St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 25th MAY 2016
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

A G E N D A				Paper	Presenter
09:30	1.	Employee of the Month - May			
09:35	2.	Patient Story			Sue Redfern
09:55	3.	Apologies for Absence			Richard Fraser
	4.	Declaration of Interests			
	5.	Minutes of the previous Meeting held on 27th April 2016		Attached	
		5.1	Correct record & Matters Arising		
		5.2	Action list	Attached	
Performance Reports					
10:05	6.	Integrated Performance Report		NHST(16) 049	Nik Khashu
		6.1	Quality Indicators		Sue Redfern/Kevin Hardy
		6.2	Operational indicators		Paul Williams
		6.3	Financial indicators		Nik Khashu
		6.4	Workforce indicators		Anne-Marie Stretch
10:20	7.	Safer Staffing report		NHST(16) 050	Sue Redfern

10:30	8.	Infection Control report	NHST(16) 051	Sue Redfern
10:40	9.	Informatics report	NHST(16) 052	Christine Walters
BREAK				
Committee Assurance Reports				
11:00	10.	Committee report - Executive	NHST(16) 053	Ann Marr
11:05	11.	Committee Report – Quality	NHST(16) 054	Sarah O'Brien
11:10	12.	Committee Report – Finance & Performance	NHST(16) 055	Denis Mahony
Other Board Reports				
11:15	13.	Audit Plan approval	NHST(16) 056	Nik Khashu
11:20	14.	FT programme update report	NHST(16) 057	Nik Khashu
11:30	15.	Information Governance report	NHST(16) 058	Christine Walters
		15.1 FOI Board report	NHST(16) 058a	Christine Walters
11:40	16.	Quarterly Mortality Review update	NHST(16) 059	Kevin Hardy
11:50	17.	Mortality Review – a new system for England	NHST(16) 060	Kevin Hardy
12:00	18.	Trust objectives – review of 2015/16	NHST(16) 061	Ann Marr
12:10	19.	Board effectiveness – ToR	NHST(16) 062	Peter Williams
12:15	20.	Quality Account – final draft for approval	NHST(16) 063	Sue Redfern
Closing Business				
12:25	21.	Effectiveness of meeting		Richard Fraser
	22.	Any other business		
	23.	Date of next Public Board meeting – Wednesday 29th June 2016		

TRUST PUBLIC BOARD ACTION LOG – 25th MAY 2016

No	Minute	Action	Lead	Date Due
1	27.01.16 (8.12.3)	Claire Scrafton will discuss WRES at the steering group on 28.01.16 and a turnaround action plan will be implemented. Update at April Board. Agenda item. 27.04.16: Anne-Marie Stretch will bring a paper to June Board before submission on 1st July	AMS	29 Jun 16

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(16)049
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 continued delivery of national and local performance standards whilst ensuring affordability across the whole health economy.

Patient Safety, Patient Experience and Clinical Effectiveness

England's Chief Inspector of Hospitals (CQC) has awarded the Trust an overall rating of **Outstanding** for the level of care it provides across ALL services. St Helens Hospital was rated as **Outstanding,** making it 1 of only 3 acute hospitals nationally to be rated at this level. Whiston Hospital has been rated as **Good with Outstanding Features** placing it amongst the best hospitals in the NHS. **Outpatient and Diagnostic Imaging Services** at **BOTH** hospitals have been given the highest possible rating **Outstanding** – The first Outpatient and Diagnostic service in the country to EVER be awarded this rating.

There have been no cases of MRSA bacteraemia during April. The Trust has a zero tolerance of MRSA.

There was 1 C.Difficile case in April. The annual tolerance for 2016-17 is 41 cases.

There were no hospital acquired grade 3 / 4 pressure ulcers in April.

There were no falls resulting a harm level greater than Low in March.

Performance for VTE assessment for March was 89.30%

There have been no "never events" since May 2013.

YTD HSMR (Apr-15 to Jan-16) is 97.7. The latest available 12 month HSMR (Feb-15 to Jan-16) is 98.2.

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 15/16 financial outturn will have implications for the finances of the Trust
Stakeholders: Trust Board, Finance Committee , Commissioners, CQC, TDA, patients.
Recommendation: To note performance
Presenting Officer: N Khashu
Date of Meeting: 25th May 2016

Operational Performance

A&E performance (Type 1) was 81.5%. Whilst this was our highest performance for 4 months, it remains of significant concern. The ED have commenced a Lean project, which will focus on improving the triage process together with the amount of time spent waiting for clinical intervention. A Rapid Improvement Event to enhance the discharge process for patients with complex needs has been arranged in May. This 4 day event will be attended by Local Authorities, CCG, NHS Improvement and the Trust, with the objective of consolidating and further improving the gains that have been evident within this area. These are all being progressed through a weekly, Exec led group focused on improving the overall emergency access metric. All other key national access standards continue to be achieved.

Financial Performance

The Trust is reporting against an Annual Plan of £3.328m surplus, as approved by the Trust Board and confirmed with the TDA.

Income & Expenditure
For the month of April 2016 (Month 1) the Trust is reporting an overall Income & Expenditure surplus of £0.115m after technical adjustments which is in line with agreed plans.

CIP
To date the Trust has delivered £0.851m of CIPs which is just under the plan for the month.

Capital
Capital expenditure in April 2016 was £0.017m out of at total plan of £5.15m.

Cash
Cash balance at the end of April 2016 is £5.552m which equates to 7 operating days.

Human Resources

The quarter 4 Staff Friends and Family Test survey results show the Trust is maintaining its excellent performance compared to the national position, particularly in relation to staff likely to recommend the Trust to friends and family if they needed care.

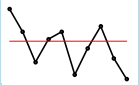
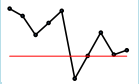
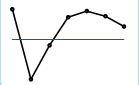
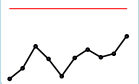
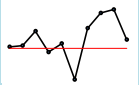
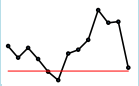
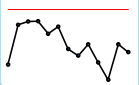
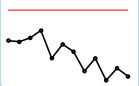
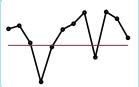
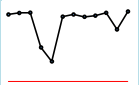
The Trust is below the mandatory training target by 8.2%. Appraisals performance remains above target. Recovery plans in place for Mandatory Training continue to be impacted by the unprecedented operational pressures. High rates of 'no shows' at booked mandatory training have wasted 35% of capacity in month.

Staff sickness for March was 4.85%. This is an improvement on February's position following continued efforts and a targeted approach between HR and managers to drive down sickness absence rates.

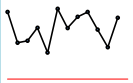
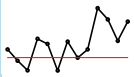
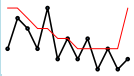
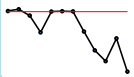
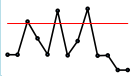
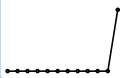
The following key applies to the Integrated Performance Report:

▲ = 2015-16 Contract Indicator
▲ £ = 2015-16 Contract Indicator with financial penalty
T = Trust internal target

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

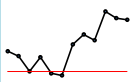
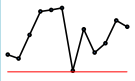
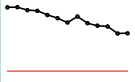
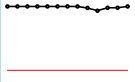
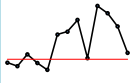
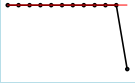
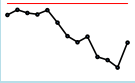
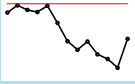
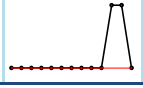
	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS												
Mortality: Non Elective Crude Mortality Rate	Q	T	Apr-16	2.4%	2.4%	No Target	2.5%		Overall SHMI and HSMR within control limits, but not 5*. Co-morbidity coding better, but not best in class. Palliative care coding suboptimal but being addressed by new consultant & his team & coding. Weekend admission mortality (Saturday admissions) is too high.	Patient Safety and Clinical Effectiveness	The Trust is exploring an electronic solution to improve capture of comorbidities and their coding. Focus on missing notes (which is improving) as this impacts on R codes (and HSMR). A drive in ED and MAU to reduce excessive use of symptom-diagnoses, as this impacts on HSMR. Palliative care consultant now in post. Work to improve management of AKI and Sepsis is demonstrating early success and will reduce 'observed' mortality.	KH
Mortality: SHMI (Information Centre)	Q	▲	Sep-15	1.03		1.00						
Mortality: HSMR (Dr Foster)	Q	▲	Jan-16	83.7		100.0	97.7					
Mortality: HSMR Weekend Admissions (emergency) (Dr Foster)	Q	T	Jan-16	103.8		100.0	111.8					
Readmissions: 28 day Relative Risk Score (Dr Foster)	Q	T	Oct-15	101.9		100.0	101.5		Much improved over last 12 months. Still not 5*.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	Work to improve listing of babies returning electively but documented as emergency admissions is underway.	KH
Length of stay: Non Elective - Relative Risk Score (Dr Foster)	F&P	T	Jan-16	93.8		100.0	88.7		Sustained reductions in NEL LOS are assurance that medical redesign practices continue to successfully embed. The elective performance is believed to be partially a result of the shifting casemix to daycase, leaving an increasing volume of the more complex patients as inpatients.	Patient experience and operational effectiveness	To verify the assumption that the elective LOS performance is as a result of shifting casemix to daycases.	PJW
Length of stay: Elective - Relative Risk Score (Dr Foster)	F&P	T	Jan-16	106.1		100.0	106.2					
% Medical Outliers	F&P	T	Apr-16	1.2%	1.2%	1.0%	2.2%		The increase is a reflection of the growth in non-elective demand within medicine. 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.	PJW
Percentage Discharged from ICU within 4 hours	F&P	T	Apr-16	46.0%	46.0%	67.7%	50.9%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	The operational turnaround actions should assist in improving this metric as it is a function of the NEL demand and subsequent impact on patient flow.	PJW
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients)	Q	▲	Mar-16	77.4%		85.0%	79.9%		eDischarge performance below target, albeit compares favourably with neighbours.		Drive to ensure realtime completion on ward rounds to improve compliance.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients)	Q	▲	Mar-16	87.3%		85.0%	88.3%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E)	Q	▲	Mar-16	99.1%		95.0%	98.5%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

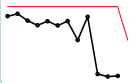
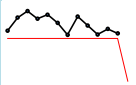
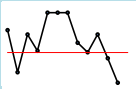
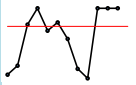
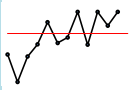
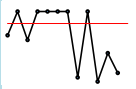
	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Mar-16	93.9%		83.0%	92.0%		Target is being achieved	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	This KPI is at risk from significant non-elective demand so the issue is reviewed at every Bed Meeting.	PJW
PATIENT SAFETY												
Number of never events	Q	▲ £	Apr-16	0	0	0	0		There have been no never events since May 2013. Theatre harm has now reduced by more than 50% overall since the implementation of the safer surgery project in October 2013.	Quality and patient safety	The implementation of NatSSIPS is on target for a July delivery against a September target to further reduce episodes of harm during interventional procedures	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Apr-16	99.5%	99.5%	98.6%	98.9%		Figures quoted relate to all harms excluding those documented on admission. StHK performs well against its neighbours and continues to maintain 99% harm free care in March.	Quality and patient safety	an annual validation study will commence in June to ensure that the methodology is being applied appropriately.	SR
Prescribing errors causing serious harm	Q	T	Apr-16	0	0	0	0		The trust continues to have no prescribing errors which cause serious harm. Trust has moved from being a 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. Trust approved national insulin training programme to try to prevent insulin errors.	KH
Number of hospital acquired MRSA	Q F&P	▲ £	Apr-16	0	0	0	0		There 1 was C.Difficile case in April. The annual tolerance for 2016-17 is 41 cases.	Quality and patient safety	The Infection Control Team continue to support staff to maintain high standards and practices. Monitor and undertake RCA for any hospital acquired BSI and CDT. CDT and Antibiotic wards rounds continue to be undertaken on appropriate wards.	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲ £	Apr-16	1	1	41	29					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Apr-16	0	0	No Contract target	1		Pressure ulcer performance continues to improve. There were no grade 3 or 4 ulcers reported in month.	Quality and patient safety	Additional education sessions are being delivered to increase the tissue viability training compliance rates for 16/17 to further support the reduction in hospitals acquired PU.	SR
Number of falls resulting in severe harm or death	Q	▲	Mar-16	0		No Contract target	21		Falls resulting in severe harm or death benchmark well against national peers	Quality and patient safety	An environmental assessment of clinical areas has been undertaken to ensure risks to falls are minimised.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲ £	Mar-16	89.30%		95.0%	93.31%		New electronic system introduced 2 weeks ago will allow eVTE assessment even when patients not on ADT.	Quality and patient safety	Intensive drive to improve VTE assessment in SAU, AMU & EAU in particular.	KH
Hospital acquired VTE events rate (National Safety Thermometer)	Q F&P	T	Apr-16	0.0%	0.0%	0.45%	0.25%					
To achieve and maintain CQC registration	Q	▲	Apr-16	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Mar-16	93.3%			96.8%		Shelford Patient Acuity Audit is currently being undertaken across the Trust.	Quality and patient safety	Daily staffing huddles supported by escalation flow chart are in place. The Trust has an escalation protocol in place which includes Executive authorisation for requesting agency staff.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Mar-16	1			1					
Intelligent Monitoring Risk Banding	Q	T	May-15	5		6	4		The Trust has improved priority banding to band 5 (Band 1 = highest risk and Band 6 = lowest risk).	Quality and patient safety	Actions plans in place for areas identified as requiring improvement.	SR

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

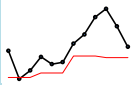
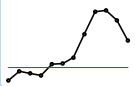
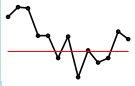
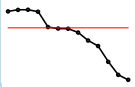
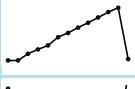
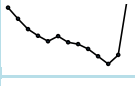
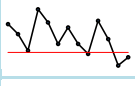
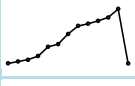
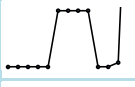
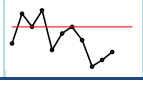
	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Mar-16	97.1%		93.0%	95.1%		Key access targets achieved in March. The revised Cancer PTL approach and increased capacity in the tracking team are assisting the achievement of this standard.	Quality and patient experience	A Programme approach to improving the timeliness of the patients journey along the Cancer pathways is underway. Ongoing work in capacity and demand modelling to bring first attendance down to within 7 days and improved patient tracking are the current areas of focus	PJW
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Mar-16	98.2%		96.0%	97.8%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲	Mar-16	89.5%		85.0%	88.6%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Apr-16	95.6%	95.6%	92.0%	95.5%		Trauma & Orthopaedics continue to fail at a speciality level.	There is a risk due to the current medical bed pressures that the elective programme will be compromised	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. Alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand.	PJW
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Apr-16	100.0%	100.0%	99.0%	99.99%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Apr-16	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Apr-16	0.7%	0.7%	0.6%	0.9%		This metric continues to be directly impacted by increases in NEL demand (both surgical and medical patients). The failure of the 28 day target in March related to three patients who were cancelled on their target date due to ITU bed availability on the day and Industrial Action.	Patient experience and operational effectiveness Poor patient experience	The planned increase in elective surgical activity in St Helens has commenced. Potential to use external theatre and bed capacity continues to be progressed.	PJW
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Mar-16	93.5%		100.0%	99.3%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Apr-16	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Apr-16	81.5%	81.5%	95.0%	85.0%		Failure to ensure patients are managed within 4 hours in the Emergency Department All Type activity includes the Trusts contribution to the local urgent care centres.	Patient experience, quality and patient safety	ED have commenced a Lean programme, focussed on improving the triage process and the time spent waiting interventions. Workstreams in ambulatory care and improving the timeliness of discharge continue.	PJW
A&E: Total time in A&E: % < 4 hours (All Types)	F&P	▲	Apr-16	88.4%	88.4%	95.0%	89.4%					
A&E: 12 hour trolley waits	F&P	▲	Apr-16	0	0	0	2					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

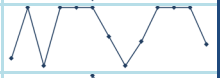
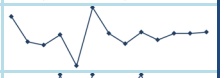
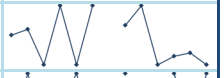
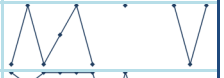
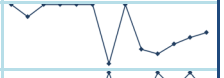
	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Apr-16	0	0	0	0		Increased demand for IP capacity has a direct bearing on the ability to maintain this quality indicator.	Patient Experience	Maintained focus and awareness of this issue across 24/7.	PJW
Complaints: Number of New (Stage 1) complaints received	Q	T	Apr-16	27	27		291			Patient experience	A revised structure to support performance improvements in complaints response will be implemented imminently.	SR
Complaints: Number of New (Stage 1) complaints received in 2016-17 and resolved in 2016-17	Q	T	Apr-16	4	4		251					
Complaints: Number of New (Stage 1) complaints received in 2016-17 and resolved in 2016-17 within agreed timescales	Q	T	Apr-16	100.0%	100.0%		61.4%					
Complaints: Number of New (Stage 1) complaints received in 2015-16 and resolved in 2016-17	Q	T	Apr-16	11	11		122					
Complaints: Number of New (Stage 1) complaints received in 2015-16 and resolved in 2016-17 within agreed timescales	Q	T	Apr-16	55.0%	55.0%		4.9%					
Friends and Family Test: % recommended - A&E	Q	▲	Mar-16	84.8%		90.0%	91.5%			Patient experience & reputation	Scores have been fed back to the ED and Maternity departments. Incremental roll out during quarter 4 will include all outpatients, day cases and all ages.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Mar-16	95.6%		90.0%	96.4%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q	▲	Mar-16	95.3%		97.3%	98.1%		New company has taken over FFT surveys on behalf of the Trust since January 2016. Number of patients being surveyed has increased greatly from January.			
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Mar-16	100.0%		98.7%	98.1%		Latest available benchmarking (Apr-15 to Feb-16) shows that nationally A&E performance is in the top half of Trusts, and Maternity has two elements in the top 25% of Trusts (Antenatal and Postnatal Community), and two others (Birth and Postnatal) in the top 50% of Trusts.			
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q	▲	Mar-16	100.0%		96.6%	95.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q	▲	Mar-16	96.9%		99.4%	98.6%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Mar-16	94.1%		95.0%	94.7%					

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2016-17 YTD	2016-17 Target	2015-16	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE												
Sickness: All Staff Sickness Rate	Q F&P	▲	Mar-16	4.9%		Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.9%		Absence has decreased in March because we have both targeted departments, gone back to basics (e.g. focus on RTWs) and held manager-targeted meetings. The Absence Support team have given increased support to mainly clinical areas. The highest reason for absence was stress. The HWWB team have been running stress busting sessions which have been really well received.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	It is proposed that the Trust introduces differential targets across the Trust to give stretch targets to those department/staff groups that are not patient facing where they should be able to achieve well under the 4.5% overall Trust target. The HR Advisory Team and Absence Support Team continue to work closely with managers with top areas being targeted and action plans invoked.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P	T	Mar-16	6.4%		5.3%	6.0%					
Staffing: % Staff received appraisals	Q F&P	T	Apr-16	86.3%	86.3%	85.0%	87.2%		Work in the latter part of quarter 4 has led to an increase in appraisal compliance to above the target of 85%. Despite providing 20% additional capacity and applying a policy of overbooking all sessions by a further 20%, compliance has continued to fall below that expected for Mandatory Training. This is due to the high level of no shows and last minute cancellations leading to 35% of available places being wasted in the current reporting period.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Capacity of clinical subject matter experts and suitable room availability restricts the provision of additional sessions. Consequently the Learning & Development team recovery plan is focussing on maximising pre-existing sessions by increasing capacity on each remaining session with the addition of extra sessions where this is feasible. Additional targeting is taking place of those managers with non compliant staff and those whose staff have been no shows to ensure best use of available capacity. The L&OD team is reviewing current programme in order to minimise the time commitment of staff.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Apr-16	76.8%	76.8%	85.0%	77.6%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q4	91.6%					The Trusts Staff Friends and Family Test results in Q4 continue to exceed the 2014/15 results and the 2015/16 national average for each question. Again the question relating to recommending the Trust as a place to receive care has returned an exceptionally high score.		The Trust will complete the 2016/17 Q1 SFFT survey during June 2016 with results for this period available from the end of July 2016.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q4	80.2%								
Staffing: Turnover rate	Q F&P	T	Mar-16	0.8%			8.9%		Staff turnover remains stable and well below the national average of 14%.	Quality and patient experience, staff morale	Turnover is monitored across all departments as part of the Trusts Recruitment & Retention Strategy with action plans to address areas where turnover is higher than the trust average. Further action is required by Ward Managers to provide more support to newly qualified nurses.	AMS
FINANCE & EFFICIENCY												
FSRR - Overall Rating	F&P	T	Apr-16	2.0	2.0	1.0	2.0		The Trust's year to date performance is broadly in line with plan. The Trust has significant contractual agreements with other NHS organisations which may impact on our ability to achieve Better Payment compliance.	Financial	Adherence against the submitted plan and delivery of CIP. Maintaining control on Trust expenditure. Agreeing with Commissioners and NHSE a more advantageous profile for receipt of planned income.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Apr-16	851	851	15,248	13,043					
Reported surplus/(deficit) to plan (000's)	F&P	T	Apr-16	115	115	3,328	(9,551)					
Cash balances - Number of days to cover operating expenses	F&P	T	Apr-16	7	7	>10	2					
Capital spend £ YTD (000's)	F&P	T	Apr-16	18	18	4,923	4,169					
Financial forecast outturn & performance against plan	F&P	T	Apr-16	3,328	3,328	3,328	(9,551)					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Apr-16	91.7%	91.7%	95.0%						

APPENDIX A

		Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	2015-16 YTD	2015-16 Target	FOT	2014-15	Trend	Accountable Exec
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																				
Breast	▲ £	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%	95.8%	100.0%	100.0%	99.2%	85.0%		99.5%		Paul Williams
Lower GI	▲ £	80.0%	100.0%	100.0%	100.0%	100.0%	77.8%	100.0%	84.6%	100.0%	100.0%	89.5%	100.0%	100.0%	94.5%	85.0%		90.6%		
Upper GI	▲ £	75.0%	100.0%	71.4%	100.0%	100.0%	100.0%	85.7%	71.4%	83.3%	100.0%	100.0%	100.0%	81.8%	88.9%	85.0%		86.3%		
Urological	▲ £	94.1%	77.8%	75.8%	82.4%	62.5%	100.0%	83.3%	76.7%	84.0%	79.2%	83.3%	83.3%	84.0%	80.8%	85.0%		87.4%		
Head & Neck	▲ £	75.0%	80.0%	50.0%	100.0%	50.0%	100.0%		83.3%	100.0%	50.0%	57.1%	60.0%	50.0%	71.1%	85.0%		59.4%		
Sarcoma	▲ £		100.0%		50.0%	100.0%			100.0%			100.0%		100.0%	87.5%	85.0%		100.0%		
Gynaecological	▲ £	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%	40.0%	100.0%	54.5%	50.0%	60.0%	66.7%	71.4%	76.4%	85.0%		88.2%		
Lung	▲ £	91.7%	66.7%	76.9%	85.7%	90.5%	75.0%	100.0%	71.4%	80.0%	100.0%	90.5%	100.0%	88.2%	86.5%	85.0%		80.9%		
Haematological	▲ £	100.0%	66.7%	100.0%	46.2%	50.0%	66.7%		60.0%	80.0%	66.7%	83.3%	50.0%	86.7%	70.5%	85.0%		77.0%		
Skin	▲ £	100.0%	94.9%	96.6%	97.0%	100.0%	90.0%	94.7%	88.5%	95.9%	95.3%	94.4%	92.5%	96.7%	94.5%	85.0%		94.6%		
Unknown	▲ £			100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	33.3%	100.0%		50.0%	83.3%	85.0%		89.5%		
All Tumour Sites	▲ £	93.9%	86.7%	86.3%	88.7%	91.0%	91.2%	91.4%	85.1%	89.3%	86.9%	87.9%	90.1%	89.5%	88.6%	85.0%		89.9%		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																				
Testicular	▲ £	100.0%			100.0%		100.0%	100.0%					100.0%	100.0%	100.0%	85.0%		91.7%		
Acute Leukaemia	▲ £									100.0%	100.0%				100.0%	85.0%		100.0%		
Children's	▲ £															85.0%				

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)050
Title of paper: Safer Staffing Report for April 2016
Purpose: The aim of the report is to provide the Board with an overview of nursing and midwifery staffing levels in the inpatient areas during the month of April 2016. This will highlight the wards where staffing has fallen below the 90% fill rate, review the impact of this on patient care and will provide a summary of actions implemented to address gaps.
Summary: The Trust is required to publish monthly nursing and midwifery staffing levels by shift as 'expected' versus 'actual' in hours via the template set up on UNIFY, to provide the URL to our own "safe staffing" web page. The URL will enable the NHS Choices team to establish this link from the NHS Choices website to the Trust website. The month of April **2016** data indicates: • Overall Trust fill rate =99.61 % (for registered and for care staff) • Overall registered staff fill rate for days was 92.27% and for nights 96.16% • Overall care staff fill rate for days was 102.63% and for nights was 107.41% There were 21 ward areas with a fill rate below 90%, 12 wards for registered staff, 9 wards for care staff and 0 wards for both registered and care staff.
Corporate objectives met or risks addressed: Contributes towards the achievement of Patient Safety and Workforce planning objectives.
Financial implications: None directly from this report.
Stakeholders: Patients, the public, staff and commissioners.
Recommendation(s): It is recommended that the Board note this report and the data to be submitted to Unify.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance
Date of meeting: 25th May 2016

SAFER NURSING & MIDWIFERY WORKFORCE STAFFING LEVELS REPORT

1. The purpose of this paper is to provide assurance regarding nursing and midwifery ward staffing levels which is an indication of the Trust's capacity to provide safe, high quality care across all wards at St Helens and Knowsley Teaching Hospitals NHS Trust.

2. The Trust is committed to ensuring that its nursing workforce is sufficiently robust to deliver high quality, safe and effective care in order to meet the acuity and dependency requirements of patients within our care. This report forms part of the organisation's commitment in providing open and honest care, through the publication of its 'safer staffing' data for each ward on the Trust's Website and formal data submission via UNIFY which is published on the NHS Choices website. The safer staffing data for April 2016 for all wards is attached for information as **Appendix 1**.

3. The Safer Staffing data calculates the 'expected' staffing levels agreed by the Trust Board in hours for each ward for days and nights for both registered and care staff against the 'actual' staffing levels on shift for the previous month. A fill rate of the 'actual' staffing levels against the 'expected' staffing levels is then calculated as a percentage fill rate for each ward and overall for the Trust for the month. This report focuses on wards where there is a fill rate of less than 90% on days or nights and triangulates that information against patient safety information for that ward to see if staffing levels have had an adverse effect on patient care during the month.

4. Guidance from NHSE and NICE on which staff are included in the 'actual' staffing numbers is followed when calculating the monthly safer staffing figures for each ward. The 'actual' numbers include both registered and care staff who works extra time, over time or flexible time and bank and agency staff usage. The supernumerary ward manager management days are also included in the 'actual' registered staff numbers.

5. Nursing and midwifery workforce daily staffing shortfalls (due to sickness, absence, vacancies and maternity leave not successfully backfilled) which are not addressed at ward level by the shift leaders / ward managers each shift by staff working extras or swapping shifts, are escalated to, monitored by and managed by the matrons/lead nurses daily. The matrons input daily staffing levels for each shift for their ward into a central database which shows the daily expected staffing levels for each shift for each ward and the actual staffing levels for both registered and care staff.

6. At the daily matron / lead nurse midday staffing level review meeting, any continuing, unresolved staffing gaps are referred to the Staffing Solutions Department to request bank staff or agency staff, the latter are only requested when all other avenues have been exhausted.

   The daily staffing review meeting is where patient dependency and staffing skill mix issues are reviewed and decisions made where best to deploy staff to best meet patient requirements across the wards for the next 24 hours. The meeting also identifies where additional staff are required to special patients who require close observation. This explains why the average fill rate is often above 100% for care staff. Also, if there is a shortfall in registered staff after every effort has been made to fill the gap with a registered nurse has been exhausted, attempts are then made to cover the

gap with care staff in order to increase the numbers of staff on the shift acknowledging the skill mix is not as required for the shift.

7. The recruitment and retention of nursing staff remains a priority for the Trust and remains an on-going challenge nationally. Stabilising and retaining the nursing and midwifery workforce in clinical areas has been an area of increased focus throughout 2015/16.
   A new preceptorship program commenced in March 2016 to improve the retention and development of newly qualified recruits who will hopefully take full advantage of the development opportunities available to them at this Trust. There are three recruitment days planned throughout 2016, the first one took place on Saturday 27th February 2016 and, as a result, we have made 31 offers across the following specialities: Care of the Elderly, Respiratory, Medical Escalation Unit, General Surgery, Burns & Plastics, Cardiology. At the June recruitment day, the following specialities will be directly targeted: Respiratory Medicine (wards 2B and 2C), Gastroenterology (ward 3D), Endocrinology (ward 2D) and General Medicine (ward 3E) – 27.13 WTE gaps in total.

   A recruitment campaign, which is now at conditional offer stage, is also taking place for St Helens theatres, where two open evenings where organised for nurses and ODP's on 23rd and 30th March, with the St Helens nursing team promoting the department/vacancies at the Edge Hill Nursing Career Fair on 24th March. The campaign resulted in three job offers, with more advertising being carried out for the remaining gaps.

8. An overseas recruitment to India was undertaken in November 2015 and 122 posts offered to registered nurses, the majority of whom will hopefully commence employment within the Trust during Q4 of 2016/17. This will address the registered nurse vacancy gap within the Trust which as of April 2016 was 52.43 wte.

9. Wards 1a, 2b, 2c, 3e, 5a and 5b are currently on the Trust Corporate Risk register scoring 15 for on-going staffing shortfalls. Five of the six wards scored below 90% for trained staff fill rate but where over 90% in untrained staff fill rate, only ward 3E scored below 90% for care staff but was above 90% for registered nurses.

10. In April 2016 there were 21 ward areas with a fill rate below 90%, 12 wards for registered staff, 9 wards for care staff and 0 wards for both registered and care staff

10.1. **The wards below the 90% fill rate for registered staff** are set out in the table below. The table shows that the majority of the wards were over-established with care staff to increase overall numbers.

	RN days	HCA days	RN nights	HCA nights
1A	74.5%	100%	77.5%	111.1%
1D	88.6%	125.5%	84.6%	119.7%
2B	78.5%	109.7%	98.9%	126.7%
2C	87.1%	129.2%	88.9%	138.8%
2D	68.2%	115.2%	98.3%	91.8%
2E	86.0%	90.3%	97.9%	110.2%
3 Alpha	88.8%	93.4%	101.7%	100%
4C	79.1%	101.2%	93.3%	100%

5A	93.1%	116.4%	80.9%	121.7%
5B	93.4%	103.2%	88.9%	91.1%
5C	89.6%	100.8%	78.4%	108.9%
Duffy	84.5%	139.9%	100%	145.0%

10.2. Wards with a care staff fill rate below 90% are set out below.

	RN days	HCA days	RN nights	HCA nights
3A	115%	82.6%	123.8%	108.1%
3E	92.3%	89.3%	105.6%	100%
3F	101.2%	86.9%	100.4%	95.1%
4A	92.7%	91.6%	107.8%	88.9%
4D	110.7%	66.1%	103.3%	45.0%
4E	92.0%	71.3%	97.8%	96.7%
4F	113.9%	82.5%	103.5%	93.4%
SCUBU	114%	40.7%	106.3%	96.9%
Delivery suite	91.4%	89.3%	95.6%	95.5%

10.3. There were no wards in April with both a registered nurse and care staff overall fill rate of less than 90% during the same shift period.

11. The table below shows the amount of bank and agency shifts for trained and care staff that were filled and remained unfilled during April 2016, including the requests for the wards where the fill rate was less than 90%. This is evidence of efforts made to address staffing shortfalls to maintain patient safety.

April 2016

staff group	Unfilled requested shifts	Filled requested shifts
Bank HCA	882	2082
Agency HCA	55	134
Bank RN / RM	347	146
Agency RN	139	403
Wards with RN shortfall	**Unfilled requested bank and agency shifts**	**Filled bank and agency requested shifts**
1A	61	21
1D	42	7
2B	55	33
2C	41	25
2D	9	13
2E	1	1
3 Alpha	7	6
4C	30	21

5A	2	1
5B	1	1
5C	17	4
Duffy	0	0

Wards with HCA shortfall	Unfilled requested bank and agency shifts	Filled bank and agency requested shifts
3A	8	30
3E	6	63
3F	0	1
4A	17	41
4D	7	12
4E	20	8
4F	0	3
SCUBU	0	5
Delivery suite	Not available	Not available

12. During April 2016, there were a total of 31 incident forms completed related to staffing. No episodes of harm where reported as a result of any staffing difficulties. This related to 15 wards/departments as indicated in the table below:

Incident date	Time	Location Exact	Description	Adverse event	Severity of harm	Staffing Establishment at time of incident
01/04/2016	21:00	Ward 5D - Stroke Rehabilitation Unit	Availability of HCA form Nurse bank to provide close observation	Lack of available staff	None (No harm caused)	Agreed staffing establishment on shift
02/04/2016	11:30	Theatre Recovery	Reduced skill mix to cover 4 theatres.	Lack of suitably skilled staff	None (No harm caused)	Staff reallocated to support theatre recovery.
02/04/2016	13:15	Ward 1E Coronary Care Unit	RN late shift sickness left late short by one staff member	Lack of suitably trained staff	None (No harm caused)	3 RGN 2 HCA
04/04/2016	22:00	Ward 1D	RN moved for the night shift to another ward	Lack of suitably trained staff	None (No harm caused)	Skill mix review agreed with matron
05/04/2016	20:45	Delivery Suite	High Number of patients on delivery suite 1 Midwife rang in sick for the night shift	Lack of suitably trained staff	None (No harm caused)	Ward 2E provided MW cover
07/04/2016	10:00	Theatres Delivery (Women's)	Cancelled procedure to reduced clinical cover	Lack of suitably skilled staff	None (No harm caused)	Patient rebooked

06/04/2016	14:00	Clinic Orthopaedic	Reduced number of plaster technicians staff on Orthopaedic clinic due to sickness	Lack of suitably skilled staff	None (No harm caused)	All patients were attended to. Resulted in extended waiting time
01/04/2016	17:00	Clinic Fracture	Clinic overbooked and overran	Lack of suitably trained staff	None (No harm caused)	Delay in clinic finish time
08/04/2016	23:00	GPAU/ Short Stay	Variance in agreed skill mix due to short term sickness	Lack of suitably skilled staff	None (No harm caused)	Cross cover from Ward 1B provided
09/04/2016	20:45	Delivery Suite	Reduced staffing for night shift by 1 MW	Lack of suitably trained staff	None (No harm caused)	Ward 2E provided cross cover
10/04/2016	21:00	A + E	HCA for Close observation patient not available from nurse bank	Lack of suitably skilled staff	None (No harm caused)	HCA moved from EAU to monitor patient
10/04/2016	21:00	A + E	Due to shortage of RN x1 (short term sickness) Zone 2 will be closed after 1am.	Lack of suitably trained staff	None (No harm caused)	ED escalation plan implemented
11/04/2016	08:00	Ward 3D	Movement of 1x RN to another ward	Reduced No of trained staff	None (No harm caused)	Staffing within the agreed establishment
11/04/2016	12:45	Theatre Recovery	Delayed transfer to ward	Lack of suitably skilled staff	None (No harm caused)	Recovery staff transferred patient back to the ward
11/04/2016	08:30	Clinic Pre-operative	HCA not available from the bank to cover sickness	Lack of suitably trained /skilled staff	None (No harm caused)	Increase in waiting time
12/04/2016	03:30	Ward 1A - Frailty Unit	HCA not available from nurse bank to provide close observation	Lack of suitably skilled staff	None (No harm caused)	Ward fully staffed close observation required in addition
11/04/2016	21:50	Ward 3D	HCA moved to cover another ward	Reduced No of HCA on shift	None (No harm caused)	Matron approved move as per staffing huddle

12/04/2016	13:15	Theatre Recovery	Delayed transfer to ward	Lack of suitably trained /skilled staff	None (No harm caused)	Recovery staff required to transfer patient (20mins)
12/04/2016	16:35	Theatre Recovery	Delayed transfer to ward	Lack of suitably trained /skilled staff	None (No harm caused)	Recovery staff required to transfer patient (15 mins)
13/04/2016	13:10	Theatre Recovery	Delayed transfer to ward	Availability of bed	None (No harm caused)	Patient stayed on the unit as delay in bed allocation
13/04/2016	09:00	Clinic Pre-operative	Short term sickness RN	Lack of suitably trained /skilled staff	None (No harm caused)	Reduced RN x1 resulted in increased waiting time
15/04/2016	20:45	Ward 1D	RN shortage due to short term sickness.	Lack of suitably trained /skilled staff	None (No harm caused)	RN not available from the bank
19/04/2016	13:30	Theatre Recovery	Delay in transfer to ward	Lack of suitably trained /skilled staff	None (No harm caused)	Recovery staff required to transfer patient (10 mins)
22/04/2016	08:50	Clinic ENT	Lack of junior doctor availability	Lack of suitably trained staff	None (No harm caused)	Reduced number drs in clinic resulted in An increase in waiting time for patients
24/04/2016	13:00	Theatre Main (Orthopaedic)	Delay in transfer to ward	Lack of suitably trained /skilled staff	None (No harm caused)	None
25/04/2016	11:30	Ward 2E	Called to delivery suite to assist from ward 2e for part of the shift due to increased activity	Lack of suitably trained /skilled staff	None (No harm caused)	5 midwives on 2e which left the ward with safe levels of MW
21/04/2016	23:00	Ward 1A - Frailty Unit	Shortage of one RN unable to provide cover from bank	Lack of suitably trained /skilled staff	None (No harm caused)	Cross cover from Ward 1a DMOP
27/04/2016	21:00	Ward 3D	Movement of RN at night to support another ward	Lack of suitably trained /skilled staff	None (No harm caused)	Matron agreed move

22/04/2016	09:30	Ward 2E	1 MW short for am shift	Lack of suitably trained /skilled staff	None (No harm caused)	Specialist role MW utilised
28/04/2016	16:18	Theatre Recovery	Delayed transfer of patient to the ward	Lack of suitably trained /skilled staff	None (No harm caused)	Recovery staff required to transfer patient (15 mins).
30/04/2016	03:00	A + E Offices	1 admin shortage on nights	Lack of suitably trained /skilled staff	None (No harm caused)	Unable to cover shift at short notice
29/04/2016	00:00	Clinic Plaster rooms	Reduced number of plaster technicians staff in plaster clinic due to sickness	Lack of suitably trained /skilled staff	None (No harm caused)	All patients were attended to. Resulted in extended waiting time

13. There were 2 recorded falls during April 2016 that resulted in moderate harm or above. These two episodes took place on wards 3B and 3D, neither of these wards fell below 90% for either trained or untrained staff at any point during April.

Appendix 2 relates to all falls that took place during the month of April 2016.
The areas for trained staff with a fill rate below 90% are coloured Red, and the areas for untrained staff below 90% fill rate are coloured Orange.

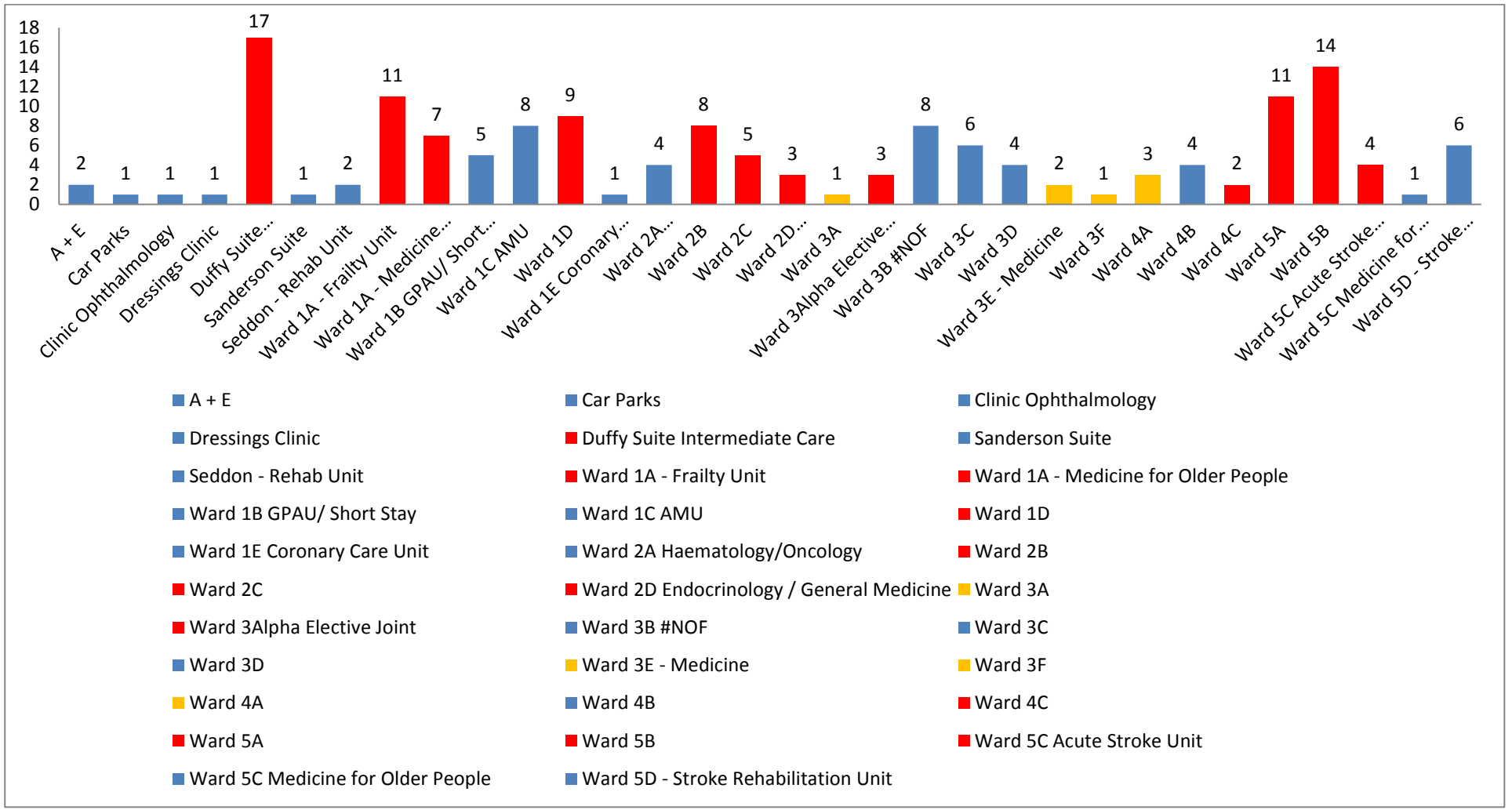
Summary
The report provides assurance that every effort was made to ensure optimum staffing levels across all wards daily during April 2016 to reduce the incidence of harm to patients and long term to address vacancies. The number of wards falling below the 90% fill rate has increased to 17 wards in March to 21 wards in April.

Appendix 1

Copy of 01 - April 2016 Upload Form.xls

APPENDIX 2

Trust wide falls by ward area in April 2016: Red = RN fill below 90% Orange = HCA fill below 90%



Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RBN St Helens And Knowsley Hospitals NHS Trust

Period: April_2016-17

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

http://www.sthk.nhs.uk/about/publication-of-information/safe-staffing

Comments

Only complete sites your organisation is accountable for

Validation alerts (see control panel)	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night			
						Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff	
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours
	RBN01	WHISTON HOSPITAL - RBN01	1A	430 - GERIATRIC MEDICINE		2169.75	1616.13	2134.25	2133.75	890.00	690.00	900.00	1000.00
	RBN01	WHISTON HOSPITAL - RBN01	1B	300 - GENERAL MEDICINE		2801.50	2720.25	1050.00	1330.25	1071.50	989.75	945.00	900.00
	RBN01	WHISTON HOSPITAL - RBN01	1C	300 - GENERAL MEDICINE		3147.98	2856.00	1434.00	1826.17	1725.00	1679.83	825.00	818.00
	RBN01	WHISTON HOSPITAL - RBN01	1D	300 - GENERAL MEDICINE		2025.00	1794.96	1342.50	1685.00	900.00	761.50	600.00	718.25
	RBN01	WHISTON HOSPITAL - RBN01	1E	320 - CARDIOLOGY		2239.00	1848.00	898.75	843.25	1200.00	1110.25	160.00	169.75
	RBN01	WHISTON HOSPITAL - RBN01	2A	303 - CLINICAL HAEMATOLOGY	300 - GENERAL MEDICINE	1552.50	1514.68	826.25	808.58	600.00	600.00	300.00	300.25
	RBN01	WHISTON HOSPITAL - RBN01	2B	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	2085.17	1636.58	1565.50	1716.90	890.00	880.00	600.00	760.00
	RBN01	WHISTON HOSPITAL - RBN01	2C	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	2166.50	1887.50	1340.25	1731.48	900.00	800.00	600.00	833.00
	RBN01	WHISTON HOSPITAL - RBN01	2D	300 - GENERAL MEDICINE		1425.00	971.75	1117.50	1287.50	600.00	590.00	600.00	550.50
	RBN01	WHISTON HOSPITAL - RBN01	2E	501 - OBSTETRICS		2921.75	2513.75	1339.25	1209.83	1200.00	1175.25	600.00	661.00
	RBN01	WHISTON HOSPITAL - RBN01	3A	160 - PLASTIC SURGERY		1665.00	1914.75	1365.00	1127.08	590.00	730.25	600.00	648.75
	RBN01	WHISTON HOSPITAL - RBN01	3Alpha	110 - TRAUMA & ORTHOPAEDICS	101 - UROLOGY	1123.25	997.25	893.00	833.75	580.00	590.00	290.00	290.00
	RBN01	WHISTON HOSPITAL - RBN01	3B	110 - TRAUMA & ORTHOPAEDICS		1552.77	1445.27	1712.25	1925.50	870.00	850.00	600.00	882.25
	RBN01	WHISTON HOSPITAL - RBN01	3C	110 - TRAUMA & ORTHOPAEDICS		1850.75	1753.25	1575.00	1898.25	900.00	911.35	900.00	1019.00
	RBN01	WHISTON HOSPITAL - RBN01	3D	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	2025.00	1849.50	1350.00	1325.17	900.00	817.00	600.00	656.00
	RBN01	WHISTON HOSPITAL - RBN01	3E	502 - GYNAECOLOGY	300 - GENERAL MEDICINE	1417.50	1308.00	817.50	729.92	550.00	580.75	290.00	290.00
	RBN01	WHISTON HOSPITAL - RBN01	3F	420 - PAEDIATRICS	502 - GYNAECOLOGY	2214.75	2241.25	450.00	391.00	1190.00	1195.00	300.00	285.25
	RBN01	WHISTON HOSPITAL - RBN01	4A	101 - UROLOGY	100 - GENERAL SURGERY	2204.25	2043.40	1348.25	1234.83	900.00	970.00	900.00	800.25
	RBN01	WHISTON HOSPITAL - RBN01	4B	100 - GENERAL SURGERY	101 - UROLOGY	2115.00	2096.97	1679.00	1695.17	1060.00	1070.00	470.00	480.00
	RBN01	WHISTON HOSPITAL - RBN01	4C	100 - GENERAL SURGERY		2231.00	1765.00	1344.50	1360.92	900.00	840.00	900.00	900.00
	RBN01	WHISTON HOSPITAL - RBN01	4D	160 - PLASTIC SURGERY		1335.00	1478.50	892.75	590.25	600.00	620.00	600.00	270.00
	RBN01	WHISTON HOSPITAL - RBN01	4E	192 - CRITICAL CARE MEDICINE		5698.50	5240.50	1473.23	1050.50	3600.00	3520.00	600.00	580.00
	RBN01	WHISTON HOSPITAL - RBN01	4F	420 - PAEDIATRICS		900.00	1024.75	447.25	369.00	570.00	590.00	300.00	280.25
	RBN01	WHISTON HOSPITAL - RBN01	5A	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1785.00	1662.17	2238.75	2606.92	890.00	720.00	890.00	1083.23
	RBN01	WHISTON HOSPITAL - RBN01	5B	430 - GERIATRIC MEDICINE		1460.00	1364.00	2147.50	2216.50	890.00	791.50	900.00	820.00
	RBN01	WHISTON HOSPITAL - RBN01	5C	430 - GERIATRIC MEDICINE		2581.50	2311.92	1793.98	1807.98	1479.50	1160.00	900.00	980.00
	RBN01	WHISTON HOSPITAL - RBN01	5D	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1491.00	1511.50	1555.75	1501.20	580.00	600.75	600.00	753.00
	RBN02	ST HELENS HOSPITAL - RBN02	Duffy Ward	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1411.25	1194.08	1348.25	1886.50	600.00	600.00	600.00	870.00
	RBN01	WHISTON HOSPITAL - RBN01	SCBU	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1346.25	1535.08	900.00	366.50	900.00	956.50	300.00	290.75
	RBN01	WHISTON HOSPITAL - RBN01	Delivery Suite	501 - OBSTETRICS		3150.00	2879.17	900.00	804.00	2100.00	2007.25	600.00	573.25
	RBN02	ST HELENS HOSPITAL - RBN02	Seddon	314 - REHABILITATION		1297.50	1512.75	1543.50	1603.00	570.00	600.00	580.00	784.25

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RBN St Helens And Knowsley Hospitals NHS Trust

Period: April_2016-17

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	RBN01	WHISTON HOSPITAL - RBN01	1A	430 - GERIATRIC MEDICINE		2169.75	1616.13	2134.25	2133.75	890.00	690.00	900.00	1000.00
			Total			63389.41667	58488.65833	40823.71667	41896.65	31196	29996.93333	18850	20246.98333

Day	
Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
74.5%	100.0%
97.1%	126.7%
90.7%	127.3%
88.6%	125.5%
82.5%	93.8%
97.6%	97.9%
78.5%	109.7%
87.1%	129.2%
68.2%	115.2%
86.0%	90.3%
115.0%	82.6%
88.8%	93.4%
93.1%	112.5%
94.7%	120.5%
91.3%	98.2%
92.3%	89.3%
101.2%	86.9%
92.7%	91.6%
99.1%	101.0%
79.1%	101.2%
110.7%	66.1%
92.0%	71.3%
113.9%	82.5%
93.1%	116.4%
93.4%	103.2%
89.6%	100.8%
101.4%	96.5%
84.6%	139.9%
114.0%	40.7%
91.4%	89.3%
116.6%	103.9%

Day	
Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
74.5%	100.0%

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)051

Title of paper: Infection Prevention & Control Report

Purpose: To provide the Trust Board with an update on the current Trust infection control status against Department of Health objectives.

Summary

Number of cases for financial year 2015-16:

- MRSA bacteraemia: 0 cases (target 0)
- CDI: 39 Positive samples (target 41) of which the Trust has successfully appealed:
  - 4 in October 2015, 3 in January 2016,1 in February 2016,1 in March 2016
  - 3 referred to Liverpool CCG decision: all upheld
  - 1 being presented to the appeals panel on 20th May

Total number of cases successfully appealed is 12 with one decision awaited.

Current total hospital attributable cases 27 against a target of 41.

Compared to 2014/15 hospital attributable cases was

Number of HCAI MSSA bacteraemia in March 2016: 1

Total number of cases for financial year 2015-16: 28

- Number of Trust attributable HCAI E coli bacteraemia in March 2016: 5

  Total number of cases for financial year 2015-16: 61

2016/17 trajectory

- MRSA bacteraemia: (target 0) 0 cases
- CDI: (target 41) cases in April 1
- HCAI MSSA bacteraemia (internal target of 15% reduction) cases April 2016 :2 RCA in progress
- HCAI E Coli bacteraemia in April 2016: 5 RCA in progress

Corporate objectives met or risks addressed: Patient Safety and Patient Care

Financial implications: There is a risk of financial penalties if the Trust does not achieve the CDI target.

Stakeholders: Trust, patients and stakeholders

Recommendation(s): That the Trust Board receive the report and discuss the contents to identify any actions required.

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

Date of meeting: 25tH May 2016

INFECTION CONTROL REPORT

1. **Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia**

   1.1. All Trusts have been given the target of zero hospital-acquired cases.

   1.2. In 2015/16 the Trust had zero cases.

   1.3. Compared to 2 cases the previous year, which were both appealed and upheld as there was no lapses in hospital care.

2. **Methicillin Sensitive Staph Aureus (MSSA) bacteraemia**

   2.1. The Trust is now required to report all MSSA blood cultures. There is currently no external target.

   2.2. During the period 1st April 2015 to 31st March 2016, there were 28 hospital acquired cases.

   2.3. This was a 65% increase compared with the 2014/2015 (17 cases).

   2.4. In 2015/2016, although the numbers of cases had increased, the number of avoidable cases was the same as the previous year. The increase in total numbers accounted for by unavoidable cases e.g. pneumonia, bone/joint infections, neutropenic sepsis etc.

   2.5. During the month of April 2016 there was I case of MSSAb .this was reported as hospital acquired as this was related to infected venflon site: VIP score 1 and on removal wound not swabbed.

   2.6. Audit of compliance is being conducted by matrons.

   2.7. This is an area for improvement during 2016/17, to support this an action plan has been developed (appendix 1)

   2.8. The action plan is being monitored through HIPG.

3. **MRSA hospital acquired colonisation**

   3.1. There were no cases of hospital-acquired MRSA (not blood cultures) in April 2016.

4. **E Coli bacteraemia.**

   4.1 There is no external target for E Coli Bacteraemia.
   4.2 There were 29 E coli bacteraemia in April 2016, 24 (73%) of which were community acquired and 5 (17%) hospital acquired.
   4.3 The mid Mersey HCAI collaborative are in the process of undertaking a 3 month retrospective audit to review all community E-coli bacteraemia

   4.4 There were 5 hospital-acquired e-coli bacteraemia cases in the month of April

   Which were related to:

- 2 patients with bacteraemia but with no identifiable focus including one patient who had neutropenia sepsis (unavoidable)
- 1 patient with probable intra-abdominal sepsis unrelated to any invasive procedure (unavoidable)

- 1patient who developed bacteraemia 3 days after ERCP, sphincterotomy and stone extraction who did not have any indication for requiring pre-procedure antibiotic prophylaxis (unavoidable)
- 1 patient with urosepsis not related to catheterisation or any invasive procedure (unavoidable).

5. **Vancomycin-resistant Enterococcal (VRE) bacteraemia.**

5.1. No cases of VRE bacteraemia so far this financial year.

6. **Clostridium Difficile Toxin (CDT)**

6.1. The target for 2015-2016 was no more than 41 hospital-acquired cases.

6.2. For 2015/16 there were 39 confirmed positive cases, of which the Trust has successfully appealed 12 and one is outstanding (Appeals panel 20Th May)

6.3. The target for 2016-2017 was no more than 41 hospital-acquired cases

6.4. During April 2016 there has been 1 case of C difficile (RCA in progress)

7. **Outbreaks.**

7.1 There has been an increased incidence of infection related to MDR Pseudomonas on wards 4D and 4E.
7.2 This involved 3 patients who acquired MDR Pseudomonas and were colonised in their wounds between the timeframe of November 2015 to January 2016.
7.3 The Index case was a transfer from Romania and was colonised on admission.
7.4 A further case of MDR Pseudomonas has been identified in March on 4D.
7.5 Typing results confirm that it is the same strain of MDR Pseudomonas.
7.6 Actions implemented included:

- Review of patients with pseudomonas over last 12 months for any other multi-resistant cases which may be related – no cases of the same type identified.
- Water sampling was carried out on all outlets on 4D and relevant outlets on 4E – 4 outlets on 4D were found to be positive for pseudomonas (although none of the strains isolated were related to the outbreak strain). Remedial action taken including replacing filters and taps on the positive outlets. Several repeat sampling results since then have been now negative.
- Review of clinical practice including hand hygiene and wound care/ANTT on 4D – no issues identified, in fact the standards of practice were excellent.
- Review of sink cleaning practices by unannounced audit – no issues identified.
- Review of flushing regimes – flushing temporarily increased when positive water samples were identified on 4D but has now been returned to base line levels (except for the burns bath which will remain as 7 min per day flushing due to being a high risk water outlet).
- Review of cleaning mechanism for bath hoist straps – recommended that these should be single patient use and sufficient straps need to be purchased by 4D for this purpose.
- 4D medical staff made aware that antibiotic treatment for any patients with or suspected to have multi-resistant pseudomonas infection must be discussed with a microbiologist (they do this anyway for most burns patients prior to starting or changing antibiotics).

- Environmental sampling carried out on 4D in rooms 5 and 7 plus bath room – no positives isolated from swabs of surfaces and equipment. All drains (sinks/bath/showers) are positive for pseudomonas, which is as expected as these are dirty areas normally colonised with biofilm including pseudomonas. However, sensitivity testing currently indicates that these pseudomonads are not the same as the outbreak strain but they will be sent for typing next week for definitive confirmation which can take up to 2 weeks.
- IPCT are working with the clinical team on 4D to produce a summary discharge cleaning chart and also a bespoke education package for the burns unit staff.
- Rooms 5 and 7 on 4D and the burns bath on 4D plus room 18 on 4E these areas should undergo a deep clean followed by hydrogen peroxide decontamination..
- Public Health England/Consultant in Communicable Disease Control has been informed. This will enable us to seek advice from national experts who have experience of dealing with similar situations.

8. **Carbapenemas – producing Enterobacteriasceae. (CPE)**

8.1 there have been no cases of CPE in April

9. **NHSI 90 day rapid HCAI improvement event**

9.1. The NHSI invited the Trust to present at the HCAI 90 day rapid improvement event; this was in relation to Executive leadership and accountability.

9.2. The DONMG and lead Nurse for IPC will participating in the next 2 events.

9.3. There were 16 different NHS hospital IPC teams from across the country present.

9.4. The feedback was positive and the Trust has been asked to Buddy up with 2 hospitals to offer support and share best practice.

ENDS

Infection Prevention & Control MSSA Action Plan Log

Action No	Date Initiated	Action	Lead	Due Date	Update	Status
ONGOING ACTIONS						
1	2015	Executive Root Cause analysis reviews of all MSSA bacteraemia. To identify any lessons learned from the review. These lessons learned are disseminated down to all relevant staff through ward meetings, link nurses, Consultant Champions, matrons, other consultants and governance structure. Issues are also addressed at Mandatory and induction training.	Sue Redfern	On-going	RCA reviews are held within 2 weeks of an MSSA bacteraemia being identified. Summary of findings attached in the introduction.	
2	March 2016	Development of a new RCA/PIR form for MSSA bacteraemia, in order to extract more relevant information. Work to be undertaken between St Helens and Knowsley and Warrington Hospitals.	Val Weston Lesley McKay	On-going	Discussions have taken place into what information will be relevant for the form and what format it should take.	
3	November 2015	Development and review of VIP charts to include post cannula site reviews for 48hrs after removal. Development of a post cannulation care plan for cannula removed with a VIP score of 1 or above.	Val Weston, Clare Harvey, Jane Osthoff and Jacqueline Owen	On-going	Care plan and new VIP chart piloted on 1D – awaiting a date from cannulation pack supplier into when new documentation can be introduced.	
4	November 2015	Development and commencement of a Trust wide IV access and Therapy Group. Aims: • To ensure that the use of intravenous devices complies with best evidenced	Val Weston and John Elmore	On-going	Monthly meetings.	

		based practice and is cost effective within the Trust. (Care and Safety) • The Intravenous Access and Therapy Group will facilitate and lead a Trust wide multidisciplinary approach to improvements in IV access and therapy. (Care, Safety and Pathways) • The Intravenous Access and Therapy Group will provide a forum for collaboration across Directorates and specialities, monitoring of quality indicators and facilitate the development of Trust wide Intravenous guidelines.(Communication) • To provide expertise for service improvement. (Safety)				
5	18/04/2016	Commencement of a pilot study project on the Vessel Health Preservation (VHP) framework on 1D to run for 6 months. Progress on the study to be reported at the Patient safety council, MCG and SCG meetings, HIPG, IV Access and Therapy and 1D ward meetings.	Val Weston	Pilot study due to finish on the 18th September.	Pilot study commenced on the 18th April.	
6	June 2016	Development and commencement of specific training sessions for all relevant Band 6 staff on Blood Cultures, Peripheral and Central line care. Training sessions to be co-ordinated with Education and training, IPC and MET teams.	Nick Bennett, John Elmore, Emily Ellis and Val Weston	On-going	First session to be delivered on June 6th.	

		The plan is for Band 6 staff to cascade this training to other members of staff. Forward plan – to develop a training package for all staff.				
7		VIP, UCAM and CVAT tools to be electronically included in EMEWS – to prompt staff on the wards to review and check all indwelling devices.	Kalani Mortimer and Christine Walters	On-going	The content of the forms have been finalised but not included in EMEWS so far as there are insufficient development days in the current phase of the EMEWS project. Conclusion from the last EMEWS project board in April 2016 was that a business case is required for the additional funding to incorporate these into EMEWS. KM has provided the requested information which is currently being reviewed by Lam Martland, Business Analyst in Informatics.	
8	August 2015	Development and commencement of an annual ANTT Key Trainers programme. Key trainers to cascade training and review competency of staff on the wards and departments	Val Weston, Alice Cruz, Emily Ellis and Lesley Connor	On-going	Key trainer training is delivered on a Quarterly basis by the IPC and ANTT department with assistance of Education and training.	
9	August 2016	ANTT annual mandatory competency programme developed and commenced. All staff in clinical areas need to demonstrate their practical ANTT competency on a yearly basis.	Val Weston, Alice Cruz, LMS and Key Trainers.	On-going	Percentage of staff who are now trained has risen from 46 % in June 2015 to 57 % at the end of March 2016.	

10	Oct 2015	Participation in ANTT regional meetings. The aim of the meetings is to standardise best practice across the region.	Val Weston, Emily Ellis and Alice Cruz	On-going		
11	January 2016	Trust wide audit of all peripheral and PICC lines on the wards. All findings on the wards feedback at the time of the audit for action – training sessions arranged for staff on the wards were necessary. Report to be collated and presented at Patient Safety Council, governance meetings, matron and ward manager meetings.	Alice Cruz and Emily Ellis	May 2016		
12	 July 2015 Oct 2015 April 2016	Policies: Indwelling IV and sub- cut Catheter Policy – reviewed and revised ANTT Policy – reviewed and revised Blood Culture Policy reviewed and revised Urine Catheter Policy reviewed and revised	 John Elmore and IPC Team Val Weston, Alice Cruz and Lesley Connor Kalani Mortimer, Alice Cruz Consultant Urologist and IPC Team	 Completed Completed Completed Awaiting finalisation		
13	May 16th 2016	Commencement of a trial of pre-filled saline flushes on Radiology, Stretcher triage (A&E) and 3D – for flushing of intravenous cannula. The aim is to reduce the risks from infection, contamination and needle stick injuries.	IV Access and Therapy Group	30th May 2016		
14	February 2016	Commencement and participation in the North West IV Forum group. Aim to share best practice and innovation.	Val Weston, Emily Ellis, Alice Cruz and John Elmore	On-going	Meeting held every quarter.	

15	May 2014	Utilisation of 3M CHG dressings for all Central Line sites. To reduce the risk of central line infections.	Emily Ellis	On -going		
16	To be developed.	To undertake regular in depth audits in conjunction with a Trust Continence Nurse of all Urinary catheters and infections within the Trust and to feedback results and actions.	IPC Team and Trust wide Continence Nurse	To be on-going	This is not yet in place. The continence nurse who works in the Trust is only working across the Surgical division. There is no capacity at the present moment for the IPC team to undertake these audits.	
17	June 2016	Proposal from 3M to bring over a Global IV expert from the US to do an educational session with specific staff on IV Access issues, incorporating staff from Aintree and the Royal.- meeting to be held at Whiston Hospital.	Val Weston	June 16th	Awaiting finalisation of the session.	
18	2015	To address the recognition of sepsis and initiation of the first dose of antibiotics without delay.	Sue Redfern	Completed	Appointment of 6 Sepsis Nurses at the end of 2015.	
19						
20						
21						

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)052
Title of paper: Informatics Report
Purpose: To update the Board on the progress of the Informatics Portfolio
Summary: This report covers the operational performance and the following projects:- • Electronic Modified Early Warning Scores (eMEWS) • ADT Implementation in Theatres • E-Prescribing and Medicines Administration (EPMA) • Electronic Document Management System (EDMS) Version 4 • Clinical Portal • Opera Theatre System • Maxims Version 10 upgrade (A&E, OCS and VTE modules) • Order Communications (OCS) • Pager System Upgrade • Smart Print Project • Electronic Palliative Care Coordination System (EPaCCs) • Upgrade to Somerset Cancer Register • Maternity Offline solution • Harlequin – Trust Charity Customer Relationship Management System • Upgrade of Myhealth Messaging System • Upgrade of the ICNet Infection Control System
Corporate objectives met or risks addressed: Contributes directly to the 2016/17 Corporate Objectives – Safety, Care, Systems
Financial implications: Benefits may not be realised or delivered late and costs may increase if projects are delayed.
Stakeholders: St Helens and Knowsley Teaching Hospitals NHS Trust Board.
Recommendation(s): Members are asked to note the Informatics Update
Presenting officer: Mrs Christine Walters, Director of Informatics
Date of meeting: 25th May 2016

Total Trust Projects	22
Total Green	15
Total Yellow	2
Total Red	1
Projects Complete since last review	4
Projects initiated since last review	5

Key

Red	Stopped / Paused
Yellow	Some Delays
Green	On Track
Blue	Delivered

Highlights

Electronic Modified Early Warning Scores (eMEWS) - phase 1 complete

Changes to the pace of the roll out programme were approved at the Project Board in January 2016. The original plan had been to roll out over six months, ending mid-August, however a rapid implementation was agreed and phase 1 of the eMEWs project was completed following a full implementation across all inpatient and theatre areas across the two hospital sites by 6th May 2016.

"eMEWS has been a clinically driven, successfully implemented project. What could have been a risk for the organisation with a large workforce all requiring a transition to using iPads for observations at the bedside, has instead been implemented in a way that has already won people over. It has instead increased enthusiasm for more applications and paved a smoother path for some of the other IT projects that will follow.

The ability of eMEWS to make bedside observations and early warning scores more transparent and enabling a more efficient response to ill patients will be pivotal in enhancing patient safety and quality" - ***Rajit Varia - Consultant AMU Physician***

"This is a compelling example of an NHS Trust taking the initiative with innovative technology to make important advances in patient safety. In particular St Helens & Knowsley Trust's implementation approach and focus on rapid solution deployment has helped to achieve early benefits and put in place a technology platform that can be expanded and extended. ***Donald Kennedy - MD, Patientrack.***

Phase 2 of the project will see the development, testing and implementation of the combined risk assessment form, consolidating five paper forms into one electronic process. It is anticipated that this will be completed and implemented across all inpatient areas by the end of July 2016, led by the Informatics Project Nurse, Debbie Warburton.

ADT Implementation in Theatres - complete

The ADT implementation in theatres was required to support eMEWs deployment. This was successfully implemented throughout March 2016.

ePrescribing and Medicines Administration (ePMA)

A newly appointed project manager has started work on the plan and the project is now being re-baselined, with a key dependency on the availability of ePMA version 2016 from the system supplier, JAC. The options for go live will be presented to the Project Board in June, dependant on the availability of this new version.

Electronic Document Management System (version 4)

This upgrade will provide faster access to patient notes, a new mobile friendly interface and the potential to approve and sign letters electronically. There have been several cycles of testing and close liaison with the supplier. This culminated in a go live of the product on 11th April 2016.

Unfortunately, a number of users encountered slow performance during the go live, which manifested itself as poor system responsiveness. Every effort was made during go live to resolve the issues raised, however the decision was taken to roll back the solution to the previous version to avoid any further disruption. This rollback process was performed safely with no data loss.

As part of this testing process, prior to go live, full user acceptance testing was undertaken and both clinical and administration sign-off was obtained.

The System Supplier has undertaken diagnostic work, and found and resolved the root cause of the performance issues. A new release has been delivered and full testing will take place during May 2016. A piece of additional software has been procured to assist with the performance testing of the solution. A revised go live date will be agreed once the testing has been completed successfully.

Clinical Portal

This system will bring together key information about the patient (current and previous episodes) into one summary view.

In order to achieve this, several interfaces from existing systems are required. Some of these interfaces are already complete (ICE for discharge information, Maxims for inpatient episodes and Carestream for Radiology images). Other interfaces have not yet been completed and tested (IMS Maxims for checked results, EDMS for outpatient clinic

information and the Summary Care Record for primary care prescribing information from the national database).

Dependencies

The EDMS interface is subject to the EDMS v4 upgrade, and the Summary Care Record information is subject to the development timetable of the Health and Social Care Information Centre.

This project is now showing as Yellow, as Maxims version 10 has been completed. SCR testing is expected to commence by the end of June but the dates for EDMS v4 have slipped. Clinicians can still access all information via the core systems, including the Summary Care Record.

Opera Theatre System

Major progress has been made since the last report. GE delivered the revised software on time and testing was undertaken. Issues were identified during the testing and further updates have been made to the software.

At the April Project Board discussion took place to consider the system implementation options. The Project Board action was to convene a multi-disciplinary working group to consider all options for implementation. The workshop was undertaken and the preferred option will be presented to the Board in June, and will describe a phased implementation over a five week period implementing St Helens Theatres followed by Whiston Theatres.

Implementation dates are subject to all software issues being tested and agreed as fit for purpose. A phased go live will complete before October 2016.

Maxims Version 10 - complete

The Maxims system was upgraded on 28th April 2016, after an eighteen month software development. The updated system provides a new user-friendly interface and enhancements to the VTE functionality.

The system will now allow doctors to complete VTE assessments prior to the patient being admitted, this will improve the process significantly for A&E patients who have had a decision to admit but not had a bed allocated. This new feature will support the doctor to complete the assessment when clerking the patient.

- Additional functionality now available is the ability to complete a VTE assessment in pre-op and validate on TCI admission.
- Learning aids have been made available to junior doctors on all computers

Order Communications (OCS)

An OCS Review paper was presented to the Project Board with a recommendation that both the roll out and the review of OCS should be paused until the Informatics strategy is sufficiently developed to give a clear direction for the future of the PAS and the OCS functions within that.

This was approved at the Project Board held on 11th April 2016

Pager System

The Trusts Pager system was successfully upgraded on the 17th March 2016, as the Trust was running an old version of the system. The switchboard team have benefited from updated software and simpler paging consoles.

Since the upgrade, there have been a number of teething problems with some bleep functionality, and software issues on the switchboard consoles. The cause of the issues was identified and resolved by the pager system supplier (Multitone) at the end of April 2016. No further issues have been raised since.

Smart Print Project

Following the approval of the business case, the project to replace single use printing with shared multi-function printing devices and reduce Trust printing costs will begin in mid-June 2016 for three months, completing by the middle of September 2016. A full implementation and communication plan has been created and agreed by the Project Board.

New Projects

Somerset Cancer Register Upgrade

The Trusts Cancer management system is scheduled to be upgraded at the end of May 2016 to support a new national cancer data collection requirement. The Informatics department are working closely with the supplier and the cancer services team to ensure the upgrade is implemented safely.

Maternity Offline solution

Following the Executive approval of the maternity offline solution business case, the project to procure and implement the offline maternity system has been initiated. Planning is underway with the procurement and implementation of the solution anticipated to take no more than twelve weeks.

Harlequin – Trust Charity Customer relationship management system

A new system is being purchased to support the management of the Trusts new Charity. The implementation of this system is currently being scoped by the Informatics and Finance departments.

MyHealth Messaging System.

Regional Cancer Network Funding has been received to support the pilot of a patient portal for breast cancer care. The project is led by the cancer services team and the IT requirements are currently being scoped by the Informatics department.

ICNet Infection Control System Upgrade

The Infection Control Management System is scheduled to be upgraded to the latest version in June 2016. The new system functionality includes many new features including the capture of ward based audits. The system is currently being tested by the infection control team.

Operational Performance

- The Performance of the Informatics service has continued to be in line with KPI targets.

- A project to oversee the scoping and business case for a new Service Desk System is underway. The benefits of which will include greater self-service functionality to log and track calls, as well as reset passwords.

Project Portfolio & Summary Update - 6th May 2016

Last Update	6th May 2016
Project Office	Informatics
Point of Contact	Christine Walters
Portfolio Projects	22
Delivered YTD	4

Key

Red	Stopped / Paused
Yellow	Some Delays
Green	On Track
Blue	Delivered

	Programme	Project Sponsor	Previous health (1 month prior)	Health	Status	Project	Summary	Planned Go Live Date	Comments	Risks	Mitigation
1		Francis Andrews	Yellow	Green	In Progress	E-Prescribing and Medicines Administration (EPMA) - Stage One - Inpatients	Procurement and Implementation of an E Prescribing and Medicine Management System in In-Patient areas within the Trust.	Oct-16	NHSE and the Project Board have approved a change to the system version and timeline. This will allow the implementation of the 2016 mobile app version, which also includes additional functionality (injectables and complex infusions).	Change in working practices which have not been identified and resolved prior to implementation. Delay in set up of remainder of system due to lack of resources in pharmacy. NHSE support of revised plan	Current and future operational processes to be mapped by a business analyst to ensure gaps and issues are identified early. Additional pharmacy resource for the project has been approved. Meeting and close liaison with NHSE has resulted in approval of rebased plan
2		Mr Idama		Green	Planning	Offline Medway Solution	Software allowing Midwives to work off line and complete forms when in the community and upload when connectivity is available	TBA	New initiative currently being scoped.	To be defined.	N/A
3		Sue Redfern	Green	Blue	Delivered	ADT implementation in theatres	Implement ADT in theatres (pre-requisite to eMEWS and EPMA)	Feb-16	Project completed as planned.	N/A	N/A
4		Sue Redfern	Green	Blue	Delivered	Electronic Modified Early Warning Scores (eMEWS)	Implementation of an electronic Modified Early Warning Scoring system across all inpatient areas.	May-16	Project completed as planned.	N/A	N/A
5		Sue Redfern		Green	Planning	eMEWS combined e-risk assessment	Combine 5 paper risk assessments into one electronic form. Stage 2 (as approved by Project Board)	Jun-16	Project on track	Dual processes in place (electronic and manual paper) as the project rolls out.	Communication plan and training of staff.
6		Christine Walters	Red	Yellow	In Progress	Electronic Document Management System (EDMS) Upgrade	Upgrade was aborted due to performance issues.	Jul-16	System testing of latest version due to commence.	Performance issues.	Software procured to test the performance ahead of go-live.
7		Rowan Pritchard Jones	Red	Yellow	In Progress	Clinical Portal	Gives read only access for patient information in a single view.	TBA	Clinical Informatics Board have agreed to delay go live until all interface elements are available. This includes OCS, A&E and SCR	EDMS interface is reliant on the system being upgraded. Summary Care Record is subject to the HSCIC timetable	EDMS upgrade is on track following close collaboration with C Cube Continual liaison with HSCIC - dates to be confirmed.
8		Darran Hauge		Green	In Progress	Somerset Cancer Register	System upgrade required to enable the recording of national data requirements from 01.06.2016	Jun-16	System downtime expected to be one hour.	Upgrade may fail.	Roll back to previous version.
9		Kim Hughes		Green	Planning	Harlequin	Implementation of the marketing module.	May-16	New initiative currently being scoped.	To be defined	N/A
10		Paul Williams		Green	Planning	Upgrade of Myhealth Messaging System	Extension of the current My Prostate Health system to implement a breast care module	TBA	New initiative currently being scoped.	To be defined	N/A

11	STHK Trust	Christine Walters	Yellow	Green	In Progress	Internet Explorer 11 (IE11) for the Acute Trust	Required for key project such as the Clinical Portal and Opera projects.	Jul-16	This is a pre-requisite for the clinical portal. Critical date - IE8 out of support end January '16. Deployment to non clinical areas underway. Deployment to clinical areas following the EDMS upgrade.	Some critical applications do not work with IE11. MS support for all versions earlier than IE11 ends at the end of January - no additional support or patches. Introduction of a new security vulnerability.	Thorough testing of all critical applications is currently taking place. Mitigation will be to continue to use applications on IE8, IE9 or IE10. HIS will support current browsers until IE11 is live
12		Christine Walters	Yellow	Green	In Progress	ICE Upgrade	For IE11 browser compatibility.	May-16	Project planning complete.	Testing not completed on time.	Resource allocated for testing and to address any issues identified.
13		Christine Walters	Yellow	Green	In Progress	Data Warehouse Upgrade	Required for clinical portal.	May-16	On track - acceptance criteria needs to be agreed with the business.	Resource working on multiple projects and there is a risk that the project may not be completed on time.	Temporary agency staff will be recruited if needed.
14		Christine Walters	Green	Blue	Delivered	Maxims V10 upgrade, software and hardware updates.	Enhancements to the current electronic VTE Risk Assessment application within the Maxims suite.	Apr-16	Project completed.	N/A	N/A
15		Mike Manning	Red	Green	In Progress	Opera theatre system including local alerting interface	To replace Ormis with an alternative solution (Ormis is end of contract July 2016)	Sep-16	Testing has progressed well. One show stopper is outstanding.	System does not meet functional requirements once tested functionally and clinically. The new system is not implemented prior to the end of the ORMIS contract. Alerts entered locally (in theatres) are not retained under the patient for future admissions	Close collaboration between the clinical, technical informatics team and the supplier has resulted in major developments and improvements to the system which have been well received recently by the clinical teams. Ormis contract to be extended. Thorough testing of the system will now take place An interface is in development locally to mitigate the risk of local alerts. This solution has been clinically signed off.
16		Christine Walters	Green	Green	In Progress	Smart Print (formerly MFD)	To replace current devices with Multi Functional devices (scan, fax, print, copy)	Sep-16	Contract in place. Phased roll out is commencing from June 2016.	Demand Challenges - specialties are not comfortable with the number of printers allocated. Increased contract costs due to reduction in copies produced.	A process is in place with criteria to assist the Project Board with demand challenges Negotiations have taken place with the supplier and we are able to scale down to a degree with no penalties
17		Sue Redfern	Green	Green	In Progress	ICNet Software Upgrade to v7.4	New initiative	Jun-16	The upgrade will result in system improvements specifically relating to running cluster alerts and screening compliance reports to include current inpatients only. In addition, it will provide new audit functionality which will also provide more efficient and streamlined date input.	To be defined.	To be defined.
18		Francis Andrews	Red	Red	On Hold	Order Communications System (OCS) in outpatients	To implement OCS in OPD setting across both hospital trusts	N/A	The Project Board has decided not to extend the roll out until the new IT strategy is agreed.	The current supplier is unable to update the system to address the main issues.	See 'Comments'
19		Kevin Hardy	Green	Yellow	In Progress	Upgrade to Innovian in ITU	To upgrade the ITU Innovian system	TBA	User acceptance testing is outstanding. Awaiting clinical lead confirmation. The plan was to implement a like for like replacement. New implementation date to be agreed by June 2016.	Upgrade is delayed due to user change management issues	The scope of this project has been revised in order to provide the upgrade which will stabilise the system. Further enhancements will be assessed in the context of the future Informatics Strategy
20		Chakri Molugu	Green	Green	In Progress	eHandover	To enhance the electronic development of the current e-handover system to include additional GPAU functionality.	TBA	Clinical lead currently undertaking system testing. Date to go live is still to be agreed.	This system meets current organisational requirements but is not integrated.	Incorporate into requirements for an integrated system. Consider as part of the 2016-19 Informatics Strategy.
21		Christine Walters	Green	Green	In Progress	MTPAS	Priority mobile phone service for key staff (20) during a national major incident.	May-16	Deployment is underway and is expected to be completed on time.	Requires a system administrator to be identified within the business Compatibility of phones/SIM cards	Operations need to agree ownership of phones New SIM cards could be provided (free of charge)
22		Christine Walters	Green	Blue	Delivered	Pager System upgrade	Project completed	Mar-16	Complete	N/A	N/A

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)053
Title of paper: Executive Committee Assurance Report.
Purpose: To feedback to members key issues arising from the Executive Committee meetings.
Summary: 1. Between the 21st April and 18th May three meetings of the Executive Committee have been held. The attached paper summarises the issues discussed at the meetings. 2. Decisions taken by the Committee included further work on the paediatric business case, to review the policy for outlying patients, and the next steps with the IT strategy. 3. Assurances regarding the safer staffing, management of bank and agency usage, CQC action plan, and mitigating strike action were obtained. 4. Investment decisions included the capital programme and non-recurrent funding to address waiting lists in paediatrics. 5. There are no specific items requiring escalation to the Board.
Corporate objective met or risk addressed: Contributes to the Trust's Governance arrangements, and its short and longer-term plans.
Financial implications: None directly from this report.
Stakeholders: The Trust, its staff and all stakeholders.
Recommendation(s): The Board are asked to note the contents of the report.
Presenting officer: Ann Marr, Chief Executive.
Date of meeting: 25th May 2016.

EXECUTIVE COMMITTEE REPORT (21st April to 18th May 2016)

The following report highlights the key issues considered by the Executive Committee.

21st April

1. CQC Action Plan – Maternity Services

   1.1. Progress against the action plan was discussed. Organisational Development work is underway and regular meetings with maternity leads are in place.

2. Outstanding Audit Actions

   2.1. Actions from the latest audits and outstanding actions were discussed. It was agreed that significant improvement in closing-out actions has occurred and this should now be reported by exception rather than being a scheduled item.

3. Safer Staffing

   3.1. Data was discussed. A variation with the vacancy dashboard was noted and a review requested.

   3.2. KH was asked to undertake a further review of staffing cover on wards and explore any correlation with the occurrence of falls.

4. Industrial Action update

   4.1. The 2-day planned action by junior doctors on 27th and 28th April was discussed along with Trust plans in mitigation.

5. Bank and agency benchmarking

   5.1. The absence of formal benchmarking data regarding expenditure was noted, however AMS reported from a workshop where informal sharing of data indicated that our spending was in the lowest quartile of NW Trusts.

6. Electronic Patient Record (EPR) evaluation

   6.1. CW presented an option appraisal document focussing on the alternatives of continuing with a best of breed EPR or to procure a single vendor EPR. It was agreed that more detailed financial data was required including costs over a longer period to better identify the differences. In the absence of national funding, the Committee had concerns on affordability and agreed that the sources used by other Trusts should be explored.

   6.2. CW agreed to liaise with other Trusts on improvements in their IT performance following investment as there is an absence of benefits realisation data.

7. North Mersey Local Delivery System (LDS)

   7.1. KH fed back from the meeting on 15 April where significant progress appears to have been made in support of their plans to be submitted in June

8. Exec to Exec meeting with Warrington & Halton and Southport & Ormskirk

   8.1. The agenda for the meeting on 28th April was considered and items agreed for sharing with the other Trusts.

9. Maxims upgrade

   9.1. The business continuity plans for the upgrade on 30th April were discussed.

28th April

10. The planned Clinical Senate was replaced with an Executive to Executive meeting with Warrington & Halton and Southport & Ormskirk Trusts. 20 Directors from the 3

Trusts discussed the Sustainability and Transformation Planning process; the Local Delivery System plans for our group of hospitals (the Alliance); the proposed organisational structure and governance arrangements; the clinical drivers for change and the required work-streams. A further meeting was planned for 26th May.

5th May

11. Medway Maternity Off-Line IT Module benefits realisation

    11.1. The Committee had requested a review of the Medway system to fully understand the original scope, its benefits to date, and the perceived benefits from procuring the additional module at circa £60k.

    11.2. The conclusion was that the upgrade would benefit patient safety, remove duplication of tasks freeing-up midwives time, and reduce traveling. This should improve productivity, therefore it was agreed that the potential revenue cost of the additional module should be offset by an agreed cost improvement initiative.

12. Paediatric Business Case

    12.1. This was an update to the original case presented to the March Clinical Senate, where further detailed financial analysis was requested. Unfortunately the further analysis remained unconvincing, as activity growth was minimal and DNA and 1st to follow-up outpatient rates appeared areas where initially efficiencies could be explored.

    12.2. It was agreed that some resource would be made available to address the waiting list, and further scrutiny of non-elective growth should be undertaken as this might present a more compelling case.

13. Nurse Specialist Review

    13.1. An update of work in progress was provided. It was agreed that benchmarking of resources with other Trusts should be undertaken, along with gaining a better understanding of the specific roles.

14. VTE

    14.1. The weekly status report was presented. CW confirmed that the IT issues had been resolved however VTE compliance rates remain at an unacceptable level. An action list circulated by KH is to be presented to the next meeting.

15. Capital Programme

    15.1. Sue Hill presented the draft capital programme for 2016/17 which has been refined since being reviewed by the Committee a few weeks ago. The shortlist is slightly above the £1m funding available, so it was agreed that two items on the list would be reviewed, and that procurement negotiations would enable the programme to proceed within the funding envelope.

16. Agency Rules

    16.1. The March and April bank and agency return was discussed where the reduction in breaches from 607 in December to 337 in April was noted.

    16.2. The recent successful nurse recruitment campaign was discussed.

    16.3. A proposal from Salford Royal to agree to enforce the cap for dermatology doctors was discussed. This requires reviewing with AM.

17. Trust Board agenda

    17.1. The agendas for 25th May were discussed and agreed.

18. IMS update

18.1. CW reported back on the upgrade that went ahead as planned on 2nd May, however some business continuity issues arose which are being explored.

19. Major Incident

19.1. Noted that a consultation exercise on the definition of a Major Incident is ongoing which we will contribute towards.

20. 4D infections

20.1. The rate of infections on Ward 4D were discussed where a specialist deep-clean is planned. It was agreed that this issue should be benchmarked with similar wards as the condition of patients may be a contributory factor.

21. Outlier Policy

21.1. It was agreed that the policy requires reviewing in light of patients being lodged during the winter months and should be discussed at a forthcoming meeting.

12th May

22. Corporate Risk Register (CRR)

22.1. The latest CRR was reviewed. There are currently 14 risks scoring 15 or above, and all have been reviewed and action plans are, or soon will be, in place.

23. CQC Action Plan

23.1. The action plan was reviewed. Of the 57 actions, 45 have been closed out. Two actions are overdue; these being risk management processes in Maternity, and supernumerary staffing on critical care.

24. Update on Maternity Services

24.1. Sue Mundy, Interim Head of Maternity, fed back on her first 4 weeks in post which was largely positive. A date for a wider maternity management attendance at the Committee was agreed.

25. Finance: IPR / CIP

25.1. The latest IPR report was discussed and final comments included.

26. Sepsis Campaign

26.1. Chakri Molugu briefed members on progress with the management of sepsis. Due to changes in data recoding it is proving difficult to agree the baseline against which progress can be measured. Actions to address this were agreed.

26.2. Posters for a campaign were tabled and leads agreed to provide comments.

26.3. The role of the new sepsis nurse, activity data, and timeliness of treatment in A&E were discussed

27. Mortality Review

27.1. KH presented a paper planned for the Trust Board regarding the new national requirements for monitoring mortality rates, which will be quite onerous. It was noted that this paper would be in addition to the regular Board update on mortality rates.

28. VTE

28.1. The weekly status report was discussed. Changes to the information presented were agreed in order to make the report more meaningful.

28.2. KH presented the action plan designed to drive improvement.

29. Away-day

29.1. The agenda for the proposed away-day on 16th June was discussed.

29.2. It was suggested that a detailed review of the Integrated Performance Report (IPR), training in effective meeting chairing (in line with Well-Led), and an update on strategic planning should be considered.

ENDS

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)054
Title of paper: Quality Committee Assurance Report.
Purpose: The purpose of this paper is to summarise the Quality Committee meeting held on 17th May 2016 and escalate issues of concern.
Summary: Key items discussed were: 1. Complaints 2. CQC action plan 3. Missed dosage audit 4. Safer staffing 5. IPR and VTE update 6. Approval of Quality Account 7. Pharmacy checklist audit update 8. Summary of Baroness Cumberledge's report on Maternity Services.
Corporate objectives met or risks addressed: Five star patient care and operational performance.
Financial implications: None directly from this report.
Stakeholders: Patients, the public, staff and commissioners.
Recommendation(s): It is recommended that the Board note this report.
Presenting officer: David Graham, Non-Executive Director
Date of meeting: 25th May 2016

QUALITY COMMITTEE ASSURANCE REPORT

Summary of the discussions and outcomes from the Quality Committee meeting held on 17th May 2016.

Action Log

1. All actions on the log were reviewed.

Complaints update

2. A Rosbotham-Williams (ARW) updated the Committee on complaints.

   2.1. There were a 29 1st stage 'approved' complaints in April 2016. This is a decrease of six in comparison to April 2015.

   2.2. There were 195 PALS contacts/enquiries during April 2016.

   2.3. The committee was updated regarding the breakdown of data which showed the areas people are complaining about. This included:

      2.3.1. Communications with relatives/carers

      2.3.2. Care needs not adequately met

      2.3.3. Communication with patients.

      2.3.4. Admission/discharges.

   2.4. The paper also provided information regarding lessons learned and actions taken following the closure of a complaint.

   2.5. A Kennah and C Umbers are both attending a customer workshop to look at what is being delivered.

   2.6. The committee discussed PALS enquiries, informal resolution and escalation processes for complaints.

   2.7. D Graham commented that the situation is improving but should remain under close scrutiny.

CQC action plan update

3. ARW briefed the Committee on the CQC action plan.

   3.1. Seven actions were due for completion by the end of April and five of these have been completed, meaning that 45 of the total 57 actions have now been completed.

   3.2. Two of the four actions reported to the April Quality Committee as having missed their completion deadlines have now been completed, one remains on track to achieve it's revised deadline and one remains outstanding. The two outstanding actions relate to Critical Care and Maternity. MIAA have conducted an audit within Maternity and the report is due in June. A business case for Critical Care to address supernumerary role (recommended by the CQC) has been drafted but needs more scrutiny. A paper is due at the Executive Committee next month.

   3.3. G Marcall (GM) will raise the MIAA report at the next Audit Committee.

   3.4. S Mundy (SM) reported on Appendix 3 of the report, which was to provide evidence to the Quality Committee regarding the dissemination of lessons learnt and changing practice as a result of serious untoward incidents and complaints in Maternity Services.

3.5. SM also said safety thermometer data now includes what patients want to know about and she is looking at changing the recording process of the safety huddles, which are not embedded in every area.

3.6. It was reported by SM that there is a noticeable change within the Maternity Unit and this was endorsed by GM.

3.7. ARW informed the committee that overall, good progress has been made with the action plan but the organisation will continue to self monitor itself against the CQC domains.

Missed dosage audit

4. N Jones summarised the paper for the Committee.

4.1. A previous Trust audit in November 2013 identified that 49% of medicine doses were omitted and only 5% of omitted doses were documented on the Drug Omission Action Log (DOAL).

4.2. A re-audit was undertaken in November 2015, showing a reduction in omitted doses – 3.7% of all audited doses were omitted.

4.3. A M Stretch asked how we compare with other Trusts, but there is no benchmarking data nationally.

4.4. Another re-audit will be carried out in September in line with the launch of the e-prescribing system.

4.5. D Graham requested, in the future there is a breakdown of the reasons why there are omissions and pointed out there may be valid reasons why drugs are not administered. The reasons should be recorded on DOAL.

Safer Staffing report

5. N Jones provided an update.

5.1. The overall Trust fill rate for April was 99.61%. There were 21 wards with a fill rate below 90%. 12 wards for registered staff and 9 wards for care staff.

5.2. 31 incident forms were completed and zero harm recorded.

5.3. Regarding Table 10.1 of the report, D Graham asked whether the Committee found it acceptable to make good the overall staffing level by increasing the HCA level? K Hardy said it was unacceptable and inappropriate to suggest that HCA's are the same as trained nurses. He reported that the problem should be solved in Q3 and Q4 when the nurses arrive from India and e-rostering is introduced at the Trust. A M Stretch also commented that there are specific action plans in place for wards that have longstanding vacancies and that are on the risk register.

5.4. D Graham said that the QC would report to the Board that there is likely to be a six month period before the situation will be resolved. G Marcall said he felt that we are doing as much as we can.

IPR

6. N Khashu summarised the IPR.

6.1. There have been no cases of MRSA during April. There was 1 C.Difficile case in April. The annual tolerance for 2016/17 is 41 cases. There were no hospital acquired grade 3/4 pressure ulcers in April. Performance for VTE for March was 89.30% and there have been no never events since May 2013.

6.2. A&E performance (Type 1) was 81.5%. Whilst this was our highest performance for 4 months, it remains a significant concern.

6.3. A Rapid Improvement Event to enhance the discharge process for patients with complex needs has been arranged for May and will be attended by Local Authorities, CCG, NHS Improvement and the Trust.

6.4. G Marcall asked why the Urgent Care centre (within A&E) was not open on Friday. Paul Williams informed the Committee that the CCG would be withdrawing the funding from 20th May. This will impact on A&E performance.

6.5. For the month of April 2016 (month 1) the Trust is reporting an overall Income & Expenditure surplus of £0.115m after technical adjustments.

6.6. To date the Trust has delivered £0.851m of CIPS.

6.7. Capital expenditure in April 2016 was £0.017m out of a total plan of £5.15m.

6.8. The Trust is below the mandatory training target by 8.2% Appraisals performance remains above target.

6.9. Staff sickness for March was 4.85%.

6.10. VTE update

6.10.1. K Hardy provided an update to the Committee.

6.10.2. The organisation is still not performing at the level required, but the new VTE electronic software has now been introduced and should improve the situation.

6.10.3. K Hardy has written to all consultants who did not achieve the target; has also written to all Clinical Directors to ensure everyone achieves the target and has asked the ADO's to report to the Executive Committee every four weeks until the problem is solved, starting the second week in June.

Approval of Quality Account

7. A Rosbotham-Williams summarised the paper.

7.1. The final draft of this year's Quality Account has been completed subject to the outstanding information being inserted, which is CQUIN information, finalisation of the C.Diff figures following the outcome of appeals and written comments from the CCGs and Healthwatch.

7.2. ARW informed the Committee that comments had been received from St Helens CCG and Halton Healthwatch and overall were quite positive.

7.3. Grant Thornton have completed the assurance report.

Medicine storage and security audit update

8. S Gelder provided an update

8.1. The paper is to provide an update on the performance of clinical areas in storage of medicines in accordance with the Trust's SOP for the Safe & Secure Storage of Medicines.

8.2. SG said that a lot of good progress has been made but there is still work to do. Compliance for May was 60-75%, with quite a few areas achieving 90-100%.

8.3. The next audit will be at the beginning of June and SG will report back to Quality Committee at the June meeting.

8.4. DG commented on the improvements made and emphasised the ongoing need to improve and to maintain the standards. N Khashu commented that he was not fully assured, as these are minimum standards, and was concerned about a specific comment that was in the audit. A Kennah has picked up the comments and has spoken to the member of staff.

8.5. AMS asked SG to map the trajectory of improvement for each ward. Medicine storage and security has to improve and a very robust message needs to be sent out.

Summary of Baroness Cumberledge's report on Maternity Services

9. S Mundy summarised the report:

9.1. The purpose of the report is to provide the committee with a summary of Baroness Cumberledge's report on Maternity Services, and an insight into the current status of Whiston Maternity Unit regarding the recommendations within the report.

9.2. Maternity Services have undertaken a self assessment of the report's recommendations and noted 16 were applicable. Of the sixteen, 7 are green rag rated, 8 amber and 1 red. With regards to the amber and red recommendations, the maternity unit will develop an action plan to address these within the timescales required.

9.3. DG asked if there would be anything which would be particularly difficult to resolve. SM said that the named midwife action could be problematic.

Feedback from Patient Safety Council

10. N Jones reported:

10.1. STHK Safety Thermometer performance is 99.52 (highest score to date).

10.2. A new acute care handover document pilot has been approved.

Feedback from Patient Experience Council

11. A Rosbotham-Williams reported:

    11.1. A concerted effort is needed to raise the response rate for FFT.

    11.2. Healthwatch quarter 4 report noted that the majority of comments received about our services were positive One comment highlighted some areas for improving pre-operative clinical appointments and this will be reviewed by the relevant Matron and Patient Booking Services Manager.

    11.3. ARW will send the report to Paul Williams.

Feedback from Clinical Effectiveness Council

12. Weekend mortality paper to be discussed at the Quality Committee June meeting.

    12.1. C Umbers will look at the low ILS training uptake.

Feedback from CQPG Meeting – April

13. N Jones reported that there was nothing to note of exception.

Feedback from Executive Committee

14. S Redfern reported:

    14.1. The final operational plan was submitted on 18th April.

    14.2. The Corporate Risk Register was reviewed. It was agreed going forward that only exception reporting is required to be presented to the Executive Committee.

    14.3. The Electronic Patient Record (EPR) options appraisal was presented to the Executive Committee. More evidence is required to demonstrate benefits associated with what the alternative systems suppliers are proposing.

Policies/documents approved by Councils

15. PSC Terms of Reference
    Trust Female Genital Mutilation policy
    Procedure for care of tracheostomy patients
    Procedure for the care of patients undergoing lumbar puncture
    Acute patient transfer of care; handover document pilot.

Effectiveness of meeting

16. D Graham and Peter Williams felt that the meeting had been effective. DG felt that the papers were of good quality and presenters drew the attention of the QC to the relevant issues. PW felt that this approach was particularly helpful for some of the longer papers. Discussion was appropriate and the meeting concluded in a timely fashion.

AOB

N Jones reported that he had been to a meeting in Liverpool attended by several Trusts. “Never events” were discussed and we were the only Trust which had not had a “never event” in the last three years. Other Trusts reported between one and two never events per year.

Date of Next Meeting

Tuesday, 21st June 2016.

TRUST BOARD PAPER

Paper No: NHST(16)055

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the activities of the Finance and Performance Committee held in May 2016

Summary:

Agenda Items

- **For Information**
  - Commercial Strategy Update
  - STP update
  - Estates Return Collection
  - Benchmarking
  - Q3 SLR - Trust wide
  - Governance Committee Briefing Papers:
    - CIP Council
- **For Assurance**
  - IPR Report Month 12
  - Provisional finance report Month 12 2015/16
  - Month 1 2016/17 Finance Report
  - CIP scheme – governance compliance
  - Efficiency dashboard
  - A&E included in IPR Executive Summary

For Decision

- Modern Slavery Act 2015

Actions Agreed

- A&E Six Sigma report to be presented in June
- PA Consulting report to be presented in July
- Estates return to be presented for approval in June
- Qlikview demonstration to be provided to Non-Executive Directors in June
- Review SCBU occupancy metrics

Corporate objectives met or risks addressed: Finance and Performance duties

Financial implications: 2016/17 Annual Plan forecasting a £3.3m surplus, based on receipt of £10.1m Sustainability and Transformation Funding

Stakeholders: Trust Board Members

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

Presenting officer: Denis Mahony Non-Executive Director

Date of meeting: 25th May 2016

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16) 056

Title of paper: Audit Plan Approval

Purpose: To advise the Trust Board of the approved Audit Plan for 2016/17.

Summary:

1. Mersey Internal Audit Agency's proposed 2016/17 Internal Audit Plan was presented to the Audit Committee meeting on 13th April 2016.
2. This plan describes how MIAA will deliver the Trust's internal audit services in 2016/17. It is based on our local risk assessment and shows how their proposed work aligns to the strategic risk assessment of the Trust.
3. Audit topics are:
   a. Carter Review Action Plan
   b. Data Quality
   c. Care Quality Commission
   d. Patient Experience
   e. Quality Spot Checks
   f. Bank, Agency and Locum Staffing
   g. Consultant Job Planning
   h. ESR
   i. Nursing Revalidation
   j. Assurance Framework Opinion
   k. Well Led Self-Assessment.
4. In the plan MIAA included a 3 year audit strategy and a detailed operational plan following consultation with Board directors and the Audit Committee.
5. The proposed fee for the work in 2016/17 is £77,050 (the same as last year). The plan and fees were approved by the Audit Committee.
6. MIAA's proposed 2016/17 Local Counter Fraud workplan was also presented.
7. The plan provided an overview of the identified fraud, bribery and corruption risks across the four NHS Protect key work areas.
8. Themes covered in the Anti-Fraud Workplan are:
   a. ensuring anti-crime measures are embedded at all levels
   b. publicising the risks and effects of crime against the NHS
   c. ensuring that opportunities for crime to occur are minimised
   d. ensuring all suspicions of fraud are investigated and that all appropriate

sanctions and redress actions are applied. 9. The annual fee is £22,875 (the same as last year). The plan and fees were also approved by the Audit Committee.
Corporate objective met or risk addressed: Contributes to the Trust's Governance arrangements.
Financial implications: None directly from this report.
Stakeholders: The Trust, its staff and all stakeholders.
Recommendation(s): The Board are asked to note the contents of the report and ratify the approval of the proposed plans.
Presenting officer: Nikhil Khashu, Director of Finance and Information.
Date of meeting: 25th May 2016.

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)057
Title of paper: Sustainability and Transformation Plan – Update
Purpose: To provide the Board with assurance that the Trust continues to participate in the development of the Sustainability and Transformation Plan (STP) for Cheshire and Mersey, and continues to develop the organisations governance and leadership capability for the future.
Summary: This paper reports on the progress in responding to the national planning guidance, the requirement to develop place based 5 year sustainability and transformation plans and the on-going elements of the FT development programme. Progress in the following areas is detailed; 1. 2016/17 Operational Plan 2. Role of NHS Improvement 3. STP Development 4. Well Led Framework Action Plan
Corporate objectives met or risks addressed: Provide high quality sustainable services
Financial implications: This paper does not include a request for additional funding
Stakeholders: Patients, Staff, Alliance LDS Partners, Commissioners, NHSI
Recommendation(s): Members are asked to note the progress report
Presenting officer: Nik Khashu, Director of Finance and Information
Date of meeting: 25th May 2016

Sustainability and Transformation Plan – Update May 2016

1. 2016/17 Operational Plan

- The operational plan submission for 2016/17 will not be formally approved by NHS Improvement (NHSI), although feedback will be given
- Providers have been required to resubmit activity plans and improvement trajectories, to reflect finalised contracts with commissioners and the "pace" of improvement expected
- A review of the Trusts emergency access target improvement trajectory has been undertaken, but the lack of confirmed winter pressures funding or new CCG community/ primary care schemes to divert A&E attendances, combined with the increase in NEL demand already experienced in the first full month of 2016/17 have potentially increased the risks to delivery.
- The criteria and weightings for accessing the sustainability and transformation fund have not yet been published by NHS England(NHSE)/NHSI

2. Role of NHS Improvement

NHS Improvement (NHSI) the new oversight body for all NHS Provider organisations, formed from the "merging" of Monitor and the NHS Trust Development Authority in April 2016, is now starting to develop its objectives and accountability framework.

NHSI will have three main roles;

i. To provide direction and leadership of the provider sector
ii. To provide regulatory oversight – performance monitoring, approvals and where required intervention
iii. Support for development and improvement

The NHSI Board is due to set objectives covering the following 5 areas of activity;

Objective	Quality	Financial Performance	Operational Performance	Strategic Service Development	Leadership
2016/17 Priorities	• Reduce the number of Trusts in special measures • Increase the number of Trusts achieving good or outstanding following a CQC inspection • Improve patient safety • Safe staffing	• Return to financial balance • Plans for 2% efficiency each year	• Meet constitutional standards • Meet mental health waiting time targets	• Support move to new models of care • Sustainability plans for the most challenged health economies	• Effective Boards • Board diversity • Continuous improvement methodologies • High quality information

NHSI will work closely with the other national bodies and regulators to deliver the NHS mandate and the NHS Five Year Forward View.

3. STP Development

- Further guidance on the requirements for the STP submission is due to be published by the end of May, this will include a standardised financial template but no other framework or template for completion.
- The guidance will clarify that the requirement is for one STP submission per footprint only. An STP at individual organisational level is not required.
- STP submissions have to be agreed by the Accountable Officers of all the partner organisations in the STP footprint.
- Locally the meetings of the Executive Teams of the three acute providers in the Alliance LDS have now been established, and these will feed into the overall Alliance LDS plans, which in turn will inform the Cheshire and Mersey Footprint submission.
- The three Executive Teams have agreed a number of specialist work streams to review current service provision and opportunities for transformation to achieve long term clinical and financial sustainability.

4. Well Led Framework Action Plan

NHSI have confirmed that one of their main objectives will continue to be to improve the effective governance and leadership of provider organisations using the Well Led Framework model.

There are 47 identified actions, of which 35 of which were due for completion by the end of April 2016. Thirty three of these have been completed and 2 are in progress. There are currently no red rated/ overdue actions. The remaining 12 actions are scheduled to be completed by July 2016.

Well Led Leadership Framework Action Plan – Following 2nd Self-Assessment

April 2016 - Progress Report

Domain	Total No of Actions	Actions Due to be Completed	Actions Completed (Green)	Actions due and in progress (Amber)	Actions not completed and overdue (Red)
Planning and Strategy	18	10	9	1	0
Capability and Culture	15*	12	12	0	0
Process and Structure	12	11	11	0	0
Measurement	2	2	1	1	0
Total	**47**	**35**	**33**	**2**	**0**

***1** action re FT membership and governors on hold

ENDS

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)058
Title of paper: Information Governance (IG) Annual Report
Purpose: *To provide assurance that St Helens and Knowsley Teaching Hospitals Trust operates within the parameters defined in the Information Governance toolkit.*
Summary: Every year the Trust must demonstrate compliance with Information Governance requirements by completing the Health & Social Care Information Centre IG Toolkit. There is a requirement for all NHS organisations to meet the minimum of level 2 across all requirements within the toolkit. The Trust continues to comply with the above requirements as it is at level 2 or above in each of the 45 requirements.
Corporate objectives met or risks addressed: Communications, Systems and Safety
Financial implications: None directly from this report.
Stakeholders: all staff, patients, third parties
Recommendation(s): The group note and approve the content of the paper.
Presenting officer: Christine Walters, Director of Informatics
Date of meeting: 25th May 2016

Introduction

The NHS Information Governance Framework is the means by which the NHS handles information about patients and employees, in particular personal identifiable information. The Information Governance Toolkit (IG Toolkit) is the means by which the NHS demonstrates implementation of good practice for information governance ensuring: Compliance with the law, implementation of Department of Health advice and guidance, planned year-on-year improvement, Information Governance assurance to support connection to the N3 Network – the IG Statement of Compliance.

St Helens & Knowsley Teaching Hospitals NHS Trust submits a yearly self-assessment to the HSCIC. Version 13 of the Information Governance Toolkit was released in June 2015. The Trust assesses itself against 45 criteria and evidence expectations have again risen considerably making it more difficult to achieve compliance.

Executive summary

An initial baseline assessment against all 45 requirements was submitted as required at the end of July, with an action plan developed through to March 2016.

Mersey Internal Audit Agency has completed an audit of a sample of the Trust's Toolkit submission during October and January to assess the Trusts compliance against these requirements. The Trust has received the audit report from MIAA – the Trust has maintained their rating of 'Significant Assurance'.

Significant Assurance

A final submission was made in March 2016. Our submission shows the Trust score has decreased by two percent against last year's submission. This is a result of the Trust decreasing its score from a level 3 to a level 2 in two requirements. Both of the requirements that we have reduced our score in relate to the limitations of our current technologies. This could be addressed with the upgrade of our current clinical systems.

Version 12 2014 -2015	Version 13 2015 – 2016
82%	80%

IG Aims

St Helens & Knowsley Teaching Hospitals Trust has a responsibility for ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The IGT's focus is on setting standards and providing tools to achieve them. The standards provide assurance across six areas:

- Information Governance Management

- Confidentiality/ Data Protection
- Information Security
- Clinical Information
- Secondary Use
- Corporate Information

Reassurance will be regularly provided to the Board of the on-going commitment to meet with NHS Standards in Information Governance and Information Security.

Information Governance Steering Group

The Information Governance Steering Group is the focus of the IG framework in the Trust. The Group, which has been operational since January 2008, oversees the implementation of the IG Agenda throughout the organisation.

Regular reports are provided to the group relating to:

- IG Toolkit submission & Action Plans
- IG Issues
- Data Loss
- Data Breeches
- Data Quality
- Records Management
- Information Security
- Freedom of Information

Information Governance Breaches

The Trust has a duty to internally report any incident regarding personal data, however minor. For the financial year 2015/2016 we reported one incident to the Information Commissioners Office (ICO). The Information Commissioners Office outcome is as follows: -

Incident 1 - **No Further Action Taken**

This incident related to the Trust accidentally disclosing limited personal and sensitive personal data about 61 patients to the Patient Safety Council via email.

The member of staff responsible was identified and the issue was reported to the ICO. Thankfully, because the patient data disclosed in this incident was very limited and, it should be emphasised, disclosed only to the Patient Safety Council. It was very quickly contained and there is no indication that the patients concerned suffered any detriment. Consequently, the case, as reported to the ICO, did not meet the criteria set out in their Data Protection Regulatory Action Policy necessitating further action by the ICO.

The reported incident was reviewed by relevant members of staff, with actions taken to minimise the likelihood of any recurrence.

The Trust has an active education and awareness programme aimed at all staff to actively promote Information Governance awareness.

March 31st 2016 IG Toolkit Submission

Version 13 of the IG Toolkit consists of 45 sequenced standards divided between six initiatives. Each of the questions is scored at a level ranging from 0 to 3 with 0 and 1 indicating non-compliance and 3 representing total compliance.

The overall percentage attainment level achieved by the Trust is based on the level of compliance with the sequenced standards in each of these initiatives between 31st March 2015 and 31st March 2016.

Overall Position

The Trust has decreased is score by two percent from last year to 80%. This is a result of the Trust decreasing its score from a level 3 to a level 2 in two requirements. The specific requirements were numbers 202 and 205. In both cases the IG Steering Group were informed as to the reasons why we couldn't maintain a score of level 3 and the group approved the revised scores.

Like last year the Trust once again received a 'Satisfactory' (Pass) rating for the IG Toolkit. This meant that the Trust had achieved at least Level 2 for all 45 requirements. The 'Satisfactory' rating from 2014-2015 has been maintained for 2015-2016

	31st March 2014 Annual Submission V.11	**31st March 2015 Annual Submission V.12**	**31st March 2016 Annual Submission V.13**
Overall Results	**82% (Green)**	**82% (Green)**	**80% (Green)**
	(45 out of 45 answered)	(45 out of 45 answered)	(45 out of 45 answered)

Submission

The Information Governance Steering Group was asked to approve and sign off the 31st March 2016 attainment levels in version 13 of the IG Toolkit prior to formal submission.

Progress Reporting

Progress against the IG Toolkit is monitored by the IG Manager and the IG Steering Group.

A report on progress, prior to each submission, is presented by the IG Manager to the IG Steering Group and subsequently to the Risk Management Council then ultimately to the Trust Board by the Senior Information Risk Owner.

Requirement details

As the Trust has declared that it is compliant with all of the requirements the RAG status for this report shows as Green ('Satisfactory').

Requirement Status

Version 13 (2015-2016) Assessment			
	Description	**Version 12 March 2015**	**Version 13 March 2016**
Information Governance Management			
10-101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	3	3
10-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	3	3
10-110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	2	2
10-111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	2	2
10-112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	2	2
Confidentiality and Data Protection Assurance			
10-200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	3	3
10-201	Staff are provided with clear guidance on keeping personal information secure and on respecting the confidentiality of service users	3	3
10-202	Personal information is only used in ways that do not directly contribute to the delivery of care services where there is a lawful basis to do so and objections to the disclosure of confidential personal information are appropriately respected	3	2
10-203	Individuals are informed about the proposed uses of their personal information	3	3

Version 13 (2015-2016) Assessment			
	Description	**Version 12 March 2015**	**Version 13 March 2016**
10-205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	3	2
10-206	There are appropriate confidentiality audit procedures to monitor access to confidential personal information	2	2
10-207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	2	2
10-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	2	2
10-210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	2	2
Information Security Assurance			
10-300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	3	3
10-301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	2	2
10-302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	3	3
10-303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	3	3
10-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	3	3

Version 13 (2015-2016) Assessment			
	Description	**Version 12 March 2015**	**Version 13 March 2016**
10-305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	2	2
10-307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	3	3
10-308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	2	2
10-309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	3	3
10-310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	3	3
10-311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	3	3
10-313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	3	3
10-314	Policy and procedures ensure that mobile computing and teleworking are secure	2	2
10-323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	2	2
10-324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	2	2
Clinical Information Assurance			

Version 13 (2015-2016) Assessment			
	Description	**Version 12 March 2015**	**Version 13 March 2016**
10-400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	2	2
10-401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	2	2
10-402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	2	2
10-404	A multi-professional audit of clinical records across all specialties has been undertaken	3	3
10-406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	3	3
Secondary Use Assurance			
10-501	National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop	3	3
10-502	External data quality reports are used for monitoring and improving data quality	2	2
10-504	Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	3	3
10-505	An audit of clinical coding, based on national standards, has been undertaken by a NHS Classifications Service approved clinical coding auditor within the last 12 months	3	3
10-506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	3	3
10-507	The Completeness and Validity check for data has been completed and passed	2	2
10-508	Clinical/care staff are involved in validating information derived	2	2

Version 13 (2015-2016) Assessment			
	Description	**Version 12 March 2015**	**Version 13 March 2016**
	from the recording of clinical/care activity		
10-510	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards	3	3
Corporate Information Assurance			
10-601	Documented and implemented procedures are in place for the effective management of corporate records	2	2
10-603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	3	3
10-604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	2	2

Freedom of Information Annual Report
(Full Report attached)

The Trust is required by the Freedom of Information Act to respond to written requests for information from the public, subject to certain exemptions within 20 working days.

The Freedom of Information Annual Report on the status of FOI requests details: -

a) the number of requests received between 1st April 2015 to 31st March 2016
b) source of request
c) type of request
d) monthly breakdown
e) year on year comparison

The Trust continues to be compliant with the Freedom of Information Act 2000.

Conclusion

The IG Steering Group will continue to monitor progress and implementation of the Information Governance Agenda within the Trust.

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)058a
Title of paper: Freedom of Information Annual Report
Purpose: To provide assurance that St Helens and Knowsley Teaching Hospitals Trust strives to comply with the Freedom of Information Act.
Summary: This report is designed to give the Trust Board, assurances that the Trust is compliant with Freedom of Information legislation. Statistical analysis of the requests and responses will be shown, comparing the year of the report (2015-2016) to previous years where relevant.
Corporate objectives met or risks addressed: systems, communication
Financial implications: None directly from this report.
Stakeholders: Staff, Patients, Executive Committee, Commissioners.
Recommendation(s): The group note and approve the content of this report
Presenting officer: Christine Walters, Senior Information Risk Owner
Date of meeting: 25th May 2016

Introduction

This report is designed to give the Trust Board, assurances that the Trust is compliant with Freedom of Information legislation. Statistical analysis of the requests and responses will be shown here, comparing the year of the report (2015-2016) to previous years where relevant.

Further analysis is available on request if members of the Board would like to see anything not shown here.

Table 1 – Annual Comparison of Requests by Applicant Type as a comparison across previous 2 years.

	Total	Press	Public	Staff	Commercial	Students/ Research	MPs	Not Given	Other	Withdrawn
Annual Total 13-14	510	111	12	1	138	35	28	157	24	n/a
Annual Total 14-15	552	146	84	0	188	36	18	28	24	24
Annual Total 15-16	479	77	86	1	212	34	11	7	21	30

Table 1 shows number of FOI requests for 2015-2016, showing that the number of requests received has decreased from the 2014-2015 figures (13%).

Chart 1 - Categories of Request for 15/16

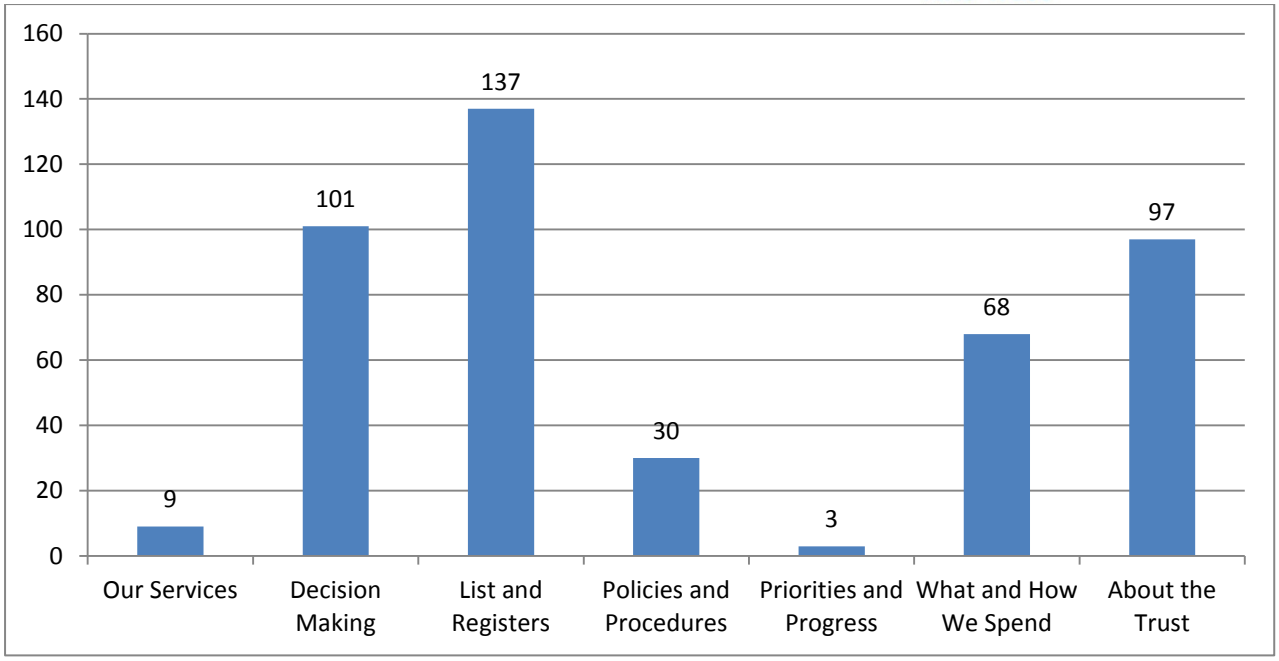


Table 2 - Examples of Category Request

Category	Example of Request
About the Trust	1. Overseas Visitors 2. English Language Classes for Staff
Decision Making	1. Trust Name Change 2. A&E Diversions
Lists & Registers	1. Software Systems 2. Advanced Skin Cancer Treatment
Our Services	1. Accident and Emergency 2. Urinary Catheters
Policies & Procedures	1. Energy Efficiency 2. Compromise Agreement
What & How we spend	1. Employee Benefits 2. Locum Staff Spend

Categories are defined by the FOI Team once a request is received at the Trust. Examples of each type of request are shown in Table 2 above and more information is available from the FOI Team.

Chart 2 – Requests by Applicant Type

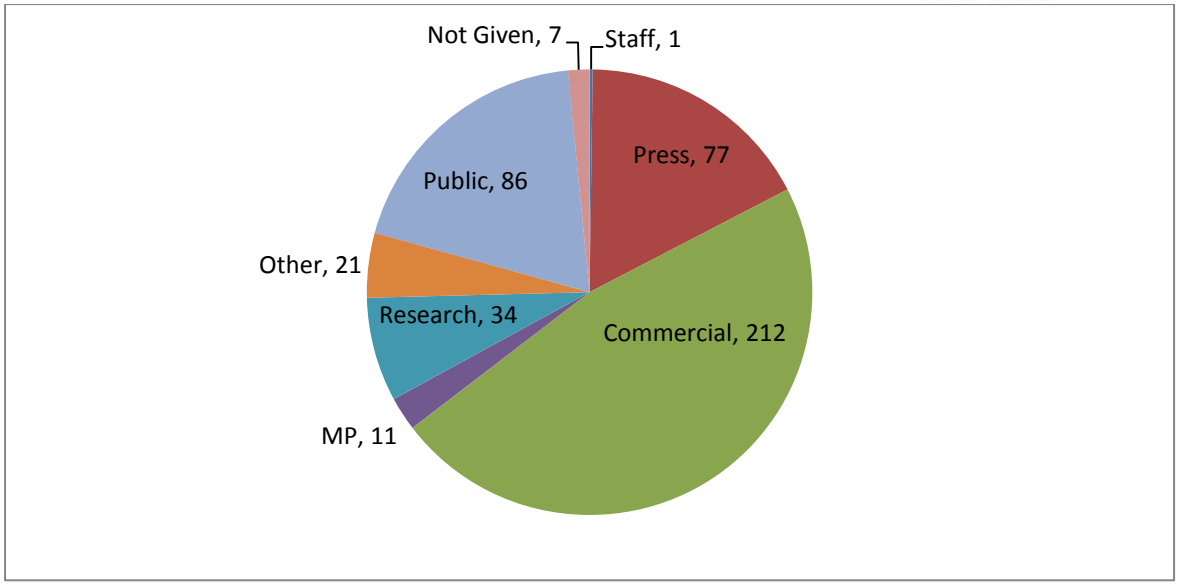
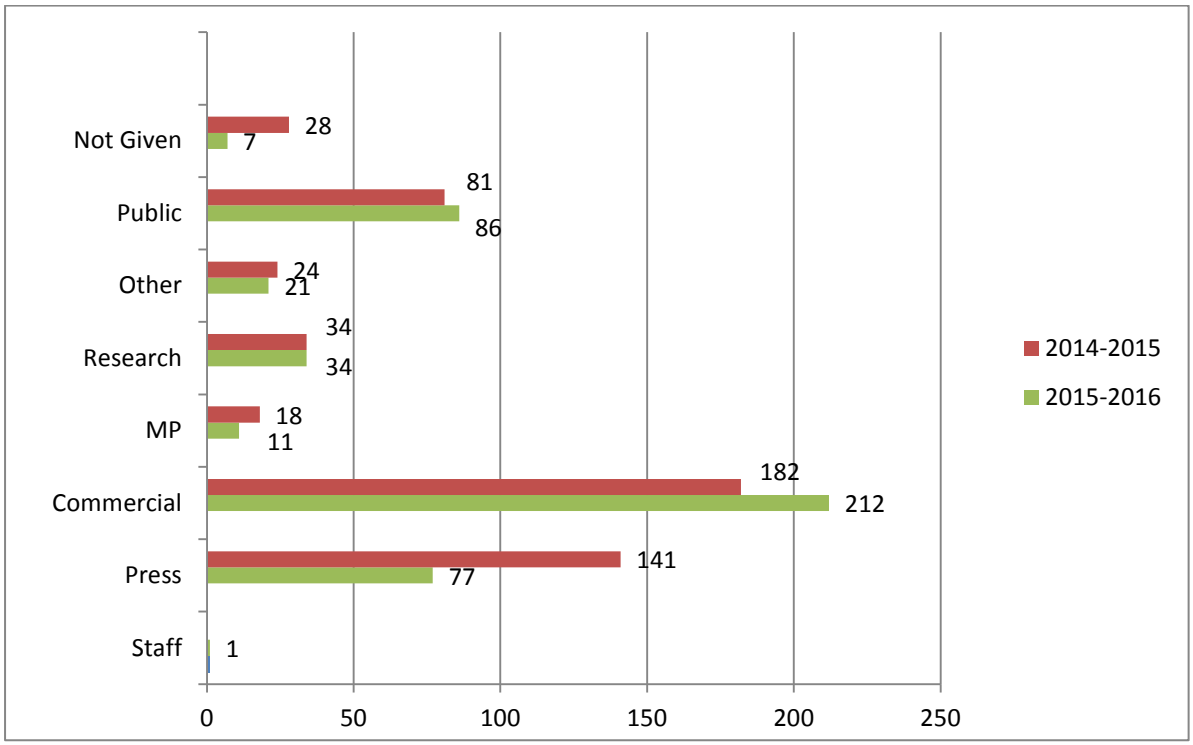


Chart 3 – Comparison of 2014-2015 and 2015-2016 Applicant Type



Continuing from the trend of the previous year the Trust has seen an increase in the number of requests that have been received from commercial companies requesting information about the Trust. Press requests have dropped over the 12 month period by 13 % compared to the same period for 2014-15.

FOIA still remains an avenue that both local and national journalists use to extract information out of the Trust and the team always works closely with the Media PR and Communications Team around these types of requests. The requests made by MP's have regressed again in 2015-16 as have the number of requests that did not contain information as to what purpose the request was being made for (Charts 2 & 3 above).

We have noticed a significant change this year in the fact that there were far fewer requesters who were choosing to not give their details, than has been reported in previous years[1].

Performance

This year the Trust received 479 FOIA requests. The Trust strives to respond to all requests in accordance with the 20 working days timeframe that the legislation dictates. Out of the 479 requests received the Trust responded to 73% within 20 working days and only 27% of responses were released after the deadline. Considering the complex nature of gathering the information and responding to the request taking into account other legislation and exemptions this represents a good response rate.

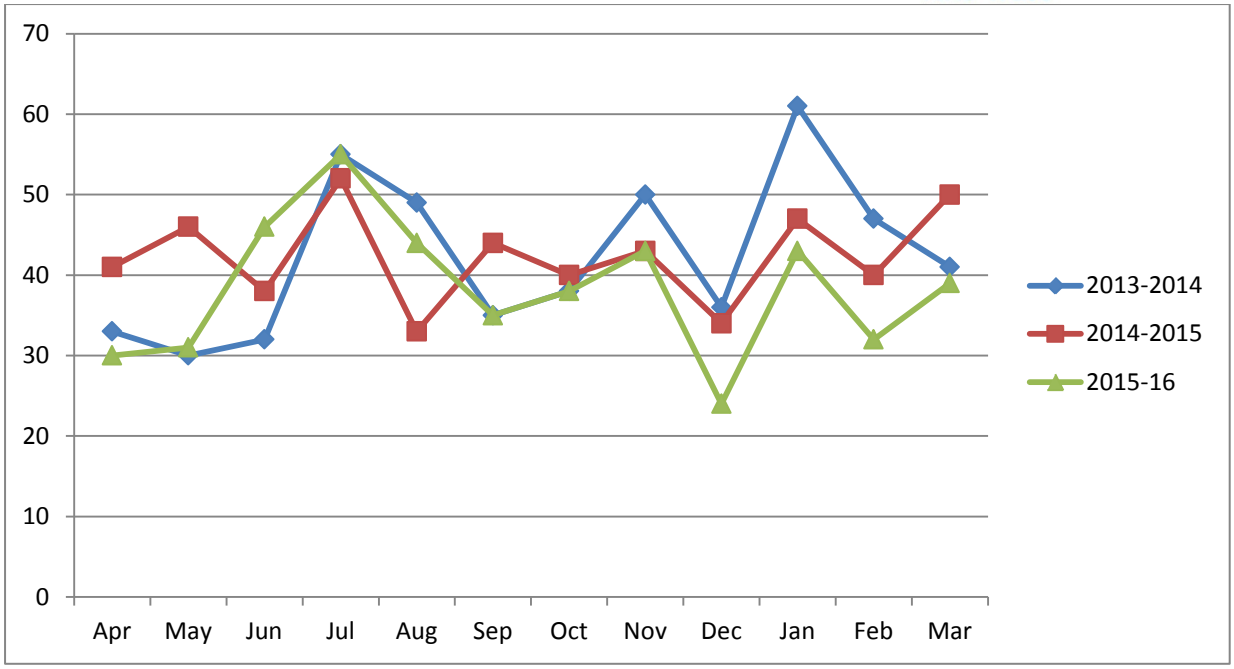
This is a decrease in last year's performance as out of the 522 requests received last year the Trust responded to 78% within 20 working days and only 22% of responses were released after the deadline.

Awareness raising and additional training has been provided in areas to try and improve the above statistics even further.

The Trust has received no formal complaints from applicants on how we responded to a request.

Chart 4: - Annual / Monthly Comparison of Requests received in 2015-2016 compared to 2013-2014 and 2014-2015

[1] 'Not Given' is where an applicant does not explicitly state an affiliation, such as press or MP. Applicants do not legally have to give this information.



Similar to the previous two financial years the department has seen an increase in the number of requests received during the months July and January. For this year the most requests received in both months were received from commercial parties. The highest number of requests for a single month was July 2015 (55 requests), with the fewest requests being received in December 2015 (24 requests). On average the Trust received 40 requests per month for the financial year 2015-2016.

Conclusion

The number of Freedom of Information requests received by the Trust in 2015-2016 decreased from the previous year (from 552 in 2014-2015). This number however doesn't highlight some of the extremely complex requests we are now receiving from requestors that have an increased awareness of Freedom of Information legislation.

We continue to comply with the large majority of requests that we receive into the Trust and this year will see the Trust introduce a new IT System to aid the processing of the requests it receives.

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

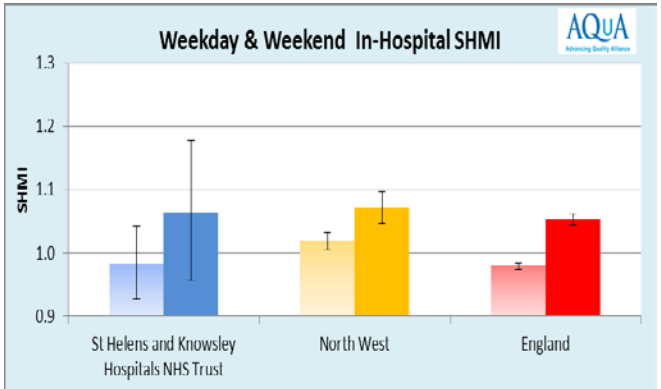
Paper No: NHST(16)059
Title of paper: STHK Board Quarterly Mortality Update, May 2016
Purpose: Update Board on Mortality
Summary: Good performance, falling weekend HSMR
Corporate objectives met or risks addressed: Safety
Financial implications: N/A
Stakeholders: All
Recommendation(s): Members are asked to approve:
Presenting officer: Kevin Hardy
Date of meeting: 25th May 2016

STHK Board Quarterly Mortality Update, May 2016
Kevin Hardy, Medical Director

Summary Mortality Data

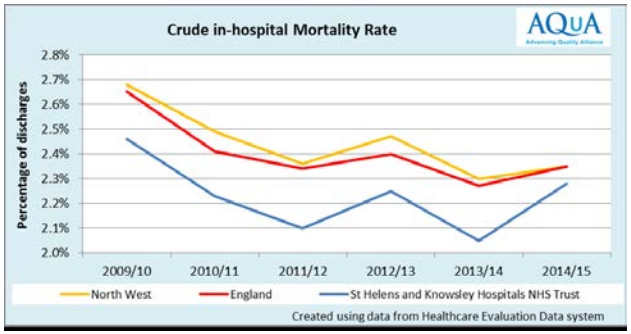
	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	YTD	15-16
Deaths	147	129	107	123	122	90	121	130	149	147	117	155	129	129	1537
Crude Rate	2.6%	2.3%	1.9%	2.0%	2.2%	1.6%	2.1%	2.3%	2.7%	2.7%	2.1%	2.7%	2.2%	2.2%	2.2%
NE Crude R	2.8%	2.5%	2.1%	2.3%	2.4%	1.7%	2.3%	2.5%	2.8%	2.9%	2.3%	2.9%	2.4%	2.4%	2.5%
SHMI	-	-	1.031	-	-	1.029	-	-	-	-	-	-	-	1.029	-
HSMR	113.8	104.0	91.0	100.8	104.1	85.7	96.9	106.4	92.6	83.7	-	-	-		97.7
HSMR W/E	130.6	125.9	113.7	121.4	129.1	85.5	100.1	115.1	101.0	103.8	-	-	-		111.8

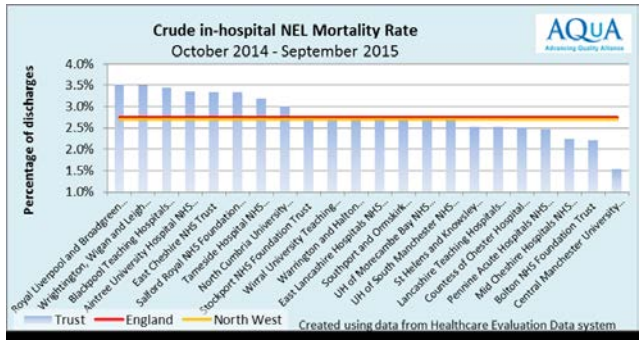
- Crude Mortality & SHMI largely stable (better than NW)
- HSMR has continued to fall – better than England & NW
- Weekend admission HSMR has fallen substantially, Apr-Aug = **124.1**; Sep-Jan = **101.1**

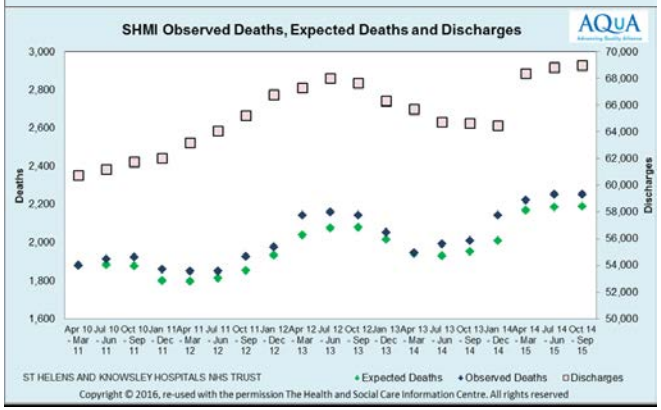


Mortality Surveillance

- New National Process – separate paper at this Board
- All mortality data & RCRR to be reviewed by Mortality Surveillance Group (MSG)
- Existing RCRR last 3-6 months working well; deep dives lagging behind primary RCRR
- New process will utilise COG expertise to deliver timely deep dives
- Palliative care coding (new consultant) will improve expected; R coding biggest on-going challenge







- Anticipate Sepsis & AKI investments to deliver reduced 'observed' deaths

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)060
Title of paper: Mortality Review – A new system for England
Purpose: To set up a Mortality Surveillance group to reduce avoidable morality & improve clinical care
Summary: NHSE has announced a new national process of morality review. This paper describes the background to this pan and StHK's proposed response.
Corporate objectives met or risks addressed: Care, safety, systems, pathways
Financial implications: None
Stakeholders: All staff
Recommendation(s): Members are asked to approve:
Presenting officer: Kevin Hardy
Date of meeting: 25th May 2016

Mortality Review – A new System for England
Paper to Board for Approval
Kevin Hardy, Medical Director
April 2016

Background

Around the world individuals, institutions and healthcare systems are grappling with the distinction between excess and avoidable mortality. In England this came in to sharp relief during the 2013 review into the 14 hospitals with the highest mortality.

Following the Keogh review into those hospitals with high mortality, Professor Nick Black from the London School of Hygiene and Tropical Medicine and Professor Lord Ara Darzi were asked to examine the relationship between excess and avoidable mortality using established case note review methodology. They determined that about 4% of deaths in our hospitals were potentially avoidable and that there was no obvious relationship with excess deaths over and above the average. Given the experience gleaned through this process NHSE are seeking to establish a standardised methodology for reviewing deaths in our hospitals with the aim of identifying themes for improvement both nationally and within organisations. They are currently procuring a training programme for retrospective case record review and have engaged the Academy of Medical Royal Colleges to help guide the process to ensure clinical relevance.

In addition, they are committed to reforming the process of death certification, with the intention of introducing Medical Examiners to improve the accuracy of local reporting and thereby support measures to reduce avoidable deaths. This was an accepted recommendation of the Francis Inquiry.

Like STHK, many Trusts already take this very seriously and have sophisticated governance processes in place, but to encourage all Trust boards to focus on this difficult issue, the NHS Mandate includes an intention to publish avoidable mortality by Trust. The exact form this will take has yet to be determined.

Mortality Governance Guide

The aim of this paper is to describe the nationally prescribed process that we must adopt to survey, review, learn from and reduce mortality. The guidance suggests it should be a board's highest priority.

General Principles

While most hospitals undertake some form of mortality review, there is wide variation in terms of methodology, scope, data analysis, and contribution to learning. By establishing a consistent process of reviewing care through a structured analysis of patient records, NHSE aim to improve the quality of care by helping hospitals to learn from problems that contribute to avoidable patient death and harm. NHS England has commissioned HQIP to manage procurement of development of a standardised

methodology and training roll out to all NHS trusts in England. A supplier will be in place by January 2016, with a pilot expected to start in Q1 2016/17.

They suggest that whilst those that die will account for 3% or less of those admitted to an acute hospital, concentrating attention on the factors that cause those deaths will also impact positively on all patients, reducing complications, length of stay and readmission rates by improving pathways of care, reducing variability of care delivery through the use of care bundles, and early recognition and escalation of care of the deteriorating patient. Retrospective case record review (RCRR) will identify examples where these processes can be improved and this information will be constantly fed back to clinicians. In time it will be possible to raise awareness amongst clinicians and managers of the need to promote best practice and behaviours, reduce variability, and make the focus on mortality everyone's business. Furthermore, it will be possible to gain an understanding of the care delivered to those whose death is expected and inevitable. In many organisations this group of patients does not receive optimal care, often because the diagnosis (i.e. this person is dying) is not made or the necessary expertise is in short supply.

Mortality will become the subject of formal and informal conversations, from the Board room to the coffee room and is relevant for all NHS providers, not just those about whom there are concerns around mortality.

Governance Processes

Mortality governance should be a top priority for trust Boards. Executive and Non-Executive Directors should have the capability and capacity to understand the issues affecting mortality and to provide appropriate challenge. It is recommended that Trusts have in place the following or similar processes in support of mortality governance, which will also help prepare for roll out of the national RCRR programme.

1) All trusts should have a mortality surveillance group (MSG), with multidisciplinary and multi-professional membership

The primary role of the MSG is to provide assurance to the Trust Board on patient mortality. Mortality indicator statistics do not in themselves constitute evidence regarding the standard of care delivered. Therefore, assurance must be based on review of care delivered to those who die as well as understanding the statistics. This group should review data on patient deaths, including results and learning generated by local mortality review, and consider strategies to improve care and reduce avoidable mortality. This should be chaired by a Board level clinician (i.e. the Medical Director or Director of Nursing). Serious consideration should be given to external membership from the local clinical commissioning group or NHS England area team and also a local service user/member of the public (e.g. a member of the local Healthwatch group).

In addition to contextual information about quality of care the MSG should also receive statistical information about all deaths in the Trust and should track those in the highest risk groups. In most Acute Hospitals the largest numbers of deaths are in those patients admitted as acute medical emergencies with the diagnoses of sepsis, pneumonia, stroke, myocardial infarction, and heart failure. Other important diagnoses are Acute Kidney Injury and fractured neck of femur. The hospital information department or a commercial provider should be able to provide regular

reports of overall crude mortality and numbers of deaths by diagnostic groups. Further detailed information on for example, deaths by ward, at weekends, Bank Holidays can be reviewed on a regular basis.

National audits providing information on mortality at Trust level, such as ICNARC, TARN, the National Bowel Cancer audit, and other aspects of care including stroke (SSNAP) and myocardial infarction (MINAP) should also be used to identify areas where care may need to be improved.

It may be useful to understand the source of referral for patients who die within 24-36 hours of admission. A significant proportion of these are people who are inevitably at the end of their lives and admission to an acute or community provider may not be in their best interest. Many will be referred from nursing homes or their own homes despite the presence of an appropriate care plan. This is easily achieved by tracking admissions by postcode. Undertaking this type of audit may provide rich information for engaging with commissioners and other LHE partners. It will also provide valuable insights into how these patients are managed in the acute trust, whether decisions, interventions and care are appropriate for this group of patients bearing in mind the recommendations of the review “One Chance to get it Right”.

If there are concerns about a cluster of cases or a distinct diagnostic group (for example fractured neck of femur) as identified by an elevated mortality rate, adverse audit report, complaints, Deanery feedback or information arising from a Morbidity and Mortality meeting then a process as described in the section “Response to a mortality alert” (below) should be followed.

2) Mortality reporting to the trust Board

Mortality reporting must be provided regularly in order that Executives remain aware and Non Executives can provide appropriate challenge. This should be at the public section of the meeting with the data suitably anonymised. We would expect the Non Executives to satisfy themselves that appropriate governance processes are in place, that the Trust is providing safe care and that systems exist to detect and reduce the level of avoidable deaths. The type of questions we expect to be asked of the Executives are:

- What process exists for review of all deaths?
- How many people died in the Trust last month?
- What are the 3 biggest causes of death in the Trust and the current mortality rates for these?
- What is the Trust’s current overall crude mortality rate, HSMR and SHMI?
- How does the Mortality Surveillance Group (MSG) function, what information does it consider, who are its members and chair?
- How will the MSG maintain oