St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 25TH SEPTEMBER 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 31st July 2019		Attached	
		5.1	Correct Record & Matters Arising	Verbal	
		5.2	Action Log	Attached	
Performance Reports					
10:10	6.	Integrated Performance Report		NHST(19) 72	Nik Khashu
		6.1	Quality Indicators		Rob Cooper for 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) 73	Ann Marr
10:40	8.	Committee Report – Quality		NHST(19) 74	Val Davies
10:50	9.	Committee Report – Finance & Performance		NHST(19) 75	Denis Mahony
11:00	10.	Committee Report – Audit (including Audit Letter Sign Off)		NHST(19) 76	Su Rai
BREAK					

AGENDA			Paper	Presenter
Other Board Reports				
11:20	11.	Strategy & Regulatory Report	NHST(19) 77	Nicola Bunce
11:30	12.	EPRR Compliance Statement	NHST(19) 78	Nicola Bunce for Sue Redfern
11:35	13.	Workforce Race Equality Standard Report & Action Plan	NHST(19) 79	Anne-Marie Stretch
11:45	14.	Workforce Disability Equality Standard Report & Action Plan	NHST(19) 80	Anne-Marie Stretch
11:55	15.	Workforce Safeguards Report	NHST(19) 81	Anne-Marie Stretch for Sue Redfern
12:05	16.	Medical Revalidation Annual Declaration	NHST(19) 82	Rowan Pritchard-Jones *(Jacqui Bussin, Responsible Officer, in attendance)*
Closing Business				
12:10	17.	Effectiveness of Meeting	Verbal	Chair
	18.	Any Other Business		
	19.	Date of Next Meeting – Wednesday 30th October 2019		

St Helens and Knowsley Teaching Hospitals NHS Trust

Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Board Meeting held on Wednesday 31st July 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
	Mr P Growney	(PG)	Non-Executive Director
	Miss L Knight	(LK)	Non-Executive Director
	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
	Mr R Cooper	(RC)	Director of Operations & Performance
	Dr T Hemming	(TH)	Director of Transformation
In Attendance:	Mr G Appleton	(GA)	Chair, Governing Body, St Helens CCG *(Co-opted member)*
	Mr M Brady	(MB)	Respiratory Registrar Trainee *(Observer)*
	Ms J Byrne	(JBy)	Executive Assistant *(Minute Taker)*
	Mr I Clayton	(IC)	Non-Executive Director Designate *(Observer)*
	Ms L Thomas	(LT)	Assistant Director of Workforce Development *(Observer)*
	Ms S Whelan	(SW)	Patient Experience Manager *(for Patient Story only)*
Apologies:	Prof K Hardy	(KH)	Medical Director
	Cllr A Lowe	(AL)	Halton Council *(Co-opted member)*

1. Employee of the Month

1.1. The Employee of the Month Award for July 2019 was presented to Shirley Bond, HCA, Intermediate Care, Duffy Suite, St Helens Hospital.

2. Patient Story

2.1. SW presented the story to the Board on behalf of the patient. CW had been diagnosed with multiple sclerosis 12 years earlier at the age of 38. At the time CW was an Auxiliary Nurse on the Maternity Unit at another North West Trust, a role she loved but sadly had to leave due to her progressive symptoms 12 months after her diagnosis.

2.2. SW met CW in May 2019, when CW had been admitted to Ward 2B due to her Chronic Obstructive Pulmonary Disease (COPD). It came to light during this admission that CW had never been referred to the community Occupational Therapy or Physiotherapy services and had purchased her own wheelchair and other equipment, and was not receiving any ongoing support to maintain her independence.

2.3. CW had been unaware that she was entitled to thorough home and wheelchair assessments therefore, following her discharge home in May, CW was provided with the necessary information to enable her to seek out support she was entitled to from NHS community and Local Authority services. As a result, twice-weekly occupational therapy sessions had been arranged and a new electric wheelchair had been ordered, which would enable her to visit her sister for the first time in several years.

2.4. SRe confirmed a lot of work was being done with the Trust's therapy teams as a result of patient feedback regarding access to community equipment services for wheelchairs and other equipment. The Trust also signposted patients to the Red Cross, who advised on entitlements. AMS noted that the Trust had received very positive feedback from Cancer patients on the benefits advice and support provided.

2.5. SW believed this story highlighted the importance of Trust staff being aware of a patient's holistic needs and thinking about their circumstances when they left hospital.

2.6. Board members acknowledged that the Trust could do more to provide information about other services to which patients were entitled.

2.7. RC clarified that, as the Trust Board had agreed, one of the 2019/20 objectives was to improve patient information produced by the Trust and he suggested that this project could also be extended to include access to other services.

2.8. During a recent Quality Walk Round, the issue of car parking charges for long stay/end of life patients had been raised with VD. The discounted weekly pass was available for relatives in this situation and was advertised in the lifts and next to the payment machines; however it was agreed that this should also be included in the ward/admission information.

2.9. Options for increasing the availability of advice for patients were considered, including the role of volunteers and strengthening ties with the local Citizens Advice Bureau, who had outreach benefits advisors.

2.10. RF asked SW to pass on the Board's thanks to CW for sharing her story and hoped that the positive suggestions made would help improve services further for patients in a similar position.

3. Apologies for Absence and Introductions

3.1. Apologies were noted as above.

3.2. RF informed Board members that Su Rai's term of office as a Non-Executive Director ended in September and her last Board meeting would be

25th September. He welcomed IC, who was observing the meeting, as SR's replacement. IC explained that he had been an accountant and finance director for 30 years, initially in commerce, before moving to a not-for-profit organisation in 2003. He had local connections as he had been a Board member for 9 years for Torus Housing (formerly Helena Partnerships, Golden Gates and Liverpool Mutual Homes). IC was also an NHS patient and was happy to share his experiences, if they could help improve services.

4. Declaration of Interests

4.1. There were no further declarations of interest to those made in previous meetings.

5. Minutes of the previous meeting held on 26th June 2019

5.1. Correct Record

5.1.1. The minutes were accepted as a correct record following a minor correction to minute 10.6.

5.2. Action List

5.2.1. Meeting 31.10.18 (Minute 14.9) – AMS/SRe to review the exit interview process to ensure it is comprehensive and lessons are being learnt to improve retention – on agenda (included in the HR Indicators report NHST(19)69). **Action Closed.**

5.2.2. All other actions were on the agenda or closed.

6. Integrated Performance Report (IPR) – NHST(19)62

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

6.2. Quality Indicators

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

6.2.2. SRe confirmed work was continuing to deliver the CQC action plan following publication of the CQC report in March 2019.

6.2.3. There had been no never events in June and none reported year to date.

6.2.4. There had been no MRSA reported in June and none reported year to date.

6.2.5. There were 8 C.Diff positive cases reported in June 2019 (5 hospital onset and 3 community onset). Year to date there had been 18 cases (12 hospital onset and 6 community onset), of which 2 cases had been successfully appealed and 5 cases were to be appealed in September. The annual tolerance assigned to the Trust by NHSE/I for 2019/20 was

48, however this was currently being challenged and there has only been 8 cases added as a result of the definition changes, which was very low compared to other similar Trusts. Given the increased incidence in June there was a focus on timely testing of samples, as if these were not taken on time the cases would become hospital attributable. SRe confirmed there were contractual penalties for each case above the threshold level. **Action: SRe provide a detailed report to the next Quality Committee on actions being taken to revise the CDiff trajectory.**

6.2.6. There were no grade 3 or 4 avoidable pressure ulcers reported for May or year to date.

6.2.7. The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for June 2019 was 98.5% and year to date performance was 98.2%.

6.2.8. There had been 1 fall resulting in severe harm in May and 2 in the year to date.

6.2.9. Venous thromboembolism (VTE) assessment performance for May was 95.32%. Year to date performance was 95.33% against a target of 95%.

6.3. **Operational Indicators**

6.3.1. RC presented the update on the operational performance.

6.3.2. The 62-day cancer standard was above the target of 85.0% in May at 87.6% against the target of 85%.

6.3.3. The 31-day cancer target was achieved with 97.2% performance against a target of 96%.

6.3.4. The 2-week cancer standard was not achieved with 87.3% against a target of 93%, which had been particularly challenged due to the volume of Breast cancer referrals requiring investigation. Board members noted the number of cancers found had remained the same, but the volume of referrals under the two week rules had increased. Work was being done with GPs to understand this change.

6.3.5. Board members noted the 2-week wait target may be phased out and replaced with a 28-day target, meaning patients would have to receive their diagnosis within 28 days. RC confirmed Breast cancer would consistently meet this 28-day target.

6.3.6. A&E access time performance in June was 64.4% (type 1). The all-types mapped footprint performance for June was 81.5%.

6.3.7. The Trust received 9,914 type 1 attendances in June and year to date growth was up 4.6% on the previous year.

6.3.8. Whiston A&E had the highest volume of ambulance attendances of all hospitals in Cheshire & Merseyside and Greater Manchester in June. The ambulance notification to handover target time was not achieved with 21.27 minutes on average for June, against a target of 15 minutes.

6.3.9. The impact of Stroke patients being received at the Trust's Hyper Acute Stroke Unit (HASU) was being reviewed to understand whether this was contributing to the increase in ambulance attendances, where patients who were found not to have suffered a stroke were retained as inpatients at the Trust.

6.3.10. DM queried whether parents were choosing to bring their children to Whiston rather than Alder Hey, however RC confirmed this was not an area of particular growth and the activity was being managed effectively and the A&E targets achieved for this cohort of patients. The main issue for the Trust remained bed capacity, with bed occupancy remaining extremely high and increased pressure on beds as the number of A&E attendances continued to grow.

6.3.11. Board members noted that unless a patient's choice of hospital threatened a drain on NWAS resource, ambulances would take the patient to their preferred hospital.

6.3.12. SR asked how the Trust was performing compared to other local Trusts. AM confirmed other Trusts had achieved the Ambulance handover time, however they had not received the same volume of ambulance attendances.

6.3.13. The Trust had been set a 40% reduction target in the number of super stranded patients (patients with a length of stay of greater than 21 days) 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 was 130. RC assured Board members that Trust, CCG and local authority partners were actively engaged in the achievement of the reduction in super stranded patients.

6.3.14. AM stated that alongside bed capacity, the number of delayed discharges was also creating pressure on patient flows. This had been discussed in detail at the last mid-Cheshire A&E Delivery Board meeting. Each borough had reported that they had beds available but closer analysis revealed that these beds were in reality not "open" to receive the patients the Trust needed to discharge. There were several reasons for this; CQC restrictions, staffing levels, specialist facilities. Board members agreed it was essential to keep the care home sector sustainable with beds open and the necessary staff to support them. GA stated that it was important for the whole system to pull together to maximise the number of community beds.

6.3.15. AM suggested a meeting with the St Helens CCG Clinical Accountable Officer and GA to understand why patterns of activity in St Helens had changed compared to 2018/19. **Action: AM.**

6.3.16. VD reflected on recent Quality Walk Rounds that palliative care and mental health patients appeared to wait longer for packages of care due to their complex needs and specialist requirements. RC confirmed that this was often the case, although recent investment in Mental Health services provided by North West Boroughs had improved the situation for patients with Mental Health issues.

6.3.17. In response to DM's query, RC confirmed all 4 boroughs had an electronic planning tool which showed bed availability. CW confirmed an IT solution was also being developed at STP level for the whole of Cheshire and Merseyside and was expected to be ready in 2020.

6.3.18. The 18-week referral to treatment target (RTT) was achieved in June with 93.3% compliance, against a target of 92%. The 6-week diagnostic target was achieved in June with 99.4% (target 99%). There were no 52+ week waiters.

6.4. **Financial Indicators**

6.4.1. NK presented the update on the financial performance.

6.4.2. At the end of month 3, the Trust reported a deficit of £2.3m which was in line with agreed plans and assumed full achievement of this year's PSF funding. The Trust had utilised c£1.5m of non-recurrent options to achieve the reported deficit.

6.4.3. Agency expenditure at month 3 was £1.9m which was £0.2m below the planned trajectory. DM observed that bank spend had gone up but was more economic compared to agency staff and AMS confirmed more shifts were being filled from the Trust bank.

6.4.4. DM asked how the Trust compared to other acute hospitals and NK confirmed that although there were some occasions when the Trust had paid higher than the national capped rates, the Trust was still very comparable. High spend areas had been targeted and requests for agency approval were tightly controlled and required Executive Director approval, with patient safety the only reason to go outside normal parameters.

6.4.5. The Trust was ahead of the CIP target of £1.5m by £0.6m.

6.4.6. NK reported that activity against plan was being monitored very closely and variations investigated to understand the causes. Financial risks related to CQUIN achievement, activity changes and losing capacity as a result of the pension tax rules.

6.5. **Workforce Indicators**

6.5.1. AMS presented the update on the workforce indicators.

6.5.2. Absence in June was 4.9%, which was 0.5% higher than last year and exceeded the Q1 target of 4.25%. The highest reported reasons for absence were stress and anxiety, which could reflect personal as well

as work issues. A deep dive report had been made to the Finance and Performance committee and a number of actions agreed, including exploring further support options for staff with, eg Citizen's Advice Bureau.

6.5.3. PG commented that his organisation had introduced a peer support group initiative where staff members were trained to support colleagues. It was agreed he should share the details with AMS to see if a similar initiative could work at the Trust.

6.5.4. LK asked whether the pilot relating to changed shift patterns had started and if so had there been any noticeable difference in absence levels amongst those staff. SRe confirmed the pilot had begun but was still in the early stages, although she had received some positive feedback. The pilot would be evaluated at the end of the 3-month trial and the impact on absence was one of the criteria.

6.5.5. Mandatory training compliance was 82.2% (target = 85%) and was being monitored closely to ensure the position recovered quickly. Appraisal compliance was 84.8% which was also below the target of 85%.

7. Committee Report – Executive – NHST(19)63

7.1. AM presented the report summarising the key issues considered by the Executive Committee at meetings held June 2019.

7.1.1. The Executive Committee had approved the annual review and uplift of car parking charges for staff and patients/visitors, and additional consultant capacity to create separate emergency and elective obstetric anaesthetic rotas.

7.1.2. The Executive Committee had received updates on flexible endoscopy decontamination equipment procurement, St Helens community services, primary care developments and the Easter Sector Cancer Hub (ESCH) selection process. AM clarified that although the ESCH submissions were being evaluated by the panel the final outcome of the process could take several more months and was likely to be subject to public consultation. DM asked if the selection criteria had been clarified and AM confirmed that the criteria and scoring systems had now been shared with both Trusts.

7.1.3. JK had noted how well the Trust managed really complex pathways during a recent visit to the Lilac Centre and Oncology team. AM agreed that one of the strengths of our services was that they were very experienced in responding to patients who had complications during treatment.

7.1.4. The Executive Committee had 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.

7.1.5. Board members noted the report.

8. Committee Report – Quality – NHST(19)64

8.1. VD presented the Chair's report to the Board, which summarised key issues arising from the Quality Committee meeting held on 23rd July and the Patient Safety, Patient Experience, Workforce and Clinical Effectiveness Councils.

8.2. VD reported concerns in relation to the future capacity of staff to complete the Liberty Protection Safeguards assessments when they became law in 2020. Secondly, there was a general issue around current capacity of the safeguarding team to manage current demand and achieve the expected number of DoLs assessments. SRe informed the Board that a business case for increased specialist capacity had been developed and was currently under consideration by the Executive Committee.

8.3. VD confirmed the committee had been assured that action and improvement plans were in place or being developed in relation to the VRE outbreak and increased number of Q1 C.Diff cases.

8.4. SR asked if there were any specific trends in the increased number of complaints being received. VD clarified that it appeared to be a general upward trend rather than clusters for particular services or themes, but this would continue to be monitored. SRe believed the number of PALS enquiries could have increased as a result of the PALS team being more visible throughout the Trust and visiting the wards on a regular basis.

8.5. Board members noted the report.

9. Committee Report – Finance & Performance – NHST(19)65

9.1. JK presented the Chair's report to the Board which summarised key issues arising from the Finance & Performance Committee meeting held on 25th July.

9.2. There were national challenges with Capital Department Expenditure Limits (CDEL); a £2bn reduction was required from the NHS. As a result, the Trust had deferred £0.7m into next year on the agreement that it was "replenished" in 2020/21. None of this would compromise safety or quality.

9.3. The committee had also undertaken the monthly review of A&E performance and the improvement actions, and had also discussed the pressure on capacity and the options being explored to increase access to appropriate beds.

9.4. The Committee received a presentation for Clinical Support Services and noted there was a national shortage of radiologists so the teams were reviewing how other members of the workforce could be trained to provide additional support.

9.5. Board members noted the report.

10. Corporate Risk Register (CRR) – NHST(19)66

10.1. NB presented the CRR to provide assurance that the Trust was operating an effective risk management system, and that risks identified and raised by front line services could be escalated.

10.2. The report was a snap shot of the risks reported and reviewed in June 2019, rather than a summary of the quarter, and included more information regarding the previous report and the same period last year which had been requested at the last meeting.

10.3. The total number of risks on the risk register was 753 compared to 741 in April.

10.4. 46% (350) of the Trust's risks are rated as 'moderate' or 'high', compared to 45% in April.

10.5. 10 risks that scored 15 or above had been escalated to the CRR; Board members noted there had also been 10 risks escalated in April 2019 (but they were not all the same risks).

10.6. JK observed there was no risk in relation to the pension tax changes. NB explained that this had been added to the risk register but in June had not been escalated to the CRR. The scoring would continue to be adjusted as a result of the government consultation document.

10.7. VD asked whether Risk 1152 relating to Bank staff ought to be a financial, as well as a quality risk. NB agreed that is was both.

10.8. SR queried the de-escalation of Risk 1555 regarding the receipt of apprenticeship levy payments for Lead Employer doctors in training. NB explained the risk was still on the Trust risk register, it had just been downgraded from the CRR as the mitigation plans had been effective in reducing the likelihood of this risk occurring.

10.9. Board members noted the report.

11. Board Assurance Framework (BAF) – NHST(19)67

11.1. NB presented the quarterly review of the BAF and highlighted a number of proposed changes to reflect actions achieved and changes to national policy:

11.1.1. The score of Risk 3 – sustained failure to maintain operational performance/deliver contracts - to be increased as a result of the operational pressures being experienced in 2019/20, e.g. increase in A&E attendances from all CCGs;

11.1.2. The score of Risk 7 – major and sustained failure of essential assets or infrastructure - to be increased to reflect the risks to national capital allocations and the impact on being able to increase Trust capacity in response to growing service demands.

11.2. Board Members approved the changes to the BAF.

12. Learning from Deaths Quarterly Report – NHST(19)68

12.1. NB presented the Q4 2019/19 learning from deaths report, on behalf of KH, to provide assurance that deaths in all specified groups had been reviewed and key learning had been disseminated throughout the Trust.

12.2. The two key learning priorities from Q4 related to fast-track discharge and improving communications between the hospital and community care services to ensure that advance care plans, e.g. DNACPR, preferred place of death, could be met.

12.3. In response to a request from VD, RC confirmed a report analysing numbers, duration and reasons for people on the fast-track discharge list was available and a report could be prepared for a future Quality Committee meeting. **ACTION: RC**

12.4. SR asked whether there were any common themes between the 3 amber deaths in February 2019. NB did not have this information to hand but endeavoured to find out and before the end of the meeting was able to confirm that these deaths had occurred in different services and there were no common causal factors.

12.5. Board members noted the report.

13. HR/Workforce Strategy and Workforce Indicators Report – NHST(19)69

13.1. AMS summarised the report which provided Board members with assurance of progress against the workforce indicators that supported the delivery of the Trust's annual objectives specifically to developing organisation culture and supporting the workforce.

13.2. The paper was presented in 2 parts, the first provided an update on strategic matters aligned to the key priorities as detailed in the NHS long term plan and the second part related to workforce indicators and summarised achievements/ progress to date.

13.3. An in-depth review of the exit interview process had indicated there were no systemic cultural issues that could be identified, but there were some services/departments which had been highlighted. An analysis of the free text from the exit questionnaires had indicated more support for new starters and more opportunities for flexible working were recurrent themes that leavers stated could improve the working environment. In response to the deep dive, a retention action plan had been developed and was to be presented to the Workforce Council in September 2019, and would then feed through to the Quality Committee.

13.4. AM queried the Trust turnover and retention rates, which seemed to be at odds with the staff survey findings that the majority of staff would recommend the Trust as a place to work. **ACTION: AMS to investigate further and report back.**

13.5. SR asked whether 44% of leavers stating they would not return to the Trust should be something to be concerned about. AMS agreed it was a high figure

and identified hot spots would be addressed, but this also had to be put in context of the reasons for leaving e.g. Retirement, relocation.

13.6. NK asked if the workforce KPIs were broken down by staff in each of the protected characteristics, to see if there were any differences with the Trust as a whole. AMS confirmed that this information could be produced, if staff had disclosed their protected characteristic, but had not been included in the paper. AMS agreed to review KPIs against particular characteristics, eg BAME. **ACTION: AMS**

13.7. Board members noted the Trust's sickness level was higher than the national average, however was in line with the north-west average.

13.8. PG informed members about an MBA leadership development scheme that his organisation accessed via John Moores University and asked whether any members of staff could be put forward for this programme. AMS was aware of the programme but was not sure it would meet the needs of Trust staff and explained the Trust was currently looking at leadership development apprenticeship programmes but the framework had not yet been finalised. LK offered to contact the programme director for leadership apprenticeships at Lancaster University, if required.

13.9. VD relayed a comment she had received during a Quality Walk Round from a member of staff in relation to there being a lack of Executive visibility; although they remembered there had been something in the past. **ACTION: AMS to refresh and re-introduce the 'buddy ward' process.**

13.10. The report was noted.

14. Learning Lessons to Improve our People Practices – NHST(19)70

14.1. AMS briefed Board members on the content of a letter sent to Provider Chief Executives and Chairs on 24th May 2019 from Baroness Dido Harding, Chair of NHS England and NHS Improvement, about why Trusts needed to learn lessons to improve their people practices.

14.2. The paper detailed the considerations and questions that Baroness Harding had asked HR Departments and Trust Boards reflect on to assess the "health" of the organisational culture and the additional guidance for the management and oversight of local investigation and disciplinary procedures.

14.3. The HR department had commenced a review of current policies and practices, and sought legal advice. There were also a series of engagement events with groups of staff to understand their experiences, and an action plan had been developed and discussed at the Workforce Council on 24th July.

14.4. AMS recommended that a scrutiny group should be established to oversee the implementation and impact of the action plan, and she had asked VD to be a Non-Executive member of this group. The recommendation was agreed and VD agreed to be involved. An assurance report in relation to improving people practices would be presented to board members once the new scrutiny group had met and agreed the action plan. **ACTION: AMS**

14.5. The first assurance report for the Trust Board was planned for September, and it was also proposed that a training and awareness session on what to consider when implementing a Just Culture approach should be included in the Board Development Programme for 2019/20. **ACTION: AMS**

14.6. Members noted the content of the report and supported the recommendations.

15. Approval of the Workforce Strategy 2019-2020 – NHST(19)71

15.1. AMS presented the Workforce Strategy 2019/2020 to Board members, who were asked to note that this was a one-year strategy only at this stage, because the NHS was awaiting the publication of the final NHS People Plan that was now expected after the Government spending review in the autumn. Staff had been consulted about the objectives in the plan and they had previously been discussed at Board, during a strategy meeting.

15.2. DM congratulated AMS on a clear and concise document that set realistic medium-term goals. NK highlighted that this was a Trust strategy and all Board members would have a role to play in its delivery.

15.3. It was agreed a half year update on delivery of the objectives should be presented to the Trust Board in 6 months' time. **ACTION: AMS**

15.4. Board members approved the strategy.

16. Effectiveness of Meeting

16.1. RF asked both observers for their reflections on the meeting.

16.2. MB felt there was a generally positive atmosphere and was reassured as a doctor who worked night shifts that Board members were aware of operational pressures and committed to tackling the issues.

16.3. LT had observed clear decision making and had found it very useful to hear about the larger system pressures in the context of the Trust pressures and the longer term plan to move towards an integrated system.

16.4. RF thanked MB and LT for their feedback and assured MB that the Board was very aware of the intense pressures on staff that are on the frontline of treating patients.

16.5. RF asked the observers whether they were able to differentiate between Executive and Non-Executive Board members, as he felt it a matter of principle personally that all members should feel able to contribute openly and equally. Both observers felt they had seen the Board made unitary decisions, with appropriate challenge and discussion from all members, which made it difficult to differentiate between members.

17. Any Other Business

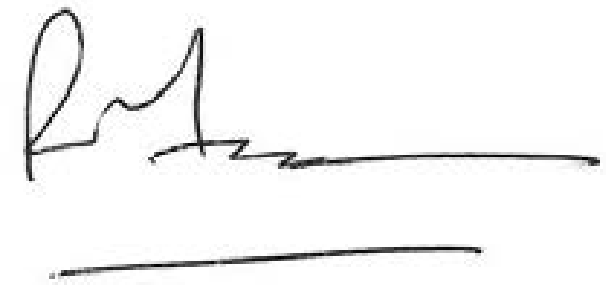
17.1. RF asked about the impact on the Trust of the closure of the 1 to 1 community midwifery service. SRe confirmed that the company had not held any major contracts locally, so it was not expected to have a significant impact on

referrals, but there had already been some, so the situation was being closely monitored. NK confirmed that financially the exposure for the Trust was less than £20k.

17.2. Board members had heard LC's patient story in September 2018 regarding the treatment she had received for severe sceptic acne and how she was now able to look forward to life events rather than dread them. At the request of Board members at the time, LC had sent a photo of herself in her Prom Dress, in which Board members unanimously agreed she looked "gorgeous"!

18. Date of Next Meeting

18.1. The next meeting will be held on Wednesday 25th September 2019 at 09:30 hrs in the Executive Boardroom, Level 5, Whiston Hospital, L35 5DR.



Chairman: ……

25th September 2019

Date: ……

TRUST PUBLIC BOARD ACTION LOG – 25TH SEPTEMBER 2019

No	Date of Meeting (Minute)	Action	Lead	Date Due
~~1.~~	~~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~~. **Included in HR Indicators report. ACTION CLOSED.**	~~AMS/SRe~~	~~31.07.19~~
2.	31.07.19 (6.2.5)	C.Diff cases for appeal – SRe to provide specific detail in relation to number of cases and potential costs (£10k per patient) to the next Quality Committee meeting.	SRe	For Quality Committee
3.	31.07.19 (6.3.16)	AM to meet with SOB/GA to understand why St Helens is an outlier for activity and delayed discharges.	AM	25.09.19
4.	31.07.19 (12.3)	As a result of the Q4 Learning from Deaths key learning priority related to fast track discharge, RC to prepare a report analysing numbers, duration and reasons for people on the fast-track discharge list for a future Quality Committee meeting.	RC	For Quality Committee
5.	31.07.19 (13.4)	AM to clarify difference between model hospital turnover vs retention figures.	AMS	25.09.19
6.	31.07.19 (13.6)	AMS to report HR KPIs against BAME characteristics.	AMS	Next HR Indicators Report 29.01.20
7.	31.07.19 (13.9)	AMS to review and re-introduce the ward buddy system to increase Director visibility.	AMS	25.09.19
~~8.~~	~~31.07.19 (14.3)~~	~~AMS to include VD in establishment of Improving our People Practices Scrutiny Group~~. **DONE. ACTION CLOSED.**	~~AMS~~	~~25.09.19~~
9.	31.07.19 (14.6)	AMS to arrange a training and awareness session for Board members on what to consider when implementing a just culture for a future Board development session.	AMS	29.01.20
10.	31.07.19 (15.3)	AMS to prepare an update on achievement of the Workforce Strategy actions for the Board meeting in November 2019.	AMS	27.11.19

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)73
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 July and August 2019. There were a total of 9 Executive Committee meetings held during this period. The Executive Committee approved: • Medical Care Group Consultant Staffing Business Case (partial approval only) • Radiology Services Staffing Business Case (approved in principle and referred to the full Trust Board for final approval, due to the level of investment sought) • Medway Benefits Realisation – replacement of paper forms project • Proposals to develop a business case for using modular buildings to increase winter bed capacity • The final 2019/20 CNST Maternity Discount Scheme declaration • CTG Centralised Monitoring Business Case There were updates on other key Trust objectives, including: Medway upgrade preparations, BLS/ILS training, implications for the Trust of the collapse of One to One Midwives, and the industrial action taken by Unison in its pay dispute with Medirest. 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.
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: 25th September 2019

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE
July and August 2019

1. Introduction

There were 9 Executive Committee meetings in July and August 2019. This report covers both months, as there was no Board meeting in August. At every meeting the Committee reviews any bank or agency staff requests that would breach the NHSI cost thresholds.

2. 4th July 2019

2.1 Board Assurance Framework (BAF)

The Director of Corporate Services presented the quarterly review of the BAF by the Committee in advance of being reported to the Trust Board, and a number of changes were recommended.

2.2 Trust Board Agenda - July

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

2.3 Medical Care Group Consultant Staffing Business Case

The Director of Operations and Performance introduced the business case, which outlined proposals for additional consultant medical staff. The case was partially approved with the conversion of current locum appointments to substantive posts, and a request for additional information and understanding of activity patterns before a further review of the overall establishment.

2.4 Basic and Immediate Life Support (BLS/ILS)Training

The Deputy CEO/Director of HR presented the proposals to improve training compliance rates. This included clarification of the staff who needed training at the different levels of competence, and also alternative methods of training using an interactive mannequin that would be more accessible for staff, and mean the training could be undertaken in the workplace. The improvement plan and funding for the training mannequin was approved, and performance against the improvement trajectory will be monitored by the Committee.

2.5 Cardiotocography (CTG) Monitoring Business Case

The Committee reviewed the reasons why there had been delays in agreeing the preferred technical solution and development of the business case for CTG monitoring. Now that these issues were resolved, it was agreed that funding would need to be prioritised in the 2019/20 capital programme. The final business case was to be brought to the Executive Committee for formal review as soon as possible.

2.6 National Capital Spending Restrictions

The Director of Finance and Information briefed the Committee on the letter received from NHSE/I asking all NHS Trusts to reduce their planned capital spending in 2019/20,

to ensure the NHS would meet the capital spending limit set by HM Treasury. The lack of flexibility within the Trust capital programme because of PFI commitments, and implications for planned schemes including the £4m central allocation for improving A&E and Same Day Emergency Care were discussed. Committee agreed that if there was no other choice, the capital scheme would have to be slipped to reduce the planned spend in 2019/20

2.7 Place Based Five Year Plans

The Director of Integration briefed the Committee on the work being undertaken to develop the St Helens five year plan, which had to be submitted to the Cheshire and Merseyside Health and Care Partnership in September. A draft financial system recovery plan had been submitted at the end of June which had been coordinated by St Helens CCG Chief Finance Officer. There was concern that the Trust had not yet been sufficiently involved in developing the plans for the Knowsley or Halton "systems".

2.8 Halton Urgent Treatment Centres (UTC)

It had been confirmed that the procurement process had been abandoned and the UTC contracts were not being awarded. It was unclear at this stage what the alternative process would be for creating the UTC model required by Halton Commissioners.

3. 11th July 2019

3.1 Radiology Services Business Case

The Director of Operations and Performance introduced a business case that proposed a substantial investment in Radiology staffing in response to increasing demand for diagnostic imaging and the need to maximise the operational capacity of all available equipment. The main increases in demands are for MRI, CT and Ultrasound. The financial modelling demonstrated that the additional income potential would be sufficient to fund the proposed new posts. The Executive was supportive of the case, however given the value, full Trust Board approval was needed. This would be scheduled for the Board meeting in September.

3.2 Patient Information Project

The Director of Nursing, Midwifery and Governance presented the plans to take forward the project to improve patient information as part of the Trust objectives for 2019/20. The first phase was to complete a scoping exercise, and the Executive supported dedicated project management support to help move this forward.

3.3 Emergency Department (ED) Patient Survey Results

The Director of Nursing, Midwifery and Governance reported the 2018 ED patient survey results and draft internal action plan. The survey response rate for 2018 had improved and there had been some very positive comments about the service. The Trust had not scored in the lowest 20% of Trusts for any of the questions, and was in the highest scoring 20% for 13 responses and the mid-range for 23 responses. The Committee noted some common themes relating to patient information and communication, which were in line with other survey results and had led to the Patient Information Project. The

Committee reviewed the draft action plan and made suggestions for how this could be strengthened.

3.4 St Helens Community Services

The Director of Operations and Performance provided an update on the discussions with St Helens CCG in relation to the Trust becoming the lead provider for additional community services, which would transfer from another local provider. The transfer is being planned in 3 phases over the coming months, and some of the specialist services could then be sub-contracted to other providers who already deliver similar specialist services. Due diligence on each service was being undertaken and this would inform the final decision to proceed.

