1%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	May-19	19	20	No Target	19		In May 2019 the average number of DTOCS (patients delayed over 72 hours) was 19.		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	Jun-19	352	344							
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Jun-19	130	132							
Friends and Family Test: % recommended - A&E	Q	▲	Jun-19	82.1%	85.6%	90.0%	86.0%		The YTD recommendation rates remain above target for inpatients and postnatal, but slightly below target for A&E, antenatal, delivery and outpatients, with improvement seen in delivery suite in May and June to above the target. Delivery and community postnatal achieved 100% recommendation rates.	Patient experience & reputation	The profile of FFT continues to be raised by members of the Patient Experience Team, by attendance at ward meetings, the Patient Experience and Dignity Champions and monthly Team Brief. The display of FFT feedback via the 'You said, we did' posters continues to be actively monitored and regular reminder emails are issued to wards that do not submit the posters by the deadline. At least two members of staff have been identified in each area to take responsibility for production of the 'you said, we did' posters which are used to identify specific areas for improvement. Easy to use guides were issued to each ward to support completion and the posters are now distributed centrally to ensure that each ward has up-to-date posters. Areas continue to review comments to identify any emerging themes or trends, and significantly negative comments are followed up with the contributor if contact details are provided to try and resolve issues.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Jun-19	94.7%	95.6%	90.0%	94.7%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Jun-19	93.3%	98.0%	98.1%	98.7%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Jun-19	100.0%	97.2%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Jun-19	98.0%	97.2%	95.1%	94.8%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Jun-19	100.0%	100.0%	98.6%	98.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Jun-19	94.3%	94.3%	95.0%	94.2%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 53-60)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Jun-19	4.9%	4.9%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	5.0%		In June, sickness was 4.9%, a 0.1% increase since May, 0.65% higher than Q1 target of 4.25%. Qualified & HCA sickness was 5.7%, higher than 2019/20 target by 0.4%.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	A large scale review of the current attendance management policy has commenced in line with "Just Culture" with the aim of driving improvements in engagement levels and attendance. Revisions to the policy include one streamlined process, introduction of a long-term trigger and management against patterns and trends of absences. The programme of wellbeing awareness events continue, including Mental Health First Aid Training and Mindfulness Sessions facilitated within the workplace. HR staff attended an NHSI course on developing a Compassionate Leadership Culture in June which will assist in the revision of relevant policies and procedures.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Jun-19	5.7%	5.6%	5.3%	6.1%					
Staffing: % Staff received appraisals	Q F&P	T	Jun-19	84.8%	84.8%	85.0%	89.6%		Appraisal compliance is below target by 0.2%. Mandatory training compliance is below the target by 2.8%.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The HRBP's alongside Education, Training & Development and Workforce Planning teams continue to ensure improvements in compliance for Mandatory Training & work with managers to ensure on-going maintenance of compliance for Appraisals. Non-compliances 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	Jun-19	82.2%	82.2%	85.0%	95.3%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q4	91.9%		No Contract Target			For both questions the Trust returned the best scores nationally.	Staff engagement, recruitment and retention.	The Q1 survey within Medical Care Group is now open.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q4	79.7%		No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Jun-19	1.0%		No Target	9.2%		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	Jun-19	3.0	3.0	3.0	3.0		At the March 2019 Board the Trust agreed to accept the issued Control Total of a £2.6m deficit excluding the Provider Sustainability Fund (PSF). This allowed the Trust to access £6.5m of PSF assuming the planned deficit is achieved. Key assumptions within the plan include:- - Full achievement of CQUINs - Activity within planned levels - Achievement of CIPs (£16.1m) - Agency spend within cap levels 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	Jun-19	2,109	2,109	16,100	14,978					
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Jun-19	(1,745)	(1,745)	3,900	(597)					
Cash balances - Number of days to cover operating expenses	F&P	T	Jun-19	4	4	2	5					
Capital spend £ YTD (000's)	F&P	T	Jun-19	660	660	7,872	9,642					
Financial forecast outturn & performance against plan	F&P	T	Jun-19	3,900	3,900	3,900	(597)					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Jun-19	91.3%	91.3%	95.0%	91.2%					

APPENDIX A

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

			May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	2019-20 YTD	2019-20 Target	FOT	2018-19	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%	95.7%	88.9%	100.0%	100.0%	100.0%	100.0%	96.0%	83.3%	100.0%	100.0%	84.6%	95.8%	85.0%		96.5%		
	Total > 62 days		0.0	0.0	0.5	1.5	0.0	0.0	0.0	0.0	0.5	2.5	0.0	0.0	1.0	1.0			5.0		
Lower GI	% Within 62 days	▲ £	76.5%	100.0%	100.0%	92.3%	100.0%	36.4%	88.9%	100.0%	87.5%	72.7%	80.0%	94.4%	100.0%	96.9%	85.0%		86.6%		
	Total > 62 days		2.0	0.0	0.0	0.5	0.0	3.5	1.0	0.0	1.0	1.5	1.0	0.5	0.0	0.5			10.5		
Upper GI	% Within 62 days	▲ £	77.8%	80.0%	66.7%	62.5%	77.8%	66.7%	33.3%	63.6%	84.6%	88.9%	75.0%	88.9%	85.7%	87.0%	85.0%		74.7%		
	Total > 62 days		1.0	0.5	0.5	1.5	1.0	0.5	1.0	2.0	1.0	0.5	1.5	0.5	1.0	1.5			12.0		
Urological	% Within 62 days	▲ £	90.2%	78.8%	80.7%	97.1%	80.6%	90.3%	75.0%	89.4%	85.2%	87.8%	90.9%	87.1%	91.3%	88.5%	85.0%		86.0%		
	Total > 62 days		2.0	3.5	5.5	0.5	3.0	1.5	3.5	2.5	2.0	2.5	1.5	2.0	1.0	3.0			29.0		
Head & Neck	% Within 62 days	▲ £	66.7%	33.3%	62.5%	42.9%	83.3%	50.0%	80.0%	57.1%	25.0%	0.0%	100.0%	0.0%	25.0%	18.2%	85.0%		57.1%		
	Total > 62 days		0.5	2.0	1.5	2.0	0.5	1.0	0.5	1.5	1.5	0.5	0.0	1.5	3.0	4.5			12.0		
Sarcoma	% Within 62 days	▲ £	100.0%	83.3%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%			50.0%				85.0%		85.2%		
	Total > 62 days		0.0	0.5	0.0	0.0	0.0	1.0	0.0	0.0			0.5						2.0		
Gynaecological	% Within 62 days	▲ £	72.7%	75.0%	100.0%	72.7%	50.0%	62.5%	100.0%	81.8%	57.1%	88.9%	77.8%	66.7%	100.0%	82.6%	85.0%		77.8%		
	Total > 62 days		1.5	0.5	0.0	1.5	0.5	1.5	0.0	1.0	1.5	0.5	1.0	2.0	0.0	2.0			10.0		
Lung	% Within 62 days	▲ £	95.8%	88.9%	100.0%	100.0%	81.8%	66.7%	94.1%	100.0%	92.9%	81.8%	92.9%	71.4%	100.0%	88.9%	85.0%		90.4%		
	Total > 62 days		0.5	0.5	0.0	0.0	1.0	2.0	0.5	0.0	0.5	1.0	0.5	1.0	0.0	1.0			8.0		RC
Haematological	% Within 62 days	▲ £	100.0%	100.0%	100.0%	66.7%	90.9%	50.0%	85.7%	66.7%	50.0%	0.0%	83.3%	100.0%	80.0%	88.2%	85.0%		76.7%		
	Total > 62 days		0.0	0.0	0.0	1.0	0.5	1.0	1.0	1.0	2.0	2.0	1.0	0.0	1.0	1.0			9.5		
Skin	% Within 62 days	▲ £	91.2%	97.6%	93.8%	98.1%	93.3%	84.6%	90.2%	98.0%	93.7%	88.1%	94.9%	95.0%	97.1%	96.0%	85.0%		93.4%		
	Total > 62 days		2.5	0.5	1.5	0.5	3.0	4.0	2.5	0.5	2.0	2.5	1.0	1.0	0.5	1.5			20.5		
Unknown	% Within 62 days	▲ £	100.0%		100.0%	75.0%	100.0%	100.0%	100.0%		100.0%	66.7%	100.0%	100.0%	50.0%	57.1%	85.0%		93.9%		
	Total > 62 days		0.0		0.0	0.5	0.0	0.0	0.0		0.0	0.5	0.0	0.0	1.5	1.5			1.0		
All Tumour Sites	% Within 62 days	▲ £	90.1%	90.3%	89.0%	89.1%	90.9%	77.8%	88.4%	89.0%	86.7%	82.6%	90.0%	89.6%	87.6%	88.6%	85.0%		88.3%		
	Total > 62 days		10.0	8.0	9.5	9.5	9.5	16.0	10.0	8.5	12.0	14.0	8.0	8.5	9.0	17.5			119.5		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £		100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%				100.0%	100.0%	85.0%		90.0%		
	Total > 31 days			0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0				0.0	0.0			1.0		
Acute Leukaemia	% Within 31 days	▲ £	100.0%			0.0%	100.0%										85.0%		66.7%		
	Total > 31 days		0.0			1.0	0.0												1.0		
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)63
Title of paper: Executive Committee Chair's Report
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 June 2019. There were a total of 4 Executive Committee meetings held during this period. The Executive Committee approved: • The annual review and uplift of car parking charges for staff and patients/visitors • Additional consultant capacity to provide separate emergency and elective obstetric anaesthetic rotas There were updates on other key Trust objectives, including; flexible endoscopy decontamination equipment procurement, St Helens Community Services, Primary Care developments and the Eastern Sector Cancer Hub selection process. The Executive Committee also considered regular assurance reports covering: appraisal and mandatory training compliance, the Risk Management Council and Corporate Risk Register, safer staffing and shift shortfall monthly reports, and the Integrated Performance Report. There are no specific issues that require escalation to the Board.
Trust objectives met or risks addressed: All 2019/20 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 July 2019

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE
June 2019

1. Introduction

There were 4 Executive Committee meetings in June 2019. At every meeting the committee reviews any bank or agency staff requests that would breach the NHSI cost thresholds.

2. 6th June 2019

2.1 Flexible endoscope decontamination - Update

The Director of Corporate Services provided an update on the procurement of new flexible endoscope decontamination equipment for St Helens Hospital. The service specification had now been completed and a partner selected to provide the managed equipment service (MES) and commence a process to select the best equipment to meet the Trust's needs. The accommodation solution was also being developed alongside the equipment procurement.

2.2 Trust Board Agenda - June

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

2.3 Annual Review of car parking charges

The Director of Corporate Services presented a paper which detailed the increasing costs of providing car parking at the Trust and benchmarking information about the charges at other local hospitals. Patient and visitor charges had not changed for 6 years and a modest increase was agreed, protecting the one hour short stay and maximum tariff for over six hours and continuing to offer a weekly ticket for frequent attenders. There was also agreement to make a increase to staff car parking charges in line with inflation, to ensure that car parking income covered the cost of providing these facilities.

2.4 Commercial Services Steering Group

The Director of Corporate Services presented the draft terms of reference for the group which had recently been established following the Use of Resources assessment feedback. Although the group currently focused on the Human Resources commercial services it was agreed that all such potential services should be included within the scope of the group and amendments to the terms of reference were agreed to reflect this.

2.5 Simon Stevens visit

The Chief Executive provided feedback from the visit of Simon Stevens, CEO of NHSE/I to the north west region. The key messages were about performance in 2019/20 and how the NHS would deliver the Long Term Plan.

2.6 A&E Delivery Board weekly call

The Director of Operations and Performance reported on the weekly call and the discussion about "Vanguard Wards" to increase the overall number of beds in each system to respond to rising demand. Committee agreed that the Trust should once again explore options for additional on-site and also community bed capacity with system partners.

3. 13th June 2019

3.1 St Helens community services

The Director of Operations and Performance provided an update on discussions with St Helens CCG about the community service contracts that were being transferred from the current provider. Terms of reference for the working group had been agreed and a suite of standard due diligence questions asked in relation to each service. The responses would then inform the next steps of the contract novation risk assessment.

3.2 Updated major incident pack

The Director of Nursing, Midwifery and Governance presented the revised major incident pack for on-call directors, which gave details of the role and responsibilities of the most senior person in the event of a major incident being declared. The packs would be circulated to directors and general managers who were part of the senior on call rota.

3.3 SafeCare Allocate – Progress report

The Director of Nursing, Midwifery and Governance provided an update on the implementation of the SafeCare system for monitoring patient acuity and staffing levels. The system was now live on all wards and the majority were reporting patient acuity 3 times a day. Two audits had been undertaken and some inconsistencies identified in how patients were categorised using the acuity scoring system. As a result the definitions had been reviewed and clarified for all specialities and a further audit was planned for July. A review of the staffing establishment on each ward is also planned for July, with a view to completing a full Shelford audit in September.

3.4 Risk Management Council and Corporate Risk Register (CRR)

The Director of Corporate Services presented the Chair's report from the June Risk Management Council, which included detail of the 11 risks currently escalated to the CRR. The report also included a briefing on the updated quality impact assessment process for cost improvement programme risks and how these were managed and reported via the risk register.

3.5 Integrated Performance Report

The Director of Finance led the review of the key performance indicators for June to agree the commentary and identify any exceptions, before presentation to the Quality and Finance and Performance Committees.

4. 20th June 2019

4.1 Anaesthetic cover of obstetric emergency and elective lists

The Director of Operations and Performance introduced the paper which detailed changes to best practice guidelines which advised that there should be separate anaesthetic day time cover for emergency and elective obstetric theatres. This was also a requirement for meeting the CNST maternity premium reduction scheme. Committee approved investment to recruit an additional consultant anaesthetist to ensure there was sufficient capacity to provide separate elective and emergency cover.

4.2 Mandatory training and appraisals

The Deputy CEO/Director of HR presented the figures for each director, for May.

4.3 Primary Care Strategy - Update

The Director of Operations and Performance introduced the report which detailed the issues being encountered to reach a common understanding of the way forward. The advent of Primary Care Networks had fundamentally changed the primary care landscape and offered different solutions to achieving sustainable primary care services. The report also detailed the actions taken to deliver the CQC action plan for Marshalls Cross, with a mock inspection being planned for July to provide additional assurance that the issues identified in the report had been addressed. It was agreed that this would be discussed at the next Strategy Board meeting.

4.4 Business case approval process

The Director of Finance had reviewed the current system and presented options in relation to lower value or self-funding cases. The committee examined the options but following discussion agreed that it was important that all directors remained involved in decision making and understanding the service developments proposed. It was agreed that all business cases within the Chief Executive's delegated authority would continue to be reviewed by the Executive Committee.

4.5 Pathology Network

The Director of Operations and Performance provided an update on the work of the Cheshire and Merseyside pathology network and the development of the outline business case for a hub and spoke model of delivery.

4.6 Pension Taxation Working Group

The Deputy CEO/Director of HR provided an update from the working group meetings on the options that had been proposed and were being examined, alongside the national consultation exercise.

5. 27th June 2019

5.1 Southport and Ormskirk NHS Trust Pathology Service Contract

The Director of Finance presented a paper that detailed options for a revised charging mechanism for changes in activity from the assumptions in the original bid. The Trust

had now held the contract for 5 years and there was an option for a further 5 year extension with the opportunity to review and amend any elements of the contract, by agreement. The objective for the Trust was to ensure that its fixed costs were covered, and to maintain the high standards of service to Southport and Ormskirk NHST.

5.2 Infection Prevention and Control Update

The Director of Nursing, Midwifery and Governance provided an update on the actions being taken in response to the detection of Vancomycin Resistant Enterococci (VRE) on Ward 3D. In four months there had been two confirmed bacteraemia, where both patients had been treated and recovered, and several positive samples of many different strains. There had been a programme of repeated enhanced and deep cleaning, including the purchase of H2O fogging machines. The presence of VRE in the general population, other hospital settings and this patient population (gastroenterology) was reviewed and it was agreed that a time line would help determine the most appropriate next steps.

5.3 Shift Shortfall Report

The Director of Nursing, Midwifery and Governance presented the report on Registered Nurse (RN) shift shortfall compared to the planned rota during May. There were two wards where there had been shift shortfalls on nights, and two different wards where there had been a shortfall on the late shift. The establishment of RNs and Health Care Assistants on every ward was being reviewed.

5.4 Clinical Quality Performance Group (CQPG)

The Director of Nursing, Midwifery and Governance provided feedback from the recent CQPG meeting with commissioners. There had been a presentation from Alder Hey Children's Hospital about the process of transferring complex patients from Paediatric to Adult services, when they reached the age of 19. The Staff Health and Wellbeing CQUIN payment for 2018/19 had also been discussed.

5.5 Activity Recording Quality Assurance

The Director of Finance presented a proposal to undertake a full audit of activity recording across the Trust to ensure accuracy. This had last been undertaken several years ago and with the changes to HRG tariffs it was agreed that a re-audit was timely.

5.7 Same Day Emergency Care Business Case

Following submission of the business case, the Director of Operations and Performance briefed committee on the preparatory work that was being undertaken to ensure the schemes could be progressed as quickly as possible, once NHSE/I approval was received.

5.8 Life Support Training

The Assistant Director of Learning and Development attended to present a paper detailing the plans to ensure staff received the correct level of basic or intermediate life support training, and how this would be monitored to ensure the Trust could demonstrate

compliance with the Resuscitation Council guidance. The Executive Committee requested further assurance on some aspects of the plan.

5.9 Eastern Sector Cancer Hub

The Director of Operations and Performance briefed the committee on the next stage in the process to determine the site of the Eastern Sector Cancer Hub. A revised template and scoring structure had been notified to the Trust and the responses had to be submitted by 24th July.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)64

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

Purpose: To summarise the meeting papers from 23rd July 2019 and escalate issues of concern.

Summary:

Matters Arising from action log:

- Perinatal Mortality Review Report: Updates on progress and compliance received. Actions added to the action list on receiving outstanding data from Bridgewater and timelines to be added to review process.
- Maternity Staffing for safety: Assurance of safe staffing provided. Over recruitment of midwives explained and the plan to offset these posts through non-replacement accepted.
- Mental Health Capacity update: Significant work is needed to ensure the Trust is acting within the legal framework for those patients who require Deprivation of Liberty Safeguards (DoLS) authorisation. The Trust is still not referring all patients who require referral for authorisation. The increase in DoLS referrals within the Trust was noted. Further work to strengthen Trust arrangements in preparation for the new Liberty Protection Safeguards (LiPS) Oct 2020 are also required. Concern was expressed with regard to capacity; noted that a business case is due to go to Executive Committee in August. An update report was requested for September (agenda item). **Matters for escalation to Board:** The Trust is still not referring all patients who require referral for authorisation.

QC(19)088 IPR:

- 0 never events have been reported year to date against a target of 0.
- 0 MRSA cases were reported against a target of 0.
- There were 8 C.Difficile positive cases reported in June (5 hospital onset and 3 community onset). YTD there have been 18 cases (12 hospital onset and 6 community onset). The annual tolerance for 2019-20 is 48 cases.
- No grade 3/4 pressure ulcers were reported. None YTD.
- Safer staffing fill rate was 98.5% for June. YTD rate is 98.2%.
- There was 1 in-patient fall in May resulting in severe harm.
- VTE assessment performance was 95.32% for May against a target of 95%.
- HMSR Feb 117.6 against a target of 100. YTD is 100.6.

The increase in activity in ED was noted. The spike in activity in June was considered to be due to patient flow and LoS. Workstreams are in place to look at this; it was noted that further focus is required on eDischarge. Comparative data from other trusts was requested (September agenda item).

QC(19)089 Patient Safety Council: The summary page was noted, and the significant decrease in falls noted. Good compliance with sepsis training, screening and administration of antibiotics was also noted. **Matters for escalation to Board**: Infection outbreaks of Vancomycin-resistant enterococci (VRE) on wards 3D, 4A and 4C and increase in number of C difficile cases in Q1. Improvement plans in place.

QC(19)089 Safeguarding Quarterly Report: PREVENT level 3 training figures need to improve. Update report on training was requested for the September meeting. There were no items for escalation.

QC(19)089 Infection Prevention and Control Report: The summary page was noted, and the

requirement for focussed attention to be given to a further hand washing campaign agreed. An outbreak of measles in Liverpool was reported. **Matters for escalation to Board**: further discussion on outbreaks of VRE, and the increased incidence of Cdiff - actions taken were detailed. Improvement plan in place.

QC(19)089 CQC Action Plan: There are 50 actions in total with 26 completed, 22 on track, 1 overdue (Urgent and Emergency Care) and 1 at risk of not being completed (Community). The summary page was noted and there were no items for escalation.

QC(19)090 Patient Experience Council Assurance Report: The summary page was noted, and the inpatient action plan discussed. The inpatient survey results will be brought to September Committee (agenda item).

QC(19)092 Complaints, PALS and Claims Report: There is an upward trend in 1st stage complaints, PALS and claims by quarter. The summary page was noted, and this will be monitored closely. At this stage there were no items for escalation.

QC(19)094 Clinical Effectiveness Council Assurance Report: The summary page was noted, there were no items for escalation.

QC(19)094 NICE Guidance Compliance Reports: Deferred.

QC(19)097 Clinical Quality and Strategy Report: The summary page was noted, there were no items for escalation.

QC(19)098 Workforce Council Assurance Report: The summary page was noted, there were no items for escalation.

QC(19)099 Safer Staffing report: The summary page was noted, and an overview provided. There were no items for escalation.

Risks:

- Non-achievement of PREVENT training target.

Matters for Escalation:

- The Trust is still not referring all patients who require referral for authorisation.
- Infection outbreaks of Vancomycin-resistant enterococci (VRE) on wards 3D, 4A and 4C and increase in number of C difficile cases in Q1. Improvement plans in place.

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: 23rd July 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)65

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance and Performance Committee, 25th July 2019

Summary:

Agenda Items

For Information

- DoF verbal update – The Director of Finance gave an update on a number of issues for the Committee's attention. These included:
  - National challenges with Capital Department Expenditure Limits (CDEL); c£2b needs to be reduced across the NHS. STHK as deferred c£0.7m into next year on the agreement that its "replenished" next year. None of this will compromise safety/quality.
  - National tax changes on pensions creating an issue which could impact on activity for providers. Consultation nationally on options is being considered.

- Integrated Performance Report
  - The Committee discussed the high number of C-diff cases reported during June, it was noted that new guidance will require us to include cases where the patient has been discharged from our care in the previous 28 days.
  - The Committee also noted the decrease in 2 week referral performance for breast cancer; this will be monitored through Quality Committee and F&P Committee.

- Finance Report
  - The Trust is reporting a £2.2m deficit YTD in line with plan. £1.5m of non-recurrent resources were utilised to achieve this position. This has not changed from last month.
  - Capital resources of £0.7m have been utilised year to date and the Trust has plans for the entire programme.
  - The Trust delivered a UoR of 3 in line with plan.
  - The financial position includes Provider Sustainability Funding (PSF) of £1.0m; this is excluding the £0.5m of PSF relating to 2018/19.
  - The Trust had a cash balance of c£4m at the end of June which equates to 4 days of operating expenses.
  - The Committee were assured of the drivers to the current NEL activity given the significant increase in A&E attendances. Actions plans are underway around reduced LoS and bed capacity to mitigate this.

- Bank and agency
  - The Committee reviewed the paper which detailed the reduction in agency spend achieved across the Trust, further work continues on the rates of bank pay and the coding of bank shifts to ensure consistency across the teams.

- PLACE development
    - The Deputy Director of finance gave a verbal update on the St Helens system including the change by NHSI/E to meeting with providers and commissioners together to understand the challenges within the system and how collectively issues can be addressed. There was positive feedback from the last meeting with NHSI in in relation to our CIP delivery and the CCG improving their underlying financial position. A formal paper is due to be submitted during August on our system wide approach.

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

For Assurance

- A&E Performance
    - The Committee reviewed the presentation from the ADO for Medical Care.
    - Information was presented on the change in attendances compared to the previous year, noting a significant improvement in performance within Paediatric ED which is currently at 91%.
    - The Committee also noted the analysis completed on reasons for delayed discharges and the key themes by CCG, it was felt additional bed capacity would be required for the winter period.

- CIP Programme update
    - The Committee noted the £13.9m of CIP plans which have already been transacted this year and were assured that the value of non-recurrent schemes wasn't increasing as the year progresses.
    - The committee were assured around the governance arrangements of CIPs

- CIP Programme update – CSS
    - The committee received a presentation for CSS which gave an overview of their current schemes and were assured by the performance to date.
    - It was noted within the presentation there is a national shortage of radiologists so the teams are looking at how other members of the workforce can be trained to provide additional support.

Risks noted/Items to be raised at Board

- National pressures on capital plans
- Current bed pressures due to increased A&E attendances and LoS performance.
- Increase in C-Diff cases seen during June.

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 July 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)66

Title of paper: Corporate Risk Register

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 Trust's 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. 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 Trust risk grading matrix;
- Any risks initially rated as high or extreme have been reviewed by a Director;
- 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 June 2019 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 753 compared to 741 in April;
- 46% (350) of the Trust's risks are rated as Moderate or High compared to 45% in April;
- 10 risks that scored 15 or above had been escalated to the CRR (there were also 10 risk escalated in April 2019 but they are not all the same risks).

The spread of CRR risks (Appendix 1) across the organisation is:

- 2 in the Medical Care Group;
- 0 in the Surgical Care Group;
- 1 in Clinical Support Care Group;
- 7 in Corporate Services;
- 0 in Primary Care and Community Services Care Group.

The risk categories of the CRR risks are:

- 7x Patient Care;
- 2x Money;
- 1x Governance;
- 0x Staff.

Following discussion at the Trust Board in April this report includes comparisons between the quarterly reports and against the same period in July 2018 (Appendix 3 and 4).

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 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 July 2019

CORPORATE RISK REGISTER REPORT – JULY 2019

1. Risk Register Summary for the Reporting Period

RISK REGISTER	Current Reporting Period 01/07/2019	Previous Reporting Period 03/06/2019	Previous Reporting Period 01/05/2019
Number of new risks reported	35	33	30
Number of risks closed or removed	12	22	57
Number of increased risk scores	2	2	5
Number of decreased risk scores	5	8	6
Number of risks overdue for review	64	40	65
Total Number of Datix risks	**753***	**727**	**715**

*based on 747 scored risks, 4 new risks not yet scored and 2 high unapproved risks

2. 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
50	**50**	**20**	**116**	**11**	**150**	**59**	**125**	**36**	**120**	**1**	**9**	**0**	**0**
120 = 16.06%			**277 = 37.08%**			**340 = 45.52 %**				**10 = 1.34%**			

3.1 Surgical Care Group - 211 risks reported 28.24% 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	**14**	**7**	**39**	**4**	**43**	**17**	**47**	**8**	**26**	**0**	**0**	**0**	**0**
27 = 12.8%			**86 = 40.76%**			**98 46.45%**							

3.2 Medical Care Group - 181 risks reported 24.23% 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
28	**23**	**1**	**29**	**0**	**31**	**7**	**22**	**14**	**24**	**0**	**2**	**0**	**0**
52 = 28.73%			**60 = 33.15%**			**67 =37.02%**				**2 =1.10%**			

3.3 Clinical Support Care Group - 86 risks reported 11.51% 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
2	**4**	**1**	**6**	**0**	**12**	**10**	**15**	**9**	**24**	**1**	**2**	**0**	**0**
7 = 8.14%			**18 = 20.93%**			**58 = 67.44%**				**3 = 3.49%**			

3.4 Primary Care and Community Services Care Group - 36 risks reported 4.81% 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**	**9**	**1**	**4**	**4**	**4**	**5**	**8**	**0**	**0**	**0**	**0**
1 = 2.78%			**14 = 38.89%**			**21 58.33%**							

3.5 Corporate (Finance, Health Informatics/Health Records, Facilities, Nursing/Governance/Quality & Risk, HR and Medicines Management) 233 risks reported 31.19% 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
14	**8**	**11**	**33**	**3**	**60**	**21**	**37**	**0**	**38**	**0**	**5**	**0**	**0**
33 = 14.16%			**99 = 42.49%**			**96 = 41.20%**				**5 = 2.14%**			

The split of the risks across the corporate departments is:

	High	Moderate	Low	Very low	**Total**
Health Informatics/Health Records	1	19	4	0	24
Estates and Facilities Management	0	3	13	7	23
Nursing, Governance, Quality & Risk	0	14	10	7	31
Finance	2	5	18	8	33
Medicines Management	0	16	38	8	62
Human Resource	2	38	16	3	59
Information Governance	0	1	0	0	1
Total	5	96	99	33	233

Appendix 1

Corporate Risk Register – July 2019

KEY	Medicine		Surgical		Clinical Support		Corporate		Community	

New Risk Category	Datix Ref	Risk	Current Risk Score I x L	Date of last review and Executive Lead	Target Risk Score I x L	Action plan in place	Monitoring and Governance
Patient Care	762	**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	23/04/2019 Anne-Marie Stretch	4 x 2 = 8	Action plan in place	Quality Committee
Money	1152	**If** there is an increase in bank and agency **then** there is a risks to the quality of patient care and ability to deliver financial targets	4 x 4 = 16	01/04/2019 Anne-Marie Stretch	4 x 3 = 8	Action plan in place	Quality Committee
Patient Care	1358	**If** the Cheshire and Mersey PACs system experiences system issues, **then** there is a risk to patient safety	4 x 4 = 16	25/06/2019 Christine Walters	4 x 1 = 4	Action plan in place	Executive Committee
Patient Care	1605	**If** the Trust is unable to fill gaps on medical Specialist Registrar (SpR) on call rota **then** there is a risk to patient safety	4 x 4 = 16	03/05/2019 Sue Redfern	4 X 1 = 4	Action plan in place	Quality Committee
Governance	1772	**If** there is a malicious cyber-attack on the NHS **then** there is risk that patient information systems managed by the HIS will be compromised which could impact on patient care	4 x 4 = 16	29/05/2019 Christine Walters	4 x 3 = 12	Action plan in place	Executive Committee
Patient Care	2334	**If** the Medway migration issues in PBS are not resolved **then** there is the risk to efficient service delivery across the Trust	4 x 4 = 16	25/06//2019 Rob Cooper	4 x 2 = 8	Action plan recorded	Executive Committee
Patient Care	2370	**If** critical care cannot recruit sufficient consultant medical staff **then** there is a risk to the level of medical cover for the service	4 x 4 = 16	27/06/2019 Kevin Hardy	3 x 2 = 6	Action plan in place	Executive Committee
Patient Care	2428	**If** the breast imaging service cannot recruit staff to cover the vacancy arising following retirement of the previous post holders, **then** capacity to deliver this specialist service will be reduced	4 x 3 = 15	17/06/2019 Anne-Marie Stretch	3 x 3 = 9	Action plan in place	Executive Committee
Patient Care	2502	**If** there is a no deal Brexit **then** there could be an adverse impact on the supply of medical consumables and devices	4 x 4 = 16	27/03/2019 Nik Khashu	3 x2 = 6	Action plan in place	Finance and Performance Committee
Money	2521	**If** the Trust cannot deliver its agreed activity and CIP **then** there is a risk to the forecast outturn and the achievement of PSF funding	4 x 4 =16	27/06/2019 Nik Khashu	4 x 3 = 12	Action plan in place	Finance and Performance Committee

*Risks escalated to the CRR since the April Board report

Risks that have been de-escalated from the CRR since the April Board report are;

Risk Category	Datix Ref	Risk
Money	1555	Risk of not receiving apprenticeship levy payments for Lead Employer Doctors in Training.
Patient Care	1080	Risk to patient safety risk and operational effectiveness if staffing levels are below establishment on wards 2B &2C
Patient Care*	2385	Temporary relocation of the Plastics Trauma Unit due to winter pressures is not fit for purpose

ENDS

Appendix 2

Trust Risk Profile – April 2019

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
50	50	20	116	11	150	59	125	36	120	1	9	0	0
120 = 16.06%			277 = 37.08%			340 = 45.52 %				10 = 1.34%			

Trust Risk Profile – July 2018

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
51	58	28	120	10	142	59	122	39	95	3	5	5	0
137 = 18.59%			272 = 36.91%			315 = 42.74%				13 = 1.76%			

Appendix 3

CRR – July 2018

The risks highlighted remain on the CRR

New Risk Category	Datix Ref	Risk	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	24/04/2017 Rob Cooper	4 x 2 = 8	Action plan in place
Governance	1772	Risk of Malicious Cyber Attack	4 x 5= 20	09/11/2016 Christine Walters	4 x 3 = 12	Action plan in place
Money	1555	Risk of unplanned cost pressures from the introduction of an apprenticeship levy.	4 x 5 = 20	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	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	3 x 5 = 15	17/11/2016 Anne-Marie Stretch	3 x 4 = 12	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	15/08/2017 Sue Redfern	2 x 2 = 4	Action plan in place
Patient Care	2223	Risk that if A&E attendances and admissions increase beyond planned levels then the trust may not have sufficient bed capacity or the staffing to accommodate patients and provide safe care	4 x 5 = 20	09/01/2018 Rob Cooper	4 x 2 = 8	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	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	27/12/17 Rob Cooper	4 x 3 = 12	Action plan in place
Patient Care	2283	Risk that replacement biochemistry blood analysers cannot be procured by December	4 x 4 = 16	11/05/18 Rob Cooper	4 x 2 = 8	Action plan in place
Patient Care	2334	Risk to outpatient booking system changes resulting from Medway switchover	4 x 4 = 16	21/05/18 Rob Cooper	4 x 2 = 8	Action plan in place
Patient Care	1266	Risk of increased DNA rates and potential impact on quality, safety, performance and income	3 x 5 = 15	04/07/18 Rob Cooper	3 x 3 = 9	Action plan in place
Staff	2336	Risk of not being able to obtain UKVI approval for internal recruits for hard to recruit specialities	3 x 5 = 15	23/05/18 Anne-Marie Stretch	3 x 2 = 10	Action plan in place

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)67
Title of paper: Review of the Board Assurance Framework (BAF) – July 2019
Purpose: For the Trust Board to review the BAF
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 April 2019. The Executive Committee review the BAF in advance of its presentation to the Trust Board and propose changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the planned actions and additional controls are sufficient to mitigate the risks being managed by the Board, in accordance with the agreed risk appetite. **Key to proposed changes:** ~~Score through~~ = proposed deletions/completed Blue Text = proposed additions Red = overdue actions **Recommended changes** The following changes should be considered: • Increase score of risk 3 as a result of the operational pressures being experienced in 2019/20 e.g. increase in A&E attendances from all CCGs • Increase score of risk 7 to reflect the risks to national capital allocations and the impact on being able to increase Trust capacity in response to growing service demands.
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to assure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSI, CQC, Commissioners.
Recommendation(s): To review and approve the proposed changes to the BAF.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 31st July 2019

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 provide the services 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
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 2019/20 Objectives and Long Term Strategic Aims

2019/20 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 provide the services 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 • Failure in the supply of critical goods or services 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	• Clinical Quality Strategy • Quality metrics and clinical outcomes data • Safety thermometer • 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 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 programme • National Patient Surveys Other; • National clinical audits • Annual CQUIN Delivery • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Reports • Learning Lessons League • IG Toolkit results • Model Hospital benchmarking	5x1 = 5	Routine reporting of quality and performance of community and primary care services delivered by the Trust	Routinely achieve 30% of discharges by midday 7 days a week Delivery of the Falls Strategy Action plan to achieve a 10% reduction in falls resulting in moderate or severe harm. Ability to demonstrate changes in behaviour to achieve a reduction in similar incidents as a result of sharing lessons learnt from incidents, never events, inquests and mortality reviews	Implementation plans for the four key 7-day service standards by 2020 ~~Transfer of acute stroke services from WHH as phase 2 of the HASU development (June 2019)~~ Risk assessment of critical suppliers and development of contingency plans for EU exit. Undertake a review of patient communication and information to improve accessibility and understanding (September 2019) Continue to work with commissioners to agree the preferred location for the Eastern Sector Cancer Hub	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 two year operational plans and the agreed control total • Failure to control costs or deliver CIP • 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	4 x 5 = 20	• Operational Plan and STP financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 5 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • 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 • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Declaration of interests • Benchmarking and reference cost group	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 monitoring Other; • NHSI monthly reporting • Contract Monitoring Board • NHSI Review Meetings • Use of Resources reviews • Contract Review Boards with Commissioners • St Helens Cares Peoples Board	4x3=12	Develop 2019 -20 detailed CIP plans and strengthen QIA monitoring to mitigate additional risk Continue collaboration across C&M to deliver transformational CIP contribution Management plans to deliver GiRFT recommendations	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 5 year plan with the local Place based systems to deliver the NHS long term plan with C&M partners for submission in September 2019 Secure maximum PSF funding in 2019/20 to achieve revised forecast outturn Via the St Helens Cares Finance and Contract group develop proposals for financial allocations and funding flows for the system (September 2019) Seek all possible sources of capital funding including national bids to support capacity planning	4 x 2= 8	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.) or PSF improvement trajectories • 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 • Bed occupancy rates • Number of super stranded patients	To Board; • Finance and Performance Committee • IPR • System winter 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 including delivery of PSF quarterly targets • CCG CEO Meetings • CQC System Reviews e.g. Halton, Liverpool	~~4 x 3 = 12~~ 4 x 4 = 16	Implementation of routine capacity and demand modelling	Achievement of targets to reduce DTOC and super stranded patients, by working effectively with health system partners Review the effectiveness of the 2018/19 health economy winter plans and learn lessons to inform the plans for 2019/20 Resolve residual Medway and operational issues with OP patient booking systems	Delivery of the Urgent and Emergency Care Summit improvement programme (September 2019 Work with Halton CCG to achieve implementation of the agreed frailty pathway model following the allocation of STP transition funding (May 2019) ~~Reduce the RTT waiting list to below the 2018/19 outturn level (March 2020)~~ Mitigation plan to improve access to Breast Imaging (September 2019). Understand changes in reported activity and increased A&E attendances and admissions (October 2019)	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/Outstanding 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 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/proactive annual programme • 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 2 = 8	Regular media activity reports , including social media, to the Executive Committee	Action plan to improve understanding of patients and carers' views (Revised to September 2019)	Update Trust internet site Review and improve patient information and communication (September 2019) Assess the impact of the combined NHSE/I accountability framework (September 2019) Delivery of the staff survey action plan (October 2019)	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 • 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 • Cheshire and Merseyside 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		C&M Health and Care Partnership performance and accountability framework ratings and reports Development of good working relationships with the new Primary Care Networks	~~St Helens Cares - development of financial and governance models – Now planned for May 2019~~ Participation in One Halton Programme Board Membership of the Knowsley Health and Care Executive Group to develop plans for integrated place based care Continue participation with the Collaboration at scale board and workstreams Work with the C&M STP to agree plans for the locally delivery of the NHS Long Term Plan (September 2019)	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 • Reduction in the supply of suitably skilled and experienced staff 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 3 = 15		Specific strategies to overcome recruitment hotspots e.g. International recruitment and working closely with HEE's Monitoring of take up of the UK Settlement Scheme by EU staff	Development of a C&M collaborative staff bank – Revised to June 2019 – but suspended by C&M H&CP Develop workforce strategy in relation to new roles e.g. Nurse Associates to maximise potential – September 2019 Revise the Workforce Strategy to align to the workforce objectives in the NHS Long Term Plan and interim people plan (July 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 • Insufficient investment in estates capacity to meet the demand for services 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 • 5 year 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 STP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity	To Board; • Finance and Performance Committee • Finance Report • Capital Council • 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~~ 4 x 3 = 12	Development of a 10 year strategic estates development plan to support the Trusts service development and integration strategies.		NHSI approval of Same Day Ambulatory care /bed capacity business case (July 2019) Commence 3 year capital programme to deliver the Same Day Ambulatory care capacity, once business case approval received and funding confirmed (October 2019) Develop proposals for additional winter capacity beds (November 2019) Revise Estates and accommodation strategy – addressing car parking and office accommodation on both sites (September 2019) Operational plans to accommodate 10 year lifecycle works with minimal service disruption (now September 2019)	4 x 2 = 8	NB

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 • Performance framework and KPIs • 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 • IT Cyber Controls Dashboard • Information asset owner/administrator register	To Board; • 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 • CareCert, Cyber Essentials, External Penetration Test • Medway benefits realisation programme monitoring	4 x 4= 16	Annual Cyber Security Business Case approval Annual Corporate Governance Structure review Staff Development Plan Technical Development Annual programme of audit NHS Digital Unified Cyber Risk Framework	ISO27001 Cyber Essentials Plus Service Improvement Plans Communications Strategy Digital Maturity Assessment Complete investigation and review of controls and business continuity resilience following IT outage in January	ISO27001 (August 2020) Cyber Essentials Plus (National deadline revised to July 2020) ~~Approval of draft Cyber Security Strategy~~ Medway benefits realisation programme delivery (August 2019) Delivery of Penetration Test Action Plan (August 2019) Information security management framework (August 2019) PA Consulting external cyber security gap analysis and technology baseline assessment (December 2019) ~~Capital Investment Action Plan (Revised to April 2019)~~	4 x 2 = 8	CW

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)68
Title of paper: Learning from Deaths Quarterly Report 2018/19 Q4
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 has been disseminated throughout the Trust.
Summary: Data is given for Quarter 4 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, policy and good practice guide.
Presenting officer: Nicola Bunce, Director of Corporate Services
Date of meeting: 31st July 2019

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	6	25
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
Jul-18	119	4	0	0	0	0	0	3	12	0	5	21
Aug-18	136	3	2	0	0	0	0	4	10	0	10	27
Sep-18	119	2	3	0	0	0	0	3	10	1	4	21
Oct-18	118	2	1	0	0	0	0	4	8	1	4	17
Nov-18	114	1	1	0	0	0	0	2	13	0	4	20
Dec-18	175	3	1	0	0	0	0	2	7	0	4	17
Jan-19	166	6	1	0	0	0	0	3	10	0	4	24
Feb-19	145	2	1	0	0	0	0	4	9	0	4	20
Mar-19	146	2	2	0	0	0	0	3	7	0	5	16
Grand Total	1,603	31	13	0	2	0	0	39	107	2	57	237

	Specified Groups			Non-Specified Groups		
	Total [5]	Reviewed	% Reviewed	Total	Reviewed	% Reviewed (Target 25%)
Apr-18	25	25	100.0%	89	23	25.8%
May-18	15	15	100.0%	118	30	25.4%
Jun-18	14	14	100.0%	104	28	26.9%
Jul-18	21	21	100.0%	98	24	24.5%
Aug-18	27	27	100.0%	109	28	25.7%
Sep-18	21	21	100.0%	98	26	26.5%
Oct-18	17	17	100.0%	101	27	26.7%
Nov-18	20	20	100.0%	94	25	26.6%
Dec-18	17	17	100.0%	158	45	28.5%
Jan-19	24	24	100.0%	142	38	26.8%
Feb-19	20	20	100.0%	125	33	26.4%
Mar-19	16	16	100.0%	130	36	27.7%
Grand Total	237	237	100.0%	1,366	363	26.6%

	% of Reviews with RAG Rating [6]		
	Total RAG Reviewed	Total Reviewed	% RAG Reviewed
Apr-18	43	48	89.6%
May-18	42	45	93.3%
Jun-18	41	42	97.6%
Jul-18	43	45	95.6%
Aug-18	50	55	90.9%
Sep-18	43	47	91.5%
Oct-18	40	44	90.9%
Nov-18	44	45	97.8%
Dec-18	58	62	93.5%
Jan-19	55	62	88.7%
Feb-19	50	53	94.3%
Mar-19	48	52	92.3%
Grand Total	557	600	92.8%

	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	41	0	2	43
May-18	42	0	0	42
Jun-18	40	1	0	41
Jul-18	39	2	2	43
Aug-18	48	2	0	50
Sep-18	41	2	0	43
Oct-18	40	0	0	40
Nov-18	44	0	0	44
Dec-18	57	1	0	58
Jan-19	54	1	0	55
Feb-19	47	3	0	50
Mar-19	47	1	0	48
Grand Total	540	13	4	557

	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-18	95.3%	0.0%	4.7%
May-18	100.0%	0.0%	0.0%
Jun-18	97.6%	2.4%	0.0%
Jul-18	90.7%	4.7%	4.7%
Aug-18	96.0%	4.0%	0.0%
Sep-18	95.3%	4.7%	0.0%
Oct-18	100.0%	0.0%	0.0%
Nov-18	100.0%	0.0%	0.0%
Dec-18	98.3%	1.7%	0.0%
Jan-19	98.2%	1.8%	0.0%
Feb-19	94.0%	6.0%	0.0%
Mar-19	97.9%	2.1%	0.0%
Grand Total	96.9%	2.3%	0.7%

[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 2018/19-Q4

2018/19-Q4 Key Priorities

(1) Ensuring that staff, patients and carers understand what is meant by the term the message 'Fast track discharge'. This relates to fast-track assurance of funding and does not a guarantee that discharge from hospital will be achieved before death. A number of reasons such as complexity of needs, family / patient preferences and availability of care in the community may impact on the ability to facilitate this.

(2) Improving the shared information platform between community and hospital care to ensure that advance care plans (DNACPR, preferred place of death) can be met as often as possible.

Assurance

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

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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 ☐.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)69
Subject: HR/Workforce Strategy & Workforce Indicators Report
Purpose: To provide assurance to the Trust Board of the progress workforce indicators that support the delivery of the Trust's Corporate Objectives, specifically to developing organisation culture and supporting our workforce.
Summary: The Trust is committed to developing the organisational culture and supporting our workforce. This paper is in two parts, the first provides an update on strategic matters aligned to the key priorities as detailed in the NHS long term plan and second part relates to workforce indicators. Overall the paper summarises achievements/progress to date. • Increase numbers of nurses and medical workforce • Focus on staff retention and outcomes of exit interview review • A compassionate and inclusive leadership culture. • Zero tolerance on violence towards NHS staff. • Increased focus on respect, equality and diversity. • Productive working through electronic rosters and job planning. • New focus on leadership and talent management. • Encouragement for and investment in volunteering initiative • Employee relations formal process case update • Key workforce performance indicators update
Corporate Objective met or risk addressed: Developing organisation culture and supporting our workforce
Financial Implications: N/A
Stakeholders: Staff, Managers, Staff Side Colleagues and Patients
Recommendation(s): The Trust Board is requested to accept the report and to note the areas of achievement/progress against corporate objectives.
Presenting Director: Anne-Marie Stretch, Deputy CEO/Director of HR
Board date: 31st July 2019

HR/Workforce Strategy & Workforce Indicators Report

31st July 2019

1.0 Purpose of the Paper

The paper provides an update on a number of workforce indicators which contribute towards the achievement of the Trust's corporate objectives 2019/20. In January this year, the NHS published its Long Term Plan which sets out an ambitious 10-year vision for healthcare in England. It sets out a new service model where Trusts need to take more action on prevention and health inequalities, where we improve quality of care and health outcomes across all major health conditions, where the NHS harnesses technology to transform services, and where the NHS gets the most out of taxpayers' investment. Underpinning this vision is an NHS that ensures our people get the backing they need.

2.0 Interim People Plan

On the 6th June 2019 the interim People Plan was published which sets out our vision for people who work for the NHS to enable them to deliver the NHS Long Term Plan, with a focus on the immediate actions we need to take. This paper will describe the key national priorities for 2019/20 and the actions the Trust is taking to address these priorities.

2.1 Improving our leadership culture

The interim people plan states that our leaders play a key role in shaping the culture of NHS organisations. It stresses that all NHS leaders, in both providers and commissioners, need to focus on developing a positive, inclusive and people-centred culture that engages and inspires all people and with a clear focus on improvement and advancing equality of opportunity. Where leaders focus on developing, engaging and supporting their people to improve services for patients and citizens, the quality, financial and performance metrics also improve. The plan states that it is no coincidence that those Trusts with 'good' and 'outstanding' use of resources ratings also have 'good' and 'outstanding' well-led ratings, demonstrating the strong relationship between greater productivity and more engaged staff. In these organisations, staff are engaged by a shared purpose and motivated to work more efficiently and effectively – improving patient experience, reducing waste and redesigning care.

2.2 How we will develop inclusive, person-centred leadership culture

This interim People Plan addresses how Trusts need to develop and spread a positive, inclusive, person-centred leadership culture across the NHS. At STHK we having been undertaking a review of current leadership training and our talent management and leadership development interventions and will prioritise outcome focussed initiatives which will be detailed later in this paper.

2.3 Addressing urgent workforce shortages in nursing

The interim People Plan discusses the workforce shortages across a wide range of NHS staff groups – doctors, including GPs and psychiatrists, paramedics, radiographers, genomic scientists and dentists, to name a few and states that the NHS is committed to addressing these shortages. It describes how the most urgent challenge is the current shortage of nurses, who are critical to delivering the 21st century care set out in the NHS Long Term Plan. The plan addresses how the NHS must act now to support and retain our existing nurses, significantly increase the number of newly qualified nurses joining the NHS, bringing in nurses from abroad and ensuring that Trusts make the most of the nurses we already have. The interim people plan sets out the key actions required in the short and medium term to build the nursing workforce we need for the future.

2.4 Health & Well Being

The interim People Plan also acknowledges that the culture of the NHS is being negatively impacted by the fact that staff are overstretched – this is evident from the 2018 NHS Staff Survey where more people have reported bullying, harassment and abuse in their workplace in the last 12 months. The theme of staffing pressures causing stress and burnout also runs through the recent Health Education England report on NHS staff and learner wellbeing, which sets out some of the most serious causes of harm to our people's mental health and wellbeing. There is an understanding that we need more people, but this alone will not be enough.

2.5 A new operating model for workforce

The interim People Plan has been produced in just three months through an inclusive approach involving all the key organisations responsible for the NHS workforce nationally. There has also been extensive engagement with NHS providers, commissioners and local health systems; public and patient bodies; trade unions; professional and regulatory organisations; think tanks; and others interested in health and social care. NHS England and NHS Improvement have published alongside the interim People Plan a document summarising the engagement to date. They advised Trusts that they will continue to work in this way and will establish permanent forums for doing so that unite the many national NHS organisations with formal responsibilities for people planning and management, together with other key partners. They will ensure they undertake workforce activities at the optimal level – whether national, regional, system or organisational – with the expectation of an increasing role for integrated care systems (ICSs) as they develop. The interim People Plan starts to set out how the principle of subsidiarity will apply to people-related functions by setting out what functions can potentially be carried out at which levels. It also states that it will extend the skills of our workforce through the development of multi-professional credentials, which formally recognise that professionals have the skills, expertise and competencies to practise in certain areas.

2.6 More flexible working and careers

The interim People Plan details how different generations want different things from their working lives and that many people joining the NHS today are aware they will be

working for longer than the generation before them and may decide to take breaks from NHS employment. It states how the NHS needs to encourage second and third careers within the NHS, offering diverse and flexible opportunities and careers. It encourages Trusts to significantly increase flexible working through a combination of technology and a change in people practices, to give people greater choice over their working patterns, help them achieve a better work-life balance, and help the NHS remain an attractive career choice. This will include the need to advertise more roles as flexible (for example, less than full time, term time only, job shares) and, where possible, enable home working to bring the employment offer into line with other sectors.

2.7 Remove practical barriers to movement of staff between organisations.

Over the next five years, Trusts will be supported to streamline their induction and on-boarding processes to reduce duplication and to recognise previous training and skills 'passported' from previous employers. In addition, all Trusts will be expected to develop tech-enabled in-house staff banks, to create greater opportunities for employees to work flexibly. All trusts will also be expected to establish collaborative staff banks with other local trusts, increasing the potential number of shifts visible to those working flexibly.

2.8 International Nurse Recruitment & Retention programme

The STHK recruitment and retention programme aligns to recent announcements from Simon Stevens, CEO NHS England and Prerana Issar NHS Chief People Officer, Prerana Issar said: "With staff turnover at a five-year low, it's clear that the NHS is competing well with other employers to retain the nurses, midwives and therapists that our patients depend on. The National Retention Programme has had a promising start and we are now looking to roll out this scheme to other Trusts and into general practice. Getting the right workforce is not just about the number of people we bring in, but keeping and rewarding the team we have."

3.0 The STHK Response to Nursing Recruitment & Retention

At STHK we have committed to recruiting 50 international nurses and have recruitment pipeline in place for qualified nurses to on-boarded into the Trust from India and the Philippines during 2019/20. The Trust has welcomed 24 international nurses between April and July 2019. A further 3 cohorts of 10 are planned for the remainder of the financial year bringing an estimated total of 54 international nurses for 2019-20. The Trust also has a pipeline of 129 external Band 5 nurses awaiting start dates with the Trust many of whom will join us once they qualify.

In the first half of 2019 the STHK Recruitment Team has facilitated over 350 offers of employment which includes both internal and external appointments. 39% of these were for Nursing and Midwifery positions. In the same period the Trust saw over 280 new starters of which 27% were Nursing and Midwifery. The Trust bank also grew during this period seeing an additional 437 new staff and 201 internal staff join the bank.

The Trust has recruited an additional 49.8 wte external RNs (not including international and newly qualified RNs) to those ward areas covered by the Safer Staffing report. The Trust has seen a sustained reduction in RN vacancies which has seen an increase in safer staffing on wards from 96.65% in January 2019 to 98.54% in July 2019, an increase of 1.89%. Since the Trust commenced its international recruitment programme a 110 additional Nurses have been recruited to date which was 56 in 2018/19 and 24 year to date 2019/20.

3.1 Retention Programme - Exit Process

In the current environment of workforce challenges, the Trust aim is to retain our staff wherever possible. However, if a member of staff wishes to leave then managers are advised to have a face to face discussion to establish the reason why and ask them to reconsider. If this fails then establish the reason why and learn from it and/or report the reason to HR so themes can be identified.

If a member of staff does not wish to speak to their manager then they are encouraged to approach HR to discuss their reason. HR may be able to intervene at this stage to avoid the member of staff leaving or if this fails, feedback to the manager concerned so that lessons can be learnt and any themes identified.

Staff are also directed to the on line exit survey on the Trust's intranet if they do not wish to have a face to face interview with their manager or HR. Staff who have left the Trust in the last 6 months have also been sent a paper exit survey to see if this proves to be a meaningful way to gather information. A response rate of 10% was achieved for the paper surveys which is lower than expected.

As we are moving to email/text communication with our patients, we are exploring a similar approach with our staff and utilising existing technology to survey staff via electronic means, email, text, and mobile apps in addition to continuing to offer/encourage face to face discussions with managers or HR.

Exit survey feedback

The exit survey asks staff a range of questions including what attracted them to join the Trust, how long they intended to stay, and what influenced their decision to leave.

The reasons for joining the Trust in rank order were as follows:

- Trust location
- Trust reputation
- Career prospects
- Learning and development opportunities
- Trust stable environment
- Recommended by a friend
- Preferred sector

- Salary prospects

More than 70% of leavers said that when they joined the Trust they intended to stay more than 5 years but more than 50% of leavers had less than 5 years' service when they left. More than 60% of leavers went to other NHS organisations. More than 50% of leavers would recommend the Trust as a place to work to a friend/colleague but only 44% would consider working for the Trust again.

The top 5 reasons which influenced their decision to leave were:

- Career move/change
- Management style
- Feeling valued
- Work life balance
- Health reasons

A review of the Trust staff survey results in the areas above would indicate that these issues are not systemic but are rather isolated to particular individuals/departments. The staff survey results were the best in the country and the Trust scored the highest nationally in the six of the ten key themes measured. The six high scoring themes were:

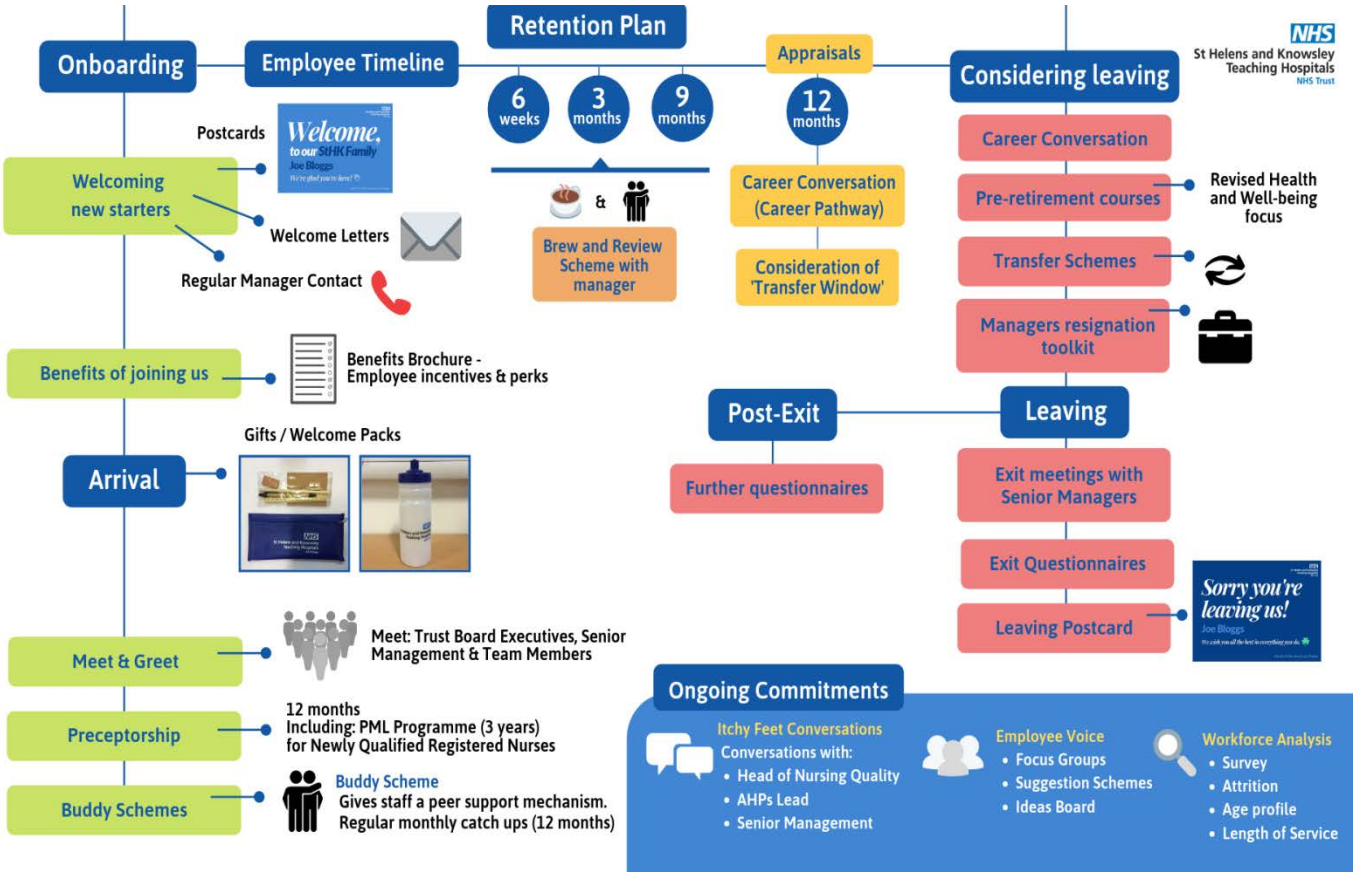
- Equality, Diversity & Inclusion
- Morale
- Quality of Care
- Safe Environment – Bullying & Harassment
- Safety Culture
- Staff Engagement

Exit Survey - Free text comments

An analysis of free text comments indicate that more support for new starters and better flexible working were a recurrent theme. This has been addressed through the development of a retention plan using information from exit surveys and interviews and from engagement with recent new starters and Nursing leadership teams. A two year retention action plan will be presented to the Workforce Council in September 2019 detailing the outcomes and deliverables expected. Initially the plan will focus on Nursing in 2019/20 extending to other staff groups thereafter.

3.2 STHK Retention Plan

While the labour stability index and turnover data detailed later in this paper demonstrates that the Trust turnover is lower than acute peer group, the North West and national position, the following table illustrates how retention will be further improved.



4.0 Employee Relations Case Update

Summary of Employee Relations cases April-June 2019

To provide transparency to the Trust Board in the reporting of employee relations cases, the table below details those cases that were managed through the disciplinary, capability, grievance or dignity at work policy in Q1 2019/20. Due to GDPR no further personal details are provided. Cases that take in excess of 12 months are usually due to the involvement external agencies such as the Police, MIAA, local authority or Regional Union representatives or where an individual subsequently is absent due to long-term sickness. The Trust is currently reviewing the time taken to conclude cases, how the duration of cases can be reduced and what resources would be required as recommended by the recent NHSI guidance on Lessons Learnt on Improving People Practices.

Duration	Data	%
0-3 months	10	34.4
3-6 months	14	48.3
6-9 months	3	10.3
9-12 months	1	3.5
12 months +	1	3.5
Total Timeline -Closed Cases	**29**	**100%**

5.0 Supporting staff to reduce Violence & aggression from patients

Following feedback from the 2018/19 annual staff survey that staff were experiencing higher levels of violence and aggression from patients. A business case has been approved to provide staff training to reduce the risk of physical assault and more serious incidents of unacceptable behaviour. Staff will receive an appropriate level of conflict resolution and/or control and restraint training for their role. Training has been procured from an accredited external provider and arrangements made for 4-6 courses being provided, (90 staff at level 2 – low level disengagement techniques, and 64 at level 3/advanced level – advanced physical intervention inclusive of high-level dis-engagement techniques, non-pain escort holds, ground work, stair extraction and relocation to seated position). This will be delivered by the 31st March 2020. The training will continue as a 3-year rolling programme to ensure that staff retain the skills necessary to avoid or if necessary deal with a conflict situation.

5.1 Conflict Resolution and Control & Restraint Training

Level 1 basic awareness training on conflict resolution is now available for all staff to complete as a mandatory e-learning programme. This course includes common causes of conflict; impact factors; warning/ danger signs; projecting a professional image; conflict de-escalation models and their application; evaluation of a potentially difficult situation (conflict management dynamic risk assessment) and reaching a positive outcome.

6.0 Junior Doctors changes to terms and conditions of employment

On the 25th June 2019 following lengthy negotiations between NHS Employers, the British Medical Association (BMA) and the Department of Health & Social Care (DHSC) on proposed improvements to the contract for doctors in training. A new Framework Agreement was finalised and has now been accepted by the BMA membership in a referendum which concluded on 25th June 2019 which now resolves the on-going dispute. The agreement covers the period from 1st April 2019 to 31st March 2023. Amongst other changes it sets down revised rates of pay/allowances, changes to the safety and rest limits within the rotas, changes to the transitional pay and pay protection arrangements, provides greater clarity on exception reporting and introduces the 'Good Rostering Guide' principles into the contract. As a consequence all 2002 contracted junior doctors will transfer to the 2016 contract as amended. There will be potentially cost implications for the Trust but as yet these are nationally unknown pending further analysis of which contracts junior doctors are currently employed.

The implementation plan commences from the 1st August 2019 with an annual 2% uplift applied during the period 2019/20 to 2022/23 backdated to the 1st April 2019. The full implementation plan of the changes continues until October 2020 with a range of revised terms and conditions being phased over the next 12 months.

7.0 Management & Leadership Development

The Trust's talent management and leadership development programme for 2019/20 is focussing on the knowledge and skills that are aligned to delivery of the national interim people plan and address areas identified from the annual staff survey, local cultural surveys, exit interviews, the retention programme and equality, diversity and inclusion priorities as detailed in the Trust's Workforce Strategy 2019/20.

The intention is to create inclusive and welcoming environment in which staff can develop and progress while gaining an overwhelming sense of feeling valued. Improved leadership and management skills will also support better behaviours around work life balance, facilitating an agile workforce through improving flexible working arrangements and building staff resilience by offering programmes of support and education. The key deliverables for 2019/20 are:

- Re-launch of the ACE Behavioural Standards
- Compassionate and inclusive leadership development
- Respect and dignity at work awareness training for all staff to promote a zero tolerance of bullying and harassment
- Development of an awareness of a restorative and just culture
- The promotion of equality, diversity and inclusion and widening participation including unconscious basis training for managers
- Implement a 3 year training programme to support the reduction of incidents of violence and abuse of staff from patient/the public
- The development of a new Nursing Leadership programme following a consultation process with staff during Q1 2019/20.
- Continuous development e-learning provision of mandatory training to release time to care.
- Launch and implementation of MyWorkPAL a digital appraisal and talent Management system for all non-medical staff groups
- To target specific leadership interventions such as having "difficult conversations" on those care groups with higher levels of employee relations and sickness absence.

7.1 Apprenticeship Programme

The Trust continues to optimise opportunities to support education and development through Apprenticeships. The Trust is currently applying to become an Employer Provider which will, if approved, allow the Trust to provide a suite of accredited apprenticeships specifically targeted at leadership and management internally, accessing the Levy directly. The Trust has staff taking part in the following apprenticeships programmes through local training providers in 2019/20 year to date. The Trust will be supporting the prioritisation of leadership development through higher level apprenticeships during Q3/4 2019/20 to ensure the levy is optimised.

Apprenticeship Course	Level	Active Students	Withdrawn
Accountancy Taxation Professional	7	2	

Accounting	2	1	
Accounting	3	1	
Business Administration	2	5	
Business Administration	3	11	
Business and Professional Administration	4	2	
Clinical Healthcare Support	3	9	3
Customer Service	3	2	
Health Pharmacy Services	3	5	
Health Pharmacy Services	2	7	
HR Consultant / Partner	5	1	
Healthcare Science Practitioner	6	13	
IT Application Specialist	3	1	1
Learning and Development	3	1	
Medical Administration	3	1	
Medical Administration	2	7	2
Nursing Associate	5	15	1
Operating Department Practitioner	6	4	
Operations / Department Manager	5	2	6
Payroll Administrator	3	10	
Registered Nurse	6	13	
Senior Healthcare Support Worker	3	22	
Senior Leader (Finance)	7	1	
Team Leader / Supervisor	3	4	3
Team Leading	2	5	1
Warehousing & Storage - Senior Warehouse	3	1	
TOTALS	**-**	**146**	**17**

8.0 Pensions and taxation

The Department of Health and Social Care (DHSC) confirmed in its response to a public consultation that it would implement a new contribution rate of 20.68 per cent for employers from the 1st April 2019 which is an increase of 6.3% compared with the current contribution rate of 14.38 per cent. The Treasury confirmed that it will cover the cost increase for NHS employers in line with the agreement with the DHSC last year over NHS funding.

The change in the rate was prompted by the revaluation of the scheme, which suggested a higher employer's contribution rate was needed. This was partly caused by the Treasury announcing the superannuation contributions adjusted for past experience discount rate – which is used when forecasting what contributions are needed to make sure public sector pension schemes are able to meet their future liabilities – would be lowered at the 2018 Budget.

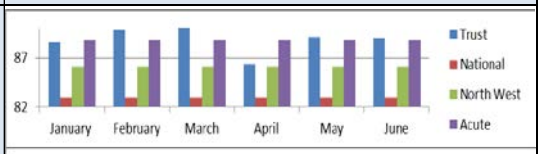
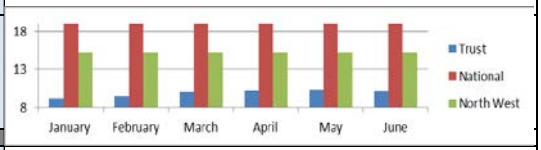
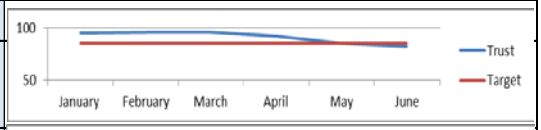
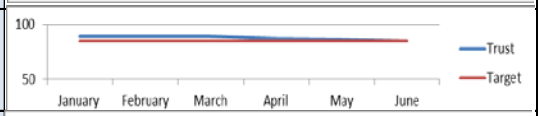
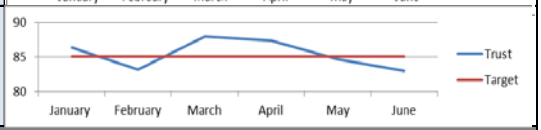
The consultation document noted many of the respondents disagreed with the proposal, raising concerns the increase was too high and the financial burden may force employers to review their workforce. In addition to the funding settlement for NHS England, announced in June 2018, the government said in its consultation response it would also provide funding for NHS pensions costs until 2023-24, including both predicted and unforeseen costs. The DHSC also confirmed from the 2017-18 tax year, Scheme Pays could be used to meet any pension tax charges. Under Scheme Pays, which is operated by NHS Pensions, part of the NHS Business

Services Authority, individuals can ask for tax bills on pension contributions worth more than £40,000 a year to be paid out of their own pension pot. This could be of particular benefit to staff who have received charges due to breaching the lifetime pension tax relief allowance.

9.0 Workforce Model Hospital & Local Trust Indicators

The table below benchmarks the Trust against National, North West and Acute peer groups for the key workforce indicators collected and reported through the NHSI model hospital report from January to June 2019.

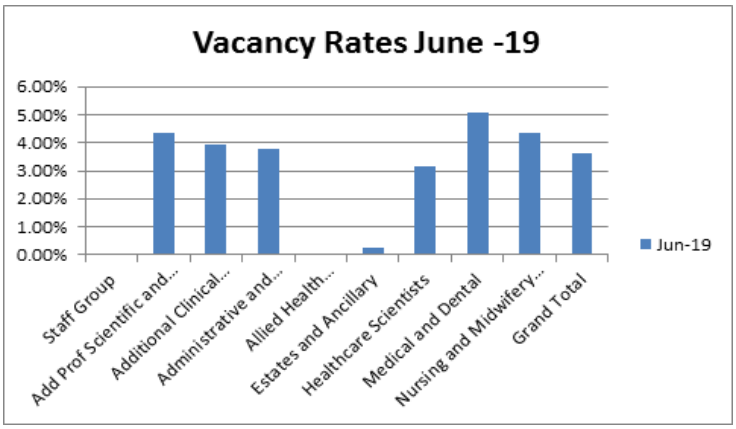
***Employee Turnover (Labour Turnover Rate)**
Is the proportion of your workforce who leave during a period of time (a rolling year).
***Employee Retention (Labour Stability Rate)**
Is the proportion of employees that stay, during a period of time (a rolling year).

Use Of Resources										
	Trust						National	North West	Acute Teaching	Trend Line
People	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Data Source NHS Digital	Data Source NHS Digital	Data Source NHS Digital	
Staff Retention Rate *Definition of Retention The number of staff who were employed at the start of the period who have remained in employement at the end of the period. The % are based over a 12 month period)	88.62%	89.88%	90.26%	86.36%	89.16%	89.00%	83.00%	86.10%	88.80%	
Sickness Absence Rate	6.12%	5.33%	5.16%	4.92%	4.78%	4.86%	4.51%	5.13%	4.36%	
Vacancy Rate (No Table as no benchmarking figs)	1.91%	1.07%	0.66%	3.22%	3.57%	3.62%	N/A	N/A	N/A	
Turnover Rate (Last 12 months) (* Definition of Turnover Number of Leavers within the period / No of staff at the end of the period)	9.21%	9.48%	9.99%	10.20%	10.35%	10.17%	19.00%	15.20%	11.00%	
Safe	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Trust Target			
Mandatory Training Rate	95.04%	95.30%	95.33%	91.85%	84.90%	82.20%	85.00%	N/A	N/A	
Appraisal Completion Rate	89.35%	89.34%	89.45%	86.86%	86.19%	84.83%	85.00%	N/A	N/A	
Medical Appraisal	86.32%	83.12%	87.90%	87.29%	84.60%	82.91%	85.00%	N/A	N/A	

9.1 Establishment v Funded Establishment

The vacancy rate for June 2019 was 3.62% which was a 2.91% increase from March 2019. The vacancy rate increased significantly (2.56%) between March (0.66%) and April (3.22%) 2019. This is due to an increase in establishment of 114.04FTE at the start of the new financial year with the majority of the increase being in Nursing & Midwifery (37.66 FTE), Admin & Clerical (34.31 FTE) and Additional Clinical Services

(26.67 FTE). As this was an increase in budgeted establishment the positions will take time to recruit to and as such show as vacancies throughout April, May and June. Turnover remains lower than benchmarking data from model hospital. Key areas for recruitment during this period have been for Healthcare Science Assistants, Healthcare Assistants, Staff Nurses and Consultants. The table below shows vacancy rates by staff group.



9.2 Retention rate by staff group - Labour Stability Index

The Trusts labour stability index remains relatively consistent across staff groups with no particular trends.

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Staff Group	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Add Prof Scientific and Technic	84.66%	87.57%	89.77%	90.66%	91.26%	90.16%	91.11%	91.11%	92.22%	90.56%	89.07%	89.56%
Additional Clinical Services	88.83%	88.66%	88.57%	89.70%	89.48%	89.33%	88.93%	89.11%	89.90%	89.44%	89.69%	86.16%
Administrative and Clerical	89.32%	89.24%	88.99%	89.55%	89.33%	88.96%	88.82%	88.54%	88.34%	85.04%	84.74%	85.22%
Allied Health Professionals	85.82%	87.31%	86.81%	86.74%	86.69%	85.14%	84.53%	85.92%	85.25%	83.45%	83.70%	83.33%
Estates and Ancillary	91.24%	91.47%	91.86%	92.31%	92.36%	92.13%	91.67%	91.65%	92.25%	93.60%	93.14%	93.18%
Healthcare Scientists	88.04%	88.10%	89.52%	89.95%	89.00%	89.95%	90.43%	89.95%	89.47%	89.37%	90.24%	91.54%
Medical and dental	82.01%	80.23%	80.56%	80.91%	81.14%	81.05%	80.54%	81.14%	81.28%	81.49%	80.67%	80.77%
Nursing and Midwifery Registered	87.78%	87.72%	88.13%	88.55%	88.71%	89.39%	89.40%	89.79%	90.99%	90.21%	90.07%	89.59%
Grand Total	**89.12%**	**89.13%**	**89.44%**	**89.73%**	**89.69%**	**89.69%**	**88.62%**	**89.88%**	**90.26%**	**86.36%**	**89.16%**	**89.00%**
+/-	**0.20%**	**0.01%**	**0.31%**	**0.29%**	**-0.04%**	**0.00%**	**-1.07%**	**1.26%**	**0.38%**	**-3.90%**	**2.80%**	**-0.16%**

9.3 Turnover

Turnover has remained relatively constant in the last 12 months and continues to benchmark below the Trust's acute peer group of 11% at an average of 9.9% from January– June 2019. This is also significantly lower than the North West at 15% and

the national position of 19%. The retention programme is intended to reduce the Trust turnover further.

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Staff Group	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Add Prof Scientific and Technic	11.74%	10.96%	8.58%	8.16%	7.87%	8.41%	7.03%	7.27%	6.00%	7.40%	9.09%	9.22%
Additional Clinical Services	8.99%	8.91%	8.19%	7.89%	8.40%	8.37%	7.48%	7.44%	7.21%	7.63%	7.67%	7.84%
Administrative and Clerical	10.04%	10.63%	10.97%	10.85%	11.44%	11.81%	11.11%	11.93%	15.02%	14.82%	14.80%	14.13%
Allied Health Professionals	13.88%	12.26%	12.26%	12.75%	11.71%	12.62%	12.86%	12.67%	13.34%	14.04%	13.87%	13.85%
Ancillary	6.67%	6.56%	6.49%	6.18%	6.13%	6.44%	6.59%	6.71%	6.43%	4.87%	5.08%	5.01%
Healthcare Scientists	8.68%	8.71%	8.29%	8.22%	8.65%	8.09%	7.51%	8.09%	10.04%	8.98%	8.99%	8.30%
Medical and Dental	17.66%	11.74%	11.38%	10.96%	10.46%	9.70%	9.57%	10.18%	9.59%	10.11%	10.72%	9.98%
Midwifery Registered	11.14%	10.77%	10.41%	10.08%	10.28%	9.86%	9.03%	9.15%	8.64%	9.21%	9.31%	9.28%
Grand Total	**10.83%**	**10.20%**	**9.89%**	**9.66%**	**9.87%**	**9.82%**	**9.21%**	**9.48%**	**9.99%**	**10.20%**	**10.35%**	**10.17%**

9.4 Potential Retirements

During 2019/20 there are 133 staff aged 65 who are eligible to retire. This equates to 2.24% of the current headcount. The figure will increase to 203 within the next 12 months equating to 3.42% of the current headcount. This data was used in the development of the 2019/20 workforce plan so that recruitment and retention plans are sited on general turnover and potential leavers due to retirement. In addition there are 265 nursing staff that are aged 55 and through special dispensation are eligible to retire equating to 4.47% of the current nursing headcount. The figures increase to 315 within the next 12 months which equates to 5.31% of the current nursing headcount.

Staff Group	Retirements Due	3 Months	6 Months	9 Months	12 Months	5 Years
Add Prof Scientific and Technic	4	4	4	4	5	11
Additional Clinical Services	38	42	47	52	57	160
Administrative and Clerical	31	37	42	43	48	131
Allied Health Professionals	1	2	3	3	3	8
Estates and Ancillary	30	34	36	40	43	93
Healthcare Scientists	4	5	5	5	5	17
Medical and Dental	8	9	11	11	12	31
Nursing and Midwifery Registered	17	19	25	28	30	92
Grand Total	**133**	**152**	**173**	**186**	**203**	**543**

Staff Group	Retirements Due	3 Months	6 Months	9 Months	12 Months	5 Years
Nursing and Midwifery Registered	265	284	295	303	315	525
Grand Total	**265**	**284**	**295**	**303**	**315**	**525**

9.5 Recruitment

In the first half of 2019 the Recruitment Team have facilitated over 350 offers of employment which includes both internal and external appointments. 39% of these were for Nursing and Midwifery positions. In the same period the Trust saw over 280 new starters of which 27% were Nursing and Midwifery. The Trust bank also grew

during this period seeing an additional 437 new staff and 201 internal staff join the bank.

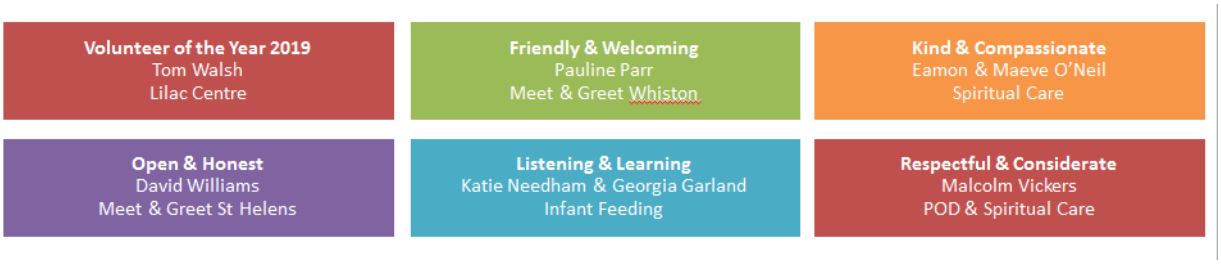
The Trust has recruited an additional 49.8 wte external RN's (not including international and newly qualified RN's) to those ward areas covered by the Safer Staffing report. The Trust has seen a sustained reduction in RN vacancies which has seen an increase in safer staffing % on wards from 96.65% in January 2019 to 98.54% in July 2019, an increase of 1.89%.

9.6 Volunteers

A revised Volunteer Strategy and outcome focussed action plan was approved at the Workforce Council on the 24th July 2019. The Trust currently has 345 active volunteers who provide support to patients, staff and visitors by undertaking a wide range of roles including the following:

- Meet & Greet
- Prevention of Delirium
- Be-friending
- Dining Companions
- Infant Feeding
- Spiritual Care

We recently held our Volunteer Annual Awards which was a great opportunity to thank our volunteers for the valuable contribution they make to our Trust. There were six awards as follows:



9.7 Flu vaccination

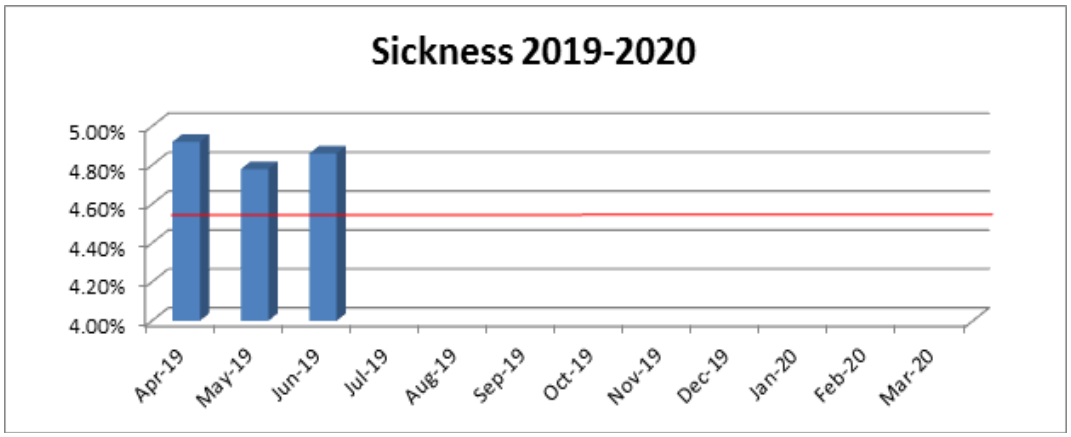
The Trust vaccinated 95% of front line staff against the flu in 2018/19 and were the best performing acute Trust nationally. The vaccination programme for 2019/20 has been developed to commence in October 2019 with the aim of vaccinating 95% staff by the 31st December 2019 to give the greatest protection to staff, their families and patients over the winter period. Supplies of the vaccine have been ordered and a resource plan with a combination of Occupational Health Nurses and Nursing peer vaccinators has been developed.

9.8 Health & Well-being

The Trust's sickness position in June 2019 was 4.86% which is above the target of 4.5%. Medirest ROE staff are the highest Care Group with June 2019 sickness at 8.02%, followed by Community Services 5.86%, Medical Care 5.74% and Medicines

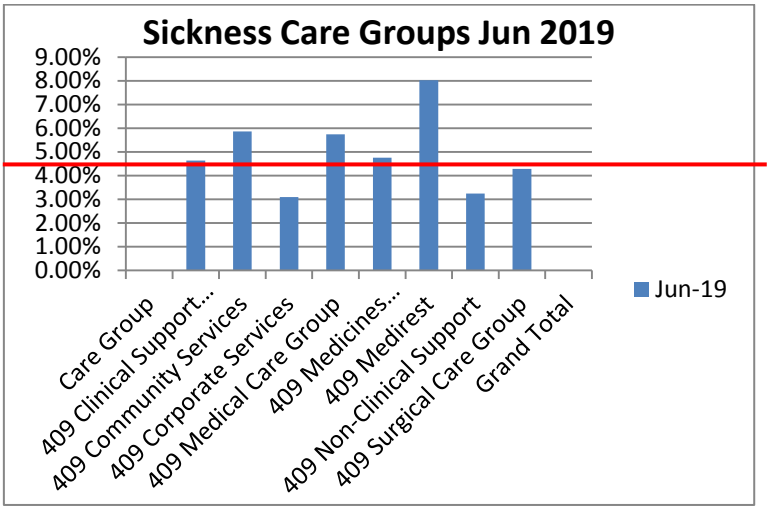
Management 4.75%. As already discussed in this paper, these are areas who will be targeted for other areas of intervention in addition to the Trust's review of the current Attendance Management policy.

Sickness Absence April 2019 to year to date



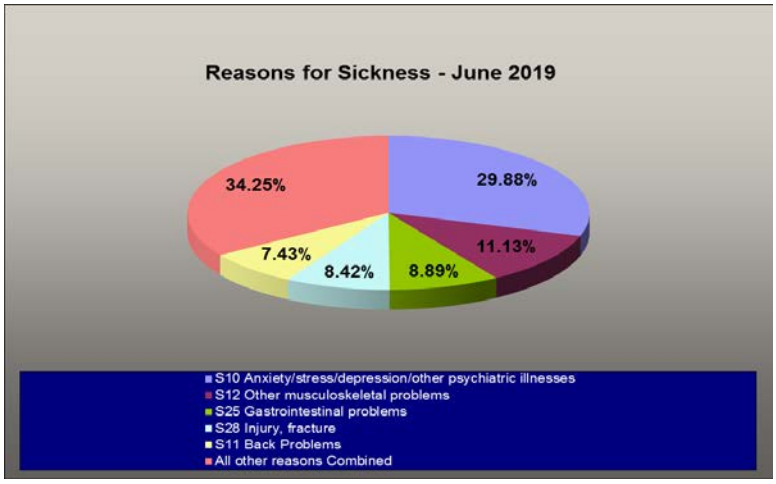
Sickness Trends by Care Group

The departments/care groups with this highest sickness in June 2019 were Medirest, Medical Care and the Community, with clinical support services and medicines management showing slight increases. Deep dives have taken place into these areas to understand the reasons for the increases in these areas. Action plans are in place at a care group level which are monitored by care group finance and performance meetings



Short Term v Long Term Sickness

Long term sickness remains higher than short at 59.77% LTS v 40.23% STS and stress remains the highest cause for sickness. The well-being section later in this paper describes actions proposed to further support staff with stress, anxiety and depression.



Actions to be delivered in the next 3 months to support improvements in sickness absence:

- Invest in further Mental Health First Aid Training with targeted intervention for areas of high rates of stress/anxiety. Currently there are 17 Mental Health First Aiders across the Trust.
- Design a pin badge for MHFAiders to wear at StHK so that individuals are aware who has been trained and who can be approached by individuals wanting help/advice.
- Review Wellbeing Champion locations across the Trust to ensure all sites have a champion available.
- Ensure there is information and support readily available for people who disclose mental health issues and concerns across all sites on platforms such as social media and the intranet.
- Invite Citizens Advice Bureau and or Debt Charities to the Trust to hold sessions/stall on both sites to provide free, confidential, independent advice to staff regarding financial and legal matters.
- Engage with Financial Well Being providers to enable staff to access a range of support organisations to suit their personal circumstances
- Ensure the revised Attendance Management policy takes account of good practice in managing mental health in the workplace for line managers.
- Work with Estates team to undertake audit of existing staff facilities (break rooms, food storage and preparation, drinking water), to identify gaps in provision
- Undertake review of current provision of Employee Assistance Programme to ensure provision for mental health wellness and MSK is fit for purpose
- Ensure Tai-Chi and Yoga sessions held in Education & Training are promoted across all sites as well as Mindfulness sessions available for teams/departments.
- HWWB to liaise with Carer Support Network regarding assistance for staff and potential training/awareness sessions.

- Investigate further the potential for a 'Book Prescription Service' in partnership with the Trust library so HWWB can 'prescribe' self-help books to individuals when required.

9.9 Temporary staffing - bank & agency

The Trust reported a final spend of £8.171M for 2018-19 against an agency cap set by NHSI of £7.256M. This is a reduction of approximately £1M compared to 2017-18 financial year. The 2018-19 spend for Bank was £11.96M compared to spend of £8.6M in 2017-18. Comparing activity in 2018-19 against 2017-18 the team have seen the following:

- 13% increase (13,518 shifts) in the number of requests to fill gaps
- 4% improvement (24,830 shifts) in fill rate
- 4% increase (22,928 shifts) in shifts filled by bank

Over 80% of the shifts filled are covered by staff on the Trust bank which supports the Trust in reducing the use of agencies and the level of spend this incurs. We continue to work with other Trusts within Cheshire and Merseyside on driving down agency rates of pay, creating consistency across the region regarding rates of pay and improving agency compliance and performance.

9.10 eResourcing

SafeCare has now been successfully implemented in 29 inpatient units across the Trust. The average compliance rates are 93% and an operational steering group has been launched to embed the use of SafeCare.

The project to implement rostering for AHPs has been successfully completed and the next phase is underway to implement job planning and activity manager for this group of staff. This will provide a detailed picture of the work being undertaken and enhance the Trust's demand and capacity modelling.

A benefits realisation plan against NHSI standards for e-rostering and e-job planning will be developed in August to be presented to the Workforce Council in September 2019 for monitoring and assurance of deliverables.

The Trust has 5 Key Performance Indicators for rostering of staff and our current performance is as follows. Work is underway with wards to improve the utilisation of unused hours in a roster period:

KPI	Definition	Ratings			Current Performance
Roster Approval Time	The number of days prior to the start of a roster period when the roster has been completed.	54 days or less	55 days	56 days or more	**56 Days**
Filled Duty Count	The number of duties within the standard roster shift demand template which have been assigned and do not remain vacant.	80% or lower	81% to 90%	91% To 100%	**81.40%**
Hours Balances (4 wk period)	The number of unused contracted hours within the four week roster period.	2.5% or higher	2.1% to 2.4%	2.0% Or lower	**4.1%**

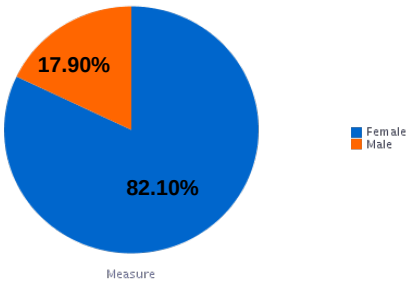
Bank & Agency Usage	The percentage of duties in the roster period which have been filled by Bank and Agency.	15% or higher		10.1% to 14.9%		10% or lower			**11.6%**
Annual Leave Rates	The percentage of staff on Annual Leave within the roster period.	8% or lower	8.1% To 10.9%		11% To 17%		17.1% to 19.9%	20% or higher	**13.20%**

9.10 Equality, Diversity and Inclusion

The Trust appointed to the new role of Workforce Equality, Diversity and Inclusion lead in May 2019 to enable a focus on the expanding agenda of E,D&I and the area of widening participation. Recent progress on the delivery of the 3 year action plan has included establishing support networks for LGBT and BME along with staff disabilities. The Trust was also a finalist for the HEAT awards for being the "Champion of Workforce of Tomorrow" on the 18th July 2019, along with delivering the "Empowerment project" in partnership with the University of Liverpool for Autistic students to assist with career readiness and potentially roles in the NHS. The Trust continues to support the Veterans armed forces programme, "Step into Health," and will be assessed for progression from the silver to gold accreditation later in the summer.

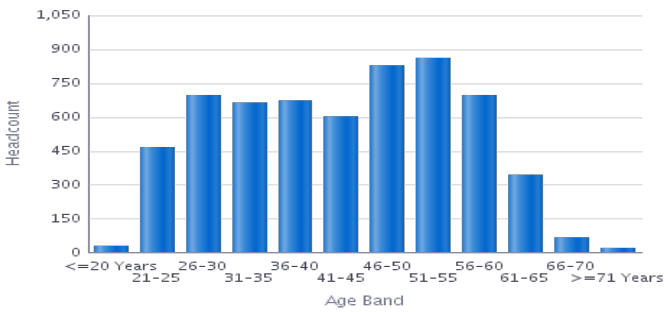
Equality & Diversity Protected Characteristics

In June 2019 the Trust's headcount was 5,929 staff with a whole time equivalent of 5,152.60 staff. Of these staff 82.10% of the gender of the workforce was female and 17.90% were male.



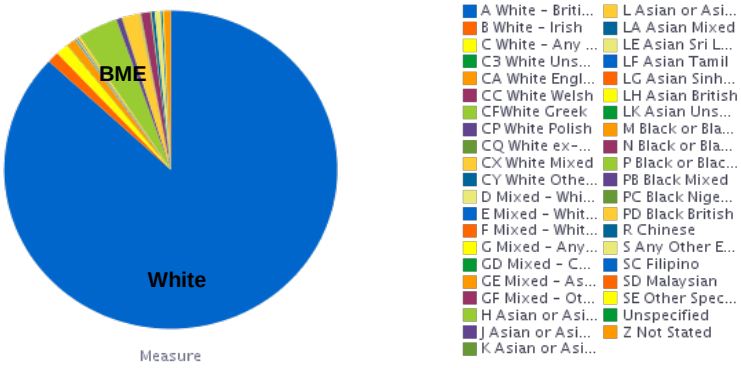
Age Profile

The Trust has a varied age range within the workforce with 14.47% at age bands 51-55, 13.95% at age bands 46-50, and 11.71% at age bands 56-60. The majority of roles are within the 51-55 age band are Healthcare Assistants, Midwives, Nursing and Administration staff.



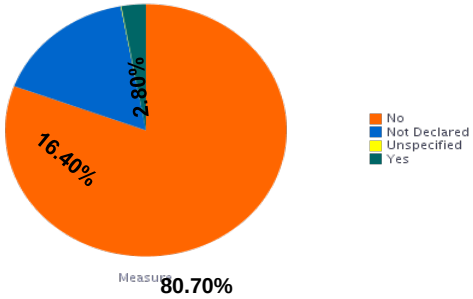
Ethnicity

90.40% of the Trusts workforce are white and 8.92% are Black, minority ethnic (BME). This compares with the local population of St Helens of 3.6%* and Knowsley, 4.4%* BME. ***Based on 2011 census information**



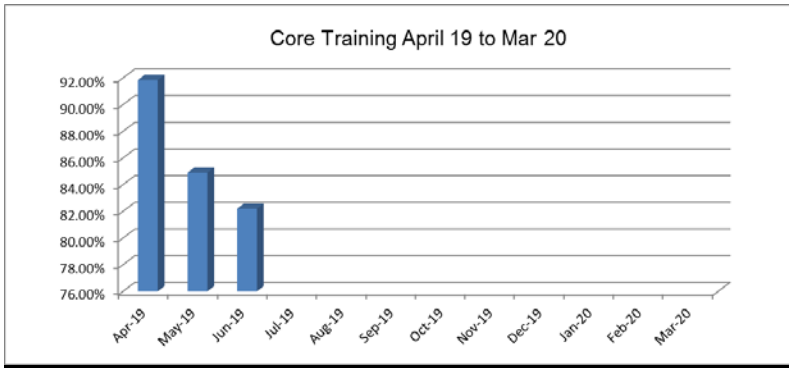
Disability

80.70% of the workforce has declared no disability compared with 2.80% who have declared they have a disability. 16.80% are undeclared. While the reporting of a disability may be under reported, the Trust continues to make reasonable adjustments to support staff who develop an underlying health condition during employment.



9.11 Mandatory & statutory training

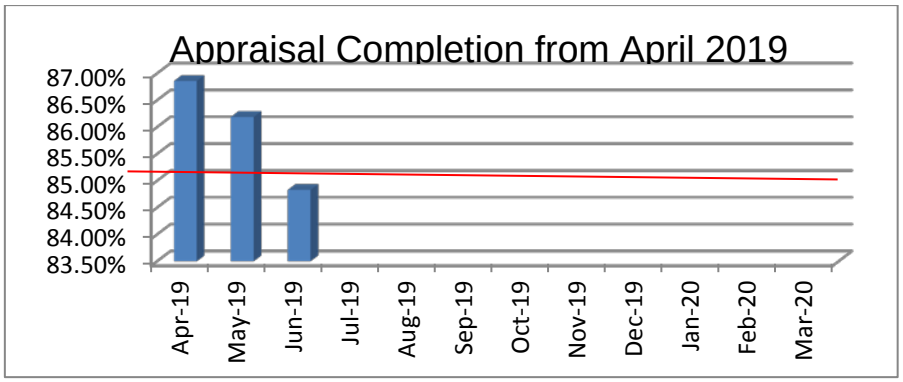
In April 2019 the Trust exceeded the target of 85% which is 100% of available staff. Compliance at the end of May 2019 reduced slightly to 84.90%, for core mandatory training subjects at the end of June 2019 it reduced further to 82.20%. Improvement plans are in place to recover this position.



9.12 Appraisal and Talent Management

Appraisal compliance at the end of June 19 was 84.83% which is just below the target of 85%. To maintain compliance for July 19, 405 staff who are due to have an annual review in July will need to be completed.

Appraisal Performance from April 2019 year to date



10.0 Trust Board Assurance

The Trust Board are asked to note the contents of this paper and progress against the achievement the Trust objectives.

Anne-Marie Stretch
Deputy Chief Executive and Director of HR
July 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)70

Subject: NHSI Chair: Learning lessons to improve our people practices

Purpose:

This paper is to advise the Trust Board about the content of a letter sent to Provider Chief Executives and Chairs on the 24th May 2019 from Baroness Dido Harding, Chair, NHS England and NHS Improvement about why Trusts need to learn lessons to improve our people practices which builds upon other recent NHSI guidance or developing a more compassionate and just culture.

Summary:

This paper outlines the recommendations from an NHSE/I commissioned Advisory Group following an enquiry into the case of Amin Abdullah who was the subject of an investigation and disciplinary procedure in late 2015 following which he tragically took his own life.

The paper details the consideration and questions that should be asked by HR Departments and Trust Boards and includes additional guidance relating to the management and oversight of local investigation and disciplinary procedures and what steps the Trust is proposing to ensure the Trust Board has sufficient information for the consideration and assessment of the 'health' of organisational culture, including aspects relating to the management of workplace issues.

In addition it summaries "A fair experience for all" a NHSE/NHSI document which promotes the closing of the ethnicity gap in rates of disciplinary action across the NHS workforce, supporting the NHS Workforce Race Equality Standard (WRES).

Corporate Objective met or risk addressed:

Developing organisation culture and supporting our workforce

Financial Implications: To be determined following the review

Stakeholders: Trust Board, Senior Management, all staff, staff side colleagues

Recommendation(s):

The Trusts Board are requested to note the content of this paper and support progression of the review and note that the Workforce Council received an action plan on the 24th July detailing how these would be implemented n prior to the Trust Board in September for approval and immediate implementation

Presenting Director: Anne-Marie Stretch, Deputy CEO/Director of HR

Trust Board: Wednesday 31st July 2019

Learning Lessons to Improve our People Practices

1.0 Purpose

This paper is to advise the Trust Board about the content of a letter sent to Provider chief executives and chairs on the 24th May 2019 from Baroness Dido Harding, Chair, NHS England and NHS Improvement about why Trusts need to learn lessons to improve our people practices. The letter shares the outcomes of an important piece of work recently undertaken in response to a very tragic event that occurred at a London NHS trust three years ago. This paper will provide details of the case of Amin Abdullah who was the subject of an investigation and disciplinary procedure in late 2015 and includes additional guidance relating to the management and oversight of local investigation and disciplinary procedures

2.0 Background

In the case of Amin Abdullah the protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life. This triggered the commissioning of an independent inquiry undertaken by Verita Consulting, the findings of which were reported to the board of the employing Trust and to NHS Improvement in August 2018. The report concluded that, in addition to serious procedural errors having been made, throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted. Verita's recommendations were accepted by the Trust, in full, and have largely been implemented.

Subsequently, NHS Improvement established a 'task and finish' advisory group to consider to what extent the failings identified in Amin's case are either unique to that Trust or more widespread across the NHS, and what learning can be applied. Comprising of multi-professional stakeholders and subject matter experts representing both the NHS and external bodies, together with an advocate for Amin's partner, the Group conducted an independent analysis of both the Verita findings and several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements. HR directors of provider organisations were advised of the Group's activity and invited to share details of any local experiences and/or examples of measures being taken to improve the management of employment issues.

The analysis highlighted several key themes associated with the Verita inquiry which were also common to other historical cases considered. Principal among these were: poor framing of concerns and allegations; inconsistency in the fair and effective application of local policies and procedures; lack of adherence to best practice guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

3.0 Advisory Group's Recommendations

The NHS England and NHS Improvement People Committees in Common received a detailed report on the outcomes of the Advisory Group's activities, which included recommendations that aim to ensure the captured learning is used to best effect in informing positive changes across the NHS. The Committees recognised that, sadly, Amin's experiences are far from unique and acknowledged there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the

circumstances. This view certainly echoed many of the comments we have received from across the NHS during our recent People Plan engagement.

Some of the proposed recommendations will require further discussion with key stakeholders, including regulatory and professional bodies. Dido Harding stated in her letter that in particular, she is keen that consideration and assessment of the 'health' of organisational culture, including aspects relating to the management of workplace issues, is given more prominence in the 'well-led' assessment domain. She however expects that the majority of the recommendations can be immediately applied by Trusts.

4.0 Actions for Trust Boards

The guidance represents the actions characteristic of responsible and caring employers and which reflect our NHS values. Dido Harding requests that HR Departments review and assess current procedures and processes in comparison and, importantly, make adjustments where required to bring Trusts in line with this best practice so that Boards can be assured that they meet the guidance. Item 7 of the guidance asks Trusts to consider how the Board oversees investigations and disciplinary procedures.

Dido Harding requests that with respect to any cases currently being considered and all future cases, Trusts ask review the following questions (and, where necessary, take corrective action in response):

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?
- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?
- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?
- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage?
- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

Dido concludes by stating that in highlighting these issues, she knows that Trust are keen to ensure we treat our people fairly and protect their wellbeing. Implementing the guidance consistently well across the NHS will contribute to that goal. Dido stresses that it is tragic that we are learning these lessons after Amin's death, but we owe it to him and the others who have suffered in similar circumstances to act now.

5.0 Additional Guidance

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures has been provided to Trusts as follows:

5.1. Adhering to best practice

a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).
b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

5.2 Applying a rigorous decision-making methodology

a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.
b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

5.3 Ensuring people are fully trained and competent to carry out their role

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

5.4 Assigning sufficient resources

Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.

5.5 Decisions relating to the implementation of suspensions/exclusions

Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, time-bound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

5.6 Safeguarding people's health and wellbeing

a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.
b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.
c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

5.7 Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

6.0 A fair experience for all

On the 2nd July 2019 Prerana Issar, Chief People Officer, NHS England & NHS Improvement wrote to Director of HR to share a new guidance document, "A fair experience for all" which promotes the closing of the ethnicity gap in rates of disciplinary action between black and minority ethnic (BME) and white staff across the healthcare system. In her letter she states that one of the key aims of the Interim NHS People Plan is to make the NHS the best place to work for all of its workforce and that it is not acceptable that if you come from some backgrounds, you are more likely to enter the formal disciplinary process, stay in it longer and have more career limiting outcomes. The document A fair experience for all outlines clear steps in this area for local NHS organisations, as well as national healthcare arm's length bodies such as NHS England and NHS Improvement

7.0 A Just Culture

In 2018 NHSI published information for Trusts to help NHS managers ensure staff involved in a patient safety incident are treated fairly. The principles of a just culture supports a culture of openness to maximise opportunities to learn from mistakes. The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame.

NHS Trusts are now being encouraged to support staff to be open about mistakes to allow valuable lessons to be learnt so the same errors can be prevented from being repeated.

8.0 Methodology - our journey so far

The HR Department commenced a review of current practices in accordance with the guidance in April 2019 with specific reference to the Disciplinary, Grievance, Attendance

Management and Dignity at Work policies and procedures. This has included seeking legal advice as to the latest best practice, focus groups and engagement events with managers, staff side and staff, external benchmarking and review of NHS guidance from e.g. NHS Employer and NHS Improvement. Further engagement with staff that have been through investigations and formal disciplinary process and those managers supporting the process as case managers and investigating officer will take place during the few months along with feedback from the Trusts Responsible Officer, Assistant Medical Directors and Assistant/Deputy/Directors who have been involved as hearing or appeal chairs.

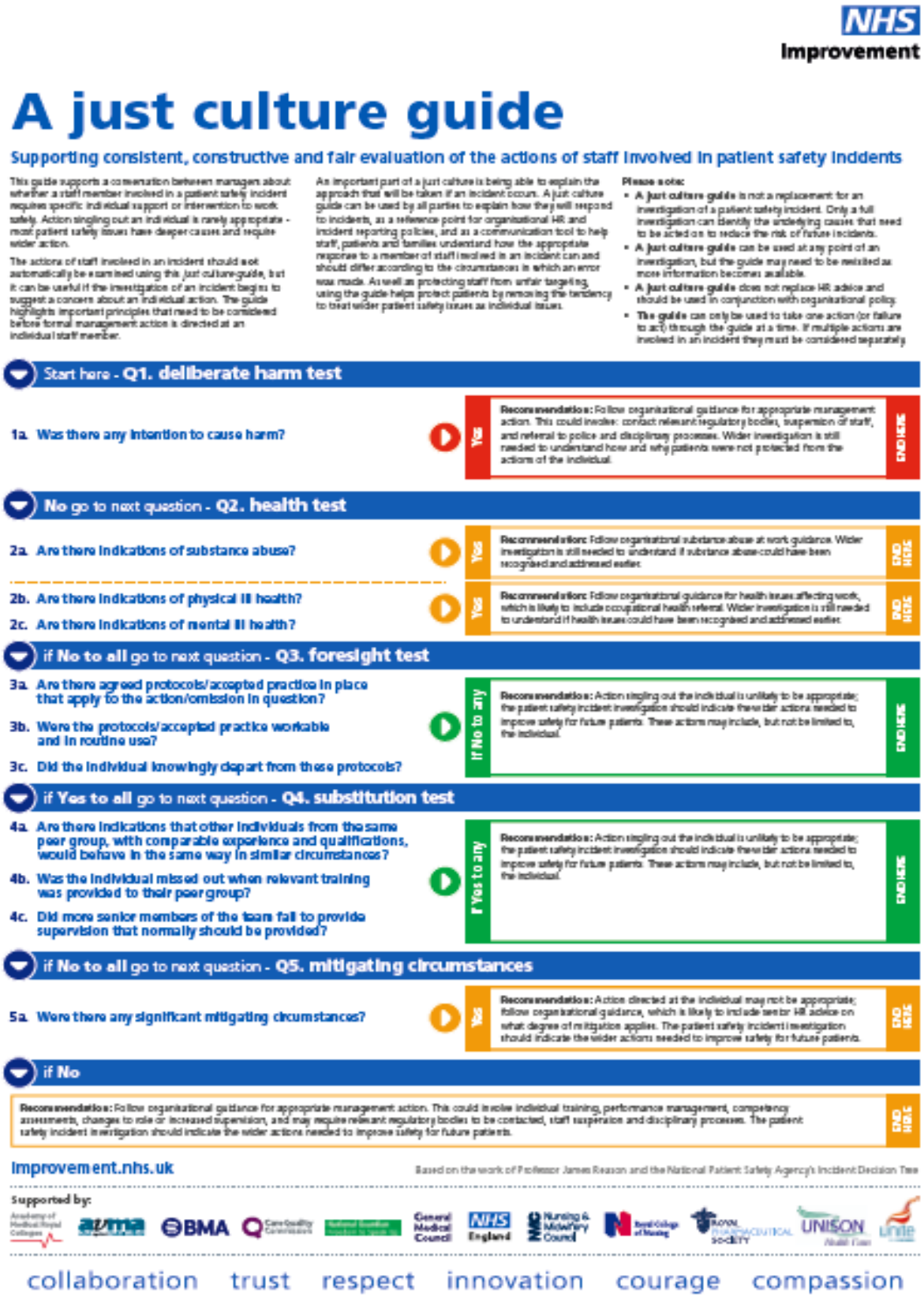
Other recent guidance in relation to the development of a compassionate leadership culture and a Just and Learning culture are also being considered. Appendices 1 attached to the paper details guidance on an NHSI checklist on what to consider when implementing a Just Culture approach. It is proposed that a training and awareness session on these subjects is provided to the Trust Board in October 2019.

9.0 Governance & Assurance

A detailed action plan on the recommendations as detailed in Dido Harding's letter was presented to the Workforce Council on the 24th July 2019. It is recommended that updates on the achievement of the action plan are monitored by the Workforce Council and reported to the Quality Committee in September 2019 to assure the Trust Board that it has sufficient information for the consideration and assessment of the 'health' of organisational culture, including aspects relating to the management of workplace issues.

It is recommended the monitoring of the implementation of the action plan is reported to the Trust Board via the Quality Committee on a bi-monthly basis with bi-annual updates to the Trust Board as part of the Trust Boards assurance process.

Appendices 1



NHS Improvement

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should not automatically be examined using this just culture guide, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

→ **Yes** → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. → END HERE

No go to next question - Q2. health test

2a. Are there indications of substance abuse?

→ **Yes** → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. → END HERE

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

→ **Yes** → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. → END HERE

if No to all go to next question - Q3. foresight test

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

→ **If No to any** → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. → END HERE

if Yes to all go to next question - Q4. substitution test

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

→ **If Yes to any** → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. → END HERE

if No to all go to next question - Q5. mitigating circumstances

5a. Were there any significant mitigating circumstances?

→ **Yes** → **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include seek for HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. → END HERE

if No

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. → END HERE

improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

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St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)71
Subject: Workforce Strategy 2019/20
Purpose: To provide assurance to the Trust Board that the Trust is addressing the workforce priorities and that these are aligned with the direction of the NHS Long term plan and the interim people plan through the Workforce Strategy 2019/20 and its associated action plans
Summary: The Trust is committed to developing the organisational culture and supporting our workforce. The attached Workforce Strategy outlines the 6 key workforce priorities: • Culture and our values • ACE place to work • Flexible working and well-being • Equality, diversity and inclusion • Education, training and careers • Leadership and development
Corporate Objective met or risk addressed: Developing organisation culture and supporting our workforce
Financial Implications: N/A
Stakeholders: Staff, Managers, Staff Side Colleagues and Patients
Recommendation(s): The Trust Board is requested to: • note the consultation process carried out; and • approve the Workforce Strategy 2019/20. It is recommended that half year update on achievement of the actions is presented to the Trust Board in November 2019.
Presenting Director: Anne-Marie Stretch, Deputy CEO/Director of HR
Board date: 31st January 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

Workforce Strategy

2019-20

"To deliver 5 star patient care, we must put our staff at the centre of everything we do"

Anne-Marie Stretch, Deputy CEO/Director of HR

Deputy Director of HR

July 2019

STHK Workforce Strategy 2019/20

The NHS "Long Term Plan"
Backing our workforce

1.0 Background

In January 2019 the Trust began a consultation process to develop a new national 5 year Workforce Strategy. When it became apparent that the publication of the NHS Workforce plan would be delayed it was agreed that the Trust should develop a one year strategy and delivery plan which was flexible to be shaped through the year as more national direction emerges. This has now been helped by the publication of the interim People Plan in June 2019 and the letters from Baroness Dido Harding in July 2019 concerning how Trusts might improve their people practices.

2.0 The National Context - The NHS Long term plan

The StHK Workforce plan for 19/20 has its foundations on the direction of the NHS Long term plan which aims to continue to increase the NHS workforce, training and recruiting more professionals, including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships. The NHS plan describes how improvements will be made to ensure the NHS is a better place to work, so that more staff stay in the NHS and feel able to make better use of their skills and experience for patients.

The themes of the Long term plans are to:

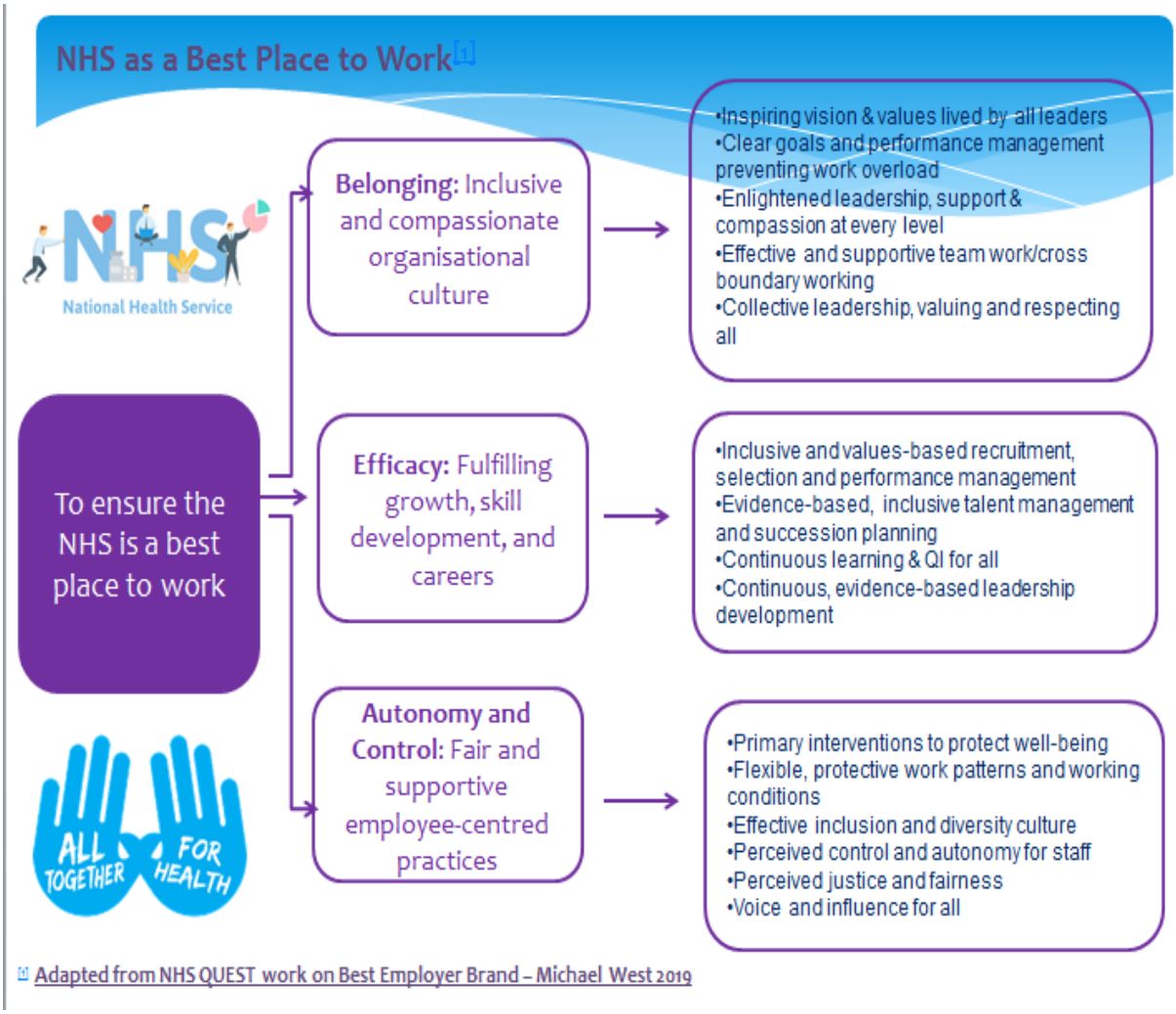
- Create the workforce we need for the next 10 years.
- Build upon a culture of innovation, continuous improvement and strong relationships with community, primary and social care.
- Provide a flexible approach to working to ensure we have the right people with the right skills at the right time
- Optimise the use of technology across workforce processes to improve employee experience
- Design roles/new models of working and develop staff to use new clinical technologies.
- Value our people and recognise that our staff are our greatest asset.
- Develop staff, providing them with clear pathways
- Provide staff with the leadership, skills and knowledge they need to reach their potential now and in the future.
- Support improved well-being and recognise and value diversity

In the NHS Long term plan – Chapter 4: "NHS staff will get the backing they need" there is national commitment to:

- Increase numbers of nurses, midwives, Allied Health Professionals and other staff.
- Grow the medical workforce with a focus on more generalist roles and increase number of doctors working in general practice.
- New arrangements to support international recruitment.
- Make the NHS a consistently great place to work and shape a modern employment culture.
- Increased focus on respect, equality and diversity.

- ❖ Productive working through electronic rosters and job planning.
- ❖ Encouragement for and investment in volunteering initiatives.
- ❖ New focus on leadership and talent management.
- ❖ Improved mental health support to doctors.
- ❖ Zero tolerance on violence towards NHS staff.
- ❖ Focus on staff retention through workforce development and multi-professional credentialing.
- ❖ Workforce implementation plan and national workforce group.

On the 2nd July 2019 Prerana Issar, Chief People Officer, NHS England & NHS Improvement wrote to Directors of HR to share a new guidance document, "A fair experience for all" which promotes the closing of the ethnicity gap in rates of disciplinary action between black and minority ethnic (BME) and white staff across the healthcare system. In her letter she states that one of the key aims of the Interim NHS People Plan is to make the NHS the best place to work for all of its workforce and that it is not acceptable that if you come from some backgrounds, you are more likely to enter the formal disciplinary process, stay in it longer and have more career limiting outcomes. The underlying principles of the Interim people plan focus on the NHS as a "Best place to work," which is illustrated in the diagram below by Michael West.

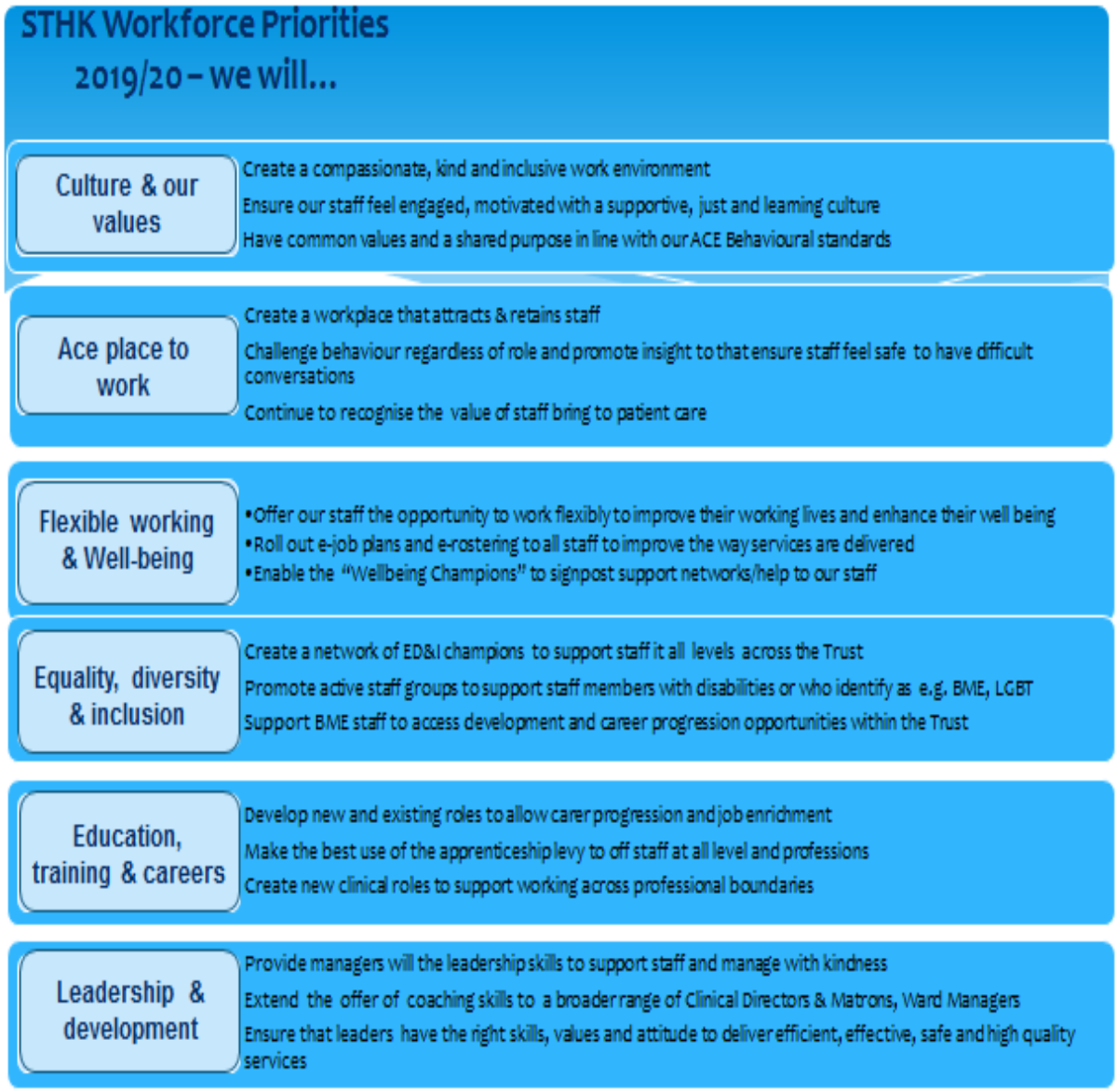


3.0 The STHK Workforce Strategy Framework

The Trusts Workforce Strategy has been developed to support the Trusts vision, to deliver 5 star patient care and align with our Trust values. The following diagram shows the elements of the strategy which will to support the successful delivery of the Trusts Workforce Strategy.

3.1 STHK Strategic Workforce Priorities 2019/20

The following 6 workforce priorities were developed following engagement across the Trust with staff from all departments, professional groups and staff side colleagues.



In considering the STHK workforce priorities for 2019/20 we reflected upon the fact that this is the first year of a 5 year strategy which will need to evolve as local and national directive is further shaped and the outcome of the national funding review is known in respect of the investment required to support the delivery of the workforce strategy as described in the NHS Long term plan. We asked the questions:

- Where are we now?
- Where do we want to be?
- How are we going to get there?
- How will we measure our success?

The tables that follow describe the objective of each of 6 STHK Trust priorities for 2019/20 along with national standards from regulatory bodies they these support and the measures through which achievement can be monitored as part of the Board Assurance process through the Workforce Council and Quality Committee.

3.2 Priority one - Culture and values

Culture and our values

Objective; To offer a compassionate, kind and inclusive work environment where our staff feel engaged, motivated and have a common values with a shared purpose in line with our ACE Behavioural standards

Links to:
- Provision of excellent patient experience
- Well Led : Culture
- KLOE: Well led
- SEQOHS

Key measures:
- Annual staff satisfaction survey
- Staff friends and family test
- Sickness absence
- Internal cultural surveys and engagement about staff experiences
- Number of disciplinary, grievances & respect at work cases

Where are we now?	Where do we want to be?	How to get there…
1. Organisation Development plans in place in departments highlighted for focused support 2. Track record of robust Staff Engagement strategy and annual implementation plans 3. Staff recognition programme in place to celebrate success 4. Sickness absence is slightly higher than peer group in the region 5. Commitment to creating a supportive and learning culture 6. Use of local cultural surveys with positive results of measurable improvement 7. Track record of staff survey and Staff friends and family test being the best acute Trust nationally/ top 20 in many categories	1. Have move towards developing a restorative, just and learning culture 2. Establish a "Cultural Champion" network for all wards /departments 3. A culture of communicating with each other, managing and caring with respect and kindness 4. Will challenge behaviour regardless of roles and promote insight 5. Creating safe spaces to have difficult conversation	1. Recruit, and train our network of Cultural Champions to support our BME staff 2. Engage with staff about what our ACE Behavioural standards mean to them and what good looks and feels like 3. Promote the role of the Wellbeing Champions to increase staff resilience peer support 4. Promote a calendar of events for ED&I and Wellbeing 5. Engage with staff and managers to undertake whole scale review of Managing Attendance Policy to support a more compassionate & supportive culture 6. Provide awareness /training for staff and managers 7. Review our on-boarding processes to ensure new starters are appropriately welcomed 8. Deliver the "Lessons learned to improve our people practices," action plan

3.3 Priority two - Ace place to work

Ace place to work

Objective: Create a workplace that attracts & retains staff and deploys our workforce to optimise resources, skill mix, new roles working across traditional professional boundaries

Links to:
- Financial resilience
- Well led: Information

Key measures:
- Staff turnover, retention & stability index
- Vacancy rate & gaps
- Staff friends and family test
- Temporary staffing metrics
- E-rostering, e-job planning & activity manager implementation & reporting
- International Recruitment targets

Where are we now?	Where do we want to be?	How to get there…
1. Best acute staff survey nationally 2. Above average for acute trust on response rate and outcomes for SFFT 3. All staff receive an induction that is aligned to C&M standards 4. Staff are recruited against values based/ the NHS leadership competencies • Well established volunteers scheme • Recruitment & HWWB processes require further improvement • Retention plan requires further development 1. 56 international nurses recruited via various initiatives - programme ongoing. 2. Good use of social media to promote a means of attraction 3. #jointhebanknow campaign has attracted 760 individuals to the bank to date is a 22.2% increase of these 257 were RGN's	1. Establish mechanisms for ensuring that the induction is streamlined at recruitment stage. 2. Build on existing programmes to develop additional pipelines for recruitment 3. Media strategy being scoped to support additional attraction activities. 4. Reduced HWWB and Recruitment waiting/processing times in order to facilitate the fast and effective joining/returning to work.	1. E-learning – 1st April 2019 Moodle launch. 2. Re-launch management skills for new managers including practical skills like having difficult conversations 3. Re-launch the preceptorship programme for new clinical staff 4. Develop a career development pathway and training programme for Nurse progression through to Matron which could be extended to other staff groups in 2020/21 5. Induction programme for new leaders 6. Review of the StHK "offer" to new starters 7. Recruitment of in excess of 50 additional international nurses 8. Implement the retention programme

3.4 Priority three – Flexible working & well-being

Flexible working & well being

Objective: To offer our staff the opportunity to work flexibly to improve their working lives and enhance their wellbeing

Links to:
- Well Led: continuous improvement & innovation
- KLOE use of resources
- Model hospital

Key measures:
- Retention & stability performance
- E-rostering & e-job planning KPI's
- Bank and agency spend & performance
- Staff survey and SFFT

Where are we now?	Where do we want to be?	How to get there…
• Good use of model hospital data • Traditional approach to flexible working requests and shift design • Widespread use of e-rostering across the Trust across the Nursing and medical workforce • E-Job planning in place for medical workforce & AHPs • Implemented Safecare acuity tool to support more efficient use of staffing • Bank fill rate has improved • Agency spend has reduced • Safer staffing levels have improved • SEQOHS accredited Health, Work & Wellbeing service with positive feedback from staff when they access support	1. Wider use of activity manager 2. Introduce difference approaches to flexible working e.g. trial self e-rostering 3. A further reduction in total agency spend 4. Maintain bank fill rate and have an operational bank retention strategy 5. See further bank growth in other Specialist staff groups such as the Medical workforce 6. To utilise #jointhebanknow to replicate the success within Medic Bank recruitment and other staff groups. 7. To meet the NHSi target next financial year. Expand the use of volunteers to provider a boarder range of support to patients and our staff across 8. Quicker access routes to well-being support for staff through an increase in investment in capacity and extended opening hours, e.g. evenings/Saturday's'	1. Wider implementation of allocate rostering software 2. Maximise use of features of rostering including auto roster and self roster tools 3. Continue to challenge use of agency spend 4. Bespoke campaigns to attract bank staff from under represented groups 5. Wellbeing Champions – increasing awareness and signposting to support networks for staff 6. Review the Attendance Management policy reduce sickness levels 7. Carry out stakeholder engagement to understand if there is a culture of presenteeism 8. Improve use of rostering data to reduce the number of staff working excessive additional hours 9. Supportive approach to flexible working requests

3.5 Priority four – Education, training & careers

Education, Training & Careers

Objective: To invest new roles and ensure we have a well educated workforce with skills and competencies to support continuous improvement and enable staff to realise their potential with life long learning opportunities

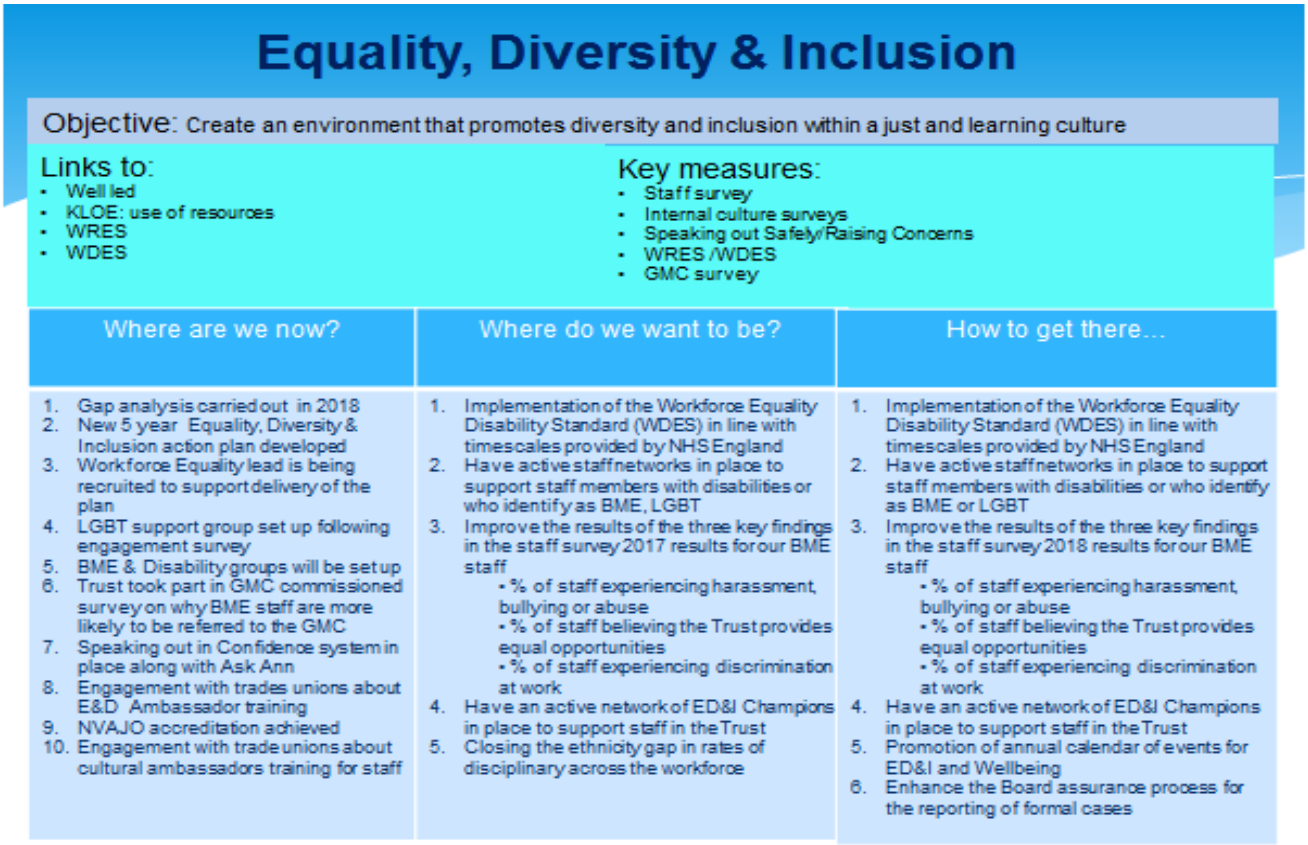
Links to:
- Improving patient outcomes and patient experience
- KLOE Safe
- Well led - capacity & capability

Key measures:
- Apprenticeship levy utilisation
- Learning & Development Agreement (HEE LDA)
- Nurse Associates /Nurse Apprenticeships/Physicians/Associate targets
- AHP and Nursing role redesign for extended scope roles

Where are we now?	Where do we want to be?	How to get there…
1. Students and trainees are offered high quality placements in partnership with Universities and HEE 2. Trust is exceeding the core skills mandatory training targets of 85% 3. Good track record in the NW of offering apprenticeships & is committed to offering opportunities to staff at all levels 4. Education & training is delivered to a competency based TNA 5. Locally commissioned development linked to role redesign with higher education establishments 6. Links with international Universities	1. To be an exemplar employer, recognising increased demand we want to maintain current high quality standards that continues to comply with the 'Quality Framework' 2. Role based competency framework across roles to develop career pathways supporting business needs. 3. Effective use of the apprenticeship levy 4. Supporting the introduction role redesign as part of clinical need and improving patient pathways 5. A clear educational framework that aligns to the workforce plan	1. Service leads to keep updated with national quality standards and governance process, mapping education provision to education curricula with outcomes aligned to national and local frameworks. 2. Development and implementation of competency frameworks for common clinical roles. 3. Creation and publication of career development 'Tube Maps'. 4. Utilisation of the Levy to support the development of new roles aligned to service need. 5. Early involvement in service redesign and planning to ensure opportunities are identified for different ways of working. 6. New on line appraisal and personal development system to support staff in their development and career planning throughout the year - Workpal

3.6 Priority five - Leadership development

3.7 Priority six - Equality, diversity & inclusion



4.0 Board Assurance

The delivery of the Workforce Strategy and the six 2019/20 priorities will be executed through the following strategies and their associated action plans which are presented to the Workforce Council as part of the annual reporting schedule. Recruitment & Retention Strategy

- Volunteer Strategy
- Workforce Development Strategy (Q4 2019/20)
- Leadership & Talent Management Strategy
- Staff Engagement Strategy
- HR Systems & Workforce Intelligence Strategy (new Q3 2019/20)
- Workforce Equality, Diversity & Inclusion Strategy
- Health, Work & Well Being Strategy

It is recommended that the Trust Board receives an update report detailing the outcomes delivered to date in November 2019 against the high level indicators as detailed in this document.

ENDS