Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 29TH JANUARY 2020
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

AGENDA				Paper	Presenter
09:30	1.	Employee of the Month - December - January		Verbal	Chair
09:45	2.	Patient Story		Verbal	
10:05	3.	Apologies for Absence		Verbal	
	4.	Declaration of Interests		Verbal	
	5.	Minutes of the Previous Meeting held on 27th November 2019		Attached	
		5.1	Correct Record & Matters Arising	Verbal	
		5.2	Action Log	Attached	
Performance Reports					
10:15	6.	Integrated Performance Report		NHST(20) 1	Rob Cooper
		6.1	Quality Indicators		Sue Redfern
		6.2	Operational Indicators		Rob Cooper
		6.3	Financial Indicators		Rob Cooper
		6.4	Workforce Indicators		Anne-Marie Stretch
Committee Assurance Reports					
10:35	7.	Committee Report – Executive		NHST(20) 2	Ann Marr OBE
10:45	8.	Committee Report – Quality		NHST(20) 3	Gill Brown
10:55	9.	Committee Report – Finance & Performance		NHST(20) 4	Jeff Kozer
BREAK					

AGENDA			Paper	Presenter
Other Board Reports				
11:10	10.	Strategic & Regulatory Report	NHST(20) 5	Nicola Bunce
11:20	11.	Corporate Risk Register	NHST(20) 6	Nicola Bunce
11.30	12.	Board Assurance Framework	NHST(20) 7	Nicola Bunce
11:40	13.	Aggregated Complaints, Claims & Incidents Report	NHST(20) 8	Sue Redfern
11:50	14.	Learning from Deaths Quarterly Report	NHST(20) 9	Rowan Pritchard-Jones *(Elspeth Worthington in attendance)*
12:00	15.	Workforce Strategy & HR Indicators Report	NHST(20) 10	Anne-Marie Stretch
12.10	16.	Annual Safeguarding Report (Adults & Children)	NHST(20) 11	Sue Redfern
Closing Business				
12:20	17.	Effectiveness of Meeting	Verbal	Chair
	18.	Any Other Business		
	19.	Date of Next Meeting – Wednesday 26th February 2020		

Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Board meeting held on Wednesday 27th November 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
	Mrs V Davies	(VD)	Non-Executive Director
	Mr J Kozer	(JK)	Non-Executive Director
	Mr P Growney	(PG)	Non-Executive Director
	Mr I Clayton	(IC)	Non-Executive Director
	Mrs G Brown	(GB)	Associate Non-Executive Director
	Ms L Knight	(LK)	Associate Non-Executive Director
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Mrs S Redfern	(SR)	Director of Nursing, Midwifery & Governance
	Mr N Khashu	(NK)	Director of Finance
	Mr R Pritchard-Jones	(RPJ)	Medical Director
	Mrs C Walters	(CW)	Director of Informatics
	Mr R Cooper	(RC)	Director of Operations & Performance
	Dr T Hemming	(TH)	Director of Transformation
	Ms N Bunce	(NB)	Director of Corporate Services
In Attendance:	Mr M Weights	(MW)	Lay Governing Body Member, St Helens CCG *(co-opted member)*
	Cllr A Lowe	(AL)	Halton Borough Council *(co-opted member)*
	Ms S Monk	(SM)	Buyer Team Leader, STHK *(Observer)*
	Mr K Madden	(KM)	Finance Management Trainee, STHK *(Observer)*
	Ms J Stark	(JS)	Associate Director of Operations, Southport & Ormskirk Hospitals NHS Trust *(Observer)*
	Ms S Whelan	(SW)	Patient Experience Manager *(for Patient Story only)*
	Mrs S Owen	(SO)	Team Leader & Physiotherapist *(for Patient Story only)*
	Ms C Checksfield	(CC)	Physiotherapist *(for Patient Story only)*
	Ms L Williams	(LW)	Therapy Operational Manager *(for Patient Story only)*
	Dr Peter Williams	(PW)	Deputy Medical Director *(for NHST(19)105 7-Day Services Board Assurance item only)*
	Ms J Byrne		Executive Assistant *(Minute Taker)*

1. Employee of the Month

1.1. The Employee of the Month Award for October 2019 was presented to Ms Emma Langan, Diabetes Dietitian.

2. Patient Story

2.1. SW, SO and CC presented the story of SP who had undergone shoulder repair surgery at the Trust. Although SP's initial operation was postponed (due to SP's low iron levels), he attended the shoulder school which provided bespoke exercises and identified post-operative equipment/other needs, plus access to educational videos on

YouTube. Access to the latter had been essential for SP, as he worked overseas and was not always available to physically attend the school. SP had regained full movement and strength in his shoulder and had been able to return to work.

2.2. SO stated the shoulder school project had shown a positive impact on length of stay of patients and believed it empowered and motivated patients to take control of their own health. The team hoped to expand their range of electronic educational material and link in with fracture clinics and create more electronic patient support materials and a digital platform for patients preparing for and recovering from surgery. CW offered the support of her team to take forward this initiative.

2.3. RF commented that he was very proud of the therapy staff for how they were innovating to empower patients and improve outcomes and asked SW to pass on the Board's thanks to SP for allowing the team to use his story.

3. Apologies for Absence

Apologies were noted as above.

4. Declaration of Interests

4.1. None.

5. Minutes of the previous meeting held on 30th October 2019

5.1. Correct Record

5.1.1. The minutes were accepted as a correct record, once GB's declaration was amended to state her appointment as a lay member of Southport & Formby CCG had ended on 31st rather than 30th October 2019.

5.2. Action List

5.2.1. Action 22, Meeting Date 30.10.19 (Minute 15.3) – Workforce Safeguards Assurance Statement sign off query – SR confirmed that she had raised this with NHSE/I. **ACTION CLOSED**.

5.2.2. Action 23, Meeting Date 30.10.19 (Minute 17.6) – Amendments to the 2018/19 Infection Prevention Annual Report – SR confirmed the changes had been made. **ACTION CLOSED**.

6. Integrated Performance Report (IPR) – NHST(19)95

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

6.2. Quality Indicators

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

6.2.2. There had been no never events in October and none year to date.

6.2.3. There had been no MRSA reported in October and none year to date. SR reported that there had however, been a positive sample for MRSA detected in November, and the Route Cause Analysis (RCA) investigation was being undertaken.

6.2.4. There were 7 C.Diff positive cases reported in October 2019 (4 hospital onset and 3 community onset). Year to date there had been 32 cases (26 hospital onset and 6 community onset), although 7 cases were in the process of being appealed and a further 2 had been identified for appeal.

6.2.5. The annual tolerance for the Trust was 48. SR reported that the Trust was still awaiting a response to its challenge to NHSE/I in relation to the appropriateness of the annual tolerance figure, but that many other Trusts had also challenged this and the methodology was now being reviewed nationally. The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for October 2019 was 94.1% and year to date performance was 96.4%.

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

6.2.7. There were 2 falls resulting in severe harm year in October (Wards 1B and 4A) and 7 in the year to date.

6.2.8. Venous thromboembolism (VTE) assessment performance for September was 95.11%. Year to date performance was 95.23% against a target of 95%.

6.2.9. The latest report HSMR (April – June 2019) was 104.5.

6.2.10. SR reported there had been 2 mixed sex accommodation (MSA) breaches in ITU in October due to delays in stepping down level 1 patients due to the availability of suitable ward beds and a contract penalty would be incurred. SR confirmed the escalation process had been reviewed to minimise the likelihood of reoccurrence.

6.3. **Operational Indicators**

6.3.1. RC presented the update on the operational performance.

6.3.2. The 62-day cancer standard was achieved overall in September at 86.2% against the target of 85%.

6.3.3. The 31-day cancer target was achieved with 99.4% performance against a target of 96%.

6.3.4. The 2-week rule cancer target was not achieved with 87.8% in month against the target of 93%. The Trust had seen incremental improvement and one of the worse hit areas, Breast Cancer, was showing improvement so far in November.

6.3.5. With reference to the anomalous figure for Head and Neck cancer, AM explained it was a very complicated pathway and confirmed discussions were still ongoing with the Professor of Head and Neck Surgery at Aintree

Hospital to improve the pathway for all referring hospitals to the specialist centre.

6.3.6. A&E access time performance was 74.3% (type 1). The all types mapped footprint performance for September was 86.0%. The Trust received 10,627 Type 1 attendances in October 2019 (the highest on record) and year to date there had been growth of 6.3% compared to 2018/19. The Trust was also now seeing high attendance levels throughout the week, rather than the traditional peak on Mondays. The rest of the Trust was supporting ED in terms of moving patients that needed to be admitted however there was constantly increasing and unrelenting pressure on services. The work streams designed to increase performance against the 4 hour standard, continued to focus on driving forward the required improvement and initiatives such as "home for lunch" made a big difference in freeing up beds earlier in the day.

6.3.7. Ambulance notification to handover time was not achieved in October 2019 with 18.27 mins/seconds on average, against a target of 15 minutes. There were 2,928 ambulance conveyances in October, an increase of 4.5% on the previous month (second highest for all EDs in Cheshire and Merseyside).

6.3.8. The average number of Super Stranded patients (patients with a length of stay of greater than 21 days) during October was 119 compared with 121 in September, which was equated to a 23% reduction. All CCG and local authority partners were actively engaged in the achievement of the reduction in super stranded patients. However, AM concluded that there was a lack of capacity across the system, with an urgent need for more beds either in hospitals or in the community/care home sector. She therefore felt that the Boards recent decision to invest in two modular wards at Whiston Hospital was the right one, and she continued to challenge other system partners, via the A&E Delivery Board to take action to commission more beds, particularly specialist EMI beds. The Board discussed the transformation plans for community and Urgent Treatment Centre services in St Helens, as the Trust gained direct managerial control of these services over the coming months.

6.3.9. PG asked whether there was any analysis of the people who came to A&E who could have gone to an Urgent Treatment Centre (UTC). RC confirmed this data was scrutinised regularly in Finance & Performance Committee meetings and JK reported that a recent survey of patients in the department had been undertaken, which showed that difficulty in getting a GP appointment and uncertainty about the services offered at UTCs were significant reasons for people choosing to come to A&E for even quite minor ailments.

6.3.10. PG wondered whether there were any Public Health campaigns around alternatives to A&E. RC observed that there was a national campaign every winter but this seemed to have little effect on patient behaviours, however he was hopeful that being able to offer patients a follow up appointment slot in the UTC or with a GP as was planned in St Helens, might start to change people's perceptions.

6.3.11. NK asked whether there were concerns about patient safety in A&E on the busiest days. RC acknowledged it was challenging when patients were

waiting in corridors, however senior nurses were on duty in conjunction with NWAS and the medical staff and the intentional rounding tool was used and additional staff deployed to monitor patients, which meant that patients remained appropriately monitored and treated and were safe.

6.3.12. The Trust Board expressed its appreciation for all the staff working so hard across the hospital to maintain high standards of care in these challenging situations. RC confirmed staff received the messages of support from the Board and did feel supported.

6.3.13. The 18 week referral to treatment target (RTT) was achieved in October with 92.3% against a target of 92%. There were no 52% week waiters. The 6-week diagnostic target was fully achieved in October with 100% compliance (YTD compliance 99.6%) against a target of 99%.

6.4. Financial Indicators

6.4.1. NK presented the update on the financial performance.

6.4.2. At the end of month 7 (October), the Trust reported a deficit of £1.6m which was in line with agreed plans and assumed full achievement of this year's Provider Sustainability Fund (PSF) funding.

6.4.3. To achieve the year to date position the Trust had utilised c£2.4m of non-recurrent resources and was forecasting to have a surplus of £3.9m including PSF.

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

6.4.5. Agency expenditure at month 7 was £4.5m which was £0.2m under the planned trajectory. LK asked why there was an agency underspend. NK explained it was not a budget but a ceiling set by NHSE/I and work had been done over the previous 3 years in relation to increasing the staff employed on the Trust's own bank. There had also been work undertaken across Cheshire and Merseyside to agree a 'rate card' which everyone would comply with. The Trust had also been successful at recruiting additional substantive staff.

6.4.6. NK also reported on the work that was being undertaken as a health system with the CCGs to develop financial recovery plans. Proposals were being discussed with St Helens in particular, which involved further transformation of the way services are delivered which would work towards financial recovery over a number of years. MW stated that St Helens CCG was very supportive of this approach.

6.4.7. The Trust continued to deliver above the year-to-date CIP target with £7.8m delivered and £15.4m transacted year to date against a plan of £16.1m.

6.4.8. DM congratulated the Trust on its CIP delivery over the last few years. NK attributed the achievement to the ownership of the challenges by all departments across the Trust.

6.5. **Workforce Indicators**

6.5.1. AMS presented the update on the workforce indicators.

6.5.2. Absence in October increased to 5.3%, against the Q3 target of 4.72%.

6.5.3. Qualified nursing and HCA sickness was 6.0% for October, which was a 0.4% reduction from September. All qualified nursing and midwifery sickness had significantly reduced by 0.9% to 4.7%.

6.5.4. Mandatory training compliance for the core skills framework subjects was 81.9% (target = 85%). Appraisal compliance was 80.9% (target 85%).

6.5.5. Further to a recent QWR, VD was aware there was a delay in referred staff being seen by Health Work and Wellbeing due to capacity and wondered whether there was a possibility of recruiting more staff. AMS acknowledged that the service was currently experiencing capacity issues which reflected the national shortages, but there was an action plan in place which included a review of how staff were signposted to access the support they needed.

6.5.6. NK added the Trust also provide telephone facilities and would discuss this further with AMS to ensure it was promoted properly.

6.5.7. In response to DM's query relating to the Trust's plans for its staff over winter, AMS confirmed the Trust had a good attendance management policy in place. NK felt it was also important for staff to be encouraged to take leave a regular intervals so they did not get "burnt out", but recognised the challenges over winter.

7. Committee Report – Executive – NHST(19)96

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

7.2. The Executive Committee approved a revised Extra and Additional Activity Payments Policy, a midwifery and midwifery support worker staffing business case, a shadow board development programme, winter flu campaign resources and a Safeguarding staff business case.

7.3. There were updates on developments in the pay dispute between UNISON and Medirest. The Committee received regular assurance reports covering; the Risk Management Council and Corporate Risk Register, the Board Assurance Framework, safer staffing and the integrated performance report. There were also progress reports for a number of key organisational objectives.

7.4. In relation to the cancer patient experience survey, IC asked whether there was any correlation between patient satisfaction and waiting time performance across the different tumour sites.

7.5. AM observed the survey covered the whole patient journey including their experiences of primary and tertiary care, but did not distinguish between the tumour sites they were receiving treatment for. It was the case that there was a significant variation in the tumour site pathways, and a lot of work had been undertaken by the Cheshire and Merseyside Cancer Alliance to improve the standardisation of complex pathways and to improve performance.

7.6. VD commented that she was pleased that business cases to support the quality of care continued to be approved by the Executive Committee, even when there were no financial benefits.

7.7. The Board noted the report.

8. Committee Report – Quality – NHST(19)97

8.1. VD presented the Chair's report to the Board, which summarised key issues arising from the Quality Committee meeting held on 19th November and reports from the Patient Safety, Patient Experience, Workforce and Clinical Effectiveness Councils.

8.2. The Committee had asked for a review of the fast track discharge process, and RC had provided an update on the work being undertaken and clarity on the definitions for different groups of patients e.g. end of life patients who required rapid enhanced discharge to their preferred place of death. This review was on going and would continue to be monitored by the Quality Committee.

8.3. ILS/BLS training compliance was improving and the RQI cart was proving successful in making resuscitation training more accessible to ward staff.

8.4. Committee had noted a reduction in the rate of fall per 1000 bed days, as a result of the falls prevention action plan.

8.5. The Patient Experience Council had approved a Learning Disability and Autism Strategy and new guidance for the support of carers. New national guidance on mixed sex breaches had been issued and was being reviewed and then the Trust policy would be updated.

8.6. A detailed report on the actions being taken to manage the increased incidence of C-Diff had been made to the Committee, to provide assurance that the Trust was responding appropriately.

8.7. The Committee had asked for a review of the effectiveness of the Clinical Effectiveness Council following a concern about attendance at recent meetings.

8.8. The results of the Maternity Inpatient Survey had been reviewed and a significant improvement had been noted, for which the Maternity service staff had been congratulated.

8.9. Committee had also received reports from the FTSU Guardian and an update on the Improving People Practices action plan.

8.10. Board members noted the report.

9. Committee Report – Finance & Performance – NHST(19)98

9.1. JK presented the Chair's report to the Board, which summarised key issues arising from the Finance & Performance Committee meeting held on 21st November.

9.2. St Helens CCG had decided to amend their forecast outturn position at month 9. The Trust was working with them to mitigate some of the risks within this revised forecast.

9.3. The publication of national planning guidance for 2020/21 was now expected in January as a result of the General Election.

9.4. Assurance reports had been received from Procurement Steering Council and CIP Council.

9.5. As requested by the Board, the Committee had reviewed the income assumptions for the modular wards business case. The Committee had felt assured by methodology and the assumptions used.

9.6. The Committee had reviewed the monthly presentation from the ADO and CD for Emergency Department activity and performance.

9.7. The Committee noted the £15.4m of CIP plans which have already been transacted for 2019/20 and a list of potential schemes for 2020/21 to the value of £16.5m had already been identified thanks to the engagement of staff across the Trust. DM commented that this organisational ownership of the CIP was impressive as in many organisations CIPs were regarded as cuts rather than opportunities for efficiency improvement.

9.8. The Committee had received an update on the management of the Lead Employer contracts. The financial and cash flow aspects of the contracts were discussed and the Committee was assured that costs were being controlled within the margins expected.

9.9. Board members noted the report.

10. Strategic and Regulatory Report – NHST(19)99

10.1. NB provided an update on key policy and regulatory developments during the period to assure Board members that the Trust continued 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.

10.2. Guidance had been published for NHS organisations regarding the General Election – the NHS was subject to the usual 'purdah' restrictions that were put in place before any general or local elections. The restrictions applied from 6th November until 13th December when the election results would be known and a new government formed.

10.3. CQC had published its annual report in October 2019 summarising the findings of the 32,000 inspections that had been undertaken up to 31st July 2019.

10.4. NHSE/I published their proposals for changes to the national tariffs for 2020/21 and these would be subject to a formal consultation period in December (following the general election). The delay in finalising the tariffs would impact on the financial planning assumptions for the next financial year and possibly the timetable for developing and approving the 2020/21 operational and financial plans.

10.5. Board members noted the report.

11. Mid-Year Review of Trust Objectives – NHST(19)100

11.1. AM presented the mid-year progress review against the 2019/20 Trust objectives, together with an assessment of the likely delivery by the end of the financial year.

11.2. The ratings showed that of the 31 objectives, 22 were rated green (71%), 9 were rated amber (29%) and no objectives were red, which was a relatively positive position for half was through the year.

11.3. The 9 amber objectives were discussed further.

11.4. In relation to the objective (1.4) it was noted that the wording was to be reviewed as the Trust could not control the number of claims it received, but could influence how it responded and learnt lessons when things went wrong. Awareness of the outcomes of claims needed to be further increased and it was suggested that they should be discussed at the CD forum and at Quality Ward Rounds in future.

11.5. Board members referred to discussions earlier in the meeting and noted some progress had been made against objective 3.2, although the transformation work would continue as the urgent treatment centres and new community services were embedded into the Trust over the next few months. VD asked how it would be possible to measure how many patients had been deflected from ED, and RC felt that a proxy might be if the UTC was operating at full capacity and reduced the number of patients they referred onto ED (which were not clinically necessary) and also the number of district nurse contacts and treatment room appointments.

11.6. In relation to 'Objective 4.1 improve information for patients, so it is available at the right time and in the right format to meet individual needs', it was noted SR would be visiting other Trusts where good practice was being demonstrated and who consistently achieved higher ratings in patient surveys for this metric.

11.7. NK requested an amendment be made to the Progress and RAG Rating October 2019 column under Objective 8.1, which should read "Procurement league ranking is 7th in the country and best in *Cheshire & Merseyside*", rather than the best in the North West. **ACTION: NB.**

11.8. Board members noted the progress that had been made in delivering the Trust's annual objectives.

12. Workforce Strategy Progress Report– NHST(19)101

12.1. AMS updated Board members on progress to date against the Workforce Strategy action plan and members noted progress was being made in all areas.

12.2. VD had heard a view expressed at a recent QWR that the e-learning system was not 'user-friendly' and it would be helpful for staff to have a dedicated area with access to computers where they could train away from the clinical environment. For staff based at Whiston Hospital, it was noted that such facilities were already available in the Library in Nightingale House. AMS informed members that the practicalities of converting some space in the restaurants at both Whiston and St Helens Hospitals were also currently being considered.

12.3. AMS noted that the Trust workforce strategy will be reviewed and updated once the final NHS People Plan is published. This is now expected to be January 2020.

12.4. Board members noted the report and agreed that the next progress report should be presented in April 2020.

13. Research & Development Annual Report and Capability Statement – NHST(19)102 and NHST(19)102a

13.1. RPJ presented the annual report which provided an update on the progress and performance of research and innovation within the Trust during 2018/19 and the capability statement for the coming 12 months.

13.2. RPJ confirmed 2018/19 had been a successful year for the team, and he was happy to present the Capability Statement assuring Board members that the R&D team could continue to deliver the Trust research-related responsibilities.

13.3. GB felt it had been a very successful year in terms of research, but also recognised the effort and commitment by everyone involved in research at the Trust to achieve these results, in a very challenging research environment.

13.4. Board members approved the annual report and capability statement.

14. Biennial Review of the NHS Constitution Compliance – NHST(19)103

14.1. NB presented the report to provide Board members with assurance on the Trust's compliance with the patient, and staff rights contained within the NHS Constitution.

14.2. VD queried whether no 4.3 relating to consent for treatment needed to be elaborated in light of the ongoing issue with DoLs; she was aware the Trust had a process but was concerned there was a standard the Trust should achieve. AM confirmed the Trust had recognised this and strengthened the Safeguarding team as a result.

14.3. The report was noted the report.

15. Trust Board Meeting Arrangements for 2020/21 – NHST(19)104

15.1. NB presented proposals for the Board meeting arrangements for the forthcoming year, including meeting dates and the work programme.

15.2. The proposals were approved.

16. 7-Day Services Board Assurance Report – NHST(19)105

16.1. PW joined the meeting and updated Board members on performance against the 7-day services priority standards as defined by NHSE.

16.2. The most recent audit in September 2019 had shown that 78% of the Consultant reviews on weekdays and 90% at weekends occurred within 14 hours of admission to hospital, which was an improvement compared to the Spring 2019 audit.

16.3. The audit also demonstrated that CS8 (daily consultant review) was met on both weekdays and weekends for the first time due to an improvement in weekend performance.

16.4. Board members noted the report and approved the submission to NHSE.

16.5. PW left the meeting.

17. Effectiveness of Meeting

17.1. RF asked for observations of the meeting.

17.2. SM explained the meeting had exceeded her expectations; the emotion shown by both the winner and manager during the Employee of the Month award presentation had made her feel proud to work for the Trust.

17.3. KM confirmed he had previously shadowed the therapy team and he had witnessed how they had taken efficiency savings into account. He believed this was a Trust culture that cascaded from the Board as staff knew it was a priority.

17.4. JS believed the Board papers were clear and concise and gave the reader a good understanding and led to a good discussion. She observed there was a golden thread that was palpable throughout the meeting of valuing the staff and care for patients. She witnessed cohesion as a team and noted the Director of Finance had asked about patient safety.

18. Any Other Business

18.1. TH reported that the Trust had been awarded the MOD Employers' Recognition Scheme Gold Award for its work with veterans/the Armed Forces.

18.2. Dame Jo Williams the Chair of Alder Hey Children's Hospital had visited the Trust to gain some insight into its CQC 'Outstanding' rating. She had walked round the hospital and met a number of staff and had been impressed by the teamwork she had witnessed.

18.3. RF had attended a Chairs' meeting at NHS Providers where the Chief Executive, Chris Hopson had spoken.

19. Date of Next Meeting

19.1. The next meeting will be held on Wednesday 29th January 2020 at 09:30 hrs in the Boardroom, Level 5, Whiston Hospital, L35 5DR.

Chairman: ……………………………………………………………………………

29th January 2020

Date: ……………………………………………………………………………

TRUST PUBLIC BOARD ACTION LOG – 29TH JANUARY 2020

No	Date of Meeting (Minute)	Action	Lead	Date Due
6	31.07.19 (13.6)	AMS to report HR KPIs against BAME characteristics in the next HR indicators report. **ON AGENDA**	AMS	29.01.20
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. **SCHEDULED FOR JANUARY 2020.** Board Time Out now being arranged for March.	AMS	29.01.20
18	30.10.19 (12.6)	NB to provide summary text explaining the risk information in the tables, in particular the table at the top of page 3 of the Corporate Risk Register. **ON AGENDA**	NB	20.01.20
19	30.10.19 (13.3)	NK to add reference to the cash risk to 'Risk 2: failure to develop or deliver long term financial sustainability plans for the Trust and with system partners'. **ON AGENDA**	NK	20.01.20
20	30.10.19 (14.7)	SRe to work with LK/GB to contextualise complaints information to provide greater clarity for Board members.	SRe/LK/GB	27.05.20
21	30.10.19 (15.3)	Layout of the quarterly Learning from Deaths Report to be improved and themes incorporated. **ON AGENDA**	RPJ/SRe	20.01.20
~~22~~	~~30.10.19 (16.5)~~	~~Workforce Safeguards Assurance Statement - SRe to feedback to NHSE/I that the Trust Board is unitary and wants to approve the statement that they were satisfied with the outcome, rather than RPJ/SRe.~~ **COMPLETED AND RETURNED. ACTION CLOSED.**	~~SRe~~	~~27.11.19~~
~~23~~	~~30.10.19 (17.6)~~	~~The dates in section 10.5 (p22) of the Infection Prevention Annual Report to be updated for 2018/19 rather than 2017/18~~. **DONE. ACTION CLOSED.**	~~SRe~~	~~27.11.19~~
~~25~~	~~27.11.19 (11.8)~~	~~Trust Objective 8.1 to be amended. Progress and RAG Rating October 2019 column should read "Procurement league ranking is 7th in the country and best in Cheshire & Merseyside", rather than North West~~. **DONE. ACTION CLOSED.**	~~NB~~	~~29.01.20~~
~~26~~	~~27.11.19 (12.2)~~	~~Execs to further consider whether a dedicated learning area is required to assist with e-learning.~~ **SCHEME IN DEVELOPMENT. ACTION CLOSED.**	~~Execs~~	~~29.01.20~~

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(20)001
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

St Helens and Knowsley Hospitals Teaching Hospitals ("The Trust") has in place effective arrangements for the purpose of maintaining and continually improving the quality of healthcare provided to its patients.

The Trust has an unconditional CQC registration which means that overall its services are considered of a good standard and that its position against national targets and standards is relatively strong.

The Trust has in place a financial plan that will enable the key fundamentals of clinical quality, good patient experience and the delivery of national and local standards and targets to be achieved. The Trust continues to work with its main commissioners to ensure there is a robust whole systems winter plan and delivery of national and local performance standards whilst ensuring affordability across the whole health economy.

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

Patient Safety, Patient Experience and Clinical Effectiveness

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

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

There were no cases of MRSA in December 2019. There has been 1 MRSA positive blood sample YTD (target = 0). The RCA indicated this was a contaminant and patient did not come to harm.

There were 4 C.Difficile (CDI) positive cases reported in December 2019 (1 hospital onset and 3 community onset). YTD there have been 34 cases (26 hospital onset and 8 community onset). The annual tolerance for CDI for 2019-20 is 48. The new guidance now requires us to include hospital onset and any community cases that have been discharged from hospital in the previous 28 days.

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for December 2019 was 95.5%. YTD rate is 96.3%.

There was 1 grade 3 avoidable pressure ulcer in November 2019. (YTD = 1).

During the month of November 2019 there were no falls resulting in severe harm. (YTD Severe harm fall = 7)

Performance for VTE assessment for November 2019 was 95.90% against a target of 95%. (YTD = 95.50%)

YTD HSMR (April -July) for 2019-20 is 109.5

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 19/20 financial outturn will have implications for the finances of the Trust
Stakeholders: Trust Board, Finance Committee , Commissioners, CQC, TDA, patients.
Recommendation: To note performance for assurance
Presenting Officer: N Khashu
Date of Meeting: 29th January 2020

Operational Performance
Performance against the 62 day cancer standard was above the target of 85.0% in month (November 2019) at 88.9%. YTD 86.4%. The 31 day target was achieved with 99.0% performance in month and YTD 97.3% against a target of 96%. The 2 week rule target was achieved with 94.4% in month and 89.4% YTD against a target of 93.0%.

Accident and Emergency Type 1 performance for December 2019 was 65.0%% and YTD 70.2%. The all type mapped STHK Trust footprint performance was 78.2% in month and 83.8% YTD**.** The Trust received 10,171 Type 1 attendances in December 2019. Year to date growth in ED attendances is 6.4% up on 2018/19. The work streams, designed to increase performance against the 4 hour standard, continue to focus on driving forward the required improvement. **Please Note: The A&E mapped performance has historically included attendances mapped from the Huyton Walk-In Centre (WIC). From 1st December 2019, only departments classed as Urgent Treatment Centres (UTC) will continue to be included in the mapped position. Huyton WIC is not designated as a UTC so these attendances will no longer be included in the mapped position.**

Ambulance notification to handover time was not achieved in December 2019 with 31 mins and 4 seconds on average (target 15 mins). There were 2,940 ambulance conveyances in December . NB: ***STHK had the highest number of ambulance conveyances in Cheshire and Merseyside and Greater Manchester in November .***

The Trust has been set a 40% reduction target in the number of super stranded patients (length of stay 21day+) by year end 2019/20. Working from the baseline figure of 154, a 40% reduction would equate to 92 patients. The average number in December was 131 which equates to 20% reduction (120 was the average in November). Medical and Surgical clinical /managerial teams and all CCG and local authority partners are actively engaged in the achievement of the reduction in super stranded. Progress and actions to address are monitored daily.

The 18 week referral to treatment target (RTT) was achieved in December 2019 with 92.5% compliance and YTD 92.5% (Target 92%). There were no 52+ week waiters. The 6 week diagnostic target was fully achieved in December with 100% compliance and YTD compliance 99.6% (Target 99%).

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

Surplus/Deficit - At the end of month 9 StHK has reported a deficit of £1.3m which is in line with agreed plans and assumes full achievement of PSF funding. The Trust has utilised c£4.1m of non-recurrent options to achieve the reported deficit.

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

The annual target for agency is £7.6m which is an increase of £0.3m on 2018/19. Agency expenditure has continued to increase and now exceeds the YTD trajectory by £0.1m.

The Trusts CIP target in year is £16.1m, the Trust has full plans that deliver this target recurrently. The Trust continues to identify schemes which will support the delivery of 20/21 CIP programme. The Trust has been notified by regulators that they will be supporting all health systems on the delivery of CIP in the coming financial year.

Human Resources
December sickness was 5.7%, a 0.4% increase on November, 0.98% higher than Q3 target of 4.72%. Qualified & HCA sickness has increased from 5.7% to 6% which remains above YTD position by 0.1% but is 0.1% lower than the 2018-19 position. All qualified Nursing & Midwifery sickness has reduced to 3.9% , a 1.7% reduction since September 2019. It is 0.82% below Q3 target. Mandatory Training compliance is 83.0% (target = 85%). Appraisal compliance is 80.4%

The following key applies to the Integrated Performance Report:

▲ = 2019-20 Contract Indicator

▲£ = 2019-20 Contract Indicator with financial penalty

● = 2019-20 CQUIN indicator

T = Trust internal target

UOR = Use of Resources

Dec-19

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 32-38)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Dec-19	2.9%	2.3%	No Target	2.2%		HSMR data for July is only released from the national toolkit at the beginning of January. Further details on the HSMR mortality will be reported at the January committee meetings.	Patient Safety and Clinical Effectiveness	The Board commissioned external review of Winter HSMR has been completed. Documentation of comorbidities is still below expected (which artificially increases HSMR) - action to improve electronic capture of comorbidities started in Oct-19.	RPJ
Mortality: SHMI (Information Centre)	Q	▲	Jun-19	1.05		1.00						
Mortality: HSMR (HED)	Q	▲	Jul-19	125.5	109.5	100.0	101.1					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Jul-19	134.1	107.2	100.0	106.9					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Jun-19	95.3	98.0	100.0	98.3		The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	The Trust continues to work internally and with healthcare partners to minimise unnecessary readmissions.	RPJ
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Jul-19	89.5	92.6	100.0	90.4		Sustained reductions in NEL LOS are assurance that Trust patient flow practices continue to successfully embed.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties. This includes robust management of delayed patients and scrutiny of superstranded patients.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Jul-19	99.2	100.6	100.0	111.5					
% Medical Outliers	F&P	T	Dec-19	2.7%	0.7%	1.0%	0.5%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in LoS, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Dec-19	38.7%	39.3%	52.5%	45.7%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. Targeted senior manager support to ensure patients are listed and transferred out of ICU in a timely manner	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Nov-19	73.1%	72.1%	90.0%	71.3%		For IP discharge summaries: An interim Discharge Notification has been developed and will be reviewed at the next CQPG meeting in January. This summary will be sent within 24 hours. Thereafter a full discharge summary will be sent within 14 days. For OP attendance letters the data which feeds the calculation has been updated with further data cleansing in progress. For ED discharge summaries the NHS Number issue was resolved on 10th October and is now above the target. ED have schedule a meeting at the end of Jan to discuss how we get back to 100% ensuring all discharge clinicians complete a summary.		IP Interim discharge summary will be discussed at the next CQPG meeting in January. ED have schedule a meeting at the end of Jan to discuss how we get back to 100% ensuring all discharge clinicians complete a summary.	RPJ
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Nov-19	91.6%	85.5%	95.0%	85.0%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Nov-19	97.5%	94.1%	95.0%	96.3%					

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Oct-19	90.6%	89.2%	83.0%	85.7%		Target is being achieved YTD. With effect from April 2017, STHK is also treating patients from the Warrington Area.	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Continued achievement.	RC
PATIENT SAFETY (appendices pages 40-43)												
Number of never events	Q	▲ £	Dec-19	0	0	0	1		No never events reported YTD	Quality and patient safety	Safer surgery actions and checks in place to minimise the likelihood of never events.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Dec-19	99.3%	98.8%	98.9%	99.1%		Achieving standard YTD	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	Dec-19	0	0	0	0		The trust continues to have no inpatient prescribing errors which cause serious harm. Trust has moved from being a historic low reporter of prescribing errors to a higher reporter - which is good.	Quality and patient safety	Intensive work on-going to reduce medication errors and maintain no serious harm. This is supported by EPMA.	RPJ
Number of hospital acquired MRSA	Q F&P	▲ £	Dec-19	0	1	0	1		There has been 1 MRSA positive blood sample in November 2019 (target = 0). The RCA indicated this was a contaminant and patient did not come to harm. YTD there have been 49 postive C Diff samples, of which 15 cases have been successfully appealed. Internal RCAs on-going with more recent cases of C. Difficile.	Quality and patient safety	The objective (i.e. target) for cases of CDI set for our Trust in 2019-20 by NHS Improvement (NHSI) is no more than 48 cases. From April 2019 onwards, the Trust's objective will include community onset healthcare associated: cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks. All CDI cases are subject to an Exec RCA review	SR
Number of hospital onset and community onset C Diff	Q F&P	▲ £	Dec-19	4	34	48						
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Dec-19	2	24	No Target	31					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Nov-19	1	1	No Contract target	0		One 3 avoidable pressure ulcer reported in November 2019	Quality and patient safety	The incident is currently undergoing an RCA process and will be evaluated for any missed opportunities or lapse in case. If the incident is classified as unavoidable by the panel, the KPI will be amended.	SR
Number of falls resulting in severe harm or death	Q	▲	Nov-19	0	7	No Contract target	18		No severe harm or above category falls	Quality and patient safety	Falls reduction and improvement work in all areas being undertaken.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲ £	Nov-19	95.90%	95.50%	95.0%	95.94%		VTE performance monitored since implementation of Medway and ePMA. An electronic solution is in the IT pipeline. Performance remains above target.	Quality and patient safety	Every effort is being made to supplement routine reviews with additional activity to improve performance pending electronic solution - risk assessment on EPMA	RPJ
Number of cases of Hospital Associated Thrombosis (HAT)		T	Oct-19	2	14	No Target	26					
To achieve and maintain CQC registration	Q		Dec-19	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards. Trust rated as outstanding following the 2018 inspection.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Dec-19	95.5%	96.3%	No Target	96.5%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	Safe Care Allocate has been implemented across all inpatient wards. All wards are receiving support to ensure consistency in scoring patients. Recruitment into posts remains a priority area. Unify report has identified some specific training relating to rostering and the use of the e-Roster System. This is going to be addressed through the implementation of a check and challenge process at ward level.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Dec-19	0	3	No Target	0					

Dec-19

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 44-52)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Nov-19	94.4%	89.4%	93.0%	92.2%		2 week performance although above standard continues to have pressures throughout most specialties. 31 day Target achieved in month. 62 Day target not met and pressures remain with Consultant workforce as well as breach reallocation rules and constraints. Radiological capacity in Breast and Dermatology patient rearrangements contributed to the performance.	Quality and patient experience	1. All DMs producing speciality level action plans to provide 2 week capacity 2. Capacity demand review on going at speciality level 3. Breast Radiologist recruited, to start ? January 2020. 4. Trust pilot site for SFIT lower GI which will improve cancer access and pathways. full roll out of pilot expected early 2020 5. Trust to commence Rapid Diagnostic Service early 2020	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Nov-19	99.0%	97.3%	96.0%	98.1%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Nov-19	88.9%	86.4%	85.0%	88.3%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Dec-19	92.5%	92.5%	92.0%	92.4%		Impact of pension / tax rules on Consultant WLI activity resulting in increase in WL and wait times	Surgical Beds have now been converted to Medical bed capacity. Bed availability to manage the Surgical demand could result in backlog increasing. Additional risk also caused by impact of RMS and MCAS	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. A backlog management plan is in place and alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand. Actions to maintain and improve RTT performance reliant on theatre and bed capacity along with staff availability in collaboration with CCG's in ensuring RMS delivers in a sustainable and manageable way. ongoing pension / tax negotiations locally and nationally	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Dec-19	100.0%	99.6%	99.0%	99.9%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Dec-19	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Dec-19	0.8%	0.7%	0.8%	0.8%		There was one breach of the 28 day re-list target in January 2019 due to difficulties in communicating with the patient.	Patient experience and operational effectiveness Poor patient experience	Proactive system in place to monitor, manage and prevent cancelled operations within the care group. Lessons learned from the 28 day re-list patient in January have been feedback to the relevant departments for learning and reflection.	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Nov-19	100.0%	100.0%	100.0%	99.5%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Dec-19	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Dec-19	65.0%	70.2%	95.0%	74.3%		Accident and Emergency Type 1 performance for December 2019 was 65.0%% and YTD 70.2%. The all type mapped STHK Trust footprint performance was 78.2% in month and 83.8% YTD. The Trust received 10,171 Type 1 attendances in December 2019. Year to date growth in ED attendances is 6.4% up on 2018/19. The work streams, designed to increase performance against the 4 hour standard, continue to focus on driving forward the required improvement. Please Note: The A&E mapped performance has historically included attendances mapped from the Huyton Walk-In Centre (WIC). From 1st December 2019, only departments classed as Urgent Treatment Centres (UTC) will continue to be included in the mapped position. Huyton WIC is not designated as a UTC so these attendances will no longer be included in the mapped position.	Patient experience, quality and patient safety	The urgent and emergency care transformation plan has several interconnected work streams designed to improve overall 4 hour access performance. Emergency Department/Front Door processes in place including 'walk in' streaming, Stretcher Triage streaming and internal departmental efficiencies and exit from ED. GP streaming in place as per NHSE recommendations. Flow through the Hospital New and refreshed workstreams aimed at improving discharges before midday also supported by a media campaign #HomeForLunch. Daily board rounds and afternoon huddles. Twice weekly discharge tracking meetings to manage medically optimised and DTOC escalation. Monthly Executive Multi-Agency Discharge Events (MADE) continue across the whole system to remove barriers and blocks that prevent patients with complex needs being discharged safely from hospital. Continue with daily AMU/ED huddles which is proving beneficial. COPD pilot in place from December continues with benefits realised of avoiding admission.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Dec-19	78.2%	78.2%	95.0%	87.1%					
A&E: 12 hour trolley waits	F&P	▲	Dec-19	0	0	0	0					

Dec-19

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲£	Dec-19	0	2	0	0		MSA breach occurred on ICU due to delay in stepping level 1 patients down for 24 hours (involved 2 patients only) as Trust was at full capacity and patients in ED waiting beds. All actions taken to try prevent this.	Patient Experience	All patients waiting step down are highlighted at bed meeting x 3 daily and an escalation plan is in place to prevent this reoccurring where possible.	RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Dec-19	22	234	No Target	266		% new (Stage 1) complaints resolved within agreed timescales continues to remain above the 90% target, year to date, although there was a slight dip in November, which was recovered in December. Number of new complaints received decreased in November and December.	Patient experience	The Complaints Team continue to work hard to respond to complaints within agreed timescales and to proactively monitor each complaint that is likely to exceed this. The backlog of overdue complaints continues to remain low as reported previously. To increase performance, weekly reminders are sent to Care Groups regarding complaint responses due a fortnight before to ensure improved performance is maintained. Additional actions taken to sustain the improved performance include messages to all staff via global email and Team Brief in December. Training provided in January on complaints investigations to support futher improvements.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Dec-19	18	231	No Target	241					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Dec-19	100.0%	93.1%	No Target	92.1%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Nov-19	22	21	No Target	19		In November 2019 the average number of DTOCS (patients delayed over 72 hours) was 22.		Tracking meetings happen with LA/CCG and wards twice weekly to ensure the numbers of DTOCs are maintained below 20.	RC
Average number of Stranded patients per day (7+ days LoS)	Q	T	Dec-19	339	336							
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Dec-19	131	129							
Friends and Family Test: % recommended - A&E	Q	▲	Dec-19	85.3%	86.1%	90.0%	86.0%		The YTD recommendation rates are above target for inpatients, antenatal, postnatal and community postnatal, but slightly below target for ED, Outpatients and delivery in line with previous month.	Patient experience & reputation	The profile of FFT continues to be raised by members of the Patient Experience Team, by attendance at ward meetings, the Patient Experience and Dignity Champions and monthly Team Brief. The display of FFT feedback via the 'You said, we did' posters continues to be actively monitored and regular reminder emails are issued to wards that do not submit the posters by the deadline. At least two members of staff have been identified in each area to take responsibility for production of the 'you said, we did' posters which are used to identify specific areas for improvement. Easy to use guides are available for each ward to support completion and the posters are now distributed centrally to ensure that each ward has up-to-date posters. Areas continue to review comments to identify any emerging themes or trends, and significantly negative comments are followed up with the contributor if contact details are provided to try and resolve issues. The Patient Experience Council Chair wrote to each area that has not displayed a current poster for the last three months in October and lower performing areas will continue to be supported.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Dec-19	95.2%	95.5%	90.0%	94.7%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Dec-19	100.0%	98.6%	98.1%	98.7%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Dec-19	100.0%	97.5%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Dec-19	100.0%	96.9%	95.1%	94.8%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Dec-19	100.0%	99.5%	98.6%	98.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Dec-19	95.5%	94.5%	95.0%	94.2%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 54-61)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Dec-19	5.7%	5.1%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	5.0%		In December sickness was 5.7%, a 0.4% increase since November, 0.98% higher than Q3 target of 4.72%. Qualified & HCA sickness has increased from 5.7% to 6% which remains 0.7% above 2019/20 target, but is 0.1% lower than the 2018-19 position.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	The Trust is carrying out a review of HWWB service to ensure the capacity and capability is aligned to the needs of staff. A business case will be presented to the Executive Committee in January. The consultation process on the revised Attendance Management policy will commence in the new year. A programme of wellbeing awareness events continue, including Mental Health First Aid Training and Mindfulness Sessions facilitated within the workplace. Case conference meetings continue into January between HR and HWWB to review those long-term cases that may require further intervention to enable timely actions inline with policy. A more compassionate approach to leadership is being promoted as part of the Trust's Improving People Practices action plan.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Dec-19	6.0%	5.9%	5.3%	6.1%					
Staffing: % Staff received appraisals	Q F&P	T	Dec-19	80.4%	80.4%	85.0%	89.6%		Appraisal compliance in December is below target by 4.6%. Mandatory training compliance has improved by 0.3% since last month, but remains below the target by 2.0%.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The HRBPs alongside Education, Training & Development and Workforce Planning teams continue to work with managers to ensure improvements in compliance for Mandatory Training & Appraisals. Non-compliant areas are being reviewed by the Trust's Executive Committee on a monthly basis and also at department level finance & performance meetings. Subject Matter Experts (SMEs) are being supported to move their material to e-learning as appropriate, this will be a responsibility of a Band 7 post being recruited to L&OD. L&OD have a rolling programme of support for MyWorkPAL across the Trust.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Dec-19	83.0%	83.0%	85.0%	95.3%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2	94.1%		No Contract Target			For both questions the Trust returned the best scores nationally.	Staff engagement, recruitment and retention.	The Q3 survey covering all areas of the Trust closed on the 30th November. Results are expected in February 2020.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2	82.8%		No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Dec-19	0.7%		No Target	9.2%		Staff turnover remains stable and well below the national average of 14%.		Turnover is monitored across all departments as part of the Trusts Recruitment & Retention Strategy with action plans to address areas where turnover is higher than the trust average. The Trust is undertaking a project with NHSE regarding retention of Nurses and this is part of our wider retention strategy and action plan for 2018/19 for the Trust.	AMS
FINANCE & EFFICIENCY (appendices pages 62-67)												
UORR - Overall Rating	F&P UOR	T	Dec-19	3.0	3.0	3.0	3.0		At the March 2019 Board the Trust agreed to accept the issued Control Total of a £2.6m deficit excluding the Provider Sustainability Fund (PSF). This allowed the Trust to access £6.5m of PSF assuming the planned deficit is achieved. Key assumptions within the plan include:- - Full achievement of CQUINs - Activity within planned levels - Achievement of CIPs (£16.1m) - Agency spend within cap levels Better payment compliance is currently not being achieved on invoice numbers but is being achieved on value.	Delivery of Control Total	Weekly update to be provided to DoF on current progress of internal schemes. Divisions to report progress at Finance & Performance Committee. Executives to engage external stakeholders regarding progress of transformational programmes that will assist in delivering the Cost Improvement Programme. The approval of invoices within the Trust is impacting compliance. The Finance department will continue to work with areas of the Trust that need to improve.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Dec-19	11,149	11,149	16,100	14,978					
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Dec-19	(1,325)	(1,325)	3,900	(597)					
Cash balances - Number of days to cover operating expenses	F&P	T	Dec-19	6	6	2	5					
Capital spend £ YTD (000's)	F&P	T	Dec-19	3,800	3,800	7,872	9,642					
Financial forecast outturn & performance against plan	F&P	T	Dec-19	3,900	3,900	3,900	(597)					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Dec-19	88.1%	88.1%	95.0%	91.2%					

APPENDIX A

			Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	2019-20 YTD	2019-20 Target	FOT	2018-19	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲£	100.0%	100.0%	96.0%	83.3%	100.0%	100.0%	84.6%	73.7%	100.0%	89.7%	100.0%	89.5%	100.0%	90.8%	85.0%		96.5%		
	Total > 62 days		0.0	0.0	0.5	2.5	0.0	0.0	1.0	5.0	0.0	2.0	0.0	2.0	0.0	10.0			5.0		
	Total > 104 days		0.0	0.0	0.5	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					
Lower GI	% Within 62 days	▲£	88.9%	100.0%	87.5%	72.7%	80.0%	94.4%	100.0%	88.9%	60.0%	60.0%	85.7%	100.0%	78.9%	83.5%	85.0%		86.6%		
	Total > 62 days		1.0	0.0	1.0	1.5	1.0	0.5	0.0	0.5	3.0	2.0	1.0	0.0	2.0	9.0			10.5		
	Total > 104 days		1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	1.0					
Upper GI	% Within 62 days	▲£	33.3%	63.6%	84.6%	88.9%	75.0%	88.9%	85.7%	83.3%	90.9%	100.0%	85.7%	100.0%	87.5%	89.1%	85.0%		74.7%		
	Total > 62 days		1.0	2.0	1.0	0.5	1.5	0.5	1.0	1.0	0.5	0.0	1.0	0.0	1.0	5.0			12.0		
	Total > 104 days		0.0	0.5	0.0	0.0	0.5	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.5					
Urological	% Within 62 days	▲£	75.0%	89.4%	85.2%	87.8%	90.9%	87.1%	91.3%	96.9%	87.5%	83.3%	92.3%	84.6%	92.0%	88.9%	85.0%		86.0%		
	Total > 62 days		3.5	2.5	2.0	2.5	1.5	2.0	1.0	0.5	2.5	3.0	1.0	2.0	1.0	13.0			29.0		
	Total > 104 days		2.0	0.5	0.0	0.0	0.5	0.5	1.0	0.0	0.5	0.5	0.0	0.0	0.5	3.0					
Head & Neck	% Within 62 days	▲£	80.0%	57.1%	25.0%	0.0%	100.0%	0.0%	25.0%	0.0%	16.7%	50.0%	28.6%	28.6%	20.0%	25.6%	85.0%		57.1%		
	Total > 62 days		0.5	1.5	1.5	0.5	0.0	1.5	3.0	0.5	2.5	1.5	2.5	2.5	2.0	16.0			12.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	1.5	1.0	0.0	3.0					
Sarcoma	% Within 62 days	▲£	100.0%	100.0%			50.0%			100.0%		100.0%	50.0%	100.0%	0.0%	63.6%	85.0%		85.2%		
	Total > 62 days		0.0	0.0			0.5			0.0		0.0	1.0	0.0	1.0	2.0			2.0		
	Total > 104 days		0.0	0.0			0.0			0.0		0.0	0.0	0.0	0.0	0.0					
Gynaecological	% Within 62 days	▲£	100.0%	81.8%	57.1%	88.9%	77.8%	66.7%	100.0%	40.0%	83.3%	40.0%	50.0%	0.0%	75.0%	66.2%	85.0%		77.8%		
	Total > 62 days		0.0	1.0	1.5	0.5	1.0	2.0	0.0	3.0	1.0	3.0	1.0	0.5	1.0	11.5			10.0		
	Total > 104 days		0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.5	0.0	1.5					
Lung	% Within 62 days	▲£	94.1%	100.0%	92.9%	81.8%	92.9%	71.4%	100.0%	88.2%	100.0%	100.0%	57.1%	90.0%	100.0%	88.0%	85.0%		90.4%		
	Total > 62 days		0.5	0.0	0.5	1.0	0.5	1.0	0.0	1.0	0.0	0.0	3.0	1.0	0.0	6.0			8.0		RC
	Total > 104 days		0.5	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	2.0					
Haematological	% Within 62 days	▲£	85.7%	66.7%	50.0%	0.0%	83.3%	100.0%	80.0%	100.0%	50.0%	85.7%	100.0%	78.9%	100.0%	85.3%	85.0%		76.7%		
	Total > 62 days		1.0	1.0	2.0	2.0	1.0	0.0	1.0	0.0	1.0	1.0	0.0	2.0	0.0	5.0			9.5		
	Total > 104 days		1.0	0.0	1.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0					
Skin	% Within 62 days	▲£	90.2%	98.0%	93.7%	88.1%	94.9%	95.0%	97.1%	94.4%	92.8%	95.0%	98.2%	80.2%	94.4%	92.4%	85.0%		93.4%		
	Total > 62 days		2.5	0.5	2.0	2.5	1.0	1.0	0.5	1.5	2.5	1.5	0.5	8.0	1.5	17.0			20.5		
	Total > 104 days		0.5	0.0	0.0	0.0	0.0	0.0	0.0	1.5	1.0	0.5	0.0	1.5	0.5	5.0					
Unknown	% Within 62 days	▲£	100.0%		100.0%	66.7%	100.0%	100.0%	50.0%	100.0%		100.0%				70.0%	85.0%		93.9%		
	Total > 62 days		0.0		0.0	0.5	0.0	0.0	1.5	0.0		0.0				1.5			1.0		
	Total > 104 days		0.0		0.0	0.5	0.0	0.0	0.5	0.0		0.0				0.5					
All Tumour Sites	% Within 62 days	▲£	88.4%	89.0%	86.7%	82.6%	90.0%	89.6%	87.6%	85.6%	85.7%	85.9%	86.2%	83.1%	88.9%	86.4%	85.0%		88.3%		
	Total > 62 days		10.0	8.5	12.0	14.0	8.0	8.5	9.0	13.0	13.0	14.0	11.0	18.0	9.5	96.0			119.5		
	Total > 104 days		5.0	1.0	2.0	2.0	1.0	1.5	2.0	1.5	3.0	1.0	2.5	5.0	1.0	17.5					
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲£	100.0%	100.0%	100.0%	100.0%				100.0%	66.7%					80.0%	85.0%		90.0%		
	Total > 31 days		0.0	0.0	0.0	0.0				0.0	0.5					0.5			1.0		
	Total > 104 days		0.0	0.0	0.0	0.0				0.0	0.0					0.0					
Acute Leukaemia	% Within 31 days	▲£										100.0%		100.0%		100.0%	85.0%		66.7%		
	Total > 31 days											0.0		0.0		0.0			1.0		
	Total > 104 days											0.0		0.0		0.0					
Children's	% Within 31 days	▲£															85.0%				
	Total > 31 days																				
	Total > 104 days																				

TRUST BOARD

Paper No: NHST(20)002
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 November and December 2019. There were a total of 5 Executive Committee meetings held during this period. The Executive Committee approved: • Re-branding of the HIS to the Mid-Mersey Digital Alliance • Copeland's Risk Adjusted Barometer (CRAB) Business Case • Ward 2A Staffing Business Case • Switchboard Replacement Business Case • Accident and Emergency Staff Review There were updates on developments in the pay dispute between UNISON and Medirest. The Committee also considered regular assurance reports covering; the Risk Management Council and Corporate Risk Register, safer staffing, mandatory training and appraisals. There were also progress reports for a number of key organisational objectives.
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 OBE, Chief Executive
Date of meeting: 29th January 2020

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were 5 Executive Committee meetings in November and December 2019. There was no meeting on 7th November due to the HSJ Awards Ceremony, and on the 14th November there was an Executive to Executive Team meeting with St Helens CCG, 26th December was a bank holiday.

At every meeting the committee reviews any bank or agency staff requests that would breach the NHSI cost thresholds.

2. 21st November 2019

2.1 Health Informatics Service – New name

The Director of Informatics explained the consultation process that had been followed with all stakeholders to agree the most appropriate name for the service to reflect the diversity of services provided. The resulting proposal was for the service to the renamed the Mid-Mersey Digital Alliance with the strap line "digital solutions in healthcare". The change was approved by the Executive Committee.

2.2 Safer staffing, vacancy dashboard and shift shortfall reports – month 7

The Director of Nursing, Midwifery and Governance presented the 3 monthly reports which reviewed different aspects of nurse staffing on the inpatient wards. The metrics across all three reports triangulated to provide assurance that the overall staffing levels continued to meet the Trusts safety thresholds.

2.3 Core mandatory training and appraisals compliance

The Deputy CEO/Director of Human Resources presented the monthly compliance report for the staff reporting to each Director, for October. The main area of concern was operations, which is the largest group of staff. It was noted that there continued to be a delay between completion of training and appraisals and them being reported by the Electronic Staff Record (ESR).

2.4 Mid–year review of Trust Objectives

The Director of Corporate Services presented the draft assessment of mid-year progress for review before submission to the Trust Board.

2.5 Acute Services Sustainability Board

The Chief Executive reported that she had been asked to chair the Cheshire and Merseyside Health and Care Partnership, Acute Services Sustainability Board.

2.6 Medirest/UNISON Pay Dispute

The Director of Corporate Services provided an update on the latest developments in the dispute between Medirest and Unison. Business continuity plans for the industrial action planned for 25th and 26th November were in place and disruption to services for patients

would be minimal. It was also hoped that the two sides in the dispute would resume talks in the near future.

3. 28th November 2019

3.1 National Estates Return Information Centre (ERIC) benchmarking

The Director of Corporate Services introduced the presentation which showed how the Trust compared to other acute Trusts across a range of estates and facilities management services. The benchmarking group contained both PFI and non-PFI Trusts and on the majority of metrics the Trust performed well, although opportunities for improved productivity and efficiency would continue to be explored.

3.2 Chief Executives Meeting

The Deputy CEO/Director of Human Resources had attended the Cheshire and Merseyside CEO's meeting on behalf of the Chief Executive and reported back on the discussions with Alan Yates, the new Chair of the Cheshire and Merseyside Health and Care Partnership.

3.3 System Financial Position

The Director of Finance and Information reported on the preparation for the forthcoming meeting with NHSE/I about the financial position of the St Helens Cares health system which was scheduled for 3rd December.

4. 5th December 2019

4.1 Emergency Department Workforce Review Business Case

The Director of Operations and Performance introduced the business case which detailed the additional medical and nursing staff needed to respond to increases in attendances and formalise capacity that was routinely relied on by the department to deliver new ways of working e.g. increased nurse triage. The case also analysed the pattern of demand and the medical staff rota needed to optimise "seeing power" in the department at all times. The case presented the additional investment required above the current expenditure run rate. It was agreed that a number of safety initiative nursing positions should be formalised into the permanent establishment immediately, so they could be recruited on a substantive basis. The Executive had a number of requests for additional information on the remainder of the case, before a final decision could be made.

4.2 Copeland's Risk Adjusted Barometer (CRAB) Business Case

The Medical Director re-presented the CRAB business case with the additional information the committee had requested. The case detailed the benefits of extending the Trust's use of CRAB to medical specialities and to purchase the Compass risk assessment module. There had been further meetings with the supplier to clarify the level of reporting that would be available from the system. Committee approved the purchase of the additional functionality from CRAB, with further work required to ensure that the available information would be used by clinicians and for Care Group

governance.

5. 12th December 2019

5.1 Pensions Tax Guidance for Senior Clinical Staff

The Deputy CEO/Director of Human Resources provided an update on the latest national guidance and initiatives to ensure senior clinicians were not penalised by the pension tax rules for undertaking additional work to support the NHS during winter. Communications had now been received from the national audit office and NHSE/I had confirmed that the provisions would be contractual. These assurances were aimed to give senior clinicians greater confidence in the proposals. The Remuneration Committee had been informed of the developments and all staff potentially affected had been sent the details of how the scheme would operate for the 2019/20 tax year. The impact of these changes on the take up of additional activities to increase capacity would be closely monitored.

5.2 Urgent and Emergency Care (UEC) improvement week evaluation

The Director of Operations and Performance introduced the paper which provided the initial evaluation of the impact of the UEC improvement week from 12th – 18th November 2019. The paper detailed how the starting position was different from the same week in 2018, due to increased attendances, ambulance conveyances and bed occupancy. All 15 UEC projects were run concurrently during the week, with 11 measured against agreed outcome metrics. It was agreed that a full action plan needed to be developed to ensure that the Trust maximised the benefits of each of the UEC projects.

5.3 Ward 2A Staffing Business Case

The Director of Nursing, Midwifery and Governance introduced the business case which detailed the changes in treatment regimens and quality standards for haematological patients receiving chemotherapy. The increased complexity of treatments meant that a ratio of 1 qualified nurse for every 2 neutropenic patients was required. Currently the staffing establishment does not allow this standard to be consistently achieved at night, on occasions when there is an increase in these patients. The committee agreed to increase the nurse establishment by 2.3 FTE nursing posts to provide the necessary levels of cover at all times.

5.4 Risk Management Council (RMC) Chair's assurance report

The Director of Corporate Services presented the RMC report from the meeting on 10th December. There were 12 risks that remained escalated to the Corporate Risk Register. The council had also received reports from the Claims Governance Group, Information Governance Group and an update on the quality impact assessments of cost improvement schemes.

5.5 Medway Outage 5th December

The Director of Informatics presented a paper which detailed the reasons for the Medway outage on 5th December and the actions taken at the time to restore functionality and the further actions planned to improve system resilience.

5.6 Medirest/UNISON Pay Dispute

The Director of Corporate Services reported that following new talks between Medirest and UNISON a revised offer had been put to members and following a ballot on 10th December, this offer had now been accepted, bringing the dispute to an end.

6. 19th December 2019

6.1 Capital Programme 2019/20

The Director of Finance and Information provided an update on expenditure against the annual capital programme. A number of contingency items were approved, where there had been slippage or cost changes compared to the original plan.

6.2 Switchboard replacement business case

The Director of Informatics presented the case to invest in replacement switchboard equipment to improve call answering times and implement voice recognition and virtual operator technology. Following a procurement exercise Netcall had been identified as the preferred provider. The business case was approved.

6.3 Plans to achieve a reduction in clinical negligence claims

The Director of Nursing, Midwifery and Governance introduced the item which detailed the improvements that had already been made to the claims governance processes and the plans to further improve the sharing of learning from claims and mechanisms to embed changes in practice. The analysis in the report showed that in the last three years the number of new claims had reduced but the number of claims that had been settled had increased. The committee thanked the team for all the work that had been put in to improving the claims process and endorsed the future plans. It was agreed that a culture of learning and ownership were vital to improving patient care.

6.4 Medway outage update

The Director of Informatics gave a further update on the progress to re-introduce replication functionality following the Medway outage on 5th December. A path to recovery had been agreed, to be undertaken in phases to ensure no adverse impact on system performance, and this was progressing well. It was expected that the replication functionality would be fully restored via this process.

6.5 Mandatory training and appraisal report

The Deputy CEO/Director of Human Resources presented the mandatory training and appraisal performance for November for each Director. Operational areas continued to experience challenges in releasing staff and were not achieving the 85% target.

6.6 Pre-operative checking incidents – update

The Director of Operations and Performance provided an update on the delivery of the action plan that had been agreed to reduce incidents. Since the issue had been raised in quarter 1 a full action plan had been put in place which had resulted in a consistent reduction in the number of incidents reported. It was stressed that all errors in theatre

checklists had been identified via the normal checking mechanisms before surgery and no harm had come to any patients. The impact of the agreed actions would continue to be closely monitored and further proposals for electronic listing forms were being developed.

6.7 Emergency Department Staffing Review Business Case – Update

Further to the consideration of the case on 5th December the Director of Operations and Performance presented the updated business case which addressed the queries raised by the committee. Committee partially approved the case for a temporary increase in staffing, subject to the impact of the modular wards and further development of Same Day Emergency Care (SDEC), which would increase bed and assessment capacity, following which a further review would be scheduled.

ENDS

TRUST BOARD

Paper No: NHST(20)003
Title of paper: Committee Report – Quality Committee Chair's Report
Purpose: To summarise the meeting papers from the Quality Committee meeting held on 21st January and escalate any issues of concern.

Agenda Items Discussed:

Matters Arising

- The Director of Nursing, Midwifery and Governance gave an update on the actions being taken to assess the impact of EPMA on antibiotic prescribing practice
- The Deputy CEO/Director of HR gave an update on resuscitation training compliance, which had now reached 74% against the target of 85% for level 1. The introduction of the RQI system had made training easier to access and further actions were being taken to achieve the target. Quality Committee will continue to monitor compliance.
- The Medical Director provided an update on the effectiveness review of the Clinical Effectiveness Council and the actions planned for improvement.

Integrated Performance Report (IPR) – QC(20)001

Committee reviewed the IPR with a focus on the Quality and Workforce KPIs, with the main areas of scrutiny were; HSMR, CDI infections, delayed discharge from ICU and FFT recommendation scores in A&E. A deep dive investigation was being undertaken to understand the reasons for the increase in the HSMR scores.

Patient Safety Council (PSC) – QC(20)002

There were no issues for escalation. The PSC had received reports on; incidents, CAS alerts, NHS Safety Thermometer results (98.98%), Medical Care Group safety report, Medical devices Q2 report, Infection prevention Control Q3 report, Clinical Support Services discrepancies review, and the SUI action management monitoring report.

Incidents, Never Events and Serious Incidents Report – Quarter 2 – QCC(20)003

The report provided an overview of the incidents, never events and StEIS Reportable incidents between July and September 2019. There had been no never events and 13 new StEIS reportable incidents. Committee was assured that incidents were being reported and discussed incidents involving Mental Health patients and the support available to staff.

Infection Prevention and Control Report - Quarter – QC(20)004

The report highlighted the increased incidence of norovirus, C- Difficile and Group A Strep infections during the period. The actions being taken to maintain good IPC and environmental practices. Committee asked for further detail on the lessons learnt from the Strep A outbreak at Newton Intermediate Care unit and how these are being applied across the Trust.

Medicines Storage and Safety Action Plan – QC(20)005

The paper explored the issues with compliance against the Safe Storage and Security of Medicines SOP although there had been improvement the target compliance was not consistently being achieved. Committee reviewed the actions being proposed and accountability routes for each Care Group.

Safeguarding Adults and Children's Annual Information and Assurance Report 2018/19 – QC(20)006
The Head of Safeguarding presented both reports to provide assurance that the Trust had met its statutory responsibilities in relation to adults and children. Plans to increase PREVENT training compliance, and prepare for the introduction of the new liberty protection safeguards regulations were discussed. The reports detailed the development plans for 2019/20 and both were approved.

Maternity – Saving Babies Lives Care Bundle Progress Report – QC(20)007
The action plan to deliver the five elements of the care bundle was making good progress for delivery by September 2020. There was a risk regarding the reporting systems for the data collection elements, but this was being developed in partnership with system C. Committee asked for a timetable in relation to the IT developments to provide additional assurance.

Pressure Ulcers Thematic Review – QC(20)009
The paper explored the reasons for the increase in pressure ulcers. There had been an increased incidence of heel pressure ulcers and the reasons for this require a further deep dive. Availability of appropriate equipment and timely assessment and handover were also discussed, with a business case to be taken to the Executive Committee.

Patient Experience Council (PEC) – QC(20)010
The PEC had reviewed a patient story relating to the upper GI cancer pathway. The monthly complaints and PALs reports. The Trust Policy on mixed sex breaches is being updated in light of revised national guidance and a new bereavement booklet is being developed. The council also received reports from Healthwatch. There were no matters for escalation.

Complaints, Concerns and Claims Quarter 3 Report – QC(20)011
The report detailed the number of complaints, PALs concerns and claims received during Q3. Targets for responding to complaints in the agreed timescales continued to be met and training for complaint response writers had been delivered. Committee discussed whether there were improvements that could be made to resolve concerns and issues before they became formal complaints, although the concerns to PALs conversion rate is only 4%.

Clinical Effectiveness Council (CEC) – QC(20)012
The report covered the CEC meeting in December and actions had been taken in relation to the issues escalated at the time.

Clinical Research Report – QC(20)013
The report detailed progress against the high level objectives set by the Clinical Research Network. All were being progressed but there was a risk in relation to the increased recruitment target which had increased from 639 in 2018/19 to 1026 in 2019/20, although good progress was being and there was an action plan in to optimise recruitment. The target had not been notified until Q2, which made achievement more challenging.

Clinical Audit Report Quarter 2 – QC(20)014
The report detailed the audits that had been planned and completed in the quarter. Audits were the action plans had not been completed were also reported and the Medical Director provided assurance that this was closely monitored.

Review of Marshalls Cross CQC Action Plan – QC(20)015
The Trust's internal auditors had been asked to review the action plan at Marshalls Cross to provide additional assurance that the changes had been effective at addressing the issues identified during the 2018 CQC Inspection. The service had completed the action plan in July 2019 and MIAA undertook their audit in September. This review concluded that the issues had been addressed and were embedded.

Safe Staffing Report – Month 9 – QC(20)016
The report detailed the safe staffing levels reported in December which were over 95%. The report also detailed the analysis of the November figures.

Workforce Council – QC(20)017
The council had received reports on; recruitment, HR KPIs, Education and Training, developing new roles, the development of the Nursing Strategy and just culture reviews. There were no matters for escalation.

Matters for Escalation to the Board:

- There were no matters for escalation to the Board from the meeting, but the Board is asked to note that the increase in HSMR is being investigated and there will be a further report to the Committee in February.

Corporate objectives met or risks addressed: Effectiveness, Experience, Safety and Workforce.

Financial implications: None directly from this report.

Stakeholders: Patients, the public, staff, regulators and commissioners

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

Presenting officer: Gill Brown, Non-Executive Director and Chair of Committee

Date of meeting: 29th January 2020

TRUST BOARD

Paper No: NHST(20)004

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance and Performance Committee, 23rd January 2020

Summary:

Agenda Items:

For Information

- Director of Finance (DoF) update:
  - NK updated the committee on the continued discussion with commissioners around agreement of financial outturn positions for 19/20. This was welcomed as it allowed for system certainty of financial positions for year end. NK advised that outturn had been appropriately adjusted for winter volumes and complexity.
- Planning Guidance update
  - The Committee were taken through a planning presentation by the Deputy Director of Finance.
  - Planning guidance has not yet been released nationally but some assumptions were known and discussed.
  - The Committee noted the key risks already identified by the Trust and the mitigations already being formulated to offset these pressures.
  - The committee noted the challenges of capital for 2020/21.
- International Financial Reporting Standard (IFRS) 16 - Leases
  - The Committee were updated on the impeding changes in to leases as a result of the implementation of IFRS 16 from April 2020.
  - The Trust has carried out an initial assessment on the impact and will include within the planning update for the committee.

For Assurance

- Integrated Performance Report (IPR)
  - The Committee reviewed the IPR.
  - The Committee noted the improved cancer performance and were assured on how breaches are reported and managed.
  - The Committee discussed the operational pressures facing the Trust as result of high occupancy and high demand for services on the consequential impact this has on performance indicators (medical outliers/ICU discharges).
  - The Committee discussed the sickness levels and the plans and support that were in place to front line staff.

- Finance Report (Month 9)
  - The Committee reviewed the report noting the YTD performance of a £1.3m deficit which was in line with plans. The Trust had utilised c£4m of non-recurrent support YTD.
  - The Committee noted and the increased capital programme as a result of National support to deliver additional bed capacity and were assured that this would be spent in year.
  - The Committee noted the cash position and the improvement in the aged debt that has reduced month on month.

- CIP – Trust wide and Medical Care Group
    - The Committee commended the Trust on the CIP progress to date and expected full achievement for the year recurrently.
    - The Committee also welcomed the significant progress in identifying schemes for 2020/21 (subject to contract and planning guidance).
    - The Committee thanked the Medical Care Group for the work undertaken in year and for the progress in delivering the 2020/21 target.

- A&E Performance
    - The Committee discussed in detail the challenges and pressures the department have been under throughout November and December and thank them for their continued hard work.
    - The department were making good progress in improving Ambulance handover times since December.
    - It was agreed to update progress being made on A&E performance every quarter.

Risks noted/Items to be raised at Board

- The chair of the committee was glad to junior members of the Trust attending the committee as part of their on-going development. This reflects the ongoing development of future leaders within the Trust.
- The committee noted that the agency expenditure was now exceeding the trajectory issued by regulators. The committee was assured that the reasons were understood and valid for the increase.
- The committee gave delegated approval for the draft financial plan to be signed off by the Executive Committee if the proposed deadline was prior to the next meeting.
- The Committee were assured that the A&E department had full understanding and grip on the controllable factors within the department. The Committee noted that the increase in bed stock was the key enabler to improving performance, therefore A&E will move to quarterly reporting.

Corporate objectives met or risks addressed: Finance and Performance duties

Financial implications: None as a direct consequence of this paper

Stakeholders: Trust Board Members

Recommendation(s): Members are asked to note the contents of the report

Presenting officer: Jeff Kozer, Non-Executive Director

Date of meeting: 29th January 2020

TRUST BOARD

Paper No: NHST(20)005
Title of paper: Strategic and Regulatory Update Report – January 2020
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. The Queens Speech 2. NHS Standard Contract changes consultation 3. Indicative budget setting and operational plan timetable 4. Joint agreement on offences against emergency workers
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: 29th January 2020

Strategic and Regulatory Update Report – January 2020

1. The Queens Speech

Following the general election there was a Queen's Speech on 19th December 2019, which introduced three bills directly related to health and social care (the NHS Funding Bill, the Health Service Safety Investigations Bill and the Medicines and Medical Devices Bill).

The government also signalled it will introduce draft legislation to implement the NHS long term plan, which is expected to be published in January for pre-legislative scrutiny.

A white paper on reforming the Mental Health Act has also been signalled for publication in 2020.

1.1 NHS Funding Bill

- Will enshrine in law the multi-year funding settlement for the NHS that will see a £33.9 billion increase in cash terms by 2023-24.
- Introduction of a new visa to allow qualified Drs, Nurses and other health professionals fast track entry to the UK
- Removal of hospital car parking charges "for those in greatest need"

1.2 Health Service Safety Investigations Bill

- Establish the Health Service Safety Investigation body, with powers to conduct investigations into incidents that occur during the provision of NHS services, which have or may have implications for patient safety
- Limit information disclosure by the investigating body to allow participants to be candid in the information they provide
- Develop standards and provide advice, guidance and training to improve local investigations
- Amend the Coroners and Justice Act 2009 to give NHS bodies in England the power to appoint medical examiners and place a duty on the Secretary of State to ensure that enough examiners are appointed.

1.3 Medicines and Medical Devices Bill

- Replicate EU law in respect of the regulation of medicines and medical devices
- Make it simpler to manufacture and trial innovative medicines and medical devices
- Support the domestic life science industry to be able to obtain licenses to manufacture and trial innovative medicines and devices

- Increase the range of professionals able to prescribe and dispense medicines in local pharmacies
- Enable the government to update relevant legislation in these areas in response to patient safety concerns and as it agrees future global relationships (trade deals post EU Exit)

In respect of social care funding the Queen's speech signalled the intention for ministers to seek a cross party consensus on the long term reform of social care, including plans to consult on a 2% precept for councils to raise a further £500m for adult social care.

Other bills included in the Queen's Speech were;

1. European Union (Withdrawal Agreement) Bill
2. Immigration and Social Security Co-Ordination (EU Withdrawal) Bill
3. Trade Bill
4. Pensions Scheme Bill (all pensions dashboard, new national pensions scheme option, enhanced powers for the pensions regulator to act of employers fail to discharge their pensions responsibilities)
5. Environment Bill
6. Building safety standards legislation – in response to Grenfell Tower
7. Serious Violence Bill

2. NHS Standard Contract changes consultation

The NHS Standard Contract is published by NHS England and is mandated, under Standing Rules regulations, for use by NHS commissioners to contract for all healthcare services other than primary care services.

NHS England has proposed a range of changes to the Contract for 2020/21 – to keep it up-to-date and relevant; to ensure it correctly relates to new legislation; to ensure it reflects significant new policies; and to deliver technical improvements. The consultation period for feedback on these changes is due to end on 31st January 2020 and it is anticipated that the final revised contract will be issued to allow the annual contract negotiations to be completed by April 2020.

The review of NHS access standards, is not due to be concluded until April 2020, so no changes are proposed to the standard contract, except to add the 28 day faster diagnosis standard which has been planned for some time.

There are a number of other significant changes proposed, including;

- Increase the percentage of women who receive **continuity of carer** during their maternity care to 51% by March 2021

- Introduction of **System Collaboration and Financial Management Agreements,** setting out how health organisations and the regional NHSE/I team for each ICP/STP will work together to deliver system financial balance
- Require providers of community health services to work with Primary Care Networks (PCNs) to implement the new national service models for **Anticipatory Care and Enhanced Care in Care Homes**.
- Requirement for acute providers to establish a **Medical Examiner's Office** to review those deaths that occur on the Trust's premises that are not referred to the coroner.
- Requirement to adopt the new **Patient Safety Incident Response Framework**, which is due to replace the current Serious Incident Framework and Never Events Policy Frameworks
- Requirement for providers to demonstrate compliance with the accreditation arrangements being introduced by the **National Patient Safety Alerting Committee**
- Removal of the contract sanctions for MRSA and CDI infections and the introduction of **new targets for the reduction of other gram negative bloodstream infections** (E.Coli, MSSA, Klebsiella and Pseudomonas)
- Requirement for commissioners to offer **patients waiting over 26 weeks** for treatment the choice to move to another provider
- New provisions have been added to the contract to enable a provider to **withhold treatment** where a patient displays behaviour which constitutes discrimination or harassment (as defined by the Equality Act 2010), towards staff or other patients
- Requirement for all NHS Trusts and NHS Foundation Trusts to ensure their premises and grounds are **smoke free**
- Requirement for all providers to ensure 24 hour a day access to **healthy eating and drink options** for patients, visitors and staff
- Requirement for all providers to use "all reasonable endeavours" to ensure all **staff are vaccinated against influenza**
- Providers must be able to demonstrate they have a plan to implement the full **NHS People Offer** to staff that will form part of the NHS People Plan
- The **redundancy and re-hiring provisions** for very senior managers that have applied to providers for some time are being extended to all NHS bodies
- Requirement to publish the names and positions of staff who do not complete an **annual declaration of interest** or make a nil return
- Providers are required to put in place a **Green Plan** to reduce air pollution, cut carbon emissions, mitigate the impact of climate change and severe weather, reduce the use of single use plastic products, reduce waste and water usage
- Implementation of the proposed **Medical Technology Funding Mandate** for specific innovative technologies

- Urgent Treatment Centres must have IT systems that enable **direct booking of appointments** by NHS 111 and UEC Clinical Assessment Services.
- All Trusts that agree a financial improvement trajectory for 2020/21 will continue to be protected from the impact of some **key contractual sanctions**. Sanctions would remain active for cancelled operations, mixed sex accommodation breaches, duty of candour and 52 week waits

3. Indicative budget setting and operational plan timetable

Although detailed planning guidance for 2020/21 has not yet been published and indicative timetable has been shared with Chief Executives.

Milestone	Indicative dates
Operational and technical guidance published	January 2020
CQUIN guidance published	January 2020
National tariffs published	January 2020
First submission of draft operational plans	21st February 2020
First submission of system-led narrative plans	21st February 2020
Deadline for contract signature	3rd April 2020
Final submission of operational plans	17th April 2020
Final submission of system-led narrative plans	17th April 2020

This timetable means that neither the Trust Board or the Finance and Performance Committee will have an opportunity to formally review the draft submissions before the deadline.

The Finance and Performance Committee in January has however reviewed the assumptions for the 2020/21 contract negotiation/operational planning.

4. Joint agreement on offences against emergency workers

The agreement came in effect on 6th January 2020 and has been developed by; the Prison and Probation Service, NHS England, National Fire Chiefs Council, National Police Chiefs Council and the Crown Prosecution Service to ensure more effective investigation and prosecution of cases where emergency workers are the victim of a crime during the course of their work.

The agreement is designed to ensure the provisions of the Assaults on Emergency Workers (Offences) Act 2018 are implemented consistently and that all the relevant parties work together. There is a seven point plan that all the signatories will work to;

1) Assaults and hate crimes against staff and volunteers will be investigated with the same care, compassion, diligence and commitment as an assault or hate crime on a member of the public.

2) The Victims' Code applies to all victims, including staff and volunteers, who have been subject to assault or hate crime.

3) The affected member of staff must never investigate their own assault or hate crime.

4) Victims recover better and more quickly if they receive the right welfare and supervision.

5) The supervisor must ensure that the head of department is informed to provide continuity of welfare support.

6) The assaulted member of staff must complete the Health and Safety incident report with their supervisor as soon as possible after the incident or if this is not possible another person should complete the report on their behalf.

7) To achieve a successful prosecution, the best evidence must be presented. Victim Personal Statements should be used and all reasonable requests to provide evidence to the Police should be complied with in order that a thorough investigation can be carried out.

The agreement is being reviewed by the Security Team and non-clinical health and safety staff to ensure that Trust policies and procedures are compliant with this new agreement.

ENDS

TRUST BOARD

Paper No: NHST(20)006

Title of paper: Corporate Risk Register

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

Summary:

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

- Have been identified and reported;
- Have been scored in accordance with the Trust risk grading matrix;
- Initially rated as high or extreme have been reviewed by a Director;
- Have an identified target risk score, which captures the level of risk appetite and has a mitigation plan that will realistically bring the risk to the target level.

This report covers all the risks reported and reviewed in December 2019 and is a snap shot, rather than a summary of the quarter. A comparison with the previous Board report in October is included to illustrate the movement in risks during the period. The report shows:

- The total number of risks on the risk register is 778 compared to 779 in October 2019;
- 45% (349) of the Trust's risks are rated as Moderate or High compared to 46% (360) in October;
- 12 risks that scored 15 or above had been escalated to the CRR (there were 14 risks escalated in October).

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

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

The risk categories of the CRR risks are:
- 9 x Patient Care;
- 2 x Money;
- 1 x Governance;
- 0 x Staff.

The report also includes comparisons between the quarterly reports and against the same period last year - January 2019 (Appendix 2 and 3).

Corporate objectives met or risks addressed: The Trust has in place effective systems and processes to identify manage and escalate risks to the delivery of high quality patient care.

Financial implications: None directly from this report.

Stakeholders: Staff, Patients, Commissioners, Regulators.

Recommendation(s): The Trust Board notes the risk profile of the Trust and the risks that have been escalated to the CRR.

Presenting officer: Nicola Bunce, Director of Corporate Services.

Date of meeting: 29th January 2020

CORPORATE RISK REGISTER – JANUARY 2020

1. Trust Risk Register Summary for the Reporting Period

RISK REGISTER	Current Reporting Period January2020	Previous Reporting Period December 2019	Previous Reporting Period November 2019
Number of new risks reported	10	16	31
Number of risks closed or removed	17	10	24
Number of increased risk scores	1	2	6
Number of decreased risk scores	7	5	15
Number of risks overdue for review	70	21	2
Total Number of Datix risks	**788***	**791**	**786**

*The report is based on the 782 risks which had been reported and scored on 2nd January.

The number of risks which had not been reviewed increased in the month, due to bank holidays and leave over the festive period. The number of unreviewed risks is monitored by the Risk Management Council and at the time of the council meeting on 14th January the number of unreviewed risks had decreased to 43.

2. Trust Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
63	**53**	**21**	**119**	**11**	**166**	**59**	**130**	**29**	**119**	**3**	**9**	**0**	**0**
137 = 17.52%			**296 = 37.85%**			**337 = 43.09%**				**12 = 1.53%**			

2.1 Surgical Care Group - 210 risks reported 26.85% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
9	**12**	**7**	**39**	**3**	**45**	**14**	**45**	**8**	**28**	**0**	**0**	**0**	**0**
28 = 13.33%			**87 = 41.43%**			**95 = 45.24%**				**0**			

2.2 Medical Care Group - 190 risks reported 24.29% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
27	**24**	**2**	**31**	**0**	**36**	**9**	**24**	**10**	**24**	**1**	**2**	**0**	**0**
53 = 27.89%			**67 = 35.26%**			**67 = 35.26%**				**3 = 1.58%**			

2.3 Clinical Support Care Group - 97 risks reported 12.30% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
8	**8**	**1**	**11**	**1**	**15**	**9**	**15**	**6**	**21**	**1**	**1**	**0**	**0**
17 = 17.53%			**27 = 27.84%**			**51 = 52.58%**				**2 = 2.06%**			

2.4 Primary Care and Community Services Care Group - 39 risks reported 4.98% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
0	**1**	**0**	**10**	**1**	**5**	**4**	**5**	**4**	**9**	**0**	**0**	**0**	**0**
1 = 2.56%			**16 = 41.03%**			**22 = 56.41%**				**0**			

2.5 Corporate (Finance, Health Informatics/Health Records, Facilities, Nursing/Governance/Quality & Risk, HR and Medicines Management) - 246 risks reported 31.45% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
19	**8**	**11**	**28**	**6**	**65**	**23**	**41**	**1**	**37**	**1**	**6**	**0**	**0**
38 = 15.44%			**99 = 40.24%**			**102 = 41.46%**				**7 = 2.84%**			

The split of the risks across the corporate departments is:

	High	Moderate	Low	Very low	**Total**
Health Informatics/Health Records	1	20	4	0	25
Estates and Facilities Management	0	4	16	8	28
Nursing, Governance, Quality & Risk	1	14	9	8	32
Finance	2	7	17	11	37
Medicines Management	0	16	39	8	63
Human Resource	3	40	14	3	60
Information Governance	0	1	0	0	1
Total	7	102	99	38	246

3. The Trusts Highest Scoring Risks – Corporate Risk Register

Risks of 15 or above are added to the CRR (Appendix 1).

Appendix 1

Summary of the Corporate Risk Register – January 2020

KEY	Medicine		Surgical		Clinical Support		Corporate		Community	

Risk Category	Datix Ref	Risk	Current Risk Score I x L	Date of last review	Executive Lead	Target Risk Score I x L	Action plan in place	Governance
Patient Care	762	If the Trust cannot recruit sufficient staff to fill approved vacancies then there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	18/10/2019	Anne-Marie Stretch	4 x 2 = 8	Action plan in place	Quality Committee
Money	1152	If there is an increase in bank and agency then there is a risks to the quality of patient care and ability to deliver financial targets	4 x 4 = 16	18/10/2019	Anne-Marie Stretch	4 x 3 = 8	Action plan in place	Quality Committee
Patient Care	1358	If the Cheshire and Mersey PACs system experiences system issues, then there is a risk to patient safety	4 x 4 = 16	04/12/2019	Rob Cooper	4 x 1 = 4	Action plan in place	Executive Committee
Patient Care	1605	If the Trust is unable to fill gaps on the SpR rota then there is a risk to patient safety	4 x 4 = 16	16/12/2019	Sue Redfern	3 X 1 = 3	Action plan in place	Quality Committee
Governance	1772	If there is a malicious cyber-attack on the NHS then there is risk that patient information systems managed by the HIS will be compromised which could impact on patient care	4 x 4 = 16	29/11/2019	Christine Walters	4 x 3 = 12	Action plan in place	Executive Committee
Patient Care	2083	If inpatient bed occupancy levels are over 95% then this will negatively adversely affect the admission of medical patients from the ED	3 x 5 = 15	02/12/2019	Rob Cooper	2 x 2 = 4	Action plan in place	Executive Committee
Patient Care	2502	If there is a no deal Brexit then there could be an adverse impact on the supply of medical consumables and devices.	4 x 4 = 16	22/11/2019	Nik Khashu	3 x2 = 6	Action plan in place	Finance and Performance Committee
Patient Care	2708	If a large number of senior medical staff are adversely impacted by the NHS pension tax rules then the Trust could experience reduced senior clinical capacity	4 x 4 =16	18/10/2019	Anne-Marie Stretch	4 x 2 = 8	Action plan in place	Remuneration Committee
Money	2746	If the Trust does not achieve its activity plans then the planned income may not be achieved	4 x 4 = 16	19/12/2019	Nik Khashu	4 x 3 = 12	Action plan in place	Finance and Performance Committee
Patient Care	2750	If there are national PDS spine data mismatch errors following the implementation of Medway then diagnostic imaging results could be affected.	5 x 3 = 15	13/12/2019	Rob Cooper	5 x 2 = 10	Action plan in place	Executive Committee
Patient Care	2772	If appropriate nurse cover cannot be identified for ward 4E Medical at times of escalation then there is a risk to patient care	4 x 4 = 16	23/12/2019	Rob Cooper	4 x 2 = 8	Action Plan in place	Quality Committee
Patient Care	2714	If an interim solution cannot be developed then the Trust may be unable to demonstrate compliance with the FAIR assessment CQUIN contract indicator.	3 x 5 = 15	27/11/2019	Sue Redfern	3 x 2 = 6	Action plan in place	Executive Committee

Blue text = Risks escalated since the October Board report

Risks that have been de-escalated from the CRR since the October 2019 Board report are;

Risk Category	Datix Ref	Risk
Patient Care	2334	If the Medway migration issues in PBS are not resolved then there is a risk to efficient service delivery across the Trust
Patient Care	2428	If the breast imaging service cannot recruit staff to cover the vacancy arising following retirement of the previous post holders, then capacity to deliver this specialist service will be reduced
Patient Care	2565	If there is not sufficient capacity or capability in the Safeguarding Team the Trust may not be able to fulfil its statutory obligations
Patient Care	2759	If there is not sufficient medical cover on ward 4E then patients in escalation beds may not receive the required standard of care

Appendix 2

Trust Risk Profile – October 2019

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
56	**53**	**20**	**119**	**11**	**157**	**58**	**131**	**35**	**122**	**4**	**10**	**0**	**0**
129 = 16.62%			**287 = 36.98%**			**346 = 44.59%**				**14 = 1.80%**			

Trust Risk Profile – January 2019

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
54	**65**	**24**	**130**	**13**	**148**	**62**	**119**	**40**	**107**	**3**	**7**	**2**	**0**
143 = 18.48%			**291 = 37.60%**			**328 = 42.38%**				**12 = 1.55%**			

Appendix 3

CRR – January 2019

The risks highlighted remain on the CRR

New Risk Category	Datix Ref	Risk	Current Risk Score I x L	Target Risk Score I x L	Monitoring and Governance
Governance	222	Risk of failure to ensure delivery of national performance targets	4 x 4 = 16	4 x 2 = 8	Finance and Performance Committee
Governance	1772	Risk of Malicious Cyber Attack	4 x 4 = 16	4 x 3 = 12	Executive Committee
Money	1555	Risk of not receiving apprenticeship levy payments for Lead Employer Doctors in Training.	4 x 5 = 20	3 x 4 = 12	Finance and Performance Committee
Money	1152	Risk to the quality of care, contract delivery and finance due to increased use of bank and agency	4 x 4 = 16	4 x 3 = 8	Quality Committee
Patient Care	1569	Risk to consultant recruitment for Clinical Support Services, due to national staff shortages	3 x 5 = 15	3 x 4 = 12	Quality Committee
Patient Care	1080	Risk to patient safety risk and operational effectiveness if staffing levels are below establishment on wards 2B &2C	4 x 5 = 20	2 x 2 = 4	Quality Committee
Staff	762	Risk that if the Trust cannot recruit sufficient staff to fill approved vacancies then there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	4 x 2 = 8	Quality Committee
Staff	2370	Risk to safe levels of medical cover, if consultant medical staff cannot be recruited to critical care vacancies	4 x 4 = 16	3 x 2 = 6	Executive Committee
Patient Care	2502	The potential impact of Brexit No Deal on the supply of medical consumables and devices	4 x 4 = 16	3 x2 = 6	Finance and Performance Committee
Money	2518	Risk to cash flow if other Trusts do not pay for their lead employer junior medical staff	5 x 3 = 15	4 x 3 = 12	Finance and Performance Committee
Money	2521	If the Trust cannot deliver its agreed activity and CIP then there is a risk to the forecast outturn and the achievement of PSF funding	4 x 4 =16	4 x 3 = 12	Finance and Performance Committee
Patient Care	767	If ED are unable to recruit to nursing vacancies and maintain nursing establishment then there is a risk to patient safety	3 x 5 = 15	4 x 2 = 8	Quality Committee

TRUST BOARD

Paper No: NHST(20)007

Title of paper: Review of the Board Assurance Framework (BAF) – January 2020

Purpose: For the Trust Board to review the BAF

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

In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in October 2019.

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

Key to proposed changes:

~~Score through~~ = proposed deletions/completed

Blue Text = proposed additions

Red = overdue actions

Recommended changes

No changes to the risk scores are proposed this quarter.

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

Financial implications: None arising directly from this report.

Stakeholders: NHSI, CQC, Commissioners.

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

Presenting officer: Nicola Bunce, Director of Corporate Services.

Date of meeting: 29th January 2020

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

Alignment of Trust 2019/20 Objectives and Long Term Strategic Aims

2019/20 Trust Objectives	Strategic Aims					
	We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes for the population	We will provide the services of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will work in partnership to create sustainable and efficient health systems
Five star patient care – Care						
Five star patient care – Safety						
Five star patient care – Pathways						
Five star patient care – Communication						
Five star patient care – Systems						
Organisational culture and supporting our workforce						
Operational performance						
Financial performance, efficiency and productivity						
Strategic Plans						

Risk Scoring Matrix

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

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

Risk 1 – Systemic failures in the quality of care	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause: • Failure to deliver the Clinical and Quality standards and targets • Failure to deliver CQUIN element of contracts • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting • Failure in the supply of critical goods or services Effects: • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage Impact: • Harm to patients • Loss of reputation • Loss of contracts/market share	5 x 4= 20	• Clinical Quality Strategy • Quality metrics and clinical outcomes data • Safety thermometer • Complaints and claims • Incident reporting and investigation • Quality Governance structure • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with lead CCG • NHSI Single Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC routine PIR return • Medicines Optimisation Strategy • Learning from deaths policy	To Board; • IPR • Patient Stories • Quality Board Rounds • Quality Committee and its Councils • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Staff Survey • Friends and Family scores • Nursing Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • National Patient Surveys Other; • National clinical audits • Annual CQUIN Delivery • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Reports • Learning Lessons League • IG Toolkit results • Model Hospital benchmarking	5 x 2 = 10		Routinely achieve 30% of discharges by midday 7 days a week Delivery of the Falls Strategy Action plan to achieve a 10% reduction in falls resulting in moderate or severe harm. Demonstrate changes in behaviour to achieve a reduction in similar incidents as a result of sharing lessons learnt from incidents, never events, inquests and mortality reviews Delivery of the C-Diff action plan agreed by the Quality Committee	Implementation plans for the four key 7-day service standards by 2020 Continue to monitor closely the impact of EU Exit on critical healthcare supplies and costs (February 2020) Undertake a review of patient communication and information to improve accessibility and understanding (Revised to March 2020) Continue to work with commissioners to complete the consultation process and implement the preferred location for the Eastern Sector Cancer Hub (April 2020) Introduce six monthly workforce safeguards reports for all clinical staff groups (March 2020) Maximise uptake of flu vaccination by front line clinical staff (February 2020)	5 x 1 = 5	R P-J/ SR

Risk 2 –-Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to deliver strategic financial plans two year operational plans and the agreed control total • Failure to control costs or deliver CIP • Failure to implement transformational change at sufficient pace • Failure to continue to secure national PFI support • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • Failure to respond to new models of care (FYFV) • Failure to secure sufficient capital to support additional equipment/bed capacity Effects; • Failure to meet statutory duties • NHSI Segmentation Status increases Impact; • Unable to deliver viable services • Loss of market share • External intervention	4 x 5 = 20	• Operational Plan and STP financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 5 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSI annual provider Licence Declarations • PMO capacity to support delivery of CIP and service transformation • Signed Contracts with all Commissioners • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Declaration of interests • Benchmarking and reference cost group	To Board; • Finance and Performance Committee • Annual financial plan • Monthly finance report • IPR • Statement of Internal Control • Annual Accounts • Audit Committee • External Audit Reports Inc. VFM assessment • SLM/R Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports • Annual audit programme • PSF Targets and Control Total • CQUIN monitoring Other; • NHSI monthly reporting • Contract Monitoring Board • NHSI Review Meetings • Use of Resources reviews • Contract Review Boards with Commissioners • St Helens Cares Peoples Board	4x 3 = 12	Continue collaboration across C&M to deliver transformational CIP contribution Monitoring of management plans to deliver GiRFT recommendations	Develop capacity and demand modelling and a consistent approach to service development proposals approval Foster positive working relationships with health economy partners to help create a joint vision for the future of health services Ensure cash flow and prompt payment of invoices from other NHS providers e.g. as lead employer to maintain cash balances Cash requirements to service capital costs for committed PFI UP charges and other essential capital demands for patients care from 2020/21.	~~Develop a 5 year plan with the local Place based systems to deliver the NHS long term plan with C&M partners for final submission in November 2019~~ Secure maximum PSF funding in 2019/20 to achieve revised forecast outturn ~~Via the St Helens Cares Finance and Contract group develop proposals for financial allocations and funding flows for the system (Draft September 2019 and final submission in November 2019)~~ Seek all possible sources of capital funding including national bids to support capacity planning	4 x 2= 8	NK

Risk 3 - Sustained failure to maintain operational performance/deliver contracts	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand Effects; • Reduced patient experience • Poor quality and timeliness of care leading to poorer outcomes • Failure of KPIs and self-certification returns • Increases in staff workload/stress Impact; • Potential patient harm • Loss of reputation • Loss of market share/contracts • External intervention • Loss of PSF funding • Increases in staff sickness rates	4 x 4 = 16	• NHS Constitutional Standards • Care group activity profiles and work plans • System Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events re DTOC patients • Bed occupancy rates • Number of super stranded patients	To Board; • Finance and Performance Committee • IPR • System winter Resilience Plan • Annual Operational Plan • Data Quality audits Other; • Contract review meetings/CQPG • Community services contract review meetings • NHSI monitoring and escalation returns/sit reps including delivery of PSF quarterly targets • CCG CEO Meetings • CQC System Reviews e.g. Halton, Liverpool	4 x 4 = 16	Implementation of routine capacity and demand modelling	Achievement of targets to reduce DTOC and super stranded patients, by working effectively with health system partners ~~Detailed 2019/20 winter plan proposals~~ ~~Resolve residual Medway and operational issues with OP patient booking systems~~	Delivery of the Urgent and Emergency Care Summit improvement programme (On going) ~~Work with Halton CCG to achieve implementation of the agreed frailty pathway model following the allocation of STP transition funding (November 2019 for CCG plans to be finalised)~~ ~~Understand changes in reported activity and increased A&E attendances and admissions (October 2019)~~ Implement contract changes for Community Services and UECs in St Helens and Halton (March 2020) Work with system partners to respond to winter pressures and maintain safe access to urgent and emergency care (March 2020)	4 x 3 = 12	RC

Risk 4 - Failure to protect the reputation of the Trust	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information Effect; • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff • Increased external scrutiny/review Impact; • Reduced financial viability and sustainability • Reduced service safety and sustainability • Reduced operational performance • Increased intervention	4 x 4 = 16	• Communication and Engagement Strategy • Communications and Engagement Action Plan • Workforce, Recruitment and Retention Strategy • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR	To Board; • Quality Committee • Workforce Council • Audit Committee • Charitable funds committee • Communications and Engagement Strategy • IPR • Staff Survey • Complaints reports • Friends and Family • Staff F&F Test • PLACE Survey • National Cancer Survey • Referral Analysis Reports • Market Share Reports • CQC national patient surveys • CQC Inspection ratings • Annual assessment of compliance against the CQC fundamental standards • Compliance review against the NHS Constitution Other; • Health Watch • CQC • NHSE/I Segmentation Rating	4 x 2 = 8	Regular media activity reports , including social media, to the Executive Committee		Update Trust internet site Delivery of the updated inpatient survey action plan (July 2020) Delivery of the updated 2018 staff survey action plan for 2019/20 (March 2020 plus further revisions for the 2019 survey results)	4 x 2 = 8	AMS

Risk 5 – Failure to work effectively with stakeholders	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Different priorities and strategic agendas of multiple commissioners • Unable to create or sustain partnerships • Competition amongst providers • Complex health economy • Poor staff engagement • Poor community engagement • Poor patient and public involvement Effect; • Lack of whole system strategic planning • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff Impact; • Unable to reach agreement on collaborations to secure sustainable services • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff • Failure to win new contracts • Increase in complaints and claims	4 x 4 = 16	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCC/ Workforce Council • Patient and Public Engagement and Involvement Strategy • CCG CEO Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • CCG Board to Board Meetings • St Helens Cares Peoples Board • Involvement in Halton and Knowsley ICS development • CCG Representative attending StHK Board meetings • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Cheshire and Merseyside Health and Care Partnership governance structure • Exec to Exec working • StHK Hospitals Charity annual objectives	To Board; • Quality Committee • Charitable Funds Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports from external events • NHSI Review Meetings • Quality Account • Review of digital media trends • Monitoring of and responses to NHS Choices comments and ratings • Participation in the C&M STP leadership and programme boards • Partnership working with NWB NHSFT to deliver the St Helens Community Nursing Contract • Membership of the St Helens Peoples Board • Collaborative working with Halton and Knowsley CCGs to develop plans for Integrated care systems in these Boroughs • Achievement of the integrated working CQUIN • Annual staff engagement events programme	4 x 3 = 12		C&M Health and Care Partnership performance and accountability framework ratings and reports Development of good working relationships with the new Primary Care Networks	Participation in One Halton Programme Board Membership of the Knowsley Health and Care Executive Group to develop plans for integrated place based care Membership of St Helens Cares Board and chair of the Provider Board Continue participation with the Collaboration at scale board and work streams Continued leadership of the Acute Sustainability Board for Cheshire and Merseyside and development of agreed plans (June 2020) ~~Continue working with the C&M H&SCP to agree final 5 year plans for the locally delivery of the NHS Long Term Plan (November 2019)~~	4 x 2 = 8	AMS

Risk 6 – Failure to attract and retain staff with the skills required to deliver high quality services	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff Effect; • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff Impact; • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	5 x 4 = 20	• Team Brief • Staff Newsletter • Mandatory training • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCC/Workforce Council • Francis Report Action Plan • Education and Development Plan • HR Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Workforce KPIs • Recruitment and Retention Strategy action plan • Nurse development programmes • Agency caps and usage reporting • LWEG/LETB membership • Speak out safely policy • ACE Behavioural standards	To Board; • Quality Committee • Workforce Council • Finance and Performance Committee • Premium Payments Scrutiny Council • IPR – HR Indicators • Staff Survey • Monthly Nurse safer staffing reports • Workforce plans aligned to strategic plan • Monitoring of bank, agency and locum spending • Monthly monitoring of vacancy rates and staff turnover • Staff F&FT snapshots • WRES and WDES reports and action plans • Quality Ward Rounds • FTSU Self-Assessment and action plan Other • Annual workforce plans • HR benchmarking • Nurse staffing benchmarking • C&M HR Work Stream	5 x 3 = 15		Specific strategies to overcome recruitment hotspots e.g. International recruitment and working closely with HEE's Monitoring of take up of the UK Settlement Scheme by EU staff Continue to expand the Nurse Associate Workforce by fully recruiting to cohort 2 and 3	Development of a C&M collaborative staff bank (Revised p Proposals accepted September 2019 for implementation by March 2020) Review of Health, Work and Wellbeing service delivery model in response to increased demand (February 2020) Implement 2019/20 NHS Pension Taxation Flexibilities for staff impacted (March 2020) Develop the local response (Trust and health system) to the NHS People Plan when published (April 2020)	5 x 2 = 10	AMS

Risk 7 – Major and sustained failure of essential assets or infrastructure	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire • Insufficient investment in estates capacity to meet the demand for services Effect; • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric or equipment • Increase in complaints Impact; • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 4 = 16	• New Hospitals / Vinci Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5 year Capital programme • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M STP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity	To Board; • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • I.P.R. Other; • Major Incident Plan • Business Continuity Plans • ERIC Returns • PLACE Audits • Model Hospital • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee, to capture: ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance	4 x 3 = 12	Development of a 10 year strategic estates development plan to support the Trusts service development and integration strategies.		Commence 3 year capital programme to deliver the Same Day Ambulatory care capacity, ~~once business case approval received and funding confirmed~~ (on going to 2022) ~~Develop proposals for additional winter capacity beds (October 2019)~~ Deliver modular ward beds by Q1, 2020/21. Revise Estates and accommodation strategy to respond to increasing demand (Revised to March 2020) Operational plans to accommodate 10 year lifecycle works with minimal service disruption (March 2020) ~~Review business continuity plans to protect service delivery during periods of disruption (November 2019)~~	4 x 2 = 8	NB

Risk 8 – Major and sustained failure of essential IT systems	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure. Effect; • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity. • Loss of data or patient related information Impact; • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 5= 20	• HIS Management Board and Accountability Framework • Procurement Framework • Health Informatics Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plan • Disaster Recovery Policy • Disaster Recovery Plan and restoration procedures • Engagement with C&M STP Cyber group • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Information asset owner/administrator register	To Board; • Board Reports • IM&T Strategy delivery and benefits realisation plan reports (5YFV) • Audit Committee • Executive committee • Risk Management Council • Information Security Assurance Group • Health Informatics Service Operations Board • Health Informatics Strategy Board • Programme/Project Boards • Information Governance Steering Group Other; • Annual financial plan agreed with partners • Internal/External Audit Programme • Data security protection Toolkit Submissions • Information asset owner framework • Information Security Dashboard • CareCert, Cyber Essentials, External Penetration Test • Medway benefits realisation programme monitoring	4 x 4= 16	Annual Cyber Security Business Case approval Annual Corporate Governance Structure review ~~Staff Development Plan~~ Technical Development ~~Annual programme of audit~~ ~~NHS Digital Unified Cyber Risk Framework~~	ISO27001 ~~Cyber Essentials Plus~~ Service Improvement Plans Communications Strategy Digital Maturity Assessment ~~Complete investigation and review of controls and business continuity resilience following IT outage in January 2019~~	ISO27001 (December 2020) ~~Cyber Essentials Plus (National deadline revised to July 2020)~~ DSP Toolkit compliance for 2019/20 Medway benefits realisation programme delivery (revised to March 2020) ~~Commission external cyber security gap analysis and technology baseline assessment (December 2019)~~ Implementation of IPS Intrusion Prevention System) that detects cyber-attacks within the network. (September 2020) Migration from end-of -life operating systems (Jan 2021)	4 x 2 = 8	CW

TRUST BOARD

Paper No: NHST(20)008
Title of paper: Incidents, Complaints, Concerns & Claims – Quarter 3 2019-20
Purpose: The aim of this paper is to provide the Board with an update on the management of incidents, complaints, concerns and claims during quarter 3 2019-20.
Summary Total incidents in Q3 = 3944 Total patient incidents in Q3 = 3302 Total patient incidents graded as moderate/severe and death in Q3 = 48 Number of complaints received in Q3 = 85 Number of PALS contacts in Q3 = 739 Number of new claims received in Q3 = 14 The highest number of incidents reported relate to pressure ulcers. The top reasons for patient complaints, PALS contacts and claims have been consistent for the last four quarters. The most common reasons remain; clinical care, communications, waiting times, patient care/nursing care and values and behaviours of staff. The Trust continues to achieve the target for first stage complaint responses agreed with the complainant in 2019 -20. The number of overdue and second stage complaints has risen in Q3. Additional training in complaint response writing was delivered in January, as part of the action plan to improve this performance.
Corporate objectives met or risks addressed: Care and safety
Financial implications: None as a direct consequence of this paper
Stakeholders: Patients, carers, commissioners, Healthwatch, regulators and staff
Recommendation(s): Members are asked to note the report
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 29th January 2020

1. Introduction

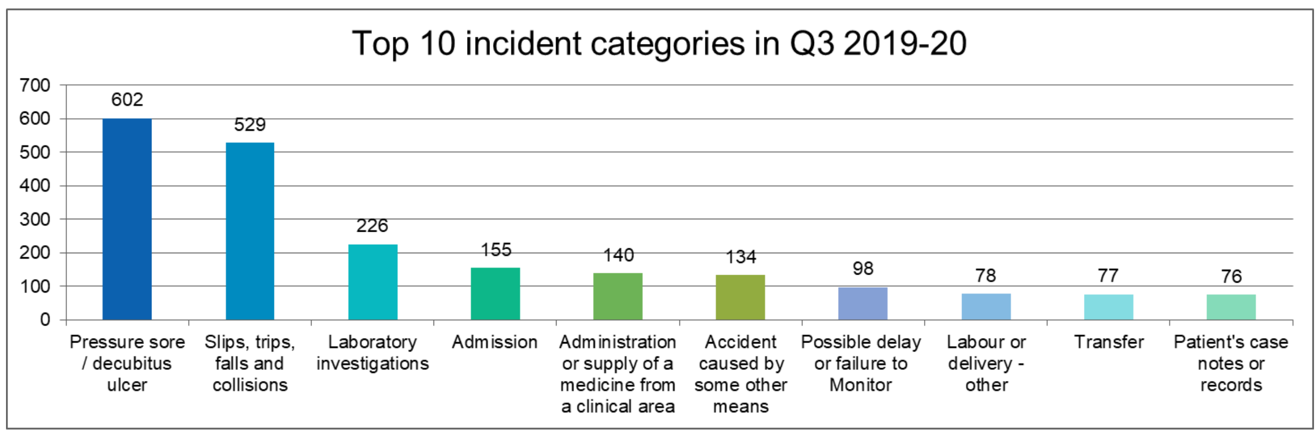
This paper includes reported incidents, complaints, PALS enquiries, claims and inquests during quarter 3 (September – December 2019-20), highlighting any trends, areas of concern and the learning that has taken place.

The Trust uses the Datix to record incidents, complaints, PALS enquiries and claims.

2. Incidents

During Q3 there were 3944 incidents reported, of which 3302 were patient safety incidents. Six incidents were reported to StEIS and 48 categorised as moderate harm, severe harm or death. In comparison, during Q2 there were 3988 incidents reported of which 3318 were patient safety incidents, indicating 1.1% and 0.48% decrease from Q2 respectively. Thirteen incidents were reported to StEIS and 42 categorised as moderate or above, which is a 14.3% increase from Q2.

All patient safety incidents are categorised by the NRLS dataset. The highest reported categories are pressure ulcers which include community acquired and hospital acquired with 602 and slip, trip and falls with 529. These are consistently the highest reported incidents as in Q2 there were 546 pressure sores reported and 544 falls.



2.1. Review of incidents reported to StEIS in Q3 2019-20

In Q3, the Trust reported six incidents to StEIS as outlined in the table below.

Incident	Total
Administration of assessment	1
Cancer - failed or delayed diagnosis	1
Connected with the management of operations / treatment	1
Pressure sore / decubitus ulcer	1
Failure to act on adverse test results or images	1
Diagnosis not normally possible at the time of the incident	1
Total	6

During Q3 there were nine StEIS reports submitted to the CCG, with examples of lessons learned and actions taken in the table below.

Lessons Learned	Action
Specialty patients admitted to ED Observation Ward, require Trust falls risk assessment completing if they stay over 6 hours	• All staff to be involved in ward Falls Pledge • Discuss the findings from the investigation and the action plan at next ward meeting, inviting Falls Nurse Specialist. • Quarterly Falls audit to be carried out and results to be presented at ED Governance meeting with an action plan if required
Falls care plans must be individualised to reflect the care needed for the individual	Link Nurse to arrange 2 teaching sessions for staff focussing on available preventative measures and how staff should choose these to ensure care individualised to the patient
Falls Risk Assessment Tool (FRAT) to be completed within 6hrs of attendance for all patients >55yrs or for any adult who has concerns relating to a heightened risk of falling	Embed new falls risk assessment in ED
Mental Capacity Act and DoLS Policy and its application needs to be embedded in practice	Arrange training from Safeguarding Team to raise staff knowledge and awareness relating to mental capacity and application of DoLS
The CRIS system (the Computerised Radiology Information System used within the Trust) on Medway was not used for investigation requests	CRIS system on Medway to be used for investigation requests and include full and correct clinical history of patient
Patient was not managed on 2 week rule pathway or allocated a Cancer Tracker	A review to be undertaken to ascertain if the reinstatement of a head and neck cancer nurse post within ENT is required

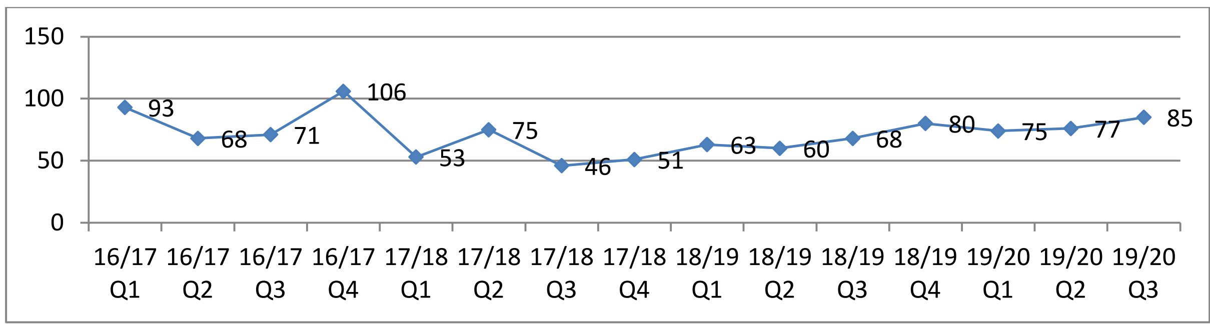
3. Complaints

Indicator	2017-18	2018-19	2019-2020			
			Q1	Q2	Q3	YTD
Total number of new complaints including community services	224	274	75	77	85	237
Total number of new complaints received (excluding community services)	224	267	74	76	84	234
Acknowledged within 3 days – target 100%	97.8%	99.3%	100%	100%	100%	100%
Response to first stage complaints within agreed timescale – target 90%	67%	92.1%	95.4%	91.9%	92.4%	91%
Number of overdue complaints	1	1	1	1	6	6
Second stage complaints	44	36	10	6	14	30

The number of overdue complaints has increased in Q3, due to operational pressures throughout the Trust impacting on the ability to provide statements in a timely manner. This is being closely monitored.

The number of second stage complaints has also increased. The main reasons that complainants lodge second stage complaints are because they want further information or do not agree with the findings. Training on complaints investigation for those involved in investigating and writing complaints took place on 15th January 2020 to refresh skills or upskill staff to carry out thorough investigations into complaints, with the aim of increasing the quality of complaints responses so that fewer progress to a second stage complaint.

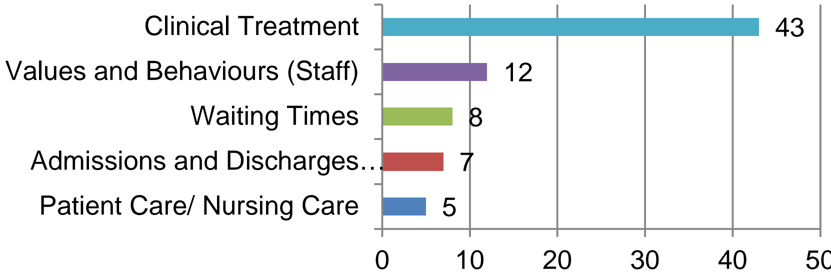
3.1. Complaints activity - First stage complaints received



The number of first stage complaints received during 2019-20 has increased compared to 2018-19, reflecting both the increase in activity, particularly within the Emergency Department as shown in the table below and range of services delivered by the Trust. It is nonetheless disappointing following a significant decrease in complaints in 2017-18, with only a slight increase last year.

Q3 activity	+/- compared to Q3 2018-19	+/- compared to Q2 2019-20
Spells including well babies	-1.3%	-1.4%
Outpatient attendances (seen)	2.5%	0.3%
A&E attendances (Type 1)	7.1%	2.0%

3.2. Top five reasons for complaints Q3 2019-20



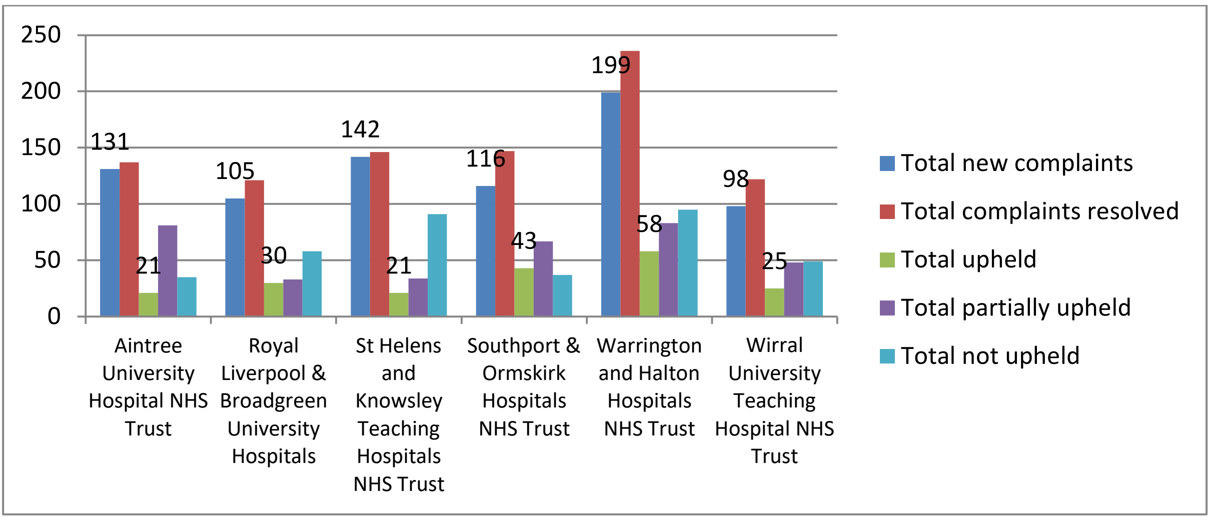
The top five reasons have remained consistent since the beginning of the financial year. Clinical treatment gives rise to the most complaints, followed by values and behaviours (staff), with the majority of these complaints relating to staff interaction with patients/families or carers. Feedback from other sources, including Friends and Family Tests rates staff attitude very positively, however, any negative feedback is taken seriously to ensure a consistently high standard of care is provided. There are plans to review and relaunch the Trust's ACE behavioural standards which will reinforce the Trust's values.

3.3. Complaints by location

Accident and Emergency received the highest number of complaints in Q3 2019-20; this is consistent with previous quarter and this can be attributed to the high levels of activity. The GP Assessment Unit received the second highest number of complaints with 5 complaints in Q3 2019-20 and this is also due to increase in activity in the department.

Locations (with 2 or more complaints in at least 1 quarter)	Q1	Q2	Q3	Total
ED (MCG)	11	17	20	48
Ward 1B GPAU/ Short Stay (MCG)	6	4	5	15
Clinic Ophthalmology (SCG	4	2	2	8
Delivery Suite (SCG)	2	2	3	7
Ward 4A Urology/General Surgery (SCG)	3	1	3	7
Ward 4C Colorectal/General Surgery (SCG)	2	1	2	5
Clinic Surgical Whiston (SCG)	0	3	2	5
Orthopaedic Surgery, Whiston (SCG)	2	2	1	5
ED Paediatrics (MCG)	0	2	2	4
Obstetrics, Whiston (SCG)	2	0	2	4
Theatre Main (Gen Surgery/Urology)	2	1	1	4
Ward 2D Endocrinology/General Medicine (MCG)	3	1	0	4
Ward 2B Respiratory (MCG)	0	2	2	4
Ward 3D Gastroenterology (MCG)	2	1	1	4
Ward 4B SAU/General Surgery (SCG)	4	0	0	4
Clinic ENT, St Helens (CSS)	2	1	0	3
Ward 1A - Frailty Unit (MCG)	2	1	0	3
Ward 3B – T&O (SCG)	0	2	1	3
Total	47	43	47	137

3.4. Comparison with neighbouring trusts of complaints received and upheld for Q1&2 2019-20



NHS Digital publishes data on written complaints for each of the NHS Trusts in the country on a quarterly basis, with Q3 figures due in March 2020. The table above demonstrates that this Trust and Aintree had the lowest number of complaints upheld.

3.5. Closed complaints

During Q3 81 complaints were closed. It should be noted that majority of the complaints relating to clinical treatment are not upheld. Additional information on complaints is contained in appendix 1.

3.6. Dissemination of learning

A summary of actions taken from complaints was provided to the Quality Committee. Each complaint response includes any learning that has been identified and the necessary actions for each area. Incidents and complaints are a standing agenda item on the Care Group and ward governance meetings' agenda to ensure that lessons are learned from complaints and to embed any actions taken to improve the quality of patient care.

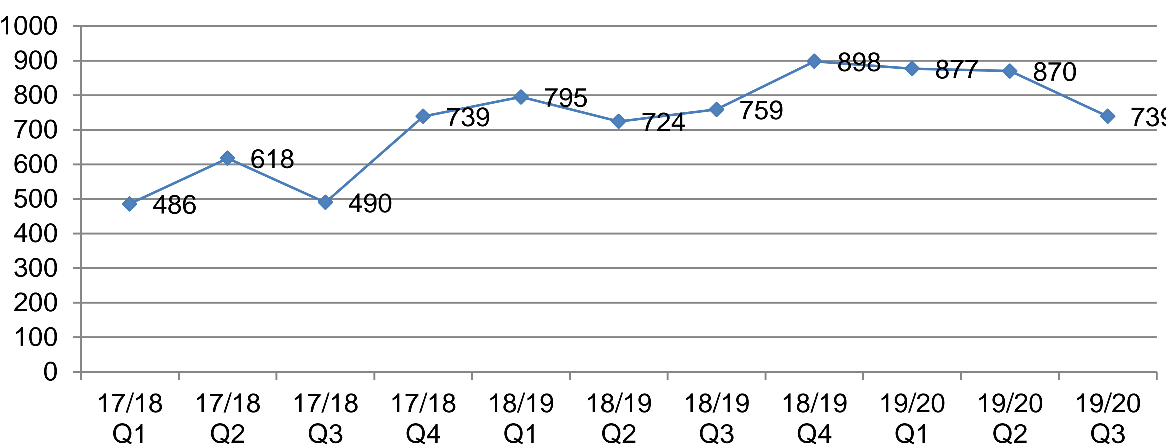
3.7. Parliamentary and Health Service Ombudsman (PHSO) Complaints Cases

There was one new PHSO case opened for investigation in Q3. This involves a complaint regarding various aspects of the complainant's maternity care in 2017, including the lack of independent review and the delay in providing her requested health records.

4. PALS

The number of PALS contacts has remained steady following an increase in previous years.

PALS enquiries by quarter



In Q3 2019-20 96% of PALS queries were resolved and closed. Thirty-one enquiries were converted to formal complaints, which is a 4% conversion rate, consistent with previous quarters.

5. PALS enquiries by subject

The top five themes remain consistent with previous reports in this financial year.

PALS enquiries themes	19-20 Q3
Communications	139
Clinical Treatment	101
Appointments	86
Patient Care/ Nursing Care	80
Admissions and Discharges (excl. delayed discharge re care package)	75

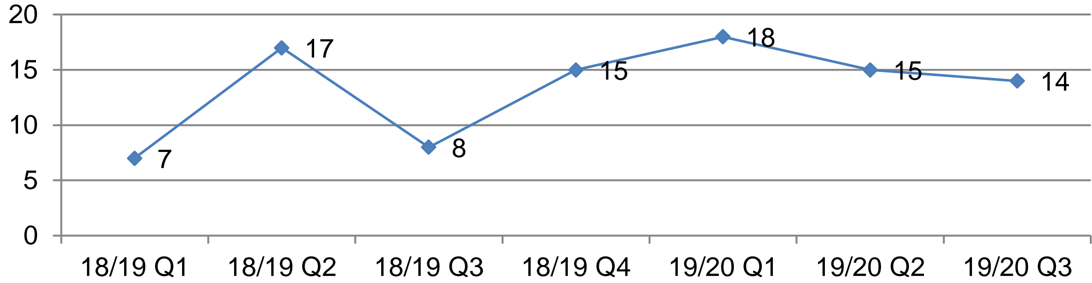
6. Clinical Negligence Claims

One of the Trust's objectives for 2019-20 is to improve learning as a result of claims, to reduce the likelihood that the same errors are repeated. An action plan was developed to deliver this, which was approved by the Executive Committee in December. A copy of the action plan was reviewed by the Quality Committee in January and updates will be reported six monthly to the Committee.

Claims are discussed at the Claims Governance Group and lessons learned are submitted quarterly to the group, with members charged with cascading the information through their governance groups. In addition, actions taken following claims are presented to the Quality Committee. Training sessions have been delivered to clinical staff on themes that have been identified from claims and more training sessions are due to be arranged later in the year.

The Trust has participated for the last two years in NHS Resolution's maternity incentive scheme, achieving full compliance with the required standards and demonstrating the systems and processes in place to deliver safer maternity care. This should result in fewer incidents and fewer maternity claims.

The number of new clinical negligence claims in Q3 was 14.

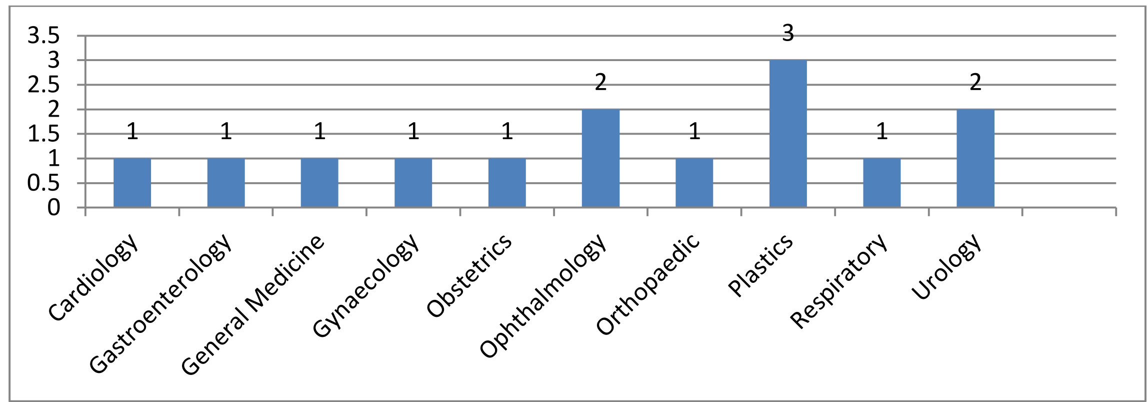


Two of the 14 claims received in Q3 2019-20 had previously been investigated as incidents and 2 others had previously been investigated as complaints.

The top three main reasons for claims have remained consist since the beginning of the financial year.

Subject	NHSR Instructed Claim
Failure to diagnose or delay in diagnosis	5
Fail/ delay in treatment	2
Failure to warn (informed consent)	2

6.1. New clinical negligence claims opened in Q3 2019-20 by specialty



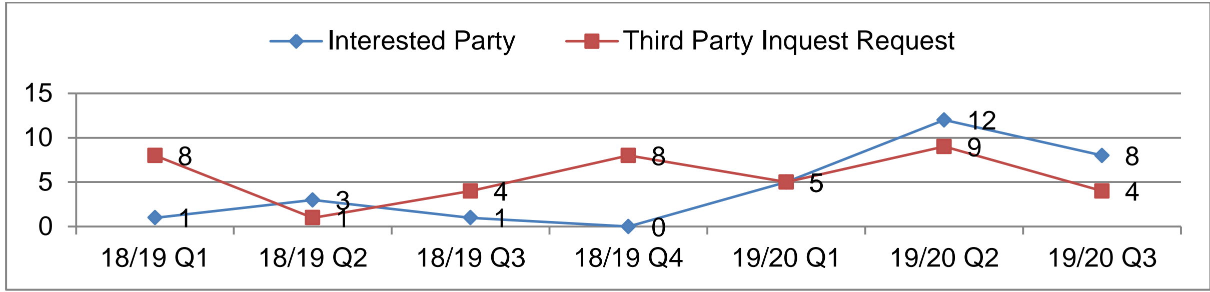
Plastics received the highest number of claims in Q3 2019-20 which is a similar number to previous quarters; however there was a reduction in obstetric and orthopaedic claims, which usually receive the most claims.

6.2. Actions taken as a result of clinical negligence claims closed in Q3

Six claims were settled with damages, four were successfully defended and two were closed following file review. Lessons learned are submitted quarterly to the Claims Governance Group and members are asked to cascade through their governance groups. In addition, lessons learned are shared with the Quality Committee.

7. Inquests

There has been a decrease in the number of inquests received in Q3 2019-20 in comparison to Q2 2019-20. Three inquests were closed in Q3, 2 of which were third party inquests and one interested party inquest with a conclusion of narrative verdict, with no actions for the Trust.

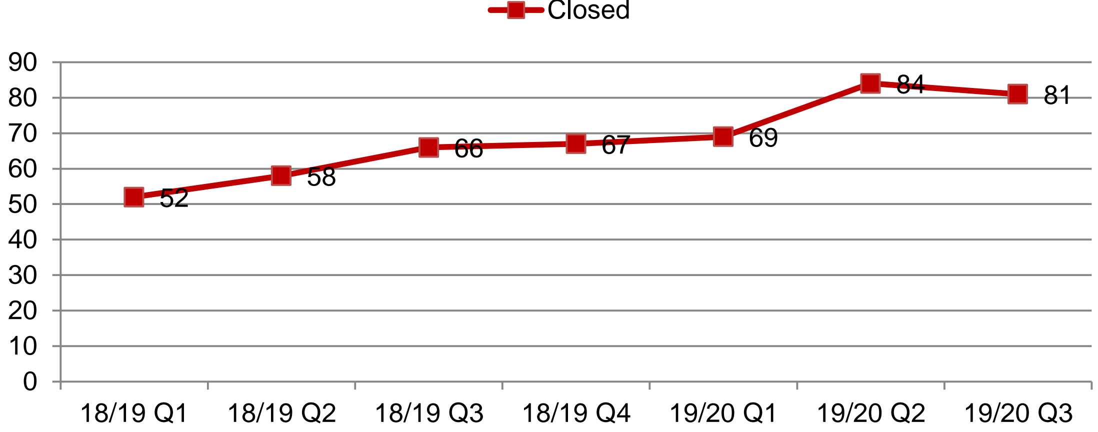


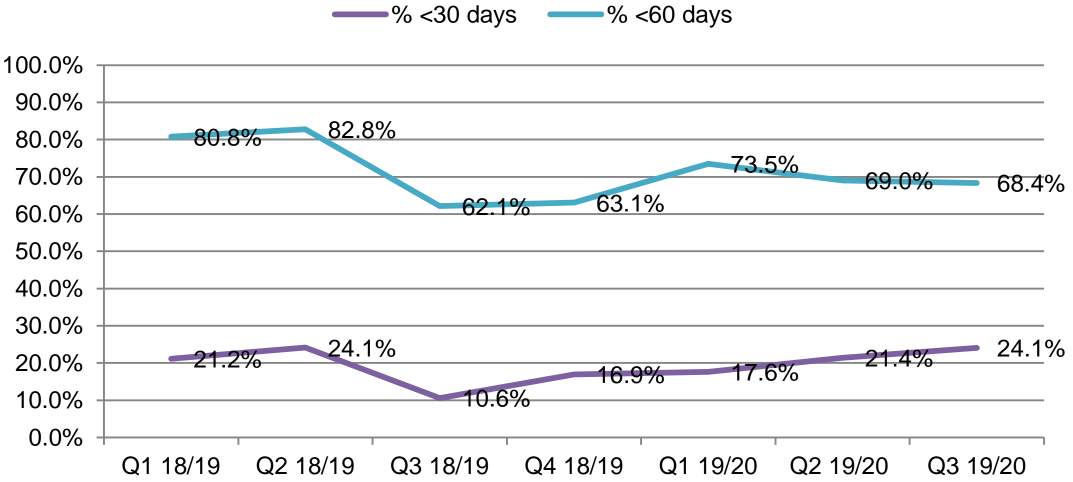
8. Recommendations

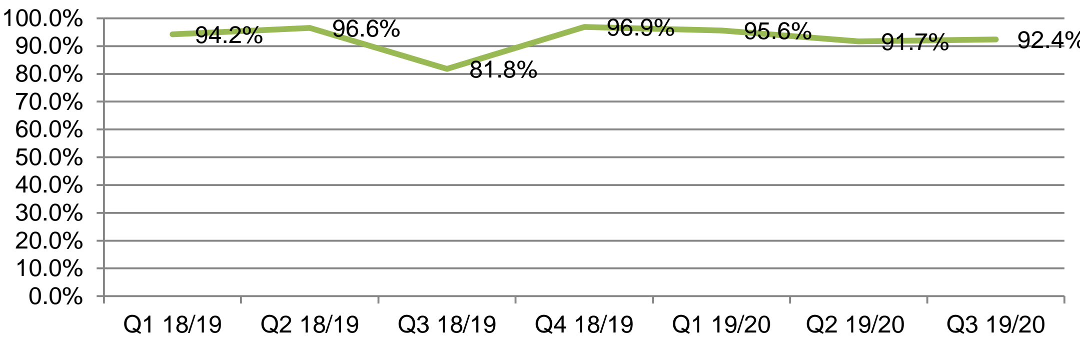
It is recommended that the Board note the report and the actions taken as a result of incidents, complaints and claims.

ENDS

Appendix 1 – Summary of complaints activity







Outcome of closed complaints in Q3

	Not Upheld Locally	Partially Upheld Locally	Upheld Locally	Total
Admissions and Discharges (excl. delayed discharge re care package)	3	3	0	6
Appointments	2	1	0	3
Clinical Treatment	20	15	3	38
Communications	5	0	0	5
End of Life Care	2	0	0	2
Facilities	0	1	0	1
Patient Care/ Nursing Care	2	2	1	5
Trust Admin/ Policies/ Procedures (Inc. Patient Record Management)	1	1	0	2
Values and Behaviours (Staff)	6	5	2	13
Waiting Times	3	2	1	6
Total	43	30	7	81

TRUST BOARD

Paper No: NHST(20)009
Title of paper: Learning from Deaths Quarterly Report 2019/20 Q2
Purpose: To describe mortality reviews that have taken place in both specified and non-specified groups; to provide assurance that all specified groups have been reviewed for deaths and key learning has been disseminated throughout the Trust.

Summary: Q2 data, final RAG rating and key learning described

In Q2 a total of 118 deaths were identified for review from the specified groups and as a % of other deaths.

During this period the target of reviewing 25% deaths was not achieved because 1 case in the specified group has no available notes yet. This is the first time this has occurred and it will be included once available.

Of the 118 reviews 111 (94%) were assessed as having no concerns and 6 (6%) were assessed as needing referral for multi professional review and there were no deaths where the death may have resulted from problems in care delivery or service provision.

	Total number of Reviews	Green/Gr with Learning	Amber	Red
July 2019	44	41	2	0
August 2019	42	40	2	0
Sept 2019	32	30	2	0

Since July 2019 a number of learning themes and trends have been identified. The learning themes and actions being taken to address them are:

- Correct completion of EOL / DNACPR – working group including Trust Solicitors to deliver a learning package for clinicians that focuses on timely identification of a dying patient and ensures clinicians, patients and families are legally and morally supported in decision-making;
- Multiple MET calls on individual patients – aggregated comprehensive report to identify learning and gain assurance that MET policy is followed in a timely and appropriate manner. Senior clinical involvement in ongoing care adds quality to the last hours or days of life for an individual patient where this is the anticipated outcome and dignity is to be preserved;
- Death Certificate completion – examples fed into FY1/FY2 case review teaching. Ongoing learning where errors have occurred. Will ultimately be superceded by appointment of senior clinicians in Medical Examiner role;
- Recognition of exceptionally good care; this is acknowledged by the Mortality Surveillance Group in writing and can be used by the individual to support appraisal & revalidation.

Despite regular submissions to the care groups of the learning generated from the structured judgement reviews (SJRs), and inclusion of the key messages at every meeting, the identification of the learning themes outlined above indicates that more work is required to ensure that this communication is reaching direct patient care givers and generates the changes required to improve care.

Following a successful palliative care study day, it has been agreed to use this format to share with Trust staff what we've learned so far, changes achieved and what we still have to do: "*Dying Matters – the Next Step (Insight to Learning from Deaths)"* which is being planned for 1st October 2020, when we will have 2 years' data from the learning from deaths process.

Learning & Sharing 2019/20 Q2

We aim to do this:

Learning from Deaths Mission Statement

"To put the patient at the forefront of what we do by being empowered to question our peers, without fear of reprisal, judgement or blame, in order to learn so that learning can lead to change. Accepting that in questioning we may raise more questions but ultimately with the aim of improving care".

Our challenge is:

Building and nurturing an improved culture

"New ways of thinking and working can be introduced, but these new ways will only become embedded within the team if they enable people to work more effectively than before. Effective culture change, therefore, is about building and nurturing an environment that allows culture change to occur naturally. When trying to encourage the adoption of a new way of doing things, we must make sure that our expectations are realistic. Culture change cannot be delivered overnight so we must try not to drive change too rapidly." *Ref: NHSI Improvement Leaders Guide 2017*

Assurance

Sharing: (Current Q1) Board (mins) □, Quality Committee (mins) □, F&P (mins) □, CEC (mins) □, PSC (mins) □, PEC (mins) □, MCG Governance (mins) □, SCG Governance (mins) □, Grand Rounds (mins) □, ED Teaching (record) □, FY Teaching (record) □, Team Brief (record) □, Intranet Message Board (record) □, Global Email (record) □, Directorate meetings (mins) □.

List any policies/procedures or guidelines changed:

………

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

Corporate objectives met or risks addressed: 5 star patient care: Care, Safety, Communication

Financial implications: None

Stakeholders: Trust patients and relatives, clinicians, Trust Board, Commissioners

Recommendation(s): To approve the report, policy and good practice guide

Presenting officer: Mr Rowan Pritchard-Jones, Medical Director

Date of meeting: 29th January 2020

STHK Learning From Deaths Board Report 2019/20

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Grand Total
	Deaths in Scope [1]	129	145	134	162	143	110	823
Specified Groups	Maternal Death	0	0	0	0	0	0	0
	Neonatal Death or Stillbirth	0	0	0	0	0	0	0
	Child Death	0	0	0	0	0	0	0
	Learning Difficulties Death	2	5	1	1	3	2	14
	Severe Mental Illness Death [2]	1	2	3	1	0	2	9
	CQC Alert Death	0	0	0	0	0	0	0
	SMR Alert Diagnosis Group Death [3]	6	3	2	5	8	8	32
	SIRI Death	0	0	1	1	1	0	3
	Concern Death [4]	3	4	4	5	5	2	23
	Post-Op Death	7	8	7	10	10	12	54
	Total [5]	18	21	17	23	25	25	129

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Grand Total
% Specified Groups Reviewed (Target 100%)	100.0%	100.0%	100.0%	100.0%	96.0%	100.0%	99.2%
% Non-Specified Groups Reviewed	26.1%	26.6%	25.6%	15.8%	15.3%	9.4%	20.2%
Total % Reviewed (Target 25%)	36.4%	37.2%	35.1%	27.8%	29.4%	30.0%	32.6%

Outcome of RAG Reviewed Deaths [6]	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Grand Total
where no concerns	44	47	43	42	40	30	246
	95.7%	90.4%	97.7%	95.5%	95.2%	93.8%	94.6%
where significant doubt about whether or not, problems in care delivery/service provision contributed to death - refer to multi professional review	2	5	1	2	2	2	14
	4.3%	9.6%	2.3%	4.5%	4.8%	6.3%	5.4%
where balance of probability is that death may have resulted from problems in care delivery/service provision - refer to SIRI investigation	0	0	0	0	0	0	0
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Grand Total	46	52	44	44	42	32	260

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

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

[3] SMR Alert Diagnosis Group under internal monitoring. Apr-Jun 19 - Intestinal infection, Liver disease; alcohol-related and Osteoarthritis.
Jul-Sep 19 - Acute and unspecified renal failure and Senility and organic mental disorders

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

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

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

TRUST BOARD

Paper No: NHST(20)010
Subject: HR/Workforce Strategy & HR Indicators Report.
Purpose: This paper is to provide assurance on the delivery of the workforce strategy over the last 6 months and update on recent or forthcoming changes to legislation or NHSE/I guidance.
Summary: The Trust is committed to developing the organisational culture and supporting our workforce. This paper provides an update on strategic matters aligned to the key priorities as detailed in the NHS long term plan and the second part relates to workforce indicators. Overall the paper summarises achievements/progress to date. • Increase numbers of nurses and medical workforce • Focus on staff retention and outcomes of exit interview review • A compassionate and inclusive leadership culture. • Zero tolerance on violence towards NHS staff. • Increased focus on respect, equality and diversity. • Productive working through electronic rosters and job planning. • New focus on leadership and talent management. • Encouragement for and investment in volunteering initiative • Employee relations formal process case update • Key workforce performance indicators update
Corporate Objective met or risk addressed: Developing organisation culture and supporting our workforce
Financial Implications: To be determined following the review
Stakeholders: Trust Board, Senior Management, all staff, staff side colleagues
Recommendation(s): The Trust Board is requested to note the content of this paper and that actions are in place to ensure continued delivery of the Workforce Strategy.
Presenting Director: Anne-Marie Stretch, Deputy CEO/Director of HR
Trust Board: 29th January 2020

HR/Workforce Strategy & Workforce Indicators Report

29th January 2020

1.0 Purpose of paper

This paper provides an update to the Board on the Trust's workforce indicators, aligning delivery against the Trust's Workforce Strategy priorities and the wider national picture.

2.0 Summary of position

The paper reviews HR indicators against national benchmarks and local intelligence and activity to determine areas of risk and assure the Board of action being taken to mitigate those risks.

Review of the core HR indicators used by the Trust, alongside national and regional benchmarks where available, indicates that the key areas for focus are sickness absence, appraisal completion and core training compliance. Staff retention remains high, with a dip in August attributed to the Medical and Dental staff group due to medical rotations. In April there was a drop in stability which when compared to previous years is an outlier, and is attributable to the out TUPE of Southport and Ormskirk staff. However the stability index when reviewed from May 2019 onwards does show a general downward trend for the Trust which is being addressed by Phase 3 of the Retention Programme. Alongside the sickness absence improvement programme, significant effort is being placed on increasing the flu vaccination update. The Trust's EDI programme is progressing well, with three expanding staff networks, an award from the Ministry of Defence Employer Recognition Scheme Gold Award, the Veterans Aware accreditation in October for its support to Veterans and the Armed Forces. The Trust was also a finalist at the HSJ awards in November for the Reservist Initiative Award.

3.0 Background

3.1 NHS Interim People Plan

The NHS Interim People Plan, published in June 2019, defines the key workforce priorities by five themes:

- Making the NHS the best place to work
- Improving our leadership culture
- Addressing urgent workforce shortages in nursing
- Delivering 21st century care
- Develop a new operating model for workforce

Alongside these themes were specific 2019/20 actions designed to address some of the most pressing challenges, while the full five year People Plan is developed. In the last six months wellbeing and flexible working have come to the fore as priorities. The Trust response to these is detailed throughout the paper.

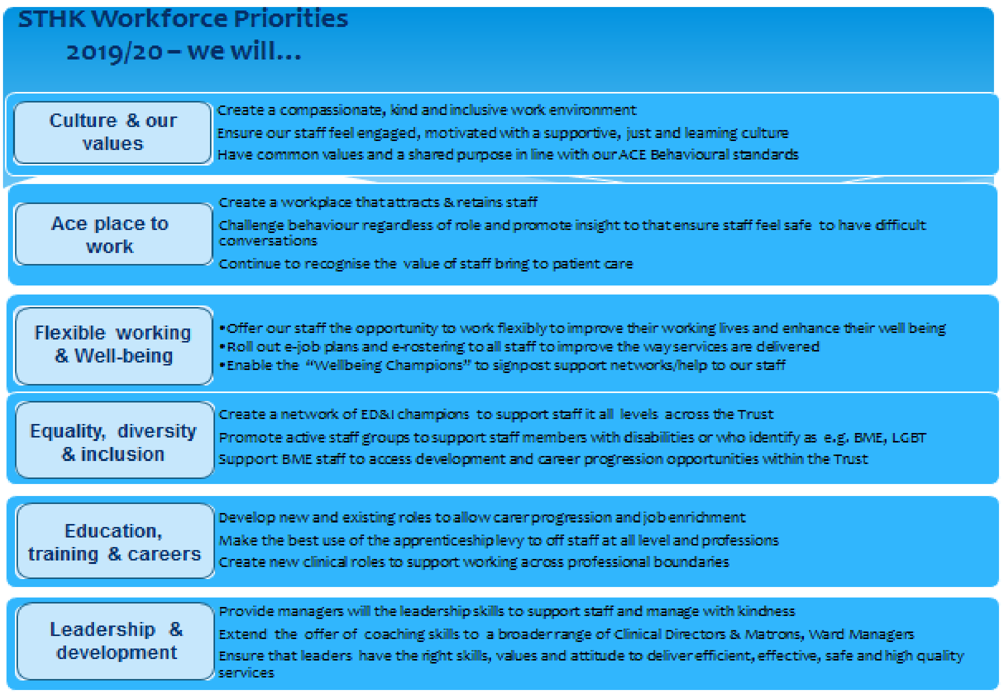
3.2 Learning Lessons to Improve our People Practices

In May 2019, the Chair of NHS England, Dido Harding wrote to all Trusts with recommendations relating to the management and oversight relating to local investigations and disciplinary procedures, following the national review of a London Trust case. These recommendations particularly focused on acting as caring and responsible employers, and asked Trusts to review their current practices in light of the recommendations. The Trust developed an action plan following our review of processes, and as per reporting to Workforce Council, all actions are on target to be delivered to support the delivery of actions to support the implementation of improving people practices.

3.3 STHK Workforce Strategy

The Trust's workforce strategy for 2019/20 was developed as a one-year strategy to allow for the anticipated five year NHS People's Plan to be published. Six priorities (Figure 1) were developed following engagement across the Trust with staff from all departments, professional groups and staff side colleagues. As per reporting to Workforce Council, all actions are on target to be delivered to support the delivery of the Workforce Strategy.

Figure 1: STHK Workforce Strategy



3.4 Alignment of Priorities

All of the Trust's Workforce Strategy priorities align to the NHS Improvement Interim People Plan, with the majority mapping to making the NHS the best place to work, improving our leadership culture and addressing urgent workforce shortages in nursing. By reviewing and implementing the recommendations from Improving our

People Practices, the Trust is proactively seeking to create a positive and supportive culture.

4.0 HR Indicators
4.1 Model Hospital

Table 1 benchmarks the Trust against National, North West and Acute peer groups for the key workforce indicators. The Trust has initiatives in place to deliver improvements in each of the metrics.

Table 1: Model Hospital Benchmarking Jul-19 to Dec-19

Use Of Resources										
	Trust						National	North West	Acute Peers	Trend Line
People	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Data Source NHS Digital	Data Source NHS Digital	Data Source NHS Digital	
Staff Retention Rate "The number of staff who were employed at the start of the period who have remained in employement at the end of the period. The % are based over a 12 month	89.74%	86.54%	87.10%	87.79%	87.81%	87.81%	85.60%	86.80%	85.10%	
Sickness Absence Rate	5.06%	4.78%	4.93%	5.26%	5.33%	5.71%	4.42%	5.09%	4.20%	
Vacancy Rate	3.21%	3.63%	4.57%	4.48%	4.01%	4.01%	N/A	N/A	N/A	
Turnover Rate (Last 12 months) "Number of Leavers within the period / No of staff at the end of the period)	10.40%	11.58%	11.77%	11.63%	12.16%	12.14%	19.00%	15.20%	11.00%	
Safe	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Trust Target			Trend Line
Mandatory Training Rate	82.56%	81.77%	82.10%	81.89%	82.60%	82.92%	85.00%	N/A	N/A	
Appraisal Completion Rate	83.85%	83.36%	82.92%	80.97%	80.17%	80.36%	85.00%	N/A	N/A	
Medical Appraisal	71.11%	78.48%	73.61%	81.07%	79.22%	74.00%	85.00%	N/A	N/A	

4.2 Vacancies

Trust vacancy rates reached a peak in September 2019 to date, reducing to 4.01% in November 2019 (Figure 2). This is based on 5,244.60 WTE staff in post against a funded establishment of 5,463.44 WTE as at November 2019, giving a gap of 218.84 WTE overall. While the vacancy rates alter on a monthly basis, the staff group analysis demonstrates that Healthcare Scientists, Medical and Dental, and Nursing and Midwifery are consistent contributors to the vacancy rate (Table 2). As Healthcare Scientists are a relatively small WTE of overall staff numbers, the c.2% increase in vacancy rate equates to an increase in 4.57 WTE vacancies (Table 3). The Medical and Dental increase is due to an increase in funded establishment, but no correlating increase in staff in post in September 2019.

Figure 2: Trust Vacancy Rates Apr-19 to Nov-19

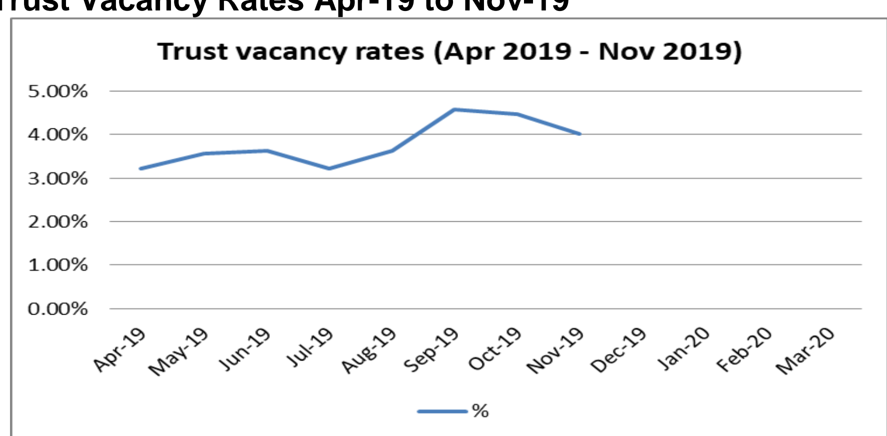


Table 2: Trust Vacancy Rate by Staff Group (Apr-19 to Nov-19)

Vacancy Rate	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
Staff Group	%	%	%	%	%	%	%	%
Add Prof Scientific and Technic	3.91%	4.81%	4.33%	3.94%	3.47%	3.86%	3.37%	0.54%
Additional Clinical Services	2.78%	3.41%	3.94%	3.58%	4.86%	5.35%	5.70%	4.93%
Administrative and Clerical	2.76%	3.87%	3.79%	3.73%	2.77%	4.49%	5.40%	4.03%
Allied Health Professionals	1.86%	3.13%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estates and Ancillary	0.31%	0.66%	0.24%	0.00%	0.00%	0.00%	0.00%	0.00%
Healthcare Scientists	6.39%	4.51%	3.17%	2.06%	4.26%	6.28%	5.81%	8.12%
Medical and Dental	6.05%	4.17%	5.05%	2.33%	2.95%	5.53%	5.95%	5.47%
Nursing and Midwifery Registered	3.28%	3.60%	4.35%	4.42%	5.37%	5.85%	4.43%	4.54%
Grand Total	3.22%	3.57%	3.62%	3.21%	3.63%	4.57%	4.48%	4.01%

Table 3: Staff Group Vacancy Rate November 2019

Staff Group	Budget	WTE in post	Gap	Vacancy %
Add Prof Scientific and Technic	194.91	193.87	1.04	0.54%
Additional Clinical Services	1114.76	1059.76	55.00	4.93%
Administrative and Clerical	1244.81	1194.67	50.14	4.03%
Allied Health Professionals	294.06	295.11	-1.05	-0.36%
Estates and Ancillary	297.14	300.31	-3.18	-1.07%
Healthcare Scientists	196.72	180.75	15.97	8.12%
Medical and Dental	492.53	465.61	26.92	5.47%
Nursing and Midwifery Registered	1628.52	1554.52	74.00	4.54%
Grand Total	5463.44	5244.60	218.84	4.01%

4.3 Recruitment

In the period July to December 2019 the Recruitment Team has achieved the following:

- 717 offers of employment (excluding international nurse recruitment programme) for 648.81wte positions within the Trust.
    - Of these 309.27wte (47%) were external appointments with 183.54wte (59%) offers being for Nursing and Midwifery positions.
- The Trust currently has a pipeline of 61.95wte external Band 5 nurses awaiting start dates with the Trust.
    - Within this are 40 student nurses that are due to qualify between January and October 2020; the majority of which complete their studies in March 2020.
- The Trust welcomed 326.35wte new starters of which 29% (94.91wte) were Nursing and Midwifery roles.
- The Trust bank also grew during this period seeing an additional 399 new staff and 250 internal staff join the bank.
- The Trust has recruited an additional 111.40 wte external RNs (not including international nurses) Safer Staffing ward areas.

The Trust has committed to recruiting 50 international nurses in this financial year and has an established recruitment pipeline in place for qualified overseas nurses to join the Trust. The Trust has welcomed 31 overseas nurses between April and December 2019. A further 2 cohorts of 11 nurses are planned for the remainder of the financial year bringing an estimated total of 53 internationally recruited nurses for 2019-20.

The Trust is currently supporting 15 Registered Nursing Degree Apprenticeships due to complete at varying stages over the next 2 years, and 15 Trainee Nursing Associates who on completion of training in December 2021 will contribute to the wider nursing team as a Registered Nursing Associate. The Trust continues to test future workforce requirements against multiple supply routes to ensure a safe, sustainable nursing workforce in line with the NHS Interim People Plan.

Since July 2019 the Trust recruited 9 international medics, in addition the Trust recruited 16 Foundation Doctors from the Czech Republic (Brno), 11 of which are EU nationals. To further support the medical rotas, the Trust is supporting the training of Physician Associates students.

4.4 Temporary Workforce

The Trust's agency spend at Month 9 is £5.88M against an agency spend cap from NHS Improvement for 2019-20 of £7.571M. This is a reduction of £0.7M compared to the same period of 2018-19. The Trust's bank spend at M9 is £10M which is an increase of £1.67M compared to the same period of 2018-19.

The Trust continues to see a high level of requests for rota gaps to be filled by bank and agency workers. The activity for the last six months is shown in the Table 4.

Table 4: Temporary Staffing Activity July 2019 – December 2019

	July	August	September	October	November	December	Overall
Requests	11028	10630	9928	10001	9875	10085	61547
Filled	9053	8849	8778	8323	8348	7865	51216
Bank	7663	7572	7495	6950	6836	6341	42857
Agency	1390	1277	1283	1373	1602	1524	8449

The Temporary Workforce Team have achieved an 83% fill rate for all shifts over the 6 month period with 84% of those shifts being filled by bank workers and the remaining 16% filled by agency. In comparison to the same period of 2018-19 whilst the number of requests remained relatively static the fill rate has increased by 4% (an additional 2,505 shifts).

The Trust has, overall, filled an additional 2,866 shifts by bank compared to 2018-19 and has seen a reduction in the number of shifts filled by agency of 271 shifts.

In September 2019 NHS Improvement (NHSI) made amendments to the rules regarding engaging agencies to supply staff. These changes specifically relate to administration and estates. With effect from Monday 16th September 2019 Trusts have been required to only use substantive, fixed term or bank workers to fill temporary administration roles. This in particular relates to corporate and professional managerial roles such as IT, Finance and HR. The Trust follows a robust Executive and NHSI approvals process if the Trust needs to utilise agency workers for admin and estates positions.

4.5 E-Resourcing

Specialist Nurse job planning is underway and work is ongoing to meet the deadline of 31st March 2020 for completion of the first round of job planning. This involves over 300 staff job planning utilising the electronic system for the first time. The Activity Manager system continues to be implemented within the Surgical Care Group with completion expected in 2020. Medical Care Group will then follow.

The Trust has 5 Key Performance Indicators for rostering of staff and our current performance is as shown in Table 5.

Table 5: E-Rostering Key Performance Indicators

KPI	Definition	Ratings			Current Performance
Roster Approval Time	The number of days prior to the start of a roster period when the roster has been completed.	54 days or less	55 days	56 days or more	48 Days
Filled Duty Count	The number of duties within the standard roster shift demand template which have been assigned and do not remain vacant.	80% or lower	81% to 90%	91% To 100%	79.4%
Hours Balances (4 wk period)	The number of unused contracted hours within the four week roster period.	2.5% or higher	2.1% to 2.4%	2.0% Or lower	3.3%

<table>
<tr><td>Bank & Agency Usage</td><td>The percentage of duties in the roster period which have been filled by Bank and Agency.</td><td>15% or higher</td><td colspan="2">10.1% to 14.9%</td><td colspan="2">10% or lower</td><td>11.4%</td></tr>
<tr><td>Annual Leave Rates</td><td>The percentage of staff on Annual Leave within the roster period.</td><td>8% or lower</td><td>8.1% To 10.9%</td><td>11% To 17%</td><td>17.1% to 19.9%</td><td>20% or higher</td><td>12.9%</td></tr>
</table>

The Trust continues to notify Ward Managers, Matrons and Senior Nurses of the roster deadlines and the compliance by wards against KPIs. The “hours balance” will currently be impacted by the 12 hour shift pilots being undertaken on 2 wards as the patterns are currently such that hours are owed at the end of a 4 week period. To improve the governance around the utilisation and benefits realisation of rostering, a new group has been established Chaired by the Director of Nursing, Midwifery & Governance. In addition to be monitored at Care Group Finance and Performance meetings, any non-compliance of the rostering KPIs is now escalated to the Better Rostering Steering Group. We are also starting to support more teams to create their own rosters with the e-Resourcing team to provide support and upskill them in system use. This is in line with national recommendations from NHSE/I to support flexible working.

4.6 Retention and Turnover

4.6.1 Stability

The Trust’s stability index from April 2019 to December 2019 remains in a positive position above the benchmarks for national, regional and acute peers, despite fluctuations across the period (Figure 3). The lower stability in August 2019 (86.54%) is attributable to the Medical and Dental staff group, and will be related to the junior doctor rotations (Figure 4). The Community Services Care Group showed a decline from April to October 2019, but has now stabilised and is improving retention (Figure 5).

Figure 3: Trust Stability Index

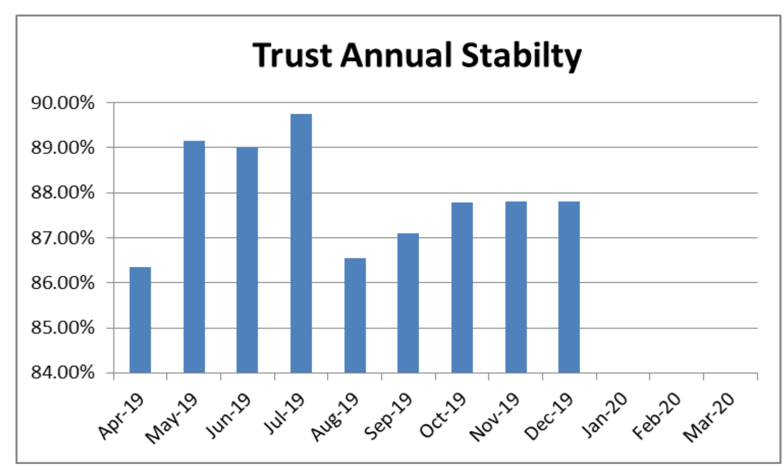


Figure 4: Stability Index by Staff Group

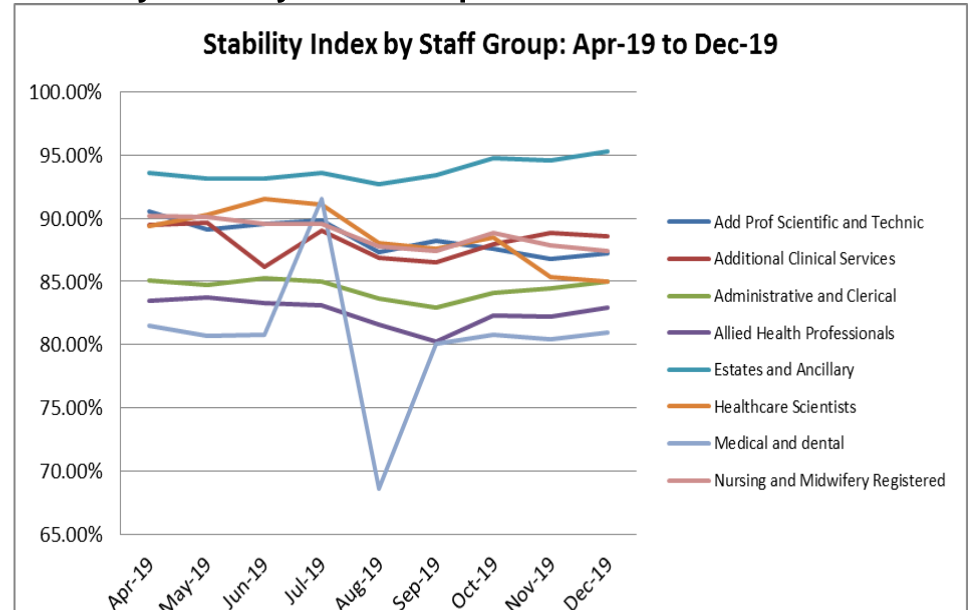
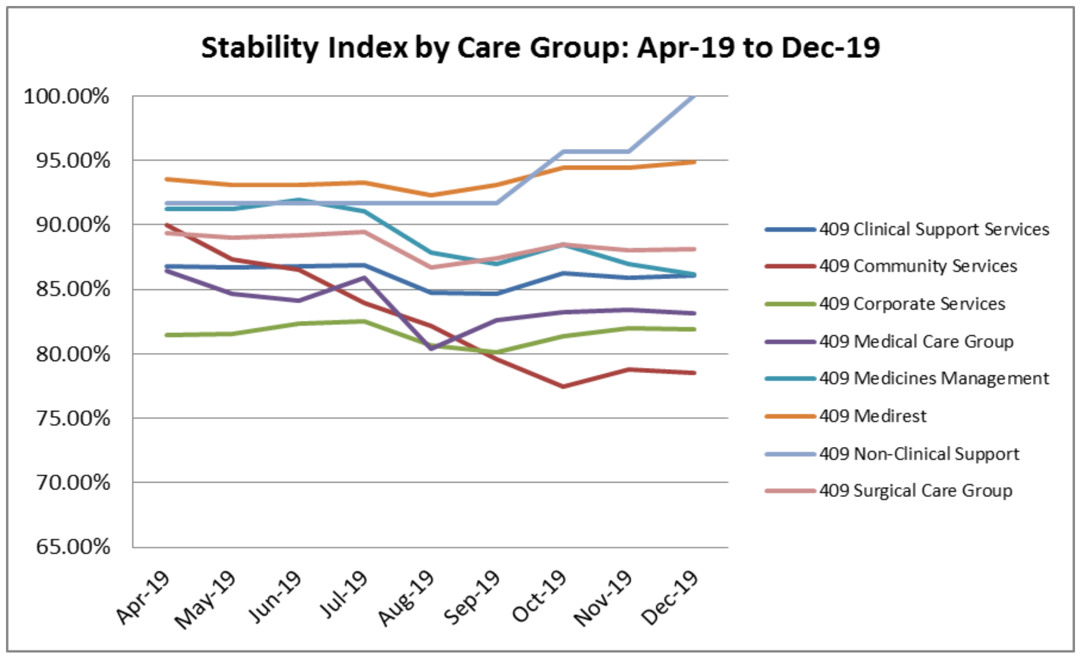


Figure 5: Stability Index by Care Group



4.6.2 Turnover

The Trust's turnover in December 2019 remained below the national and regional benchmark at 12.14% (Table 1) but above the acute peer benchmark of 11%. The annual turnover rate (Figure 6) indicates the highest turnover was seen in Medical and Dental staff, attributed to the annual junior doctor rotations. Table 6 compares the actual number of leavers for the period to the average FTE to provide the turnover rate.

Figure 6: Trust Turnover Rate by Staff Group: January – December 2019

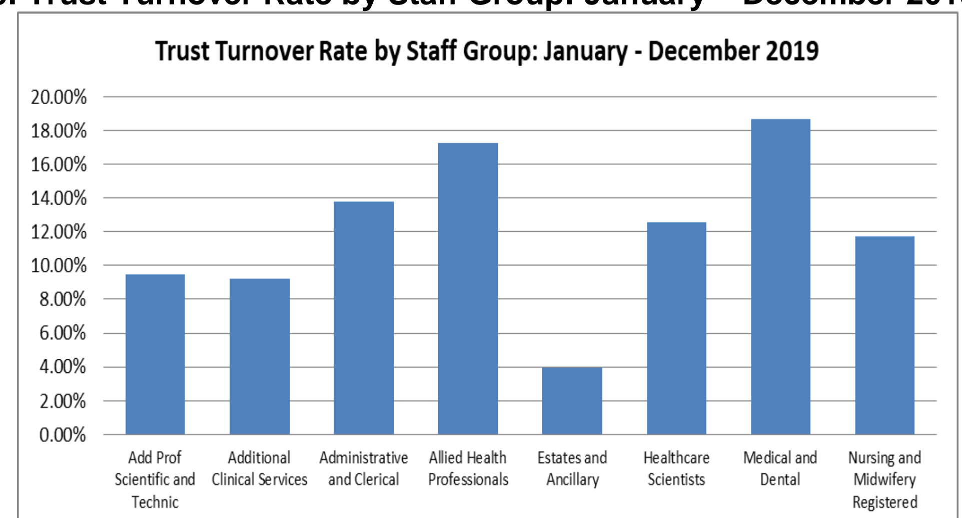


Table 6: Trust Turnover and Leavers by Staff Group: January – December 2019

Staff Group	01.01.2019 - 31.12.2019		
	Average FTE	Leavers FTE	%
Add Prof Scientific and Technic	186.28	17.68	9.49%
Additional Clinical Services	1041.02	96.14	9.24%
Administrative and Clerical	1180.18	162.43	13.76%
Allied Health Professionals	286.91	49.52	17.26%
Estates and Ancillary	291.81	11.55	3.96%
Healthcare Scientists	186.96	23.45	12.54%
Medical and Dental	460.89	86.19	18.70%
Nursing and Midwifery Registered	1549.04	182.15	11.76%
Grand Total	**5183.1**	**629.11**	**12.14%**

4.6.3 Potential Retirements

As at 31st December 2019 there were 239 staff aged 65 eligible to retire, the figure will increase to 336 in the next twelve months (Table 7). Of the Nursing and Midwifery 370 are aged 55 and eligible to retire, the figure will increase to 443 in the next twelve months. The current retention programme makes use of retire and return opportunities. Approximately 50% of nursing staff return after retirement on part-time hours which enables the Trust to retain skills and experience, and support the effective development of more junior staff.

Table 7: Potential Retirements Due – Cumulative

Retirement at age 65						
Staff Group	**Retirements Due**	**3 Months**	**6 Months**	**9 Months**	**12 Months**	**5 Years**
Add Prof Scientific and Technic	6	6	7	8	9	18
Additional Clinical Services	72	81	90	102	111	262
Administrative and Clerical	57	59	68	74	82	207
Allied Health Professionals	4	4	4	4	4	9
Estates and Ancillary	34	38	41	42	45	98
Healthcare Scientists	6	6	6	7	8	17
Medical and Dental	24	25	26	27	28	53
Nursing and Midwifery Registered	36	39	42	48	49	137
Grand Total	**239**	**258**	**284**	**312**	**336**	**801**
Retirement at age 55						
Staff Group	**Retirements Due**	**3 Months**	**6 Months**	**9 Months**	**12 Months**	**5 Years**
Nursing and Midwifery Registered	370	379	397	421	443	722

4.6.4 Retention Programme

Since July 2019, the retention focus has been on enhancing the STHK welcome, in addition to understanding why our staff choose to leave the Trust.

This has led to the implementation of a welcome pack, which has been distributed to all new starters in the Trust from November 2019. This pack contains lots of Trust information and 'how to' guides as well as items of use tailored to the requirements of the role – depending upon the staff group appointed– i.e. RN's receive a fob watch, Admin & Clerical receive a pencil case and highlighter. Feedback from this initiative has been extremely positive across all roles.

A benefits brochure has been created, which outlines all of the financial, development and wellbeing benefits enjoyed by members of the Trust – this is used as both an attraction and on-boarding tool.

Work is currently ongoing to set up a Trust Welcome meeting which every new starter to the Trust will be required to attend. This will provide:

- A corporate welcome to new staff
- Help staff to understand and appreciate the Trust's significant achievements
- Provide an overview of the aim, strategy and vision of the Trust
- An understanding of the STHK family ethos.

This will be rolled out before the end of the financial year.

The exit questionnaire has recently been revamped and relaunched, which has seen a significant uptake in responses. To date 66 responses to this anonymous questionnaire have been received. These responses are in the process of being analysed for remedial action to be considered if appropriate.

Work is ongoing to launch a Managers guide on supporting the leaving process for staff. The guidance will act as an aide memoire with associated resources to assist managers in effectively managing the staff leaver process, including the requirement for a face to face meeting, accurate reporting and stay conversations.

4.7 Volunteers

The Trust has increased the number of active volunteers by 35% since November 2019. A review of the application and on-boarding process has resulted in a more streamlined approach being taken to bringing in new volunteers. This means that the Trust has been able to increase the number of engagement events by 20%.

The Trust continues to be a popular choice for those seeking volunteering opportunities and so with minimal advertisement, each event attracted attendance levels of between 60 and 80 applicants.

In September 2019, the Trust moved to e-roster to record volunteer's hours. From September to December 2019, our volunteers contributed a combined total of more than 10,000 hours (10,308) to the Trust. The movement to e-roster supports the better deployment of volunteers across the Trust and enables the volunteer team to accurately record the volunteering contribution and to easily identify gaps in service provision, so that action can be taken.

Established roles such as meet and greet in the Emergency Department (ED) and at the reception of both Whiston and St Helens Hospital remain a popular choice for our volunteers, as do the ward based volunteer roles and those providing support to the Lilac Centre.

After recently securing a bid for additional funding from NHSI, the Trust is committed to delivering a 'Response Volunteer' programme, supporting the timely discharge of patients by undertaking a range of activities such as collecting prescriptions, supporting patients to collect together their belongings and accompanying patients to discharge lounges. In addition the development of volunteer roles supporting end of life patients is underway, both new roles are likely to be in place by April 2020.

In collaboration with Operations, the ED volunteer role has recently been reviewed in light of the pressures in the department to ensure that the role provides the right services to meet the needs of staff, volunteers and patients. Work is ongoing to provide volunteers on a rolling shift basis from 9am – 9pm to support the department.

The Trust has recently been selected to take part in a "Helpforce" scheme to test a volunteer training platform, which if successful will be rolled out to other Trusts. Twenty volunteers will take part in the scheme, initially completing a self-assessment supported by a training plan, utilising and subsequent e-learning modules to address areas identified Through this scheme the Trust will co-host a workshop with education leads that engages other Trusts from a variety of settings in working through the platform prior to roll out.

The volunteering service has been nominated for the 2020 Queens Award. Initial assessment and interview has taken place and initial feedback is positive. The recipients of the awards will be announced as part of the Queen's Birthday Honours list in 2020.

4.8 Wellbeing

4.8.1 Flexible Working

Flexible working is one of the key areas of the Interim People Plan to enable the NHS to become the best place to work. The focus of flexible working approaches is to enable staff to input into their working patterns to improve work-life balance, with a

recent report from Timewise[1] recommending that Trusts utilise the team-based approach with supporting guidance and governance, and that Trusts also develop better training and guidance on e-rostering for work life balance.

Steps have been taken at the Trust to test out new shift patterns and rostering approaches, such as piloting twelve hour shifts and a review of the Nursing and Midwifery e-Rostering Good Practice Guide. The feedback on twelve hour shifts has been extremely positive and will support the Trust to explore other working patterns that provide work-life balance including team based self- rostering.

4.8.2 Flu Vaccinations

Currently within the Trust 85% of front line clinical staff have been vaccinated against flu. While slightly behind plan due to more staff being unwell with seasonal viruses so unable to receive the vaccination. A plan has been implemented to reach the Trust target of 95% by the end of February 2020. Low uptake and high risk areas are being targeted daily by Flu nurses and peer vaccinators. Managers and matron are aware of their percentage and are actively encouraging at risk staff to have the vaccine.

4.8.3 Sickness Absence

The Trust's sickness position in December 2019 was 5.71% which is above the target of 4.5% (Figure 7). Year to date figure is 5.09% for sickness as at 31st December 2019, (April 19 to Dec 19), which is above the target of 4.5%. Medirest staff are the Care Group with the highest December 2019 sickness at 10.27%. Medirest has consistently had the highest sickness rate through 2019. In December, Community Services (7.76%), Clinical Support (6.22%), Surgical Care (5.61%) and Medical Care (5.24%) were the following highest sickness rates after Medirest (Figure 8). Benchmarking across Cheshire and Merseyside indicates that sickness in December is averaging c.6.3%. This has been attributed to long lasting seasonal viruses, and the significant levels of activity that NHS Trusts are experiencing. Anxiety and stress remain the highest cause for sickness absence in Dec-19 (26.32%) (Figure 9).

The Trust has a sickness absence improvement programme in place which includes:

- An increase in Mental Health First Aiders from 17 to 31 since July 2019 to support staff with mental ill health including stress and anxiety
- A review of Wellbeing Champion locations across the Trust is currently underway
- Citizens Advice Bureau have now been into the Trust to advise on financial and legal matters with staff, a key local and national concern
- Initial engagement with Financial Well Being providers has taken place to support our financial wellbeing strategy, as per national guidance
- Tai-Chi, Yoga and Mindfulness sessions have been running across the hospital available to staff, alongside a "Book Prescription Service" so HWWB can "prescribe" self-help books from the library, and the static bike loan across several departments so staff can exercise in the workplace

[1] https://timewise.co.uk/wp-content/uploads/2019/09/Timewise-Nursing-Report-2019-1.pdf

Figure 7: Trust Sickness Absence Apr-19 to Dec-19

Sickness 2019-2020

Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
4.92%	4.78%	4.86%	5.06%	4.78%	4.93%	5.26%	5.33%	5.71%

Figure 8: Sickness Absence by Care Group Dec-19

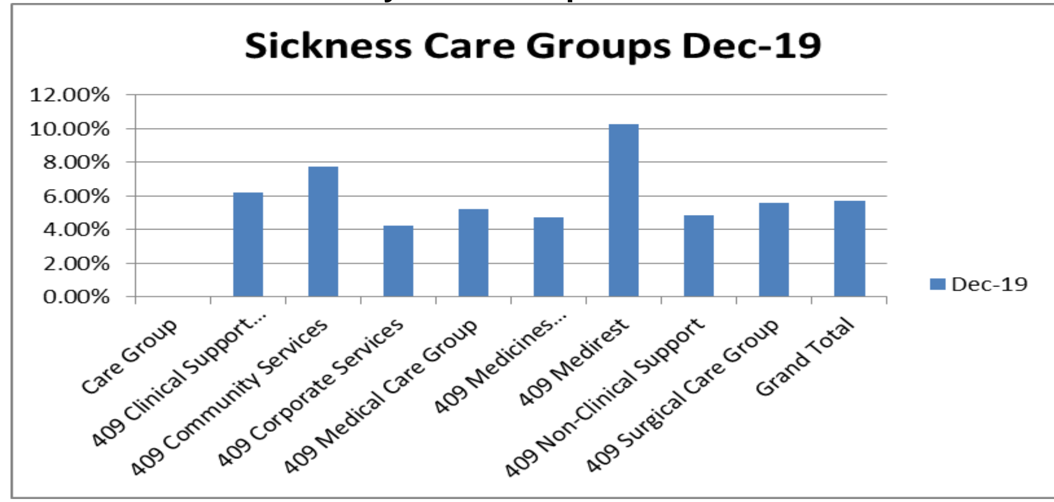
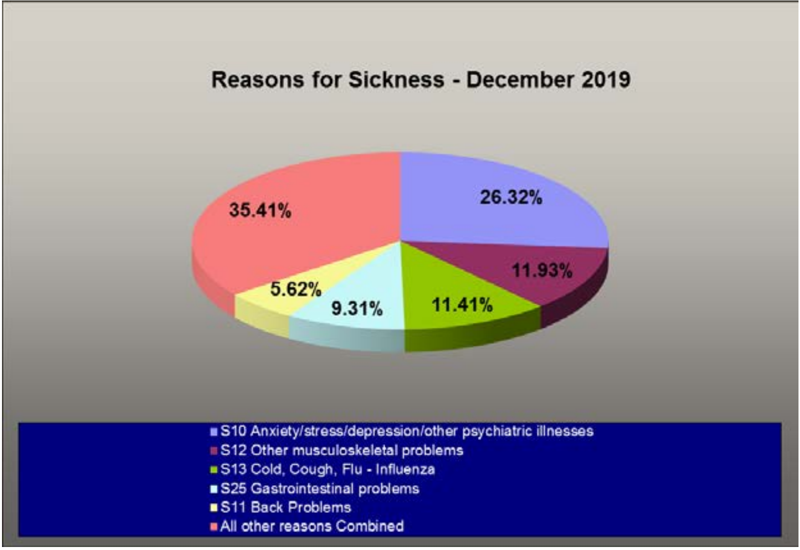


Figure 9: Reasons for Sickness Absence Dec-19



4.9 Equality, Diversity and Inclusion

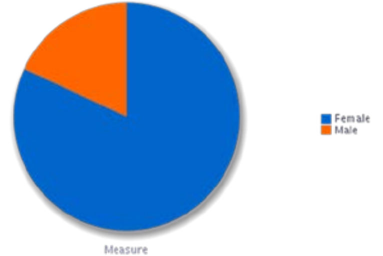
The Trust has established three staff networks – Building a Multicultural Environment (BME), Disability & Wellbeing and a Carers Network and membership to these networks have been increasing since the initial launch in September. The aim of

these networks is to support staff, signpost to relevant services and drive forward the Diversity and Inclusion agenda. The Trust Lead is also working with external stakeholders to broaden the reach of these networks and provide further support to staff. The Trust also played an integral part in the first St Helens Pride event in August. Our work with the Department of Work and Pensions continues in the area of pre-employment programmes for HCA's. This widening participation programme is designed to support the local community back into employment in the health sector, providing them with the skills to work on the Trust bank. The latest cohort to join us in November had 13 people successfully complete the programme who are now going through the recruitment process. The Workforce Race Equality Standard and the Workforce Disability Equality Standard were both successfully submitted in August and both action plans are currently being implemented.

In August the Trust was successfully awarded the Ministry of Defence Employer Recognition Scheme Gold Award and the Veterans Aware accreditation in October for its support to Veterans and the Armed Forces. The Trust was also a finalist at the HSJ awards in November for the Reservist Initiative Award. The Workforce E, D & I lead was also invited to speak at the very first Step into Health conference in London to share our knowledge about supporting the Armed Forces with other Trusts.

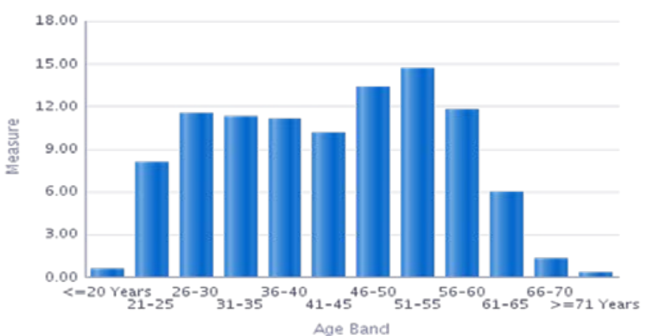
Equality and Diversity Protected Characteristics
In December 2019 the Trust's headcount of staff was 6,095 with a WTE of 5,293.85 staff. Of these staff 81.9% were female and 18.1% were male (Figure 10).

Figure 10: Gender Profile



The Trust has a broad age range across the organisation, with 34% of the total workforce aged over 50 (Figure 11). The majority of the workforce is aged 26 to 50 at 57.4%.

Figure 11: Age Profile



The Trust continues to have a greater proportion of Black and Minority Ethnic (BAME) staff than the local population of St Helens (3.6%) and Knowsley (4.4%)[2] at 8.94% BAME staff (Figure 12). Further analysis was requested by the Trust Board to review HR KPIs against BAME characteristics. For the period 1st April 2019 to 31st December 2019, the sickness absence rate for BAME staff was 3% in comparison to 5% for white staff (Table 8). There has been a higher proportion of starters from BAME backgrounds during this period (17% in comparison to 13% for white starters), while the proportion of leavers is similar (13% compared to 12%), (Table 9). BAME staff have a lower compliance rate with appraisals by 4%, (Table 10) but a higher compliance core training compliance than white staff, by 4%, (Table 11).

Figure 12: Ethnicity Profile

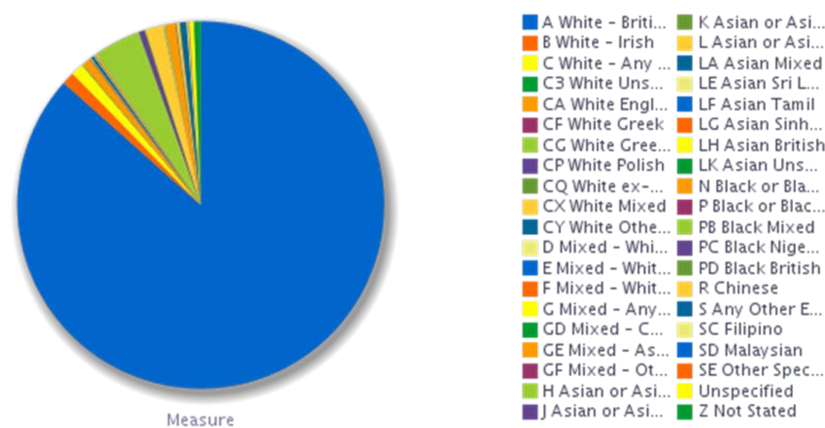


Table 8: Sickness Absence by Ethnicity

Ethnicity	Sickness Absence Rate
BAME	3%
White	5%
Other/Not specified	8%

Table 9: Starters and Leavers by Ethnicity

Ethnic Group	Starters Headcount %	Leavers Headcount %
BAME	17%	13%
White	12%	12%
Other/Not specified	8%	18%

Table 10: Appraisal Compliance by Ethnicity

Ethnicity	Reviews Completed	Total Staff	Reviews Completed %
BAME	412	542	76%
White	4,431	5,567	80%
Other/Not specified	31	40	78%

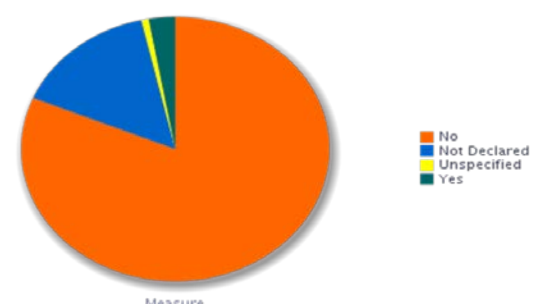
[2] Based on 2011 census information

Table 11: Core Training Compliance by Ethnicity

Ethnic Group	Average Compliance
BAME	72.12%
White	68.13%
Other/Not specified	73.66%

81.3% of the workforce declared no disability compared with 2.8% who have declared a disability (Figure 13). 15.9% are undeclared or unspecified. While the reporting of a disability may be under-reported, the Trust continues to make reasonable adjustments to support staff who develop an underlying health condition during employment.

Figure 13: Disability Profile



4.10 Education, Training and Careers

4.10.1 Apprenticeship Programme

The Trust continues to optimise opportunities to support education and development through Apprenticeships in partnership with local providers. The Trust is supporting the prioritisation of leadership development through higher level apprenticeships during Q3/4 2019/20 to ensure the levy is optimised. These programmes are incorporated into the Nursing Development Programme. Currently, The Trust has 140 active students on clinical and non-clinical apprenticeships programmes. Year to date, 41 students have completed an apprenticeship.

4.10.2 Core Training and Appraisal Compliance

During April and May 2019 the Trust achieved the 85% appraisal compliance target (Figure 14) but has seen a monthly decline in position from June to November, with a slight increase in December's compliance. Core training compliance was 91.85% in April 2019, exceeding the 85% target. From May to December 2019 the position has fluctuated under the 85% mark, between 81.77% and 84.9% (Figure 15). November and December have consecutively improved the Trust position. Improvement plans remain in place to recover the Trust position.

A training plan is in place to ensure the cohort of Appraisers across the Trust remains in proportion to the number of Clinicians requiring Appraisals, taking into account recruitment activity in both the Trust and Bank. A review is currently being undertaken into the appraisals non-participation process to ensure non-compliance is acted upon as soon as possible to ensure discussions between Clinician and the RO

can occur much earlier to provide guidance and support. The Responsible Officer and Revalidation and Appraisal Lead are confident that the target of 85% will be achieved in March 2020.

MyWorkPAL, a digital appraisal and talent management system for all non-medical staff groups launched in August 2019. MyWorkPal brings together work with performance appraisals and learning. It supports individuals' career development, and will support improvements to the Trust's talent management approach. From 1 January 2020 it is the sole appraisal tool for AfC staff in the Trust.

Figure 14: Appraisal Compliance

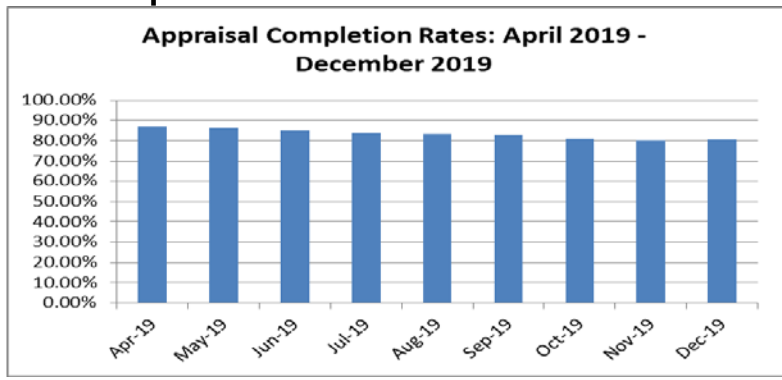
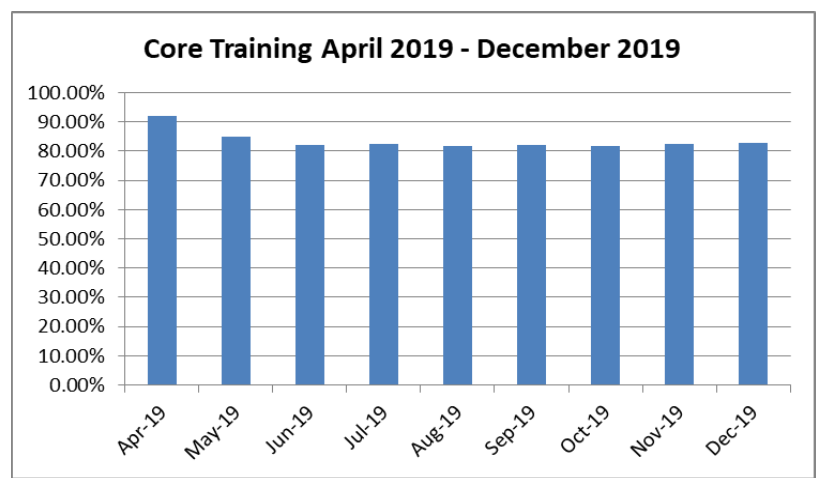


Figure 15: Core Training Compliance



4.10.3 Expansion of Clinical Placement Capacity

The Trust has developed two initiatives which are increasing Clinical Placement Capacity. Firstly, the Trust was successful in bidding for £50,000 from NHS Improvement to support an increase in Clinical Placement capacity for pre-registration nursing and midwifery students in 2019/20. The funding will enable the Trust to develop the Education Link role that supports students on the wards, and will embed sustainable practices to ensure the increased capacity is viable long-term. The additional capacity provided will be 38 students (27 adult nurses and 11 midwives), taking the total provision for these two professions to 132 for the September 2019 intake.

Secondly, the Trust is supporting ten Physician Associate students commencing in January 2020. The Physician Associates complete a two Post-Graduate Degree/Masters built on the medical education model, with core clinical placements across acute specialities, paediatrics, mental health and primary care. All acute placements will be delivered at Whiston for the ten “home” students, beginning to grow our Physician Associate workforce.

4.10.4 Speciality and Associate Specialist Doctors

Initial findings from the GMC’s first Speciality and Associate Specialist Doctors (SAS) and Locally Employed Doctors survey were published in early January and identified three key issues for SAS and Locally Employed doctors nationally:

- 30% of SAS doctors and 23% of LE doctors reported being bullied, undermined or harassed in the last year, either by colleagues or by patients and their families
- Almost half of LE doctors and 41% of SAS doctors had difficulties accessing continued professional development opportunities
- Around 30% of LE doctors and 25% of SAS doctors said they felt burnt out to a high or very high degree

Local information from the survey will be available in due course to support the development of a SAS doctor development programme.

4.10.5 Management and Leadership Development

]

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

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

- Refresh of the ACE Behavioural Standards and demonstrate clear links to the Corporate Values – focus groups to begin Q4
- Compassionate and inclusive leadership development – links made to national developments of the People Plan including the Leadership Compact
- Respect and dignity at work awareness training for all staff to promote a zero tolerance of bullying and harassment
- The promotion of equality, diversity and inclusion and widening participation including unconscious basis training for managers

- Development of an awareness of a restorative and just culture – HR policies are being updated on a rolling programme
- A new first-line management programme started in Q2 for HR and HIS staff. This will be replicated across the Trust in the future and become a standard offer
- Implement a 3 year training programme to support the reduction of incidents of violence and abuse of staff from patient/the public
- The development of a new Nursing Leadership programme and career framework following a consultation process with staff during Q1 2019/20
- Continuous development e-learning provision of mandatory training to release time to care
- Induction being redesigned to be more 'welcoming' with less emphasis on mandatory as this moves to e-learning – to be fully rolled out in 2020/21
- MyWorkPAL, a digital appraisal and talent Management system for all non-medical staff groups launched in August 2019. From 1 January 2020 it is the sole appraisal tool for Agenda for Change staff in the Trust
- To target specific leadership interventions such as having "difficult conversations" on those care groups with higher levels of employee relations and sickness absence

4.11 Junior Doctor Contract

The Trust is continuing to work through the implementation of the revised 2016 Junior Doctor Contract within the Trust. There are a number of elements to the revisions that have different implementation dates. HR is in the process of finalising rota templates and work schedules for the February 2020 trainee rotation.

Work will now be undertaken as follows:

- Review the rotation process to ensure that we are incorporating all of the revised elements going forward
- Review the compliance of all rotas that do not move in the February rotation in preparation for the next implementation date and forthcoming rotations
- Continue to consult with operational colleagues and Doctors in Training regarding making any required amendments
- Review the transfer of trainees employed on the 2002 contract to the 2016 contract and any associated pay protection as per national terms and conditions

4.12 Changes to Written Statements of Basic Employment Terms

Employers must provide written details of the main terms and conditions of employment to all employees whose employment lasts for more than one month. From the 6th April 2020, there will be an extended range of information that must be included and the terms must be given to all workers, therefore including those working under a contract rather than a direct employee. This information includes:

- Details of paid leave, e.g., maternity, special and carer leave
- Details of benefits.

- Details of compulsory training entitlement and who pays for it
- Employer provided training entitlement

The information will be required from the first day of employment rather than within the first month, in a single document. Work will be undertaken to establish the requirements of each staff group and the subsequent actions will be undertaken to ensure the Trust is compliant with the new legislation.

4.13 Assaults on Emergency Workers Act

The Assaults on Emergency Workers (Offences) Act came into force on 13th November 2018. A joint agreement, effective from 6th January 2020, provides a broad framework to ensure more effective investigation and prosecution of cases where emergency workers, including NHS workers, are victims of a crime. The improvements in the actions the Crown Prosecution Service will be able to take will support the Trust in its local plans to support the well-being of staff

4.14 Employee Relations Case Update Q2 and Q3 2019/2020

To provide transparency to the Trust Board in the reporting of employee relations cases, the summary tables below (Table 12 and Table 13) for Q2 & Q3 2019 / 2020 that have been managed through the relevant Employee Relations policies such as disciplinary, capability, grievance and / or respect and dignity at work.

The Trust has reviewed its employee relations processes in line with Dido Harding's letter and guidance on Improving People Practices in May 2019 and as a result has established a new Employee Relations Oversight Steering Group. This group is chaired by a Non-Executive Director and has the role of providing the Trust Board with assurance that disciplinary matters are being managed in accordance with national guidance and best practice.

Table 12: Q2 Summary July – September 2019 / 2020

Duration of case	Number of case closed in Q2	% of closed cases by duration
0-3 months	22	68.75
3-6 months	8	22
6-9 months	1	3.12
9-12 months	1	3.12
12 months +	0	0
Total Timeline Closed Cases	**32**	**100%**

Table 13: Q3 Summary October – December 2019 / 2020

Duration of case	Number of cases closed in Q3	% of closed cases by duration
0-3 months	14	45.16
3-6 months	8	25.80
6-9 months	8	25.80

9-12 months	0	0
12 months +	1	3.22
Total Timeline Closed Cases	**31**	**100%**

5.0 Trust Board Assurance

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

TRUST BOARD

Paper No: NHST(20)011
Title of paper: Safeguarding Adults Annual Information & Assurance Report 2018/19
Purpose: To provide the Trust Board with information and assurance that it effectively discharged its safeguarding adults responsibilities during 2018/19
Summary: The report provides information and assurance for all aspects of safeguarding adults during the financial year 2018/19. It highlights that the Trust is rated as giving reasonable assurance following CCG scrutiny and that PREVENT Level 3 compliance is affecting the Trust's assurance rating.
Corporate objectives met or risks addressed: Care, Safety, Communication
Financial implications: None
Stakeholders: Trust Board, Commissioners, Patients
Recommendation(s): Members are asked to approve the report, agree the future developments recommended in the report and support the team in addressing PREVENT Level 3 compliance.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance and Executive Lead for Safeguarding.
Date of meeting: 29th January 2020

Safeguarding Adult

Annual Information and Assurance Report

April 2018 - March 2019

Completed by:
Susan Norbury, Assistant Director of Safeguarding

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Safeguarding Adults Annual Information and Assurance Report 2018-2019

Introduction

St Helens & Knowsley Teaching Hospitals NHS Trust has a statutory responsibility to safeguarding adults at risk from harm across all service areas in accordance with the Care Act 2014. This activity is closely monitored by the Care Quality Commission (CQC), NHS England and the Clinical Commissioning Groups (CCG) as well as the Local Safeguarding Adult Boards (LSABs). It is everybody's business to help prevent abuse and to act quickly and proportionately to protect adults where abuse is suspected. The purpose of this Annual Report is to provide an overview of safeguarding adult activity across the Trust for the last financial year (April 2018 – March 2019) and to provide assurance to the Trust Board.

Safeguarding Adult arrangements include:

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

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

This report is in two sections:-

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

SECTION 1: SAFEGUARDING ADULTS

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

1.1 Safeguarding Adult Policy

The Trust's Safeguarding Adults Policy is available on the Trust Intranet for all staff to access and contains Standard Operating Procedures to cover all areas of safeguarding adults. The Policy was reviewed and amended in January 2018. There have been no requirements to update the policy this year. Scrutiny of other policies pertinent to safeguarding has been reviewed.

1.2 Internal Governance Processes to Safeguard Adults

The Executive Director of Nursing, Midwifery and Governance is the Executive lead responsible for Safeguarding. There was a change in the structure of the Safeguarding team in 2016, when the Head of Safeguarding post was replaced with a substantive Named Professional post to lead on the Safeguarding adult agenda. The Named Professional resigned from the post due to a promotion opportunity and left the organisation in July 2018. Interim arrangements were made to support the Safeguarding adult's agenda by the Named Nurse Safeguarding Children acting up across both teams. An Assistant Director of Safeguarding was recruited to and commenced in post January 2019 to be the safeguarding strategic lead across children and adults. The Safeguarding Adults team in Quarter 4 consisted of a Lead Nurse for Safeguarding Adults (1 WTE), a Safeguarding Development Nurse Band 6 (0.6 WTE) and Band 3 administrator (0.8 WTE).

The Trust's Safeguarding Adults Steering Group, which reports to the Patient Safety Council, has responsibility for ensuring the Safeguarding adults agenda is achieved and is chaired by the Deputy Director of Nursing. The group membership has representatives from all service areas within the Trust and external agencies are also invited to attend, including Designated Nurses from the CCG's and Healthwatch colleagues. The group met four times during 2018 - 2019 to review the overarching work plan which ensures that the Trust has a clear oversight of the agenda, the work it is undertaking and progress being made. Attendance is not always adequate with some areas of the Trust not represented at every meeting. The governance framework for safeguarding will be reviewed by the Assistant Director of Safeguarding in the next year.

The Patient Safety Council reports into the Trust's Quality Committee which is a sub-group of the Trust Board. In addition to this, a quarterly Safeguarding Adult Report containing commissioner feedback from the CCG's Safeguarding Designated Professionals is reviewed at the joint commissioner and Trust's Clinical Quality Performance Group.

1.3 Safer Recruitment including Trust Volunteers

The Trust complies with the NHS Recruitment Standards. The Human Resources IT TRAC Recruitment system supports this, ensuring every step required to recruit safely is complied with prior to the start date. This includes the volunteer service to ensure the same robust standards apply to the voluntary workforce.

1.4 Safeguarding Adult Training

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

Level 1 training is delivered as part of the Trust's Induction Programme for all new starters, then within the Trust's mandatory training for all staff. This is a face to face session delivered by a member of the Trust's Safeguarding Team. This training is combined with the safeguarding children's' awareness training.

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

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

Level 4 is for key Safeguarding specialist staff and is sourced externally via national conferences and bespoke training applicable to the safeguarding agenda.

With the Adult Safeguarding: Roles and Competencies for Health Care staff document it is anticipated changes will be required to the adult safeguarding training requirements which will have a significant impact in the amount of training required, additional training hours for staff currently undertaking Level 2 training. A review of how this information will be captured to support the additional requirements will be required.

Safeguarding Adults training compliance figures at the end of March 2019 are listed below against a CCG KPI target of 90%.

- Level 1 93.9%
- Level 2 90.8%
- Level 3 90.8%
- Level 4 100%

1.5 PREVENT Training

Prevent is part of the UK's counter terrorism strategy and is firmly embedded into safeguarding practice. The Assistant Director of Safeguarding is the Trust's PREVENT Lead.

The Prevent TNA is included in the main Safeguarding Adult TNA and staff are assigned a training level according to job role. Level 1-2 training is delivered to all staff as part of induction and mandatory training. It is also included in all other levels of safeguarding training. Level 3 training is a face to face session delivered by a Home Office approved facilitator (Trust staff have been trained to deliver), although NHS England have recently rolled out an e-learning PREVENT Level 3 package that staff will be encouraged to undertake.

Prevent Compliance figures as of the end of March 2019 are listed below against a CCG target of 90%, although the NHS England compliance target is 85%.

PREVENT training level	**Compliance level March 2018**
Level 1- 2	93.9%
Level 3	30.5%

The Trust was previously deemed to be compliant at Level 3 PREVENT training in 17/18, however with a new commissioning team in the CCG questions were raised regarding the very low levels of staff deemed to require Level 3. It was subsequently acknowledged that the Training Needs Analysis identifying the staff requiring this level was inaccurate. This resulted in excess of 3300 additional staff requiring training at this level. It was agreed that an 18 month trajectory would be in place to increase compliance and the CCG would monitor the Trust against this trajectory. An initial drive in early Quarter 3 2018 ensured the

Trust met its first quarter target, however it was clear from early Quarter 4 that winter pressures and sickness would hinder achievement in Quarter 4. Despite significant targeting by the Safeguarding adults team the trajectory target at Quarter 4 was not met, achieving 30.5% against the Trust's own set trajectory target of 38%. There is monthly monitoring by NHS England and the CCG regarding training compliance. Should the Trust not meet its own set trajectory again there is a risk of sanctions being applied against the Trust by the CCG.

1.6 Allegations of Abuse against a Professional Policy Activity

The Safeguarding Adults team was involved in 1 case of alleged abuse made against a member of nursing staff, relating to an adult patient. The case was managed appropriately as per the relevant policy.

1.7 Multi-agency Partnership working

It is acknowledged that the Safeguarding Adults team is an active partner who engages with local Safeguarding Adults Boards, sub groups of the Safeguarding Adult Boards and partner agencies by the evidence provided as part of the safeguarding KPI's and Commissioning Standards returns.

1.7.1 Safeguarding Adult Review (SAR) Involvement

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

They are commissioned when:

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

and

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

or

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

St Helens Safeguarding Board is yet to undertake a SAR.

Knowsley has a SAR group, chaired by Merseyside Police who review information as per the SAR process. The Trust supports the SAR panel in considering the information and provides initial information regarding the Trust input as required. There has been one chronology requested this year by the Knowsley SAR group. There has been no cause for concern regarding the Trust raised by the SAR information gathering this year.

1.7.2 Domestic Homicide Review

One request for a chronology on four members of a family dating back seven years of attendances to the Trust was received in late March 2019 from Knowsley CCG and will be submitted in April 2019. Early indication from the initial review does not identify any significant concerns regarding Trust actions.

1.7.3 Multi-agency working

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

The safeguarding adult's team participate when requested in meetings and discussions, with excellent compliance against the KPI targets in relation to attendance at multi-agency meetings for adults at risk.

1.7.4 Information Sharing

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

The Safeguarding Adult Team work alongside partner agencies to ensure that information about adults at risk is shared in a proportionate and timely manner.

A safeguarding response template will be devised to ensure a standard format is returned to Local Authorities that details the nature of the issue that has been raised regarding the Trust and the response to that issue.

1.8 Safeguarding Adults Activity

The Safeguarding Adults Team provides support and advice to all Trust staff who have concerns about an adult at risk. This activity is referred to as a contact. A referral is when the contact generates a formal safeguarding referral to the local authority. The data shows a high level of contacts between areas of the Trust and the Trust's Adult Safeguarding Team which is viewed as being very positive and indicates staff are requesting advice and support from the safeguarding team. It may be with further advice and support from the team a referral is not required, staff can sometimes make alternative referrals, for example for a social care assessment or the risks staff feel are present may be addressed regarding managing the risk as opposed to making a safeguarding referral. The data also shows the number of safeguarding referrals that are formally referred to the local authority, where no other actions are appropriate.

The average number of safeguarding referrals made to the Local Authority each month is 9. Although there was an increase in the number of referrals in Quarter 3, generally there is a consistency in the number of contacts and referrals that are generated.

Table 1 below shows the comparison between the Contacts to the Safeguarding Adults team for safeguarding support and advice and the referrals to Adult Social Care in each

quarter of 2018/2019. The referral to contact rate equates to 22%, indicating the support, advice and risk management can prevent safeguarding referrals.

Quarter	Contacts	Referrals
1 – 2018	113	25
2 – 2018	124	25
3 – 2018	127	34
4 - 2019	142	25
Total	**506**	**109**

Staff in the Trust will make contact with the safeguarding team, however there needs to be a culture of safeguarding being everybody's business and an increase in confidence of staff referring non-complex safeguarding referrals to the Local Authority, without an expectation that the safeguarding adults team will make every referral. There needs to be an infrastructure that captures the referrals that ensures safeguarding team scrutiny of all referrals and follow up of any omissions by staff in safeguarding activity and a system that makes it easy for staff to report concerns and make referrals. This could be done by using the Datix system already in place. This work will be progressed in the following year.

1.9 Safeguarding Adults Incidents

There have been no significant incidents relating to Safeguarding Adults in 2018 / 2019 which required an internal review, RCA or SIRI.

1.10 External Assurance of Effective Processes during 2018 / 2019

1.10.1 Safeguarding Adult Commissioner Assurance

The Trust's safeguarding adult systems and processes are monitored externally by achieving key performance indicator requirements which are submitted monthly in the Trust's Integrated Performance Report and quarterly to St Helens CCG. St Helen's CCG subsequently provides assurance to Knowsley and Halton CCG's.

Overall the Trust received reasonable assurance (amber) rating from the CCG following submission of KPI and corresponding evidence. It is PREVENT Level 3 compliance that is preventing a significant assurance (green) rating for the safeguarding adults' performance.

Organisation	**Q1 (2018/19) Assurance rating**			**Q2 (2018/19) Assurance rating**			**Q3 (2018/19) Assurance rating**			**Q4 (2018/19) Assurance rating**		
STH&K	**C**	**A**	**T**	**C**	**A**	**T**	**C**	**A**	**T**	**C**	**A**	**T**
			⟷		↓				↑			⟷

1.10.2 CQC Inspection

The CQC undertook a full inspection between July and August 2018 with a subsequent Trust rating of Outstanding. Findings in relation to the safeguarding agenda in adult services were as follows:

• There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguard them from abuse.

• Staff had received up-to-date training in safety systems.

• Safeguarding vulnerable adults, children and young people was given sufficient priority.

• Deprivation of Liberty safeguards were used proportionately and appropriately in the best interest of the person.

• The department (Emergency Department) should continue to provide training and guidance to staff while the new mental health capacity assessment tool is embedded into daily practice.

1.11 Summary of Achievements 2018/2019

- Reasonable assurance has been received from the CCG in relation to Safeguarding Adult KPI compliance.
- An Assistant Director of Safeguarding post was recruited to in January 2019
- An increase in 0.2 WTE Band 6 resource supporting the adult team.
- The principles of the Care Act 2014 continue to be embedded into practice, with making safeguarding personal data starting to be captured.
- The Safeguarding Team has continued to actively participate in LSAB activity in the three main local areas.

1.12 Future Developments

- The Trust will endeavour to maintain KPI compliance with safeguarding standards and work towards gaining a significant assurance rating
- The Trust will review safeguarding resources following a gap analysis by the Assistant Director of Safeguarding.
- The Trust will actively target staff to ensure PREVENT Level 3 compliance is achieved as per Trust set trajectory by Quarter 4, March 2020
- There will be a focus on improving and sustaining Safeguarding Adult training compliance
- Safeguarding audits will continue to monitor compliance to trust process.
- Improve staff confidence in making referrals and less reliance on safeguarding team for non-complex cases
- Standard template for safeguarding responses to be developed
- Audit plan to test the compliance with safeguarding legislation and Trust policies to be devised
- The Trust will improve its mental capacity and deprivation of liberty safeguards understanding to ensure it is acting in line with legislation.
- Review safeguarding data reporting and scrutiny mechanisms in the Trust

- Review assurance processes to consider a joint children and adults assurance group for a “think family” approach.
- Co –location of the safeguarding team to promote cross working and “think family" agenda and to provide peer support.
- Discussions to be held regarding submission of the Annual Report for Safeguarding Adults earlier in the year and consideration of a future joint children and adults annual safeguarding report.

SECTION 2: Supporting Adults with Additional Needs

Overview

A high number of our patients have additional needs and require support whilst using Trust services. The way that the Trust identifies and supports this group of patients is key to achieving positive outcomes for patients, their carers, families and representatives. The ability to identify patients with additional needs, risk assessing and managing these needs may involve making reasonable adjustments. Whilst the implementation of these 'reasonable adjustments' and provision of support for individual patients is a legal obligation, the manner in which the Trust undertakes the process and the confidence it has in all staff complying to this obligation requires monitoring and oversight to ensure the Trust avoids causing harm.

The Safeguarding Adult Team provides support to staff in the Trust in relation to supporting patients with additional needs who have increased vulnerabilities such as those who

- Lack mental capacity or have fluctuating capacity
- Require a Deprivation of Liberty Safeguards referral
- Have a Learning Disability
- Have a Mental Health diagnosis

2.1. Mental Capacity Act (MCA)

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

The Trust's MCA Training Strategy is embedded within the overall Safeguarding Adults Training Strategy which details the competences expected of staff and compliance was monitored through the Key Performance Indicator throughout 2018/2019.

2.2 Deprivation of Liberty Safeguards (DoLS)

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

The table below highlights the Trust DoLS activity. This shows a decrease in applications in 2017 /18 which is contradictory to the expectation that activity would increase following the 2015 Cheshire West ruling which broadened the criteria for urgent authorisations. From Quarter 4 2018/19 the Safeguarding Adult team have actively promoted that staff should refer for DoLS authorisation when advice has been sought for safeguarding referrals and a lack of capacity is identified as an issue. Resources have not allowed for actively following up the referrals and poor quality referrals have not always been returned by ward staff after a request for further information. However the data does indicate an increase in referrals and this will be an ongoing focus in 2019/20 to ensure the Trust is

complying with the legal framework. A mental capacity act audit to understand staff knowledge will be undertaken to address the low referral rates for DoLS. The Safeguarding Team will also continue to support staff with the DoLS decision making process through training and supervision.

Year	DoLS Applications
2012/13	13
2013/14	12
2014/15	69
2015/16	190
2016/17	191
2017/18	162
2018/19	232

The table below details the outcome of the applications. A significant number of patients subject to an urgent authorisation are discharged prior to the completion of any assessment by the Local Authority involved. An urgent authorisation is put in place by the Trust for a maximum of 14 days whilst awaiting Local Authority to arrange the appropriate Best Interest Assessor and Section 12 Doctor assessments to take place. This usually does not take place and therefore if the patient remains in Trust care after the 14 day period they are no longer subject to a DoLS authorisation. The Safeguarding Adults team actively engage with Local Authority DoLS Leads to generate DoLS assessments for complex patients or circumstances where further DoLS scrutiny is advisable.

	Authorised	Unauthorised	D/C prior to assessment	Not assessed by Local Authority	Total
St Helens	7	5	34	41	87
Knowsley	5	12	33	20	70
Halton	1	10	10	14	35
Liverpool	5	3	13	4	25
Out of Area	3	2	6	4	15
Total	**21**	**32**	**96**	**83**	**232**

14% of DoLS referrals are not authorised. This is usually due to the patient regaining capacity by the time the assessment is commenced by the Local Authority and does not indicate that the referrals were not appropriate at the time of referring. The Safeguarding Adults team will liaise with Local Authority staff when they are made aware of a patient regaining capacity to ensure assessments that may be being planned are halted.

2.3 Learning Disability (LD)

The Safeguarding Adults team continues to support the improvement of access to healthcare provision and patient experience for people with a learning disability and/or autism who access our hospitals and services. There were 125 patients referred for support with reasonable adjustments and for multi-agency liaison requirements, which is a reduction from the previous year when 153 referrals for support were made. It is not known whether this is due to staff knowledge increasing in how to make reasonable adjustments without requiring support; however the data for capturing all those who are supported with reasonable adjustments needs to improve so the Trust can evidence the support it is giving. Support in ensuring health passports are in place has also been undertaken, supporting staff to provide appropriate care and be aware of key safety issues.

The Safeguarding Adults team continues to be an active partner in multi-agency work to support people with a learning disability and/or autism, their families and carers. Representatives from the team have attended the Cheshire and Merseyside Acute LD Network forum and the Learning Disability Partnership board in St Helens on behalf of the Trust this year and continue to do so. Partnership working with our local community LD nursing colleagues continues to strengthen and arrangements are now in place for St Helens and Knowsley teams to attend the wards on a fortnightly basis, offering additional specialist support and guidance to patients with a learning disability, their families and carers and Trust staff.

The Learning Disabilities Mortality Review (LeDeR) Programme aims to make improvements to the lives of people with learning disabilities. The Safeguarding Team will refer those with a Learning Disability who die whilst a patient at the Trust to the LeDeR review programme. It identifies any potentially modifiable factors associated with a person's death, and works to ensure that these are not repeated and that learning is shared nationwide. The Safeguarding Adults Team is working alongside partner agencies to facilitate reviews of the deaths of those with a learning disability as well as performing internal reviews on behalf of the Trust.

2.4 Mental Health

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

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

The Safeguarding Adults Team scrutinises section papers following Trust policy to ensure the Trust is acting within the legislative framework. Gaps in documentation requirements are followed up by the Safeguarding team. There has been an increase in the number of patients being sectioned in the Trust's care this year as the table below indicates.

Time period	No. of sections
April 2017 - 18	51
April 2018 - 19	66

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

2.5 Summary of Achievements 2018/19

- Reasonable assurance has been received from the CCG in relation to Safeguarding Adult Key Performance Indicator's (KPI) compliance.
- The Safeguarding Team has continued to actively participate at the local Learning disability network forum
- Wards continue to seek support for reasonable adjustments and learning disability health passports information
- Positive support has been provided to adults with additional needs which has led to improved patient experience.
- There has been an increase in DoLS referrals this year

2.6 Future Developments

- The Trust will develop a Learning Disability and ASD strategy to detail the direction for improvements
- The Trust will review national standards from NHS England's benchmarking exercise and ensure the Trust Board is sighted on any shortfalls in Trust provision
- The Trust will endeavour to maintain safeguarding KPI compliance
- The Trust will consider resources for the safeguarding team in covering the additional needs agenda
- Audits will monitor compliance to Trust processes covering those with additional vulnerabilities
- The Safeguarding Adult Team will continue to update the Trust on changes in legislation and national guidance for adults with additional needs and will update Policy and training in line with such developments, with a particular focus on the Liberty Protection Safeguards that will replace Deprivation of Liberty Safeguards from October 2020.

END

TRUST BOARD

Paper No: NHST(20)011a
Title of paper: Safeguarding Children Annual Information and Assurance Report 2018/19
Purpose: To provide the Trust Board with information and assurance that it effectively discharged its safeguarding responsibilities during 2018/19. It details that the Trust's safeguarding children assurance has been deemed consistently as reasonable assurance (amber). Maternity safeguarding supervision requires clarity and meeting attendance needs improving to gain a significant assurance rating (green).
Summary: The report provides information and assurance for all aspects of safeguarding Children during the financial year 2018/19.
Corporate objectives met or risks addressed: Care, Safety, Communication
Financial implications: None
Stakeholders: Trust Board, Commissioners, Patients
Recommendation(s): Members are asked to approve the report and agree the recommendations for future development and the work to be undertaken to gain a significant assurance rating.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance and Executive Lead for Safeguarding.
Date of meeting: 29th January 2020

Safeguarding Children

Information and Annual Assurance Report

April 2018 – March 2019

Completed by: Susan Norbury Assistant Director of Safeguarding
Anne Monteith, Named Nurse Safeguarding Children

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Safeguarding Children Annual Information and Assurance Board Report

2018 - 2019

1. Introduction

St Helens & Knowsley Teaching Hospitals NHS Trust (STHK) has a statutory responsibility to safeguarding children and young people at risk from harm across all service areas in accordance with Section 11 of the Children's Act 2004. This activity is closely monitored by the Care Quality Commission (CQC), NHS England and the Clinical Commissioning Groups (CCG) as well as the Local Safeguarding Children Boards (LSCBs). Safeguarding children is everybody's business to help prevent abuse and to act quickly and proportionately to protect children where abuse is suspected whether staff are working directly or indirectly (with children's parents or carers) with children and young people. The purpose of this annual report is to provide an overview of safeguarding children activity across the Trust for the last financial year (April 2018 – March 2019) and to provide assurance to the Trust Board.

Safeguarding Children arrangements include:

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

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

2.1 Safeguarding Children Policy

The Trust Safeguarding Children Policy is available on the Trust Intranet for all staff to access. The Policy is due for review in August 2019. Risk strategies have been put in place to address the amendments to the Working Together to Safeguarding Children document 2018 as agreed with St Helens CCG Designated Nurse.

2.2 Internal Governance Processes to Safeguard Children

The Executive Director of Nursing, Midwifery and Governance is the Executive lead with overall responsibility for Safeguarding. In Quarter 4 18/19 an Assistant Director of Safeguarding commenced in the Trust. The Trust has a Named Nurse, Named Doctor and Named Midwife as per statutory requirements.

The Trust's Safeguarding Children Steering Group, which reports to the Patient Safety Council, has responsibility for ensuring the Safeguarding children agenda is achieved. The group was established in September 2009 with representatives from all service areas within the Trust and met four times during 2018 - 2019 to review the

overarching Safeguarding Children work plan which ensures that the Trust has a clear oversight of the agenda, the work it is undertaking and progress being made.

The Patient Safety Council reports into the Trust's Quality Committee which is a sub-group of the Trust Board. In addition to this, a quarterly Safeguarding Children report containing commissioner feedback from the CCG's Safeguarding Designated Professionals is reviewed at the joint commissioner and Trust's Clinical Quality Performance Group.

2.3 Safer Recruitment including Trust Volunteers

The Trust complies with the NHS Recruitment Standards. The Human Resources IT TRAC Recruitment system supports this, ensuring every step required to recruit safely is complied with prior to start date. Appointment to the Trust's volunteer service is also done under the TRAC system to ensure the same robust standards apply to the voluntary workforce.

2.4. Safeguarding Children Training

The Trust's Safeguarding Children Training Strategy and Training Needs Analysis sets out which staff groups are to receive which of the 3 levels of Safeguarding Children training according to their role, as set out in the Intercollegiate Safeguarding Children training standards, last updated in June 2018. This update has resulted in a substantial broadening of the staff groups requiring 'Level 2' training to all Trust clinical staff and has increased those requiring Level 3 training. All levels of training have been updated to reflect the changes in the revised Working Together to Safeguard Children Statutory Guidance (2018).

Level 1 training is delivered as part of the Trust's Induction Programme for all new starters, and is then included in the mandatory training programme for all staff. This is a face to face session delivered by a member of the Trust's Safeguarding Team. This training is combined with the vulnerable adults' awareness training. Attendees receive additional safeguarding children information in a Level 1 reader distributed following mandatory and induction training by email.

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

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

Safeguarding Compliance figures as of the end of March 2019 are listed below against a CCG target of 90%

- Level 1 93.9%
- Level 2 90.3%
- Level 3 91.4%

Additional staff were identified within the Emergency Department and Obstetrics and Gynaecology as requiring Level 3 safeguarding children training. This followed the

June 2018 amendments in the Royal College of Paediatrics and Child Health - Safeguarding Children and Young People Roles and Competencies for Health Care Staff intercollegiate document . Clinical staff working with children and young people, parents and carers should be trained at level three in children's safeguarding. This increases the training requirements for middle grade doctors working in the Emergency Department and coordinating nurses. A plan is in place and this will be addressed early in 2019/20 to ensure compliance is achieved by those identified.

2.5. Safeguarding Children Policy and Assurance of Compliance

Evidence of compliance with the policy and Trust Safeguarding procedures was provided by the completion of audits this year which reviewed process within paediatrics, maternity, emergency department and sexual health services.

Audit findings and actions are reviewed and progress monitored via the Safeguarding Children Steering group.

2.6 Allegation of Abuse against a Pofessional Policy Activity

In addition to employing STHK staff, the Trust is also lead employer to doctors in training covered by this Allegations policy. It incorporates the process for making referrals to the Local Authority Designated Officer (LADO) when an allegation is made against a member of staff involving children. During the reporting period, the Safeguarding Team and the Human Resources (HR) department were involved with 6 LADO referrals, 1 in relation to one Trust employee case and 5 LADO referrals in relation to 14 cases involving Lead Employer Doctors in training. All cases were managed appropriately in accordance with Trust Policy.

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

2.7. Safeguarding Children Supervision Policy

Supervision activity is monitored through the Trust's Key Performance Indicators (KPI's). 100% compliance was achieved for staff directly involved with the case management of children made subject to safeguarding procedures within the paediatric department, however a robust and clear plan is required to give clarity regarding maternity staff supervision to demonstrate it is being undertaken as per requirements for key staff.

2.8. Effective (Multi-agency) Partnership working

2.8.1 Serious Case Review (SCR) Involvement

A SCR should take place if abuse or neglect is known, or suspected, to have been involved and a child has died or has been seriously harmed and there is cause for concern about how organisations or professionals worked together to safeguard the

child. An SCR should also be considered if a child dies in custody or by suspected suicide. During 2018 /2019 the Trust was involved in three Serious Case Reviews, however there were minimal actions required of the Trust. Actions and progress against the action plan are managed via a SCR work plan which is reviewed by the Safeguarding Children Steering Group.

2.8.2. Multi-agency working

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

2.8.3 Information Sharing

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

The Trust has a dedicated Paediatric Liaison Team which ensures information in relation to attendances for all children and young people up to the age of 18 are shared with relevant community practitioners, including school nurses and health visitors, as well as social workers when indicated. The team also processes information from the maternity department when a safeguarding cause for concern has been raised and across the trust when adults present and concerns are raised in relation to their children. The team acts as an additional safety net in ensuring staff have undertaken all appropriate referrals and supporting getting any missing information required for appropriate referrals. There is close working between the safeguarding children team and paediatric liaison.

2.8.4 Local Safeguarding Children Board (LSCBs) Activity Sharing

The Trust is an active partner at the three Local Safeguarding Children Boards (LSCBs) in St Helens, Halton and Knowsley with representation at several sub groups. The minutes from each of the Boards are provided to the Trust's Children Safeguarding Steering Group. The Trust also has representation and contributes when appropriate to LSCB multi agency audits. The Assistant Director of Safeguarding will ensure the Trust has representation to receive information and represent the acute trust perspective in the new safeguarding arrangements that will come into place from June 2018 following the Wood report and recommendations.

The Local Authority, CCG and Police will be the lead agencies to ensure the safety of children in their area, with sub groups to support partnership work of the Board.

The Trust Safeguarding Children team are part of the following sub groups:

Area	**Sub Group**
St Helens	SOS implementation group
	Audit and review group
	Case review group
	MACSE
	MARAC
Knowsley	SOS implementation group
	Audit and review groups
	MACSE
	MARAC
	Health Sub group
Halton	Health Sub group

3. Safeguarding Children Activity and Social Care Referrals

3.1 Paediatric and Emergency Department Activity

The table below shows the number of attendances where a safeguarding concern was noted for a child and information shared with the Trust's Safeguarding Children Team for the last 5 years. These attendances vary from low levels of concern e.g. notification of a child with current or historical social care involvement, to a child who is thought to have suffered significant harm e.g. attended with a non-accidental injury, who require an immediate social care referral. Although there has been a small decrease this year there have been no concerns raised that indicate staff are not following policy.

Year	No of attendances with recorded safeguarding concern
2014/2015	1560
2015/2016	1641
2016/2017	1860
2017/ 2018	2129
2018/ 2019	2067

The table below is the number of actual referrals made to Children's Social Care, requesting assessment under the guidance of the Children Act 1989 and show the number of referrals for a safeguarding concern has increased in this year.

Year	No of referrals to Children's Social Care
2013/2014	98

2014/2015	84
2015/2016	101
2016/2017	115
2017/2018	101
2018/ 2019	164

A large percentage of safeguarding activity is generated by children and young people attending with mental health problems, such as low mood, self-harm and attempted suicide. The Trust has a clear self-harm pathway, which covers all aspects of mental health and ensures these young people are assessed by both the paediatric medical team and the Child and Adolescent Mental Health Services (CAMHS) Assessment and Response Team (CART, an in-reach service provided by North West Boroughs Healthcare Trust)). This pathway complies with current National Institute of Clinical Excellence (NICE) guidelines and was previously shared across a regional mental health network, and highlighted as good practice.

The numbers of young people attending the Trust with associated mental health problems is recorded in the table below showing a 5 year comparison. The figures highlight an increase in attendances this year.

Year	No of attenders with mental health problems
2014/2015	454
2015/2016	528
2016/2017	481
2017/2018	411
2018/ 2019	434

3.2 Maternity Safeguarding Activity

When a safeguarding concern is noted in the Maternity Department a "Cause for Concern Form" is completed by a member of the midwifery team in relation to mental health, drug and alcohol misuse, domestic abuse or anything else that may affect a mother's ability to care for the baby without additional support or monitoring. This is shared with the Safeguarding Specialist Midwife, G.P, Health Visitor and if necessary Children's Social Care and actions and plans implemented accordingly to maintain the new-born's safety.

The table below represents the number of Cause for Concerns initiated during the last 5 years. There has been a notable increase since 2014 /2015. Although there has been a small decrease this year the numbers are generally comparable with the previous year and there has been no concerns raised regarding staff not following Trust policy.

Year	No of Cause for Concern Forms initiated
2014/2015	961
2015/2016	1109
2016/2017	1190
2017/2018	1374
2018/ 2019	1358

3.3 Safeguarding Children Incidents

There have been no significant incidents relating to Safeguarding Children during 2018/2019 which required an internal review, RCA or SIRI.

4. External Assurance of Effective Processes during 2018/19

4.1. Safeguarding Children CCG Assurance

The Trust's safeguarding children systems and processes are monitored externally by achieving key performance indicator requirements which are submitted monthly in the Trust's Integrated Performance Report and quarterly to the CCGs designated nurses who commission children's safeguarding. KPIs are monitored by St Helens CCG who provide assurance to Halton and Knowsley CCG's. The quarterly submissions in 2018/2019 provided an overall reasonable (amber) assurance rating as demonstrated in the table below. A lack of clarity regarding maternity staff supervision has prevented the children's team from achieving a significant (green) assurance rating. This will be addressed with the Maternity Department to ensure a clear plan and monitoring arrangements are in place. Safeguarding meeting attendance by midwives will be monitored as this has also been raised by the CCG during the KPI monitoring this year. The Named Midwife has previously reviewed the meeting invitation/ attendance process to improve compliance.

Organisation	Q1 (2018/19) Assurance rating			Q2 (2018/19) Assurance rating			Q3 (2018/19) Assurance rating			Q4 (2018/19) Assurance rating		
STH&K	C	A	T	C	A	T	C	A	T	C	A	T
			⟷		↓				↑			⟷

4.3 Section 11 Audit

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

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

- A clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children;
- A senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements;
- A culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services;

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

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

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

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

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

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

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

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

The Trust submitted Section 11 evidence as per requirements, however there has been no external scrutiny in relation to the submission by the St Helens LSCB during this year. A member of the Knowsley Safeguarding Children Board did undertake a front line visit to the Trust in January 2019 where discussions were had with a focus group of staff from across the organisation who work with children, as arranged by the safeguarding team, regarding the processes in place in the Trust and staff's knowledge of safeguarding procedures. Positive feedback was provided by the Board member in relation to this visit.

4.3. CQC Assurance

The CQC inspection between July and August 2018 resulted in the Trust receiving an outstanding rating.

During the inspection it was identified that the Trust needed to train additional staff in the Emergency and Maternity departments to Level 3 safeguarding children following the amendments in June 2018 to the Royal College of Paediatrics and Child Health -

Safeguarding Children and Young People Roles and Competencies for Health Care Staff intercollegiate document as detailed under the training section. A plan is in place to ensure all staff are compliant with the required level of training.

5. Summary of Achievements

- The Trust has achieved reasonable assurance in Safeguarding Children Compliance against the Safeguarding KPI's and Commissioning Standards
- There has been a positive feedback form the CCG as part of the local CCG review of safeguarding processes
- Assurance has also been received from the Annual Section 11 Audit submission and the front line review by a member of the Knowsley Safeguarding Children Board
- Safeguarding children activity was maintained whilst the Named Nurse was acting up across children and adults without additional resource. Significant support was given to the adult team for 6 months
- Specific training and support has been given to the Emergency Department staff in the management of 16 – 17 year olds
- Continued to report Child deaths as per CDOP requirements and cases reviewed internally by the Trust as per the Learning from Deaths policy
- All levels of training have been updated to reflect the changes in the revised Working Together to Safeguard Children Statutory Guidance (2018).

6. Future Developments

- The Trust will endeavour to maintain KPI compliance.

- Ensure the maternity department develop a clear plan regarding maternity safeguarding supervision in line with KPI requirements

- Ensure robust monitoring of attendance by midwives at multi agency safeguarding meetings and non-attendance addressed

- There will be a focus on maintaining Safeguarding Children training compliance.

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

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

- More joined up working with the safeguarding adults team to promote "Think Family" agenda

- Consider the expanding of safeguarding expertise within current Trust resources, e.g. Paediatric Liaison service.

- Clarify safeguarding arrangements due to staff roles sitting in other directorates.

- Ensure Trust engagement with the safeguarding partnership board arrangements following the new arrangements that will come into being following the publication of working together to safeguard children 2018 as a consequence of the Wood review recommendations.

- Roll out of Signs of Safety training and implementation of same, a strength based model of safeguarding to be implemented by Knowsley and St Helens Local Authorities.

- Discussions to be held regarding submission of the Annual Report for Safeguarding Children earlier in the year and consideration of a future joint children and adults annual safeguarding report.

- The safeguarding children policy will be revised and updated to reflect changes in national and local agenda