3.5 Non Elective (NEL) Activity Analysis

The Director of Finance presented the analysis of the changes seen in NEL activity and average length of stay resulting from the increase in A&E attendances and pressure on medical beds. It was agreed that this should be presented to the Finance and Performance Committee, and options to increase bed capacity at Whiston Hospital needed to be considered.

3.6 BLS/ILS Training Compliance

The Director of Nursing, Midwifery and Governance provided the weekly update on BLS/ILS training compliance. Improvements in compliance rates and the recruitment of ward champions were reported.

3.7 Risk Management Council (RMC) Report and Corporate Risk Register (CRR)

The Chair's report from the RMC meeting on 9th July was presented. There were 10 risks escalated to the CRR, including a new risk relating to issues with the Cheshire and Merseyside PACs system for sharing diagnostic imaging results.

4. 18th July 2019

4.1 Learning lessons to improve people practices

The Deputy CEO/Director of HR presented a paper that outlined the recommendations from Baroness Dido Harding on behalf of NHSE/I to embed a just culture for all staff, and support the values of compassionate management. A project was proposed to benchmark the Trust against these criteria and develop an action plan. A report would also be given to the Trust Board.

4.2 Mandatory training and appraisals

The Deputy CEO/Director of HR presented the figures for each director, for June, with action required to ensure that 85% compliance was achieved across all areas.

4.3 BLS/ILS Training Compliance

The Director of Nursing, Midwifery and Governance presented the weekly report which demonstrated some further improvement. The ROI mannequins had been ordered and were expected to be operational within a few weeks, which would help to make the training easier to access and complete in the ward setting. The Executive Committee requested more detailed analysis of which staff had recently fallen out of compliance and the staff requiring training at each level of competence.

4.4 Integrated Performance Report (IPR)

The Executive Committee members reviewed the IPR for June and agreed the commentary, noting that there continued to be pressures on the cancer 2 week waiting time target, due to specialist diagnostic imaging capacity and ambulance handover times as a result of the increasing A&E attendances.

4.5 NHSE/I Peer Review Visit

The Director of Operations and Performance reported on the recent visit which had focused on systems in Halton.

4.6 Medirest Staff Ballot

The Deputy CEO/Director reported that the results of the Medirest staff ballot had been in favour of industrial action and Unison was planning for a one day strike on 31st July, although talks were continuing with Medirest in the hope of resolving the issues before any action was taken. Business continuity and contingency plans were being put in place to minimise any impact on patients.

5. 25th July 2019

5.1 Replacement of Paper Forms

The Director of Informatics presented a proposal to replace paper forms with electronic forms generated by Medway. Becoming paperless was an ambition for the NHS and part of the Medway benefits realisation programme. The project management arrangements were agreed, with a multidisciplinary steering group to be established to give advice on the clinical requirements.

5.2 Medway Upgrade

The Director of Informatics presented the plans for managing the first Medway upgrade since the new system had been installed. The upgrade will improve the functionality of the system and will be rigorously tested before “go live”, which is scheduled for September.

5.3 Medirest Staff Industrial Action

The Deputy CEO/Director of HR presented a paper giving details of the Medirest Staff dispute seeking pay parity with staff that retain Agenda for Change (AfC) pay and conditions of service. A number of other North West Trusts will also be impacted by the

day of industrial action on 31st July. Although the dispute is not with the Trust, the Executive Committee reviewed the implications.

5.4 BLS/ILS Training

The latest weekly report was presented, which highlighted the actions being taken to improve compliance rates. A condensed training package that can be delivered on the wards has been developed and those areas in need of targeted support had been identified.

5.5 Safer Staffing Report

The Director of Operations presented the report for June on behalf of the Director of Nursing, Midwifery and Governance. The overall RN fill rate remained above 98% and the number of vacancies for qualified staff had reduced, supported by the international recruitment programme. A deep dive into Maternity Staffing was requested before a decision could be made to review the current establishment.

5.6 Clinical Quality Performance Group

The Director of Operations and Performance provided feedback from the monthly meeting with the CCG. Data flows in relation to the North West Boroughs sub-contract was discussed and the Safeguarding team capacity.

5.7 St Helens Five Year Place Strategy

The Director of Integration presented the draft 5 year strategy for review. The deadline for submission of the initial plan was now 27th October, with the final plan for Cheshire and Merseyside to be submitted on 15th November. Equivalent plans for Halton and Knowsley also needed to be reviewed by the Executive Committee.

5.8 Fair to Refer Report

The Deputy CEO/Director of HR presented this national research which had been undertaken by the General Medical Council (GMC). This had analysed why BAME doctors were more likely to be referred to the GMC for fitness to practice concerns, and how this bias can be addressed. The Trust had completed the self-assessment exercise and identified the need for more education and training for staff involved in conduct and competency processes.

6. 1st August 2019

6.1 Capital Programme

Following the national call to reduce capital expenditure by 20% the Committee reviewed the capital programme, and predicted expenditure during the year. The prioritisation was also reviewed to agree which items could not be delayed.

6.2 Infection Prevention Control – VRE

The Director of Nursing, Midwifery and Governance presented an update on the actions that had been taken to reduce the cases of VRE contamination. It was reported that the

Hydrogen Peroxide fogging machines had now been purchased and a rolling deep clean of the wards undertaken. A literature review had also been undertaken and this demonstrated that the Trust was taking all reasonable precautions and was compliant with current advice and guidance. Close monitoring of the environment and screening of patients would continue.

6.3 Winter Planning – Bed Capacity

The Director of Operations and Performance presented a paper that set out the options for increasing bed capacity via the use of temporary modular wards. This detailed the potential site locations, procurement route and outline timetable. The Committee agreed that given the lead in time, work should continue to develop these outline proposals into a full business case for a step down ward and a winter escalation facility.

6.4 Payroll Contracts

The Deputy CEO/Director of HR presented proposals to take on the payroll services contracts for three further local NHS Provider Trusts in the next few months.

7. 8th August 2019

7.1 CNST Maternity Incentive Scheme Submission

The Director of Nursing, Midwifery and Governance presented the final assurance statement in relation to the maternity incentive scheme declaration. As agreed by the Trust Board, due to the timing, the final declaration was approved by the Executive Committee.

7.2 2018/19 Estates Return Information Collection (ERIC)

The Director of Corporate Services presented the ERIC report which provided assurance about the accuracy of the information submitted to the national database, and the results of initial benchmarking comparisons with other Trusts in the North of England. It was noted that the Trust compared favourably across the majority of metrics, and all Trust costs had been impacted by the Agenda for Change pay increase in 2018. Full national validated benchmark information would be published in October.

7.3 Nurse Bank pay model

The Deputy CEO/Director of HR presented an evaluation of the changes to the pay model for band 5 Registered Nurses who worked for the staff bank. The change to recognise previous service had been put in place in January 2018 and the evaluation showed that this had helped bank recruitment, shift fill rates and the reduction in agency costs for qualified nurses. It was therefore agreed that the pay model had delivered the intended benefits and should continue.

7.4 Gender Pay Gap

The Deputy CEO/Director of HR presented the report which explained how the gender pay gap information was calculated. This information had to be published by all organisations and the Trust compared well with other NHS provider organisations. The

information has to be published each year, and for the Trust there had been a reduction compared to 2017/18. The HR department were reviewing the information to determine if the Trust needed to take action for specific professions or staff groups.

7.5 NHS Pensions Tax Rules

The Deputy CEO/Director of HR reported that the incoming government team had announced new consultation proposals on NHS pension flexibilities for senior clinical staff. The Trust would respond to the revised consultation document when it was published.

7.6 Medway Upgrade Plans

The Director of Informatics presented the report which detailed the progress being made to prepare for the planned Medway upgrade. The first round of acceptance testing had been completed and another round was planned. Although some issues had been identified, these were all assessed as low risk, and the upgrade would not proceed until they had been mitigated. The benefits of the upgrade including a number of system fixes were also reviewed.

7.8 One to One Midwives

The Director of Nursing, Midwifery and Governance gave an update on the community midwifery company that had gone into administration. The NHS in the North West had contracts with this service and all NHS maternity units were working to ensure that women were referred to a NHS maternity unit for their on-going care. The impact for the Trust was not expected to be significant because the local CCGs had not used the company, but a small number of additional referrals had already been seen. The Trust would continue working with NHSE/I to offer mutual aid as required, and ensure all patients were safe.

7.9 Medirest Staff Industrial Action

The Committee reviewed the impact of the industrial action that had occurred on 31st July and it was agreed that the business continuity plans had worked well, with very little impact on patient care. These were being formally reviewed and updated as the dispute had not yet been resolved and there was potential for further industrial action.

8. 15th August 2019

8.1 Mandatory Training and Appraisal Report

The Deputy CEO/Director of HR reported the mandatory training and appraisal figures for July, for each Director.

8.2 Hospital Standard Mortality Ratio (HSMR) Analysis

The Medical Director introduced a report which had analysed the causes of the reported increase in HSMR using the CRAB database. The report benchmarked the Trust HSMR with other local acute hospitals for the period December 2018 – February 2019, and also provided a breakdown of the HSMR by speciality. An issue had been identified with

Acute Kidney Injury (AKI) and the committee agreed that an action plan needed to be developed in response to these findings, particularly in relation to monitoring fluid balances for vulnerable patients.

8.3 St Helens Community Services

In the absence of the Director of Operations and Performance the Assistant Director of Operations for Community and Primary Care gave a progress report on the discussions with St Helens CCG and the current provider. The due diligence information provided so far had helped to identify a number of issues that would need to be mitigated, either pre or post transfer of the services. Members of the paediatric team also described the clinical benefits that could be delivered by more integrated working with community paediatric services.

8.4 Mersey Internal Audit Agency review of the CQC Provider Information Request (PIR) 2018 completion

The Director of Nursing, Midwifery and Governance presented the audit findings. The audit had indicated that there had been adequate systems for internal control, but there were four recommendations for improvement, all of which had been addressed.

8.5 Agenda for Change – closure of band 1

The Deputy CEO/Director of HR presented the paper that provided an update on the closure of band 1 to new entrants to the NHS and the transfer of existing staff. The majority of the band 1 staff had been Retention of Employment (ROE) staff working in soft facilities management services for Medirest. Opportunities for role expansion to create greater flexibility across this workforce, by offering enhanced training when required, were noted.

8.6 Risk Management Council (RMC) Chair's Report

The Director of Corporate Services presented the Chair's report from the RMC. This included a review of the Corporate Risk Register (CRR) and reports from a number of governance groups. There were 13 risks escalated to the CRR, including 3 new high risks reported in July.

8.7 Integrated Performance Report (IPR)

The Director of Finance and Information presented the draft IPR for review. Some of the KPIs were queried and changes to the commentary agreed. It was agreed that the IPR should be circulated to Board members, as there was no Board meeting in August.

9. 22nd August 2019

9.1 CTG Centralised Monitoring Business Case

The Director of Nursing, Midwifery and Governance presented the business case to introduce centralised CTG monitoring for the delivery suite. The business case included the system to support centralised monitoring and a number of new monitors that could be linked to this system. The Executive Committee discussed how the system could be

operationalised to maximise the benefits for mothers and babies. The business case was approved.

9.2 Journey of a surgical patient – presentation

Mr Rowan Pritchard-Jones attended the Executive Committee to share the presentation he had given at the Care and Compassion Conference. This explored the experience of a patient coming into hospital and how, as a senior clinician, he could support patients and help reduce their anxiety.

9.3 Safer staffing, shift shortfall and nurse vacancy report

The Director of Nursing, Midwifery and Governance presented the monthly report for July which showed that the safer staffing overall fill rate for Registered Nurses was 98.44%. There were 4 occasions when wards had reported a fill rate of less than 90%, during the month. The vacancy dashboard showed 51.8 FTE nurse vacancies, but with 65 offers currently being processed. 477 requests for supplementary one to one care had been made during the reporting period, and new approval criteria had been introduced to provide better information on the reasons for these requests.

9.4 Electronic Staff Record (ESR) and Moodle

The Director of Nursing, Midwifery and Governance reported that the interface issues between ESR and Moodle had now been resolved, which would enable more e-learning packages to be developed for mandatory training.

9.5 HSMR Action Plan

The Director of Nursing, Midwifery and Governance reported that she had met with Graham Copeland and the Clinical Director of the Acute Medical Unit, following his presentation to the Executive Committee the previous week, and they had agreed a number of actions that would reduce the risk of hospital acquired Acute Kidney Injury (AKI).

9.6 Local Clinical Excellence Awards (LCEA)

The Committee discussed the level of applications received for the LCEA to date, and the suspected impact of the NHS pension and taxation issues on individual decisions to apply.

9.7 Joint NHSE/NHSI St Helens System Performance Review

The Director of Finance and Information provided feedback on the first joint NHSE/NHSI system performance meeting, under the new accountability arrangements. The focus had been on the governance arrangements whereby the system partners collectively took responsibility for achieving financial balance for St Helens.

9.8 Medirest/Unison Industrial Action

The Director of Corporate Services informed the Committee that the latest member ballot by Unison had rejected the most recent Medirest pay offer, and further industrial action was now planned for 27th and 28th August. Medirest were putting contingency plans in place to ensure that patient services were not disrupted.

10. 29th August 2019

10.1 St Helens Community Services

The Director of Operations introduced the paper which provided an update on the discussions to transfer a number of community service contracts to the Trust. The changing emphasis within St Helens Cares and implications for the Lead Provider concept were debated, and it was agreed that this needed to be discussed further with the CCG. The committee also reviewed the appropriateness of the existing Community Nursing sub-contract arrangements, in light of the other proposed changes.

10.2 2019/20 CQUINs – Quarter 1 Performance

The Director of Finance and Information introduced the paper which provided an update on 2018/19 CQUIN achievement and noted there was still outstanding payments due in relation to the Staff Survey results CQUIN. Performance at Q1 for the 2019/20 CQUINs, was on track, taking in to account the late publication of the CQUIN guidance and the revised provisions for achievement to be measured over the full 12 months, rather than for each quarter separately.

10.3 Winter Capacity Planning

The Director of Operations and Performance outlined proposals to increase the trolley spaces in AMU to 12 (from 8) to increase capacity as part of the preparation for the coming winter. This proposal was agreed.

10.4 Clinical Quality Performance Group (CQPG) meeting feedback

The Director of Nursing, Midwifery and Governance provided feedback from the meeting on 20th August 2019. Cancer waiting time breach reporting was discussed including the pressures on the Dermatology Services for skin cancer patients, as a result of other local Trusts no longer offering this service. Progress reports on Sepsis awareness and NEWS2 implementation were also made, and the Q4 learning from deaths report was presented.

10.5 Review of the impact of the Medirest Industrial Action

The Director of Corporate Services provided an update on the impact of the industrial action taken by Medirest staff, earlier in the week. Contingency plans had worked well and there had been no material impact on patient services. The noise made by the protestors outside Whiston Hospital had however caused distress to a number of patients and relatives, despite polite requests by the Trust to reduce the noise levels.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)74

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

Purpose: To summarise the meeting papers from 17th September and escalate issues of concern.

Agenda Items Discussed:

- Safer Staffing – QC(19)100
  There has been a decrease in overall RN fill rates in month (August) to 95.59%; however the fill rates remained above the 90% target. 76.26% of bank and agency requests were filled in month 5. Daily staffing meetings take place to ensure every ward is safe.
- Saving Babies Lives(SBL) version 2 – QC(19)101
  SBL updated bundle needs to be implemented by March 2020 to achieve the CNST maternity premium. A gap analysis and action plan has been developed. Some elements require updates to national guidance, but other actions are on track for delivery. There is a need to ensure that electronic systems are able to capture all the necessary data to avoid manual collection. The committee received assurance that the actions are on track and progress is being made.
- CNST Incentive Scheme Update – QC(19)102
  The Trust is compliant against all 10 safety actions set by the CNST and the self-declaration was submitted on 13th August, following approval by the Executive Committee as agreed at the July Trust Board.
- Telephone Interpreter Update
  The Trust is in the process of moving to a new contractor which will be more effective and include video links as well as face to face and telephone interpretation.
  Triangular MET call data with SafeCare Allocate Data
  The gathering of data is ongoing and the action will be carried to the next meeting.
- **Perinatal Mortality Report – QC(19)103 (Escalation to Board as below)**
- Prevent Level 3 training – QC(19)104
  The Trust achieved the internal target for Q1. Email reminders and meetings are taking place to ensure that we are fully compliant for Q2 by the end of September.
- Update on BLS/ILS & DFIBS – QC(19)105
  Training compliance is going in the right direction and continues to be monitored on a weekly basis, with areas targeted as necessary. Mobile training using a mannequin is now being rolled out to facilitate training in the ward environment. The Trust has purchased 5 additional external defibrillators.
- **Checking errors detected in Theatre – QC(19)106 (Escalation to Board as below)**
- Shelford Update was deferred
- **Medicine Storage – QC(19)108 (Escalation to Board as below)**
- NEWS2 Update - QC(19)109

The roll out in March was successful; the system has been extended to A&E and is well embedded in clinical practice. The impact on MET calls is being monitored and a full benefits realisation will be presented to the Quality Committee in November.

- Integrated Performance Report - QC(19)110
    - There were no Never Events in August 2019 (YTD 0)
    - There were no cases of MRSA in August 209 (YTD 0)
    - There were 5 CDI positive cases reported in August 2019 of which 5 were hospital onset. 7 cases have been successfully appealed in September. (YTD 22 cases of which 20 were hospital onset and 2 community onset). The annual tolerance is 48.
    - There were no grade 3 or 4 avoidable pressure ulcers in July 2019 (YTD 0)
    - During the month of July there were no falls resulting in severe harm (YTD 4)
- Patient Safety Council Assurance Report – QC(19)111

  The report was noted by the committee. Nothing to escalate.
- Incidents, Never Events & Serious Incidents – QC(19)012
  There were a total of 3949 incidents reported in Q1 2019/20; an increase of 8.79% on Q1 2018/19 (3630 incidents). There had been no never events and 9 StEIS reportable incidents.SR summarised the lessons learned and actions in place to provide assurance to the Committee.
- Safeguarding Quarterly Report
  A verbal update was given and the Quality Committee were assured by the actions in place.
- Infection Prevention and Control Report - QC(19)013
  SR gave an update on Trust performance against infection control and gave assurance that suitable processes are being implemented to prevent and control infections. The QC continues to monitor CDI and VRE.
- CQC Action Plan – QC(19)114
  There are 50 actions in total, 42 have been completed, 5 are on track for completion by the agreed deadline, 2 are overdue and 1 is at risk of not being completed by the deadline (achievement of the ED access standard). The two overdue actions have been escalated and recovery plans are now in place. All of the actions for Marshalls Cross Medical Centre have been completed and are being tested by MIAA to provide additional assurance.
- Healthcare Safety Investigation Branch (HSIB) Maternity Investigations – QC(19)115
  Five cases referred for HSIB investigations were subject to a roundtable review. All the issues identified had already been picked up by the Trust internal rapid review process. None of these issues were a direct cause of the incident. Action plans were in place to ensure the learning was embedded.
- Patient Experience Council Assurance Report – QC(19)116 (Escalation to Board as below)
- Clinical Effectiveness Council Assurance Report – QC(19)118
  The CEC report was noted by the Committee. A focus on NICE guidance is required at the next meeting.
- Workforce Council Assurance Report – QC(19)119

The report was noted by the Committee. There was nothing to be escalated.

- Any Other Business
  There was no other business discussed

Matters for Escalation:

Perinatal Mortality report:
The Maternity Service had undertaken further analysis of the Perinatal Mortality Review Report as part of the MBRRACE process, this has highlighted some issues with women receiving antenatal care in the community and then delivering at StHK. Committee agreed that the report should be shared with Commissioners at the next CQPG meeting.
ACTION: SR to give an update on the findings of the Perinatal Mortality Report to Commissioners at the CQPG
Checking errors detected in Theatre:
There was an increased number of incidents reported that related to errors in the checklists which had been detected in theatres, which could result in errors being made. Committee discussed the actions that needed to be taken to increase awareness of the importance of correctly completing pre-operative documentation. This was to be discussed at the Executive Committee with an updated action plan and progress report at the next Quality Committee meeting.
ACTION: SR to feedback following the Executive Committee review
Medicine Storage:
The latest Medicine Storage audit results were reported and although there had been an improvement overall there were still some areas where issues remained to achieve consistent compliance with the Trust policy in all areas at all times.
ACTION: SR, RC & SG to review the escalation procedure for non-compliance and report back in November.
Patient Experience Council Assurance Report:
ARW gave an update from the Patient Experience Council. Key points included the Children and Young People Patient Survey, for which an action plan is being developed. Complaints performance is being maintained. There was also a report on the National Inpatient Survey results which had been published in July 2018. A more detailed analysis of the results would be presented at the next meeting.
ACTION: Inpatient Survey Results and analysis report at the next Quality Committee.

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: Val Davies, Chair of Committee

Date of meeting: 25th September 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)75

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance and Performance Committee, 19th September 2019

Summary:

Agenda Items

For Information

- DoF verbal update – NK gave an update on a number of issues for the Committee's attention. These included:
  - Procurement Team have been ranked 7th in the NHSI Procurement league tables and best in Cheshire & Merseyside.
  - STP / LTP – A 5 year draft plan has been submitted to the STP which shows a breakeven position for the Trust in 2020/21 with incremental surpluses in the outer years; an event is being held for DoFs and HRDs to view the system positon in October before a final submission later in the year.
  - There have been changes in the way providers and commissioners are monitored by NHSI/E, the focus is on ensuring the overall system is affordable rather than individual Trusts/CCG's.
  - It was reported last month the Trust had been asked to reduce its capital plan by c£0.7m, further guidance has now been released which confirms the reduction is no longer needed and we can continue with our original capital plan.
  - Junior doctor contract changes are due to be paid during September, as Lead Employer this will have cash implications for the Trust of c£5m.
  - A paper is to be taken to Remuneration Committee to detail the options available for senior staff affected by the change in pension tax.

- Integrated Performance Report
  - The Committee discussed the high number of C-diff cases reported during August as there have been a couple of high months this year. Meetings have taken place with the Infection Control team and a number of actions are being implemented.
  - The small decrease in sickness levels was noted and discussions around seasonality of sickness were considered.

- Finance Report
  - The Trust is reporting a £3.3m deficit YTD which is in line with plans. £0.7m of non-recurrent resources were utilised to achieve this position, a reduction of £0.8m from last month.
  - Capital resources of £1.7m 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 £1.8m; 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 September which equates to 4 days of operating expenses.
  - The underperformance of NEL activity was highlighted which while had improved is still behind plan YTD. It was noticed that there was a reduction in income due to lower than expected take up of WLIs from the medical workforce. The estimated net impact was adverse c£450k.

- NK summarised the financial risks currently being managed, they were:-
    - Outstanding disputes with CCGs, which have been escalated to DoFs
    - NEL admission rates given the significant increase in A&E attendances
    - Clinical income achievement given pensions tax impact.

- Briefings were accepted from:
    - CIP Council including ratification of the policy for managing CIP risks
    - Procurement Steering Council

For Assurance

- A&E Performance
    - The Committee reviewed the presentation from the ADO and CD for Emergency Care.
    - The increase in attendances were discussed, particularly those from Warrington & Liverpool. Further work was being undertaken to assure that stroke mimics were being captured by the stroke team as they might be being triaged within ED. An audit of patients transferred by Warrington is to be done to ensure the transfers are appropriate.
    - Actions to improve the 4 hour target were presented including a plan to review of the current medical and nursing staff levels.

- CIP Programme update
    - The Committee noted the £14.9m 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 having tested a scheme at random.

- CIP Programme update – MCG
    - The ADO for Medical Care presented an updated on their CIP performance to date including details on the process within the division of how CIPs are identified.
    - The Committee were assured by the multi-disciplinary approach to generating savings and felt there had been an increase in engagement across the organisation over the previous year.

Risks noted/Items to be raised at Board

- Summary financial risks reported in briefing which are being actively managed

- Cash risk due to Jnr Doctors backdated payment & non-payment of PSF to date.
    - The Committee endorsed a short term loan for October if required (£5m or less) and request ratification by Trust Board.

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: Denis Mahony, Non-Executive Director

Date of meeting: 25th September 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)76

Title of paper: Committee Report – Audit

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

Summary:
A meeting of the Audit Committee was held on 2nd August 2019. The following matters were discussed and reviewed:

Matters Arising

- Gareth Winstanley (GW) from audit firm Grant Thornton (GT) updated the committee that all year-end audit documentation was submitted by them as per national schedules with no issues of concern to report.

- NK updates the committee that post submission of the accounts StHK was informed that a further £0.5m PSF would be allocated by NHSI. This was be reflected in 2019/20 control total plans and not 2018/19.

External Audit Update

- **Annual Audit Letter** – GW presented the letter and advised that no issues were of concern for the Committee. This report was accepted by the Audit Committee. GW also commented on the favourable VFM and Going Concern opinions they were able to declare. He noted that it was becoming rare to make these good opinions give the financial position of many acute care providers and congratulated the Trust.

Internal Audit Update

- **Overseas & Private Patients – Limited Assurance.** Audit Committee were assured with the management actions. Recruitment to vacant post will expedite actions required.

- **CQC Provider Information Request – Moderate Assurance.** Audit Committee were assured with the management actions and lessons learnt around logging submissions and "date stamping" evidence provided.

- **Emergency Preparedness – Substantial Assurance.** Audit Committee were assured with the favourable report and positive comments.

- **Q1 MIAA follow up report of management actions** – Audit Committee were assured with progress on actions and oversight of agreed deliverable milestones.

Standing Items

- **Audit Log** – Report was accepted and triangulated with MIAA internal audit update received.

- **Loss, Write-offs & Compensation –** Report was discussed and Committee wanted to keep focus on clinical errors given significant rise in CNST costs over the last few years.

- **Aged Debt –** Overdue debt for June 2019 has risen to £8.5m. This was reflective of the

cash challenges within the NHSI but also that against a cash annual turnover of c£1bn this would be expected to grow proportionally.

- **Tender Waivers Report –** Compliance with policy and report was noted with assurance.

Governance & Assurance Update

- The Director of Nursing took the committee through 7 key updates of governance and assurance. This included CQC action plan, infection control and Quality Committee feedback as examples. Assurance was received regarding progress and compliance.

Issues/Risk to be escalated to Board

- **Aged Debt –** It is recommended the Board and F&P committee continue to consider the risks to cash given financial challenges of other organisations and shared service growth.

Corporate objectives met or risks addressed: Contributes to the Trust's Governance arrangements
Financial implications: None as a direct consequence of this paper
Stakeholders: The Trust, its staff and all stakeholders
Recommendation(s): For The Board to note this update
Presenting officer: Su Rai, NED and Chair of Audit Committee
Date of meeting: 25th September 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)77
Title of paper: Strategic and Regulatory Update Report – September 2019
Purpose: To provide the Board with assurance that the Trust continues to take account of external strategic developments that could impact the future direction of the organisation and all regulatory requirements to comply with governance good practice.
Summary: The report provides a briefing on the key policy and regulatory developments including; 1. NHS Oversight Framework 2019/20 2. Government Spending Round September 2019 3. NHS Patient Safety Strategy July 2019 4. Draft Board Development Programme 2019/20
Trust objectives met or risks addressed: Provide high quality sustainable services
Financial implications: This paper does not include a request for additional funding
Stakeholders: Patients, Staff, C&M H&CP, Commissioners, Regulators
Recommendation(s): The Board is asked to note the report.
Presenting officer: Nicola Bunce, Director of Corporate Services
Date of meeting: 25th September 2019

Strategic and Regulatory Update Report – September 2019

1. NHS Oversight Framework 2019/20

A new oversight framework was published in August 2019, setting out how NHSE and NHSI will provide integrated oversight of the NHS. This new approach puts more emphasis on systems rather than individual organisations and also sets out the role of the new Regional teams, working with Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) leadership in delivering the new oversight framework.

Oversight is to be characterised by several key principles:

- NHS England and NHS Improvement teams speaking with a **single voice**, setting consistent expectations of systems and their constituent organisations
- a greater emphasis on **system performance**, alongside the contribution of individual healthcare providers and commissioners to system goals
- working **with and through system leaders**, wherever possible, to tackle problems
- matching **accountability for results** with improvement support, as appropriate
- **Greater autonomy** for systems with evidenced capability for collective working and track record of successful delivery of NHS priorities.

The statutory responsibilities of NHS Improvement and NHS England in relation to Providers and Commissioners are not altered, but the context in which they will be applied is to change, so that they will collectively focus on;

- Performance issues in organisations that directly affect system delivery
- Development issues which may, if not addressed, threaten future performance
- Leadership and culture in organisations

Four new metrics have been added to the national standards applied to providers. These are based on the annual NHS Staff Survey and cover bullying and harassment, teamwork and inclusivity.

Oversight for providers will be the same for NHS Trusts and NHS Foundation Trusts.

Oversight will involve System Review Meetings (SRMs) based on;

- Core national requirements for quality, population health, financial performance and sustainability, and delivery of national standards (appendix 1)
- Emerging organisational health issues
- Implementation of the transformation objectives in the NHS long Term Plan

There will be common areas covered;

Theme	Aim
Quality of care (safe, effective, caring, responsive)	To continuously improve care quality, helping to create the safest, highest quality health and care service. In close collaboration with the CQC.
Finance and use of resources	To balance finances and improve the productivity of the provider sector.
Operational performance	To maintain and improve performance against NHS constitutional standards.
Strategic change	To ensure providers are contributing through ICSs and/or STPs to the development and delivery of clinically, operationally and financially sustainable patterns of care.
Leadership and improvement capability (well-led)	To build provider leadership and improvement capability to deliver sustainable services. In 19/20 this also includes culture and organisational health.

Providers and CCGs will be segemented to one of 4 levels, which will standardise the level of oversight and support provided by NHSE/I. The frequency of the SRMs will be quarterley for systems in segments 1 and 2.

	Providers		CCGs	
Segment/ category	**Description of support needs**	**Level of support offered**	**Description of support needs**	**Level of support offered**
1 (Maximum autonomy)	No actual support needs identified across the five themes described in the provider annex. Maximum autonomy and lowest level of oversight appropriate. Expectation that provider supports providers in other segments.	**Universal (voluntary)**	No actual support needs identified across. Maximum autonomy and lowest level of oversight appropriate.	**Universal (voluntary)**
2 (Targeted support)	Support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or formal action is not considered needed.	**Universal + targeted** (not mandatory) support as agreed with the provider to address issues identified and help move the provider to segment 1.	Support needed but mandated action is not considered needed.	**Universal + targeted** support as agreed with the CCG to address issues identified and help move the provider to segment 1
3 (Mandated support)	The provider has significant support needs and is in actual or suspected breach of the licence (or equivalent for NHS trusts) but is not in special measures.	**Universal targeted + mandated** support as determined by the regional team to address specific issues and help move the provider to segment 2 or 1.	The CCG has significant support needs and is placed in the dedicated support regime.	**Universal targeted + mandated** support as determined by the regional team to address specific issues and help move the CCG to segment 2 or 1
4 (Special measures for providers; legal directions for CCGs)	The provider is in actual or suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean it is in special measures.	**Universal targeted + mandated** support as determined to minimise the time the provider is in special measures.	The CCG is failing or at risk of failure with very serious/ complex issues that mean it is placed under legal directions.	**Universal targeted + mandated** support as determined to minimise the time the CCG is under legal direction.

2. Government Spending Round September 2019

The new conservative government announced its spending plans for 2020/21 in a "fast track" spending round on 4th September. A full 3 year spending review will now not take place until 2020 to set multi-year budgets for government departments. Following the

announcements about capital and infrastructure spending made in August the plans focused on revenue spending.
The key points impacting on health and social care are;

- The Department of Health and Social Care will receive a 3.1% real terms increase in budget
- Confirmation that the NHS England budget will increase by £33.9bn by 2023/24 compared to 2018/19
- The Health Education England (HEE) will increase by 3.4% for Continuing Professional Development and training
- Local government received a grant of £1bn for adult and children's social care, in addition to the existing £2.5bn previously announced.

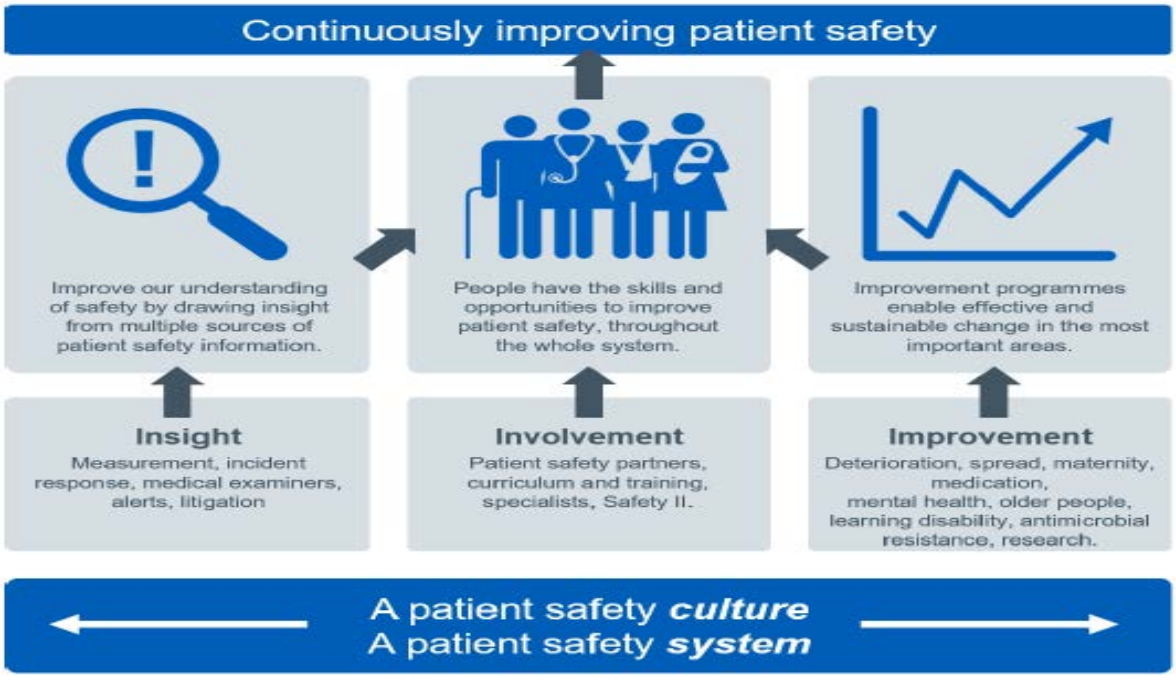
3. NHS Patient Safety Strategy July 2019

NHSE/I have published a new Patient Safety Strategy, following a consultation exercise that was launched in December 2018.

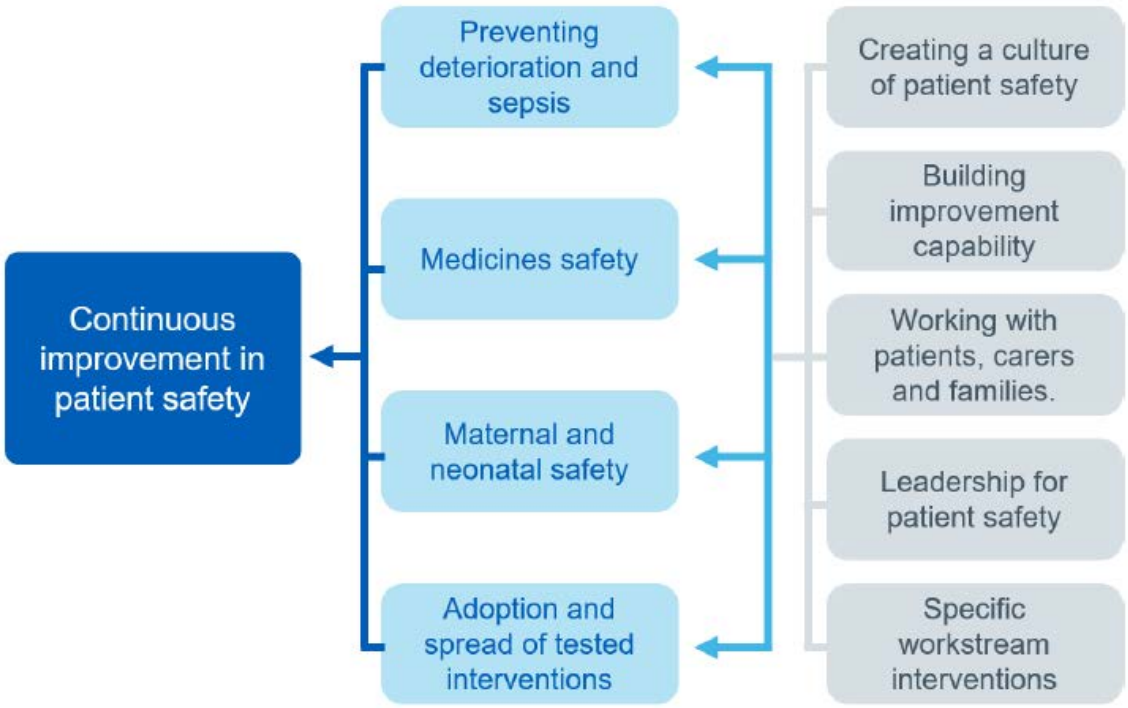
Patient safety is about maximising the things that go right and minimising the things that go wrong for people experiencing healthcare. The new NHS safety vision is **to continuously improve patient safety** through improvements to the **patient safety culture** and **patient safety systems**. There are three strategic aims to support this:

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information (**Insight**)
- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (**Involvement**)
- designing and supporting programmes that deliver effective and sustainable change in the most important areas (**Improvement**).

This is summarised in the following diagram;



The identified national patient safety improvement priorities for 2019/20 are;



These actions are encompassed within the Trusts agreed corporate objectives for 2019/20 or Care Group plans.

The longer term implications of the national Patient Safety Strategy will be evaluated and incorporated into the Trust strategy.

4. Draft Board Development Programme 2019/20

The CQC Well Led domain and NHS Improvement Well Led Framework support the principles of effective Board governance by reinforcing the importance of Boards developing and critically evaluating; performance, the future plans of the Trust and the strategic landscape. To this end the Board develops an annual Board development programme. This sets out the collective training and development activities and how the Board will utilise the Strategy Board meetings and planned time out during the year.

The programme is indicative, as the Board needs to retain a measure of flexibility to respond to events, however the draft programme for 2019/20 is attached (appendix 2) for consideration.

ENDS

Appendix 1

Oversight Metrics

1. New service models		Oversight
	Integrated primary care and community health services	
1	Patient experience of GP services	CCGs
2	Patient experience of booking a GP appointment	CCGs
3	Emergency admissions for urgent care sensitive conditions	CCGs
	Acute emergency care and transfers of care	
4	Percentage of patients admitted, transferred or discharged from A&E within four hours	CCGs and providers
5	Achievement of clinical standards in the delivery of 7-day services	CCGs and providers
6	Delayed transfers of care per 100,000 population	CCGs
7	Population use of hospital beds following emergency admission	CCGs
8	Percentage of NHS continuing healthcare full assessments taking place in an acute hospital setting	CCGs
	Personalisation and patient choice	
9	Personal health budgets	CCGs
10	Use of the NHS e-referral service to enable choice at first routine elective referral	CCGs

2. Preventing ill health and reducing inequalities		
	Smoking	
11	Maternal smoking at delivery	CCGs
	Obesity	
12	Percentage of children aged 10-11 classified as overweight or obese	CCGs
	Falls	
13	Injuries from falls in people aged 65 and over	CCGs and providers
	Antimicrobial resistance	
14	Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	CCGs
15	Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	CCGs
	Health inequalities	
16	Proportion of people on GP severe mental illness register receiving physical health checks in primary care	CCGs
17	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions	CCGs
3. Quality of care and outcomes		
	General	
18	Provision of high-quality care: hospitals	CCGs and providers
19	Quality of Care metrics: a set of 30 quality proxies to identify any emerging quality concerns at acute, mental health, ambulance and community trusts – **see Provider annex for more details**	Providers
20	Provision of high-quality care: primary medical services	CCGs

21	Evidence that sepsis awareness raising among healthcare professionals has been prioritised by CCGs	CCGs
22	**Evidence-based interventions**	**CCGs**
	Maternity services	
23	Neonatal mortality and stillbirths	CCGs
24	Women's experience of maternity services	CCGs
25	Choices in maternity services	CCGs
	Cancer services	
26	Cancers diagnosed at an early stage	CCGs
27	People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	CCGs and providers
28	One-year survival from all cancers	CCGs
29	Cancer patient experience	CCGs
	Mental health	
30	Improving Access to Psychological Therapies – recovery	CCGs and providers
31	Improving Access to Psychological Therapies – access	CCGs and providers
32	People with first episode of psychosis starting treatment with a National Institute for Health and Care Excellence (NICE)-recommended package of care treated within two weeks of referral	CCGs and providers
33	Mental health out-of-area placements	CCGs and providers
34	Quality of mental health data submitted to NHS Digital (DQMI)	CCGs and providers
	Learning disability and autism	

35	Reliance on specialist inpatient care for people with a learning disability and/or autism	CCGs
36	Proportion of people with a learning disability on the GP register receiving an annual health check	CCGs
37	Completeness of the GP learning disability register	CCGs
38	**Learning disabilities mortality review: the percentage of reviews completed within 6 months of notification**	**CCGs**
	Diabetes	
39	Diabetes patients that have achieved all the NICE recommended treatment targets: three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children	CCGs
40	People with diabetes diagnosed less than a year who attend a structured education course	CCGs
	People with long term conditions and complex needs	
41	Estimated diagnosis rate for people with dementia	Providers
42	Dementia care planning and post-diagnostic support	CCGs
43	The proportion of carers with a long-term condition who feel supported to manage their condition	CCGs
44	Percentage of deaths with three or more emergency admissions in last three months of life	CCGs
	Planned care	
45	Patients waiting 18 weeks or less from referral to hospital treatment	CCGs and providers
46	**Overall size of the waiting list**	**CCGs**
47	**Patients waiting over 52 weeks for treatment**	**CCGs**
48	Patients waiting six weeks or more for a diagnostic test	CCGs and providers

4. Leadership and workforce		
49	Quality of leadership	CCGs and providers
50	Probity and corporate governance	CCGs and providers
51	Effectiveness of working relationships in the local system	CCGs and providers
52	Compliance with statutory guidance on patient and public participation in commissioning health and care	CCGs
53	Primary care workforce	CCGs
54	Staff engagement index	CCGs
55	Progress against the Workforce Race Equality Standard	CCGs and providers
56	Effectiveness of shared objective-setting and teamworking	Providers
57	Providing equal opportunities and eliminating discrimination	Providers
58	Black and minority ethnic (BME) leadership ambition for executive appointments	Providers
59	Reducing/eliminating bullying and harassment from managers and other staff	Providers
5. Finance and use of resources		
60	In-year financial performance	CCGs and providers
61	Delivery of the mental health investment standard	CCGs
62	**Children and Young People and Eating Disorders investment as a percentage of total mental health spend**	**CCGs**
63	Expenditure in areas with identified scope for improvement	CCGs
64	Children and young people's mental health services transformation	CCGs
65	**Reducing the rate of low priority prescribing**	**CCGs**

Appendix 2

St Helens and Knowsley Teaching Hospitals NHS Trust

DRAFT v 2

BOARD DEVELOPMENT PROGRAMME 2019/20

Purpose	Provider/Lead	Date
New Director Internal Board Induction • About the Trust – services, activity • Role of the NEDs • Role of the Executive Team • Director portfolio's • Corporate Governance structure • Board Assurance Framework • Management structure • How the Board and Committees work	Executive Team (Nicola Bunce to coordinate)	September /October 2019 (TBC)
Just culture and compassionate leadership – what it means for the Board	Anne-Marie Stretch (Amanda Oates – Mersey Care)	30th October 2019 Strategy Board
Corporate Law annual update	Hill Dickenson LLP	
Mid-year review against Trust objectives	Nicola Bunce	27th November 2019 Board Meeting
Mid-year review against 2019/20 operational, activity and financial plans	Nik Khashu/Rob Cooper	
What to expect in the next 12 months and what it will mean for the Trust; • Who's who (changes) • STP plans • Becoming an ICS/ICP • Place plans • NHS Long Term Plan • Spending review	Ann Marr	November 2019 (1 -1.5 days dates TBC) Board time out
Primary Care Networks – how they will change community services	Local PCN Clinical Lead/Rob Foster??	
Developing our next Strategic Estates Strategy	Nicola Bunce	
Strategic review of community services and expansion plans within St Helens	Rob Cooper	
2020/21 Planning assumptions and timetable	Nik Khashu	29th January 2020

Estates Strategy 2020 - 2028	Nicola Bunce	Board Meeting
Developing the IT Strategy 2020 - 2023	Director of Informatics	26th February 2020 Strategy Board
Community Services contracts – risk assessment /transfer / mobilisation plans and assurance framework	Rob Cooper	
Approval of 2020/21 draft operational plan, opening budgets and Trust objectives	Nik Khashu/Nicola Bunce	25th March 2020 Board Meeting
Approval of the final 2020/21 Operational Plan	Nicola Bunce	29th April 2020 Strategy Board
Review of "winter" 2019/20 and lessons learnt	Rob Cooper	
Non-executive Directors – Corporate Mandatory Training Day	NEDs	May 2020
Working as part of an ICS/ICP – what this means for Trust Board accountability and governance	Nicola Bunce	May 2020 (1 day date TBC) Board time out
STP update	Ann Marr	
Board skills matrix	Anne-Marie Stretch	
Review of 2019/20 performance against the Trust objectives	Nicola Bunce	27th May 2020 Board Meeting
Annual Board Effectiveness Review Feedback and development recommendations	Nicola Bunce	
Approval of the Annual Report and Accounts and Quality Account	Ann Marr	
Clinical and Quality Strategy Annual Progress Report	Rowan Pritchard-Jones	24th June 2020 Strategy Board
HR/Workforce Strategy 2019/20 review and Workforce Strategy 2020 - 2023	Anne-Marie Stretch	
Board-level cyber security training	Director of Informatics &NHSX	29th July 2020 Board Meeting

Key	
	Strategy Board Meetings
	Board Meetings
	Board time out events
	One off training events

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)78

Title of paper: Statement of Compliance with national core standards for Emergency Planning Response & Resilience (EPRR) for 2019/20.

Purpose: The Trust's statement of compliance with EPRR national core standards is presented to Board members.

Summary:

The purpose of the EPRR Annual Assurance Process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR Core Standards.

As part of the NHS England EPRR Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients. NHS England has set out NHS Core Standards for EPRR, which are the minimum requirements expected. In addition core standard 60 requires acute hospitals to assure themselves against the Decontamination Checklist.

It is a requirement that the Statement of Compliance with the national core standards for Emergency Planning Response & Resilience for 2019/20 is presented to Trust board before the 30th September each year.

The self-assessment consists of 64 questions (applicable to the Trust) on Major Incident preparedness and business continuity including questions on HAZMAT/ CBRN preparedness. For 2019/20 there are an additional 5 'deep dive' questions on climate change and weather preparedness that do not affect the overall score, with which the Trust is fully compliant.

The Trust is 'fully compliant' with 60 of the 64 question and is 'partially compliant' with 4 questions. The 4 questions all relate to Chemical, biological, radiological and nuclear defence (CRBN) training:

1. CBRN decontamination capability 24/7 – additional staff need to be recruited in ED;
2. CBRN Training programme – refresher training is required for previously trained staff;
3. HAZMAT/CBRN training trainers – previously trained staff requires the National Ambulance Resilience Unit (NARU) 'train the trainer' training. This training is provided by NWAS and has limited places. The Trust has requested places on the next available course and has secured support from Cheshire and Merseyside EPRR lead to be able to deliver this training in house.
4. CBRN staff training in decontamination - refresher training is required for previously trained staff.

The Emergency Department CRBN lead is addressing the actions required to ensure full compliance. Last year the Trust achieved substantially compliance with 92.19%. This year's audit shows that the Trust is again substantially compliant with 93.75% The Statement of Compliance is attached at Appendix A.
Corporate objectives met or risks addressed: Compliance with EPRR National Core Standards required by regulators and commissioners and ensuring the continued and effective safety and care of patients, staff, partner agencies, visitors and others in the event of a Major Incident or business continuity disruption.
Financial implications: None
Stakeholders: Staff, patients, commissioners, regulators, partner agencies, Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) partners
Recommendation(s): The Trust's statement of compliance with EPRR national core standards is attached for approval by Board members.
Presenting officer: Nicola Bunce ,Director of Corporate Services On behalf of Sue Redfern, Director of Nursing, Midwifery & Governance
Date of meeting: 25th September 2019

Cheshire & Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2019-2020

STATEMENT OF COMPLIANCE

St Helens & Knowsley Teaching Hospitals NHS Trust has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR.

Following assessment, the organisation has been self-assessed as demonstrating the Substantial compliance level (from the four options in the table below) against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
64	00	04	60
Acute providers: **64** Specialist providers: **55** Community providers: **54** Mental health providers:**54** CCGs: **43**	**0%**	**6.25%**	**93.75%**

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.
I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan.

Sign Name _____

SUE REDFERN,
Director of Nursing, Midwifery & Governance,
The organisation's Accountable Emergency Officer

25/09/2019
Date of Board meeting

_____
Date signed

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)79
Title of paper: Workforce Equality, Diversity & Inclusion Update – Workforce Race Equality Standard (WRES)
Purpose: To inform and provide the Trust Board with an update relating to the Workforce Race Equality Standard (WRES) results and actions.
Summary: Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS provider organisations. The Trust is monitored against the 9 indicators of the WRES and this report provides an update on action taken to date.
Corporate objectives met or risks addressed: Developing organisational culture and supporting our workforce.
Financial implications: N/A
Stakeholders: Staff, Managers, Executive Board, Patients.
Recommendation(s): The Trust Board are requested to note and approve the updated WRES report and actions.
Presenting officer: Anne-Marie Stretch, Deputy CEO & Director of Human Resources
Date of meeting: 25th September 2019

1. Introduction

Workforce Race Equality Standard Annual Update 2019 (WRES)

NHS England and the NHS Equality and Diversity Council introduced the Workforce Race Equality Standard (WRES) in 2015. Since then, NHS organisations have been compelled to review their workforce race equality performance and develop action plans to make continuous improvement on the challenges within this agenda.

The WRES is made up of nine indicators; the first four measure staff experience over a 12 month period for harassment, bullying, or abuse from patients, relatives or the public. Another four measure workforce data, in relation to fellow colleagues, managers or team leaders and progression opportunities. Indicator nine considers BME representation on executive boards, in relation to the workforce.

The main purpose of the WRES is:

- ✓ to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
- ✓ to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and,
- ✓ to improve BME representation at the Board level of the organisation.

The data presented refers to the following periods

Indicator 1	1st April 2018 – 31st March 2019
Indicator 2	1st April 2018 – 31st March 2019
Indicator 3	1 April 2017 – 31 March 2019 two year rolling average
Indicator 4	1st April 2018 – 31st March 2019
Indicator 5,6,7 & 8	Staff Survey Results 2018
Indicator 9	31st March 2019

2. WRES Results and Actions

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

Results:

Results:

- Overall Staff Workforce BME: 8.7%
- Non-Clinical BME: 0.86%
- Clinical BME: 11.89%

8.7% of staff identify themselves as being BME at STHK which is an increase on last year which was 7.8%. This trend could be as a result of the recent international recruitment campaign.

The most recent Census (2011) regarding the local BME population (Census Data 2011, next census is 2021):

- St Helens (2.4%) & Knowsley (2.9%)
- Liverpool (12.3%)
- North West (11%)
- England (14%)

This means that the Trust's BME workforce is significantly higher than the local population.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
1.1. Analyse the data output for WRES Indicator 1 further by care group, job role and disaggregation by ethnic origin to identify any trends or gaps and make recommendations for actions to address gaps.		Head of Workforce Planning & ESR	End of Nov 2019	

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

Results:

Relevant likelihood of White staff being appointed from shortlisting is 1.15 times greater than BME Staff in comparison with 1.39 times higher in 2017.

There has been a 0.24 decrease in this year's results compared with the 2017 Staff Survey.

The National Guidance states that a figure below "1" would indicate that White candidates are less likely than BME candidates to be appointed from shortlisting.

In 2018, the National NHS Trusts Average figure was 1.45, the North was 1.39 and for Acute Trusts 1.55 which the Trust has performed well against (Source: NHS Workforce Race Equality Standard – 2018 Data Analysis report for NHS Trusts, first published January 2019).

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
2.1 Seek alternative advertisement methods via regional and national BME networks to capture a wider audience. Work with E, D & I leads at Higher Education Institutions to promote BME employment at STHK.		Workforce Equality, Diversity & Inclusion Lead	End of Dec 2019	
2.2. Produce promotional material (video's and posters) of BME staff across ethnic origins to profile career progression success stories. Load onto recruitment intranet / internet pages.		Workforce Equality, Diversity & Inclusion Lead	End of March 2020	
2.3. Roll out of programme for Unconscious Bias leaflets to staff at Trust.		Workforce Equality, Diversity & Inclusion Lead	End of Oct 2019	

2.4. Commission in house training for 20 'trainers' (Unconscious Bias) and cascade to recruiting managers.		Workforce Equality, Diversity & Inclusion Lead	End of March 2020	
Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.				
Results: BME staff are 1.11 times as likely to enter the disciplinary process in comparison to white staff with 2.12 times as likely in 2017. Since the last WRES, there has been a positive reduction of BME staff entering the formal disciplinary process. In 2018, the National NHS Trusts Average figure was 1.24, for the North it was 1.36 and Acute Trusts was 1.14 (Source: NHS Workforce Race Equality Standard – 2018 Data Analysis report for NHS Trusts, first published January 2019).				
Action	**Update (as appropriate)**	**Lead**	**Target/Review Date**	**RAG Rating**
3.1. Undertake listening events / focus groups / engagement events with BME staff across different ethnicities to deep dive into any issues raised.		Workforce Equality, Diversity & Inclusion Lead / Head of HR	End of Dec 2019 - Ongoing	
3.2. Implement Equality Impact Assessments prior to new HR cases being triaged for appropriate action (links to Just Culture and Improving People Practices)		Head of HR	End of Oct - Ongoing	
Indicator 4: Relative likelihood of staff accessing non-mandatory training and Continuing Personal Development.				
Results: • 2018 results = 0.86				

- 2017 results = 0.90

A figure below “1” would indicate that white staff members are less likely to access non-mandatory training and CPD than BME staff.

The National Acute average in the 2018 survey results was 1.15 for England, 1.11 for the North of England and 1.16 for Acute. (Source: NHS Workforce Race Equality Standard – 2018 Data Analysis report for NHS Trusts, first published January 2019).

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
4.1 Targeted promotion of non-mandatory training programmes through the staff network.		Head of Learning & Organisational Development	End of Oct 2019 – Ongoing	
4.2 Line manager briefings to ensure BME staff are released for non-mandatory training programmes.		Head of Learning & Organisational Development	End of Dec 2019 - Ongoing	
4.3. Incorporate question around non-mandatory training and CPD in WorkPal and Prep to initiate discussion.		Head of Learning & Organisational Development	End of Dec 2019	

Indicator 5: relates to Staff Survey findings.
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

Results:

- White Staff: 23.7% in 2018 compared with 25.2% in 2017
- BME Staff: 30% in 2018 compared with 26.5% in 2017

The figure has decreased for White staff experiencing harassment, bullying and abuse from patients, relatives or the public in comparison with 2017. However the figure has increased by 3.5% for BME staff since the last staff survey.

The National average in the 2018 survey results was White 27.8% and BME 29.8% (Source: 2018 NHS Staff Survey Results Website)

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
5.1. Interrogate data from Datix against		Head of HR	End of	

cases escalated through HR and how they compare with the staff survey results.			Nov2019	
5.2. Complete Equality Impact Assessments of protected characteristics in new and existing HR cases.		Head of HR	End of Oct 2019 - Ongoing	
Indicator 6: relates to Staff Survey findings Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months				
Results: • White Staff: 17.05% in 2018 compared with 18.56% in 2017 • BME Staff: 12.82% in 2018 compared with 26% in 2017 There has been a decrease in White Staff experiencing harassment, bullying or abuse from staff and a significant decrease of BME staff experiencing harassment, bullying or abuse from other staff. The National average for 2018 survey results was White 18% and BME 23.5%.(Source: 2018 NHS Staff Survey Results Website)				
Action	**Update (as appropriate)**	**Lead**	**Target/Review Date**	**RAG Rating**
6.1. Monthly scheduled ward rounds with Assistant Director of Patient Safety to promote the Freedom to Speak Up mechanism and to speak with BME staff to identify any issues in relation to harassment, bullying or abuse.		Workforce Equality, Diversity & Inclusion Lead / Assistant Director of Patient Safety	End of Oct 2019 - Ongoing	
6.2. Raise further awareness and promotion in Team Brief of the Speak Up mechanism to capture any reports of incidents.		Assistant Director of Patient Safety	End of Oct 2019	
Indicator 7: relates to Staff Survey findings Percentage believing that the Trust provides equal opportunities for career progression or promotion				

Results:

- White: 94.29% in 2018 compared with 94.87% in 2017
- BME: 85.20% in 2018 compared with 83.78% in 2017

There has been a slight decrease in White staff believing that the Trust provides equal opportunities for career progression or promotion compared with a positive increase in BME staff believing that the Trust provides equal opportunities in career progression.

The National average for 2018 survey results was White 86.3% and BME 69.9%. (Source: 2018 NHS Staff Survey Results Website)

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
7.1 Engaging with the BME staff network to actively promote the following opportunities to BME staff: • Stepping up programme (Bands 5 – 7) • Apprenticeships		Workforce Equality, Diversity & Inclusion Lead	End of Oct 2019 - Ongoing	
7.2. Develop online resources for staff to access. To include support with: • Completing NHS Application forms • Competency based questions • Interview techniques		Workforce Equality, Diversity & Inclusion Lead	End of March 2020	
7.3. Offer 121 support from HR to any BME staff considering applying for a role.		Workforce Equality, Diversity & Inclusion Lead	Oct 2019 - Ongoing	

Indicator 8: relates to Staff Survey findings
In the last 12 months have you personally experienced discrimination at work from any of the following?

- Manager/team leader or other colleagues

Results:

- White: 3.17% in 2018 compared with 5.2% in 2017.
- BME: 14.63% in 2018 compared with 16% in 2017.

Both the BME and White responses show a decrease in employees experiencing discrimination at work from managers/team leaders or other colleagues since the 2017 Staff Survey.

The National average for 2018 results was White 6.4% and BME 15.3%. (Source: 2018 NHS Staff Survey Results Website)

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
11. Celebrate and raise awareness of BME key religious holidays and dates such as Black History Month, Eid, Diwali etc. to raise cultural awareness.		Workforce Equality, Diversity & Inclusion Lead / Head of Communications	Oct 2019 - Ongoing	
12. Development of BME "Allies" across the Trust		Workforce Equality, Diversity & Inclusion Lead	End of Feb 2020	

Indicator 9: Percentage difference between the organisations' Board voting membership and its overall workforce.

Results:

Trust Board BME is 13.3%. The overall workforce by ethnicity is 8.7%. The difference between Board voting membership and overall workforce for BME is 4.7%.

The Trust Board figure as at 31st March 2019 was made up of 15 board members, inclusive of Non-Executive Directors.
When comparing the Board to the local BME population of St Helens & Knowsley, Liverpool, North West and England in total, these are as follows:

- St Helens (2.4%)
- Knowsley (2.9%)

- Liverpool (12.3%)
- North West (11%)
- England (14%)

(Census Data 2011, next census is 2021)
This means that the Trust's BME Board is significantly higher than the BME local population.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
9.1. Provide quarterly updates from the BME Staff Network meetings via the E, D & I steering group of any actions and updates.		Workforce Equality, Diversity & Inclusion Lead	Oct 2019 - Ongoing	

Summary:

- Overall improved results from last year's WRES report with the exception of Indicator 7 (number of staff believing that the Trust provides equal opportunities for career progression or promotion). This is in line with the National Average which is at its lowest level since 2014.
- Undertake further analysis to identify trends in care groups and by bands.
- Focus on engagement events to build trust and relationships between peers by Care Groups.
- Utilise the staff network to understand how the Trust can provide equity of opportunities for BME staff around career progression.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)80
Title of paper: Workforce Equality, Diversity & Inclusion Update – Workforce Disability Equality Standard (WDES).
Purpose: To inform and provide the Trust Board with an update relating to the Workforce Disability Equality Standard (WDES) results and actions.
Summary: Implementing the Workforce Disability Equality Standard (WDES) is a requirement for NHS commissioners and NHS provider organisations. The Trust is monitored against the 10 indicators of the WDES and this report provides an update on the proposed actions.
Corporate objectives met or risks addressed: Developing organisational culture and supporting our workforce.
Financial implications: N/A
Stakeholders: Staff, Managers, Executive Board, Patients.
Recommendation(s): The Trust Board are requested to note and approve the updated WDES report and actions.
Presenting officer: Anne-Marie Stretch, Deputy CEO & Director of Human Resources
Date of meeting: 25th September 2019

1. Introduction

Workforce Disability Equality Standard Annual Update 2019

The NHS Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. It has been designed to improve workplace experience and career opportunities for disabled people working, or seeking employment in the NHS.

The WDES is made up of ten indicators; which cover such areas as the Board, recruitment, bullying and harassment, engagement and the voices of disabled staff. The main purpose of the WDES is:

- ✓ to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the ten WDES indicators,
- ✓ to produce action plans to close the gaps in workplace experience between disabled and non-disabled staff, and,
- ✓ to improve representation at the Board level of the organisation.

Please note that at the time of this report the WDES National Report has not been produced so there is nothing to benchmark the Trust results against.

The data presented refers to the following periods

Indicator 1	Snapshot as at 31st March 2019
Indicator 2	1st April 2018 – 31st March 2019
Indicator 3	This Metric will be based on data from a two year rolling average of the current and previous year. However this metric was voluntary for this submission and was not completed.
Indicator 4,5,6,7,8 & 9a	Staff Survey Results 2018
Indicator 9b	Time of completing report
Indicator 10	Snapshot as at 31st March 2019

2. WDES Results and Actions

Please note that at the time of this report the WDES National Report has not been produced so there is nothing to benchmark the Trust results against

Indicator 1: Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and very senior managers (including Executive Board Members) compared with the percentage of staff in the overall workforce.

Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes. Links to EDS2 3.1: Fair NHS recruitment and selection processes lead to a more representative workforce at all levels

Results:

Non Clinical Workforce	Disabled %	Non-Disabled %	Disability Unknown / Null	Band % of Non-Clinical Workforce
Bands 1 - 4	3%	74%	23%	76.36%
Bands 5 - 7	2%	88%	10%	17.18%
Bands 8a - 8b	6%	77%	17%	4.09%
Bands 8C - 9 & VSM	0%	83%	17%	2.37%

Bands 1 – 4 comprise of the largest part of the workforce for non-clinical staff of which 3% are disabled staff compared with 74% of non-disabled staff. There are still 301 members of staff in Bands 1 - 4 that have not declared whether or not they have a disability within these bands.

Clinical Workforce	Disabled %	Non-Disabled %	Disability Unknown / Null	Band % of Clinical Workforce
Bands 1 - 4	2%	82%	16%	30.91%
Bands 5 - 7	3%	82%	15%	53.89%
Bands 8a - 8b	4%	79%	17%	3.67%
Bands 8C - 9 & VSM	15%	85%	0%	0.30%
Medical & Dental Staff, Consultants	0%	75%	25%	6.03%
Medical & Dental Staff, Non Consultants career grade	1%	81%	18%	2.81%
Medical & Dental Staff, Medical and Dental Trainee Grades	1%	99%	0%	2.35%

Bands 5 – 7 comprise of the largest part of the workforce for Clinical Staff of which 3% are disabled staff and 82% are non-disabled. A quarter of all Consultants have not declared whether they are disabled or not disabled.

Please note that as per the national guidance provided by NHS England percentages for disabled staff, non-disabled staff and disability unknown have been rounded to the nearest whole figure.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
1.1 Analyse the data output for Indicator 1 further by care group, job role and disaggregation by disability to identify any trends or gaps and make recommendations for actions to address gaps.		Head of Workforce Planning & ESR	End of Nov 2019	

Indicator 2: Relative Likelihood of Disabled Staff compared to Non-Disabled Staff being appointed from shortlisting across all posts.				
Results: Relevant likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff: 1.04 A figure above 1:00 indicates that Non-Disabled staff are more likely than Disabled staff to be appointed from shortlisting. As a Trust we offer a guaranteed interview for all disabled staff that meet the essential criteria.				
Action	**Update (as appropriate)**	**Lead**	**Target/Review Date**	**RAG Rating**
2.1. Seek alternative advertisement methods via regional Disability networks to capture a wider audience and review impact after 12 months of the number of disabled applicants appointed.		Head of Strategic Resourcing / Workforce Equality, Diversity & Inclusion Lead	End of Nov 2019	
2.2. Develop positive employee case studies of disabled staff to profile career progression success stories and encourage existing managers and individuals, as well as attracting potential staff to apply for vacancies and load onto internet.		Workforce Equality, Diversity & Inclusion Lead	End of Nov 2019	
2.3. Facilitate delivery of free disability training that the DWP can provide. Identify suitable training for recruiting managers e.g. menopause awareness.		Workforce Equality, Diversity & Inclusion Lead	End of Jan 2020	

Indicator 3: Relative likelihood of disabled staff compared to non-disabled staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Note:

i) This Metric will be based on data from a two-year rolling average of the current year and the previous year.

ii) This Metric is voluntary in year one.

Results:

As this Metric was voluntary in the first year this data was not provided as our data is in the process of being transferred over to a new system.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
3.1. Implement Equality Impact Assessment prior to new HR cases being triaged for appropriate action (links to Just Culture and Improving People Practices).		Head of HR	End of Oct 2019	

Indicator 4a): Relate to Staff Survey findings

Percentage of Disabled Staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

I. Patients/Services users, their relatives or other members of the public
II. Managers
III. Other colleagues

Results:

Patients/service users, their relatives or other members of the public:

- Disabled Staff: 28.2%
- Non-Disabled Staff: 23.4%

Disabled staff are more likely to experience harassment, bullying or abuse from patients/service users, their relatives or other members of the public than non-disabled staff.

Managers:
- Disabled Staff: 10.9%
- Non-Disabled Staff: 7.8%

Disabled staff are more likely to experience harassment, bullying or abuse from managers than non-disabled staff.

Other colleagues:
- Disabled Staff: 18.9%
- Non-Disabled Staff: 10.6%

Disabled staff are more likely to experience harassment, bullying or abuse from other colleagues than non-disabled staff.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
4.1. Interrogate available data to undertake useful cross analysis for example, how do numbers of formal bullying & harassment based issues compare with the staff survey results from the Employer Relations Case Tracker and information on Datix where staff have noted an incident in relation to disability.		Workforce Equality, Diversity & Inclusion Lead	End of Nov 2019	
4.2. Consider disability awareness campaign for patients, service users and staff (in relation to a zero tolerance of abuse).		Patient Inclusion & Experience Lead	End of March 2020	

Indicator 4b): Relate to Staff Survey findings
Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

Results: • Disabled Staff: 47.6% • Non-Disabled Staff: 52.3% 4.7% more non-disabled staff compared to disabled staff said that the last time they experienced harassment, bullying or abuse at work they or a colleague reported it.				
Action	**Update (as appropriate)**	**Lead**	**Target/Review Date**	**RAG Rating**
4.3. Team brief promotion of Speaking out Safely to increase staff reporting of incidents.		Workforce Equality, Diversity & Inclusion Lead	End of Nov 2019	
4.4. Incorporate statement via WorkPal and Prep to capture any reports of incidents by staff.		Head of Learning & Organisational Development	End of Dec 2019	
Indicator 5: Percentage of Disabled Staff compared to Non-Disabled Staff believing that the Trust provides equal opportunities for career progression or promotion.				
Results: • Disabled Staff: 89.9% • Non-Disabled Staff: 94.2% 4.3% more non-disabled staff believed that the Trust provides equal opportunities for career progression or promotion than disabled staff.				
Action	**Update (as appropriate)**	**Lead**	**Target/Review Date**	**RAG Rating**
5.1. Survey staff about what additional support the Trust can provide staff with disabilities to assist with career progression and/or promotion.		Head of Learning & Organisational Development	End of Jan 2020	
5.2. Hold focus groups for staff with disabilities to identify what additional resources the Trust can offer staff around		Head of Learning & Organisational	End of Jan 2020	

career progression and/or promotion.		Development		
Indicator 6: Percentage of Disabled Staff compared to Non-Disabled Staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.				
Results: • Disabled Staff: 30.3% • Non-Disabled Staff: 19.3% Disabled staff are more likely to feel pressured by their manager to return to work despite not feeling well enough to perform their duties in comparison to non-disabled staff.				
Action	**Update (as appropriate)**	**Lead**	**Target/Review Date**	**RAG Rating**
6.1. Through the Disability Staff Network ask staff about what additional support the Trust can provide staff with disabilities when they are not well enough to return to work to perform their duties.		Workforce Equality, Diversity & Inclusion Lead	End of Jan 2020	
6.2. Review the Trusts Flexible Working Policy to promote a culture of alternative working practices.		Head of HR	End of March 2020	
Indicator 7: Percentage of Disabled Staff compared to Non-Disabled Staff saying that they are satisfied with the extent to which their organisations value their work.				
Results: • Disabled Staff: 43.4% • Non-Disabled Staff: 60.1% Less than half of disabled staff that responded said that they were satisfied with the extent to which their organisations value their work in comparison with 60.1% of non-disabled staff.				
Action	**Update (as appropriate)**	**Lead**	**Target/Review Date**	**RAG Rating**
7.1. Through the Disability Staff Network ask how the Trust		Workforce	End of Jan 2020	

could make staff feel more valued for the work that they undertake.		Equality, Diversity & Inclusion Lead		
7.2. Add additional questions into WorkPal and Prep whether staff have a protected characteristic (e.g. a disability) and ask permission to record in ESR (if not previously declared) to ascertain what additional support may be required.		Head of Learning & Organisational Development	End of Jan 2020	
Indicator 8: Percentage of Disabled Staff saying their employer has made adequate adjustments to enable them to carry out their work.				
Results: • Disabled Staff: 81.5% This figure supports our status of being a Disability Confident Employer however there is still work to do in the area of making adequate adjustments to enable disabled staff to carry out their work. It should also be noted that not all disabled staff will require adjustments.				
Action	**Update (as appropriate)**	**Lead**	**Target/Review Date**	**RAG Rating**
8.1. Review reasonable adjustments process and guidance and relaunch with managers.		Head of HR	End of Jan 2020	
Indicator 9a: The staff engagement score for Disabled Staff compared to Non-Disabled Staff and the overall engagement core for the organisation.				
Results: • Disabled Staff: 7.2 • Non-Disabled Staff: 7.7 • Overall Engagement Score: 7.6 This is actually the most improved theme from 7.1 in 2014 to 7.6 in 2018 and it is best nationally for the 3rd consecutive year.				
Action	**Update (as appropriate)**	**Lead**	**Target/Review Date**	**RAG Rating**
9.1. Through the Disability Staff Network discuss what more		Workforce	End of Oct 2019	

the Trust can do to increase engagement.		Equality, Diversity & Inclusion Lead		

Indicator 9b: Has your Trust taken action to facilitate the voices of Disabled Staff in your organisation to be heard?

Results:
Yes - The Disability staff network will be further promoted at this year's AGM and HWWB days.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
9.2. Disability Staff Network to be launched in October 2019 through the AGM, HWWB Open Day, Team Brief, global emails and during National Inclusion Week. Disability Staff Survey to be sent in preparation for first network meeting.		Workforce Equality, Diversity & Inclusion Lead	End of Oct 2019	

Indicator 10: Percentage difference between the organisation's Board voting membership and it's organisation's overall workforce disaggregated

Results:

- By voting membership of the Board.
  Disabled Staff: 0%
  Non-Disabled Staff: 80%

- By Executive membership of the Board.
  Disabled Staff: 0%
  Non-Disabled Staff: 80%

20% of those on the Board with voting membership & Executive Membership have not disclosed whether they have or have not got a disability.

Action	Update (as appropriate)	Lead	Target/Review Date	RAG Rating
10.1. Trust is working towards the 'Disability Confident Leader' status. Future adverts and Job Descriptions for Board Appointments to include awareness raising.		HR Director	Ongoing	

Summary:

- The Trust will continue to promote and encourage staff to update their ESR personal information to confirm whether they have or haven't got a disability, in particular for Consultants and Bands 1 – 4 non-clinical staff e.g. to be asked at appraisals.
- Undertake further analysis to identify trends in care groups and by bands.
- HR to continue to incorporate disability status in the Employee Relations Case Tracker in preparation for next year's report (Metric 3).
- Utilise the staff network to understand how the Trust can provide equity of opportunities for disabled staff around career progression.

Ends.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)81
Title of paper: Workforce Safeguards – safe and effective staffing
Purpose: To provide assurance that the Trust is compliant with the Workforce Safeguards standards introduced by NHS Improvement from 2019/20.
Summary: In October 2018 NHS Improvement (NHSI) published the *Developing Workforce Safeguards – Supporting providers to deliver high quality care through safe and effective staffing*. The document was developed to support organisations to use best practice in effective staff deployment and workforce planning. It also setout guidance on governance issues relating to redesigning roles and responding to unplanned changes in workforce. The paper included 14 recommendations to strengthen workforce safeguards and each Trust will be assessed against these recommendations. The trust has completed a self –assessment against these recommendations and identified that for 12 of the 14 we are currently complaint but for the remaining 2 more work is required for the organisation to be fully compliant. The actions to achieve full compliance are detailed in the report
Corporate objective met or risk addressed: Provide high quality personalised care
Financial implications:
Stakeholders: Trust Board, Staff, NHSE/I, CQC, Commissioners, Patients, members of the public
Recommendation(s): The Board approves the proposals for meeting the Workforce safeguards standards
Presenting officer: Anne-Marie Stretch, Deputy CEO/Director of HR (on behalf of Sue Redfern, Director of Nursing, Midwifery and Governance)
Meeting date: 25th September 2019

1. Overview of Standards

In October 2018 NHS Improvement (NHSI) published the *Developing Workforce Safeguards – Supporting providers to deliver high quality care through safe and effective staffing* paper. The document was developed to support organisations to use best practice in effective staff deployment and workforce planning. It also setout guidance on governance issues relating to redesigning roles and responding to unplanned changes in workforce. It also described the regulatory requirement for NHS Improvement (Now NHSE/I) to assess the effectiveness of workforce safeguards annually. The paper included 14 recommendations to strengthen workforce safeguards and the NHS commitment to safe, high quality care, to help Trusts manage common workforce problems and make informed, safe and sustainable workforce decisions.

Trusts will be assessed on their compliance with the 'triangulated approach' to deciding staffing requirements described in National Quality Board's (NQB) 2016 guidance Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing.This combines evidence-based tools with professional judgement and outcomes to ensure the right staff, with the right skill are in the right place and time.

The guidance is is applicable to **all** clinical staff.

There are 14 recommendations as follows:

<table>
<tr><td>1</td><td colspan="2">Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.</td></tr>
<tr><td>2</td><td>Trusts must ensure the three components are used in their safe staffing processes:
evidence-based tools (where they exist)
professional judgement
outcomes
NHSI will check this in their yearly assessment.</td><td> 
</td></tr>
<tr><td>3</td><td colspan="2">Assessment will be based on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable.</td></tr>
<tr><td>4</td><td colspan="2">NHSI will review the annual governance statement through their usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.</td></tr>
<tr><td>5</td><td colspan="2">As part of this yearly assessment NHSI will also seek assurance through the Single Outcomes Framework (SoF), in which a provider's performance is monitored against five themes.</td></tr>
<tr><td>6</td><td colspan="2">As part of the safe staffing review, the Director of Nursing and Medical</td></tr>
</table>

	Director **must** confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.
7	Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting.
8	Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.
9	An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.
10	There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.
11	As stated in CQC's NHSI Well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.
12	Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.
13	Given day-to-day operational challenges, NHSI expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.
14	Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.

2. Trust Assessment

Although the guidance applies to all clinical staff; this paper will only outline Nursing and Midwifery's current compliance with the 14 safeguard recommendations and identify areas for improvement. It is intended that an assessment will take place for the Allied Health Professional and other clinical staff groups imminently and work will be undertaken to bring the existing systems together into one central report.

The Nursing and Human Resources teams have undertaken an assessment of the Trusts compliance against the workforce safeguards recommendations to provide this assurance statement to the Board.

This demonstrated that we are fully compliant, for the Nursing & Midwifery staff group, against 12 of the recommendations and partially complaint against the remaining 2.

The Model Hospital workforce metrics such as care hours per patient day (CHPPD) and cost per care hour (CPCH) are already used by the Trust help identify and benchmark nursing and care staff utilisation and now need to be incorporated into routine safer staffing reporting.

Metrics for other elements of the NHS workforce are being developed by Model Hospital – for example, clinical hours to contact (CHtC) and cost per contact for non-ward based settings and once in use will also be incorporated into the Trusts workforce governance processes.

No	Recommendation	Lead	Performance Update	Compliance
1	Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	Director of Nursing	There are 3 main expectations from the NQB 2016 guidance relating to safe staffing regarding the right people with the right skills are in the right place at the right time. **Safe, Effective, Caring, Responsive and Well-Led Care** **Measure and Improve** - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback - - Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing - **Expectation 1** / **Right Staff**: 1.1 evidence-based workforce planning; 1.2 professional judgement; 1.3 compare staffing with peers **Expectation 2** / **Right Skills**: 2.1 mandatory training, development and education; 2.2 working as a multi-professional team; 2.3 recruitment and retention **Expectation 3** / **Right Place and Time**: 3.1 productive working and eliminating waste; 3.2 efficient deployment and flexibility; 3.3 efficient employment and minimising agency The Executive Committee and Quality Committee receive a monthly report on Nurse staffing levels and this is reported to the Trust Board through the Quality Committee Chair's report and the Trust's Integrated Performance Report (IPR). This enables the Board to identify concerns at an early stage and develop strategies, such as the Trusts recruitment and retention strategy, to mitigate risks. Regular consideration is given to nursing establishment based on acuity and dependency data. Nurse staffing establishments	Fully Compliant

			are reviewed twice yearly taking into consideration the patient acuity and dependency data and the Care Hours Per Patient Day (CHPPD) information. Staffing numbers are flexed to meet the need of the patients, under professional advice of Director of Nursing, Human Resources and finance leads or their representative. The Allocate SafeCare system has been implemented on all inpatient wards. This is used to monitor patient dependency / acuity and Nursing skill mix in real time. Data is collected and reviewed 3 times a day and is used to review staffing levels in conjunction with the Professional Judgment model. Operationally in -patient ward staffing requirements are formally reviewed every day at a matron safer staffing meeting and discussed 3 times a day at operational bed meetings. Shelford reviews of Nurse staffing are conducted twice a year (October and March) which inform establishment reviews.The staffing levels are also reviewed as part of operational planning and budget setting for the next financial year and in March the trust Board approves a workforce plan, which details the staffing numbers needed across all disciplines and specialties to take account of expected activity levels and planned service developments The Trust undertook a Shelford review in early 2018. Implementation of the SafeCare system began in September 2018 which required a number of Shelford reviews to take place as part of the implementation process. The system was rolled out for live use in January 2019. Following a review of the utilisation of the patient acuity	

<table>
<tr><td></td><td></td><td></td><td>categories within the system disrepacies were highlighted regarding the assigning of acuity levels to patients. This was discussed with the national SafeCare team and work was undertaken to ensure the data reflected our patient base.

A further Shelford review is currently in progress and it is expected to be reported to Board in October 2019.</td><td></td></tr>
<tr><td>2</td><td>Trusts must ensure the three components are used in their safe staffing processes:
evidence-based tools (where they exist)
professional judgement
outcomes
NHSI will check this in their yearly assessment.</td><td>Director of Nursing</td><td>The following table outlines the range of methodologies and and guidelines followed in the different clinical settings:

<table><tr><th>Area</th><th>Methodology</th></tr><tr><td>Wards – adults, paediatrics, AMU and SAU</td><td>Safer Nursing Care Tool (SNCT)</td></tr><tr><td>Outpatient and Day Care Departments</td><td>Professional Judgement as no current validated tool available</td></tr><tr><td>Neonatal Unit</td><td>BAPM guidelines</td></tr><tr><td>Intensive, Coronary & High Dependency Care Units (including outreach teams)</td><td>BACCN/RCN critical care forum/ICS guidelines</td></tr><tr><td>Theatres</td><td>Association for Perioperative Practitioners (AfPP)</td></tr><tr><td>Emergency Department</td><td>BEST Activity & Acuity/dependency but as soon as SNCT released for ED this will be utilised</td></tr><tr><td>Maternity services</td><td>Birthrate+</td></tr><tr><td>Community Services</td><td>Professional Judgement as no current validated tool available. Based on case load</td></tr></table></td><td>Fully Compliant</td></tr>
</table>

			<table><tr><td>Endoscopy</td><td>JAG guidance/Professional Judgement methodology</td></tr><tr><td>Cancer services</td><td>NICE guidance</td></tr><tr><td>General Practice</td><td>Professional Judgement as no current validated tool available</td></tr></table> The Trust triangulates safe staffing fill rate with a Registered Nurse short shift report and the Nursing workforce dashboard, which monitors recruitment and turnover. NHS Improvement receive the annual operational plan and the Trust annual report. There have also been quarterly performance meetings where staffing is discussed. NHS Improvement have raised no concerns with the Trust about the level of Nurse staffing.	
3	NHSI will base their assessment on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable.	Director of Corporate Services	Annual governance statement completed and is published within the 2018/19 Annual Accounts. An external audit has taken place into our governance framework including the annual governance statement and no issues or concerns were identified. **Workforce Strategy and Workforce Safeguards** The Board has a workforce strategy with agreed objectives for ensuring that the Trust can attract and retain the right number of staff with the necessary skills to deliver high quality patient care, and who are fully engaged and offered opportunities to develop their careers within the organisation. This strategy is currently being refreshed to ensure that it aligns with the	Fully Compliant

			workforce aspirations set out in the NHS Long Term Plan. The Board approves the high level workforce plan each year as part of the annual operational planning cycle, which takes into account projected activity growth or change and agreed service developments. The Trust utilises a suite of rostering tools to roster staff, plan activities and monitor staffing in line with patient acuity on a day to day basis. Nurse safer staffing information is reported to the Trust Board in the Integrated Performance Report every month, and there are detailed workforce key indicator reports twice a year which include recruitment, vacancy and turnover information. Establishment reviews are undertaken by a multi-disciplinary team every 6 months to ensure that staffing numbers and skill mix are appropriate and these are reported to the Quality Committee. The Trust has a guardian of safe working who reports twice a year on the working hours and shift patterns of Doctors in training.	
4	NHSI will review the annual governance statement through their usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.	Director of Corporate Services	see 3 above	Fully Compliant

5	As part of this yearly assessment NHSI will also seek assurance through the SOF, in which a provider's performance is monitored against five themes. *The assessment will review more detailed metrics (where appropriate and in line with the SOF) that are collated within individual Trusts. These will be available from 'board to ward' and sourced from ESR, e-Rostering and financial systems as well as a quality dashboard reviewed by the Trust Board.*	Director of Finance	The following 5 themes are monitored at Trust Board: - Quality of Care - Finance and Use of Resources - Operational Performance - Strategic Change - Leadership and Improvement Capability Board receive the Trusts Integrated Performance Report (IPR) on a monthly basis which covers all of the above areas. The IPR is discussed at the open board meeting each month. The quality section includes Nurse safer staffing These 5 themes are also monitored at the Quaterely performance Meetings with NHSI (see point 3 above) and the Trust has for a number of years been categorised as segmentation level 2.	Fully Compliant
6	As part of the safe staffing review, the Director of Nursing and Medical Director **must** confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	Director of Nursing and Medical Director	The Trust currently undertakes Shelford reviews of staffing (see No 1) and reports monthly on Nurse safer staffing. As part of this the Trust will, moving forward, include a statement in this report confirming the Director of Nursing and Medical Director are satisfied with the outcome of the assessment arounf staffing being safe, effective and sustainable. For 2019/20 the first statement for Nursing will come to the Board in October. The Trust will, moving forward, review and amend the safer staffing report to include other units and staff groups besides inpatient wards.	Partially Compliant
7	Trusts must have an effective workforce plan that is	Director of HR	See section 3	Fully Compliant

	updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting.		The narrative operational plan for 2019/20 was approved by the March Trust Board meeting. In July 2019 the Trust Board approved a workforce strategy and received a detailed HR indicators report which included information on hard to recruit posts/specialities and the actions being taken by the Trust to improve recruitement and retention	
	Establishment setting must be done annually		Meetings currently take place between Nursing, Finance, Operations and electronic resourcing leads to undertake establishment reviews in line with Shelford reporting outcomes and budget setting timelines. This informed the workforce plan that is included in the annual operational plan and the opening budgets that are approved by the Trust Board in March each year.	
	A mid-year review of establishment should take place		Meetings currently take place between Nursing, Finance, Operations and electronic resourcing leads to review establishment in line with Shelford reporting outcomes and budget setting timelines. February / March. The mid year review of the nursing establishement is scheduled to be presented to the Trust Board in October.	
	Establishment reviews should take account of: • *patient acuity and dependency using an evidence-based tool* • *activity levels* • *seasonal variation in demand* • *service developments* • *contracts commissioning* • *service changes*		Establishment review meetings will be amended to incorporate the following: • *patient acuity and dependency using an evidence-based tool* Shelford, SafeCare, • *activity levels* Bed occupancy, patient attendances • *seasonal variation in demand* Taking a reflective review of the previous 6-12 months • *service developments / contracts commissioning / service changes* Any new services or service redesign supported by	

	• *staff supply and experience issues* • *where temporary staff have been required above the set planned establishment* • *patient and staff outcome measures* *Data should be utilised from a number of sources:* • *ESR* • *Evidence based decision support tools* • *E-Rostering system* • *E-JobPlan system* • *Financial systems* • *Model hospital (I.e. CHPPD, CHtC)*		business cases • *staff supply and experience issues* Review of recruitment activity and success also preceptorship etc for new staff to ensure they stay • *where temporary staff have been required above the set planned establishment* Temporary workforce data on bank and agency requests and filled including reasons for requests, with a regular report to the Executive Committee. • *patient and staff outcome measures* Friends and Family Test, compliants, harms, staffing shortfalls, safeguarding, rostering performance KPIs Rostering Performance is reviewed and monitored by the Senior Nurse Team on a monthly basis relating to the following Key Performance Indicators (KPIs): - Roster Approval Lead Time - Filled Duty Count - Unused Contracted Hours - Bank & Agency Usage - Annual Leave During the annual staff job planning reviews performance information is provided to senior clinicians and operational managers (we have a wider workforce than Medical & Dental that have job plans e.g. Specialist Nurses and ANPs) in order for the job planning process to be monitored efficiently and effectively. Job plans are then fed into the software for areas that utlise “activity based rostering”. It is the intention of the Trust to have rolled this out to all specialties by 31 March 2021.	

			Our baseline establishment does not include an allowance for patients who require close observation. This is met by additional duties being filled by temporary workforce which are predominantly HCAs. .	
8	Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month. *Individual Trust's are expected to collate and review data every month for a range of workforce metrics, quality and outcomes indicators and productivity measures – as a whole and not in isolation from each other. We also expect evidence of continuous improvement across all these areas. To optimise allocation of workforce resources and improve outcomes, boards should implement the NQB (2016) and Carter recommendations together*	Director of Nursing and Medical Director	The Trust utilises benchmarking data to provide assurance on its quality performance via a range of reports to the Board and its Committee's, however Model Hospital data is not reported in the IPR because of the time lag in the national data being reported Please see section 3	Partially Compliant

	with the information available from Model Hospital.			
9	An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance5 and NHS Improvement resources. This must also be linked to professional judgement and outcomes.	Director of Nursing	See section 7	Fully Compliant
10	There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	Director of Nursing	There is no manipulation of evidence-based data. Data from the system is directly reported to the Executive Team. Rostering data is provided in advance of the working period and shows the predicted staffing levels for each unit. A KPI report is sent to the Senior Nurse team highlighting the performance of each ward/team against the following Trust KPIs: - Roster Approval Lead Time Target – 56 days or more - Trust Filled Duty Count Target – 90% or more - Trust Hours Balances Target – 2% or less - Trust Bank / Agency Use Target – 10% or less	Fully Compliant

			- Trust Annual Leave Target – Between 11% and 17% SafeCare data is provided retrospectively on a monthly basis which shows the number of staff on duty against the dependency level of the patients. Safe staffing levels are also reported from the rostering system on a monthly basis where expected and actual staffing levels are compared.	
11	As stated in CQC's NHSI Well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.	Service lead/ADO	The Trust has an established QIA process that is used to review any significant service changes.	Fully Compliant
12	Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.	Service lead/ADO	QIA has been developed based on NHSI template. The Assistant Director of Workforce Development supports departments in completing a QIA for new roles being considered within the Trust. A QIA is currently being undertaken for the introduction of Nursing Associates.	Fully Compliant
13	Given day-to-day operational challenges, NHSI expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal	Director of Nursing	Daily staffing reviews are completed utilising SafeCare data to move staffing or authorise additional bank shifts, where appropriate, to maintain safe staffing. Staffing below the optimum levels is reported as an incident.	Fully Compliant

	escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.			
	An organisation must have a process or standard operating procedure (SOP) to recognise the risks and co-ordinate a response on a shift-by-shift or daily basis.		Trustwide Staffing Shortfall Escalation SOP in place in relation to Nursing.	
	A staffing safeguards SOP should provide assurance from the front line to the board that safe staffing standards are being achieved and risks to quality and safety mitigated. Within this associated thresholds need to be developed with frontline staff to inform and trigger concerns about safe staffing deployment. This includes clear escalation approach describing the steps that may be required to ensure safe staffing levels to meet every patient's needs on each shift.			
14	Should risks associated with staffing continue or increase and mitigations prove	Director of HR	Staffing risks are escalated to Board via Executive Committee via the established risk management process.	Fully Compliant

	insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.		Minutes are taken of Executive Committee and reports to Board where issues are raised and actions taken. The corporate risk register is reported to the Board 4 times and year. There is also a Board Assurance Framework which identifies staffing levels as a strategic risk for the organisation	

3. Next Steps and Timetable

The Trust will complete an assessment against these standards for the AHP and Medical & Dental staff groups by 31 October 2019.

Review of partially complete standards for Nursing & Midwifery and create action plans for improvement by 31 October 2019.

4. Assurance

We have embedded and robust systems in place for Nursing including escalation processes and as such we are fully assured.

There is further work that has been identified in order that we can be fully assured in relation to the remaining staff groups.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)82
Title of paper: A framework of quality assurance for Responsible Officers & Revalidation
Purpose: The purpose of this paper is to provide feedback and assurance to the Board that arrangements for Medical Appraisal and Revalidation are operating effectively at the Trust and in accordance with regulations.
Summary: In accordance with structured template. • General • Effective Appraisal • Recommendations to the GMC • Medical Governance • Summary & Conclusion
Corporate objectives met or risks addressed Assurance that the Trust as a designated body is adhering to the GMC revalidation & appraisal regulations
Financial implications: *None as a direct consequence of this paper.*
Stakeholders: *Staff, the Trust, patients, regulators.*
Recommendation(s): The Board are asked to accept the report and to approve the 'statement of compliance' confirming that the organisation, as a designated body, is compliant with the regulations.
Presenting officer: Dr Jacqui Bussin, Responsible Officer, on behalf of Mr Rowan Pritchard-Jones, Medical Director
Date of meeting: 25th September 2019

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of St Helens & Knowsley Teaching Hospitals NHS Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 23rd May 2019
Action from last year:
Comments:
Action for next year: to train more doctors to become medical appraisers

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:
Comments: Yes. In January 2019, the Trust appointed a new Responsible Officer, Dr Jacqueline Bussin.
Action for next year:

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year:
Comments: Yes. Funding comes from the core HR budget. The Trust has recently extended the contract for the electronic appraisal system.
Action for next year:

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year:
Comments: Yes. We have recently had a data cleanse, and are working with a number of colleagues from different teams to ensure all records are accurate and up to date.
Action for next year:

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:
Comments: Yes.
Action for next year: We are in the process of reviewing the flowchart for non-engagement. We have also commenced a Responsible Officer Advisory

Group, which will actively monitor and review policies and procedures. We have also introduced an updated Remediation Policy.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year:

Comments: No. We have internal reviews undertaken as part of the audit process by the Responsible Officer and Clinical Appraisal Lead.

Action for next year: From September 2019 we are holding regular Appraisal Support Groups, and will be looking at holding similar groups for non-appraisers.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year:

Comments: Yes. The number of 'bank' doctors within the Trust has significantly risen. The team offers support and advice when requested, and tries to ensure this group of doctors fully understand the appraisal and revalidation process. We emphasise the importance of ensuring their Designated Body and Responsible Officer details are kept up to date

Action for next year:

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:

Comments: Yes. Doctors have access to information on complaints and significant events via the Quality & Risk Department on request. Some individual specialties have access to outcome data relating to their specialty.

Action for next year: The Quality and Risk Department are looking at ways to make the process for accessing information on complaints and significant events easier for doctors.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Comments: Some Trusts provide information to doctors in relation to complaints and serious incidents and put this information into the doctor's appraisal documentation. At the present time the Trust does not have the resources to do this. It would require significant changes to the Datix incident reporting system and a time commitment from staff in the Quality & Risk Department and the Medical & Revalidation Officer. Action for next year:

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Comments: Yes. The Medical Appraisal and Revalidation policy was last updated and approved on 23rd May 2018. Action for next year:

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Comments: No. The Trust has a large number of trained medical appraisers, but following the medical management restructure in late 2018, early 2019, resulted in a number of appraisers stepping down or significantly reducing the number of doctors they appraise. We have secured 4 places for new appraiser training in October 2019 and are looking at further in-house training dates during November 2019, with a view to training 10-15 doctors as appraisers. Action for next year:

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Comments: Yes, all appraisers are required to attend appraiser refresher training every 3 years and an in-house appraiser support group annually. The Responsible Officer and Clinical Appraisal Lead attend regular regional

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

networks and audit appraisers using the NHS England Appraisal Summary PDP Audit Tool Guide.

Action for next year:

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:

Comments: The minutes taken at the ROAG meeting are shared with Workforce Council.

Action for next year:

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year:

Comments: Yes. The Responsible Officer also meets with the Trusts allocated Employer Liaison Advisor around 3 times per year, and will have an early discussion when needed regarding any potential concerns.

Action for next year:

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year:

Comments: Yes. When a positive recommendation is made to the GMC, the Responsible Officer will email the doctor to inform them of the decision. Prior to a deferral or non-engagement recommendation, the Responsible Officer will have a face to face meeting with the doctor and inform the doctor of her decision and rationale. An action plan will be agreed, which will be followed up in an email to the doctor once the recommendation has been made to the GMC. When making the appropriate recommendation, the Responsible Officer must select the reason for defer or non-engagement. The GMC will then contact the Responsible Officer for further information. The medical revalidation team keep an audit trail and log of all emails and correspondence regarding the revalidation recommendation.

Action for next year:

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:

Comments: The Trust completes the annual GMC survey and meets annually with Health Education England. We have a newly appointed Director of Medical Education and have recently begun using the GMC dashboard information. Action for next year: We need to secure a non-executive director for the ROAG and further develop lay engagement. The SIRI process is also to be reviewed.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Comments: Yes, we have effective systems in place, and if a doctor is required to reflect, we would ensure this is completed. Action for next year:

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Comments: Yes, we have a number of policies in place such as – Remediation, Handling Medical Concerns, Raising Concerns and Respect and Dignity at Work. Action for next year:

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and

outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year:

Comments: Yes, we have a new Professional Standards group, The Trust is active in completing WRES reports, and has recently appointed an Equality, Diversity and Inclusion Lead. Reports are presented to the Board for all staff around exclusion and exception figures.

Action for next year:

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year:

Comments: The Trust uses Medical Practice International Transfer (MPIT) forms, and when required, would contact the previous Responsible Officer. The Trusts Responsible Officer and Clinical Appraisal Lead regularly attend Responsible Officer regional networks. We are currently discussing the most appropriate ways to capture the doctor's whole scope of work.

Action for next year: To have a more robust process for sending and requesting MPIT forms and capturing the whole scope of work.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:

Comments:

Action for next year: The Trust will be reviewing its systems for all staff with regards to implementing a "Just Culture" and improving processes for responding to concerns as advised in the "Dido Harding Letter". In addition, the trust will be reviewing its processes regarding fitness to practice issues in response to the GMC Fair to refer Report. The Trust has recently appointed a dedicated Equality, Diversity & Inclusion Lead.

Section 5 – Employment Checks

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Comments: Yes. We have recently held a number of Responsible Officer Task and Finish group meetings, where the processes for pre-employment checks have been reviewed and a number of standard operating procedures (SOP's) have been devised to support this. The Trust adheres to the NHS Safer Recruitment Standards. Action for next year: Finalise and implement the agreed SOP's.

Section 6 – Summary of comments, and overall conclusion

The key areas for development next year in relation to appraisal and revalidation are:

- **Increasing the number of trained appraisers.**
- **Implementing an up to date robust flowchart for non-engagement in the appraisal process.**

The key areas for development next year in relation to governance are:

- **Improving information flows regarding doctors who are leaving or joining the Trust.**
- **Improving processes for responding to concerns about a doctors practice.**

The key areas for development next year in relation to Employment Checks are:

- **Implementation of updated standard operating procedures.**

Overall conclusion: The Trust can confirm they are compliant with the Responsible Officer Regulations and have identified a number of areas for development over the next year.

Section 7 – Statement of Compliance:

The Board of St Helens & Knowsley Teaching Hospitals NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of designated body [Chief Executive]

Signed: _

Official name of designated body: **St Helens & Knowsley Hospitals Trust**

Name: Anne-Marie Stretch

Role: Deputy Chief Executive

Signed: _

Date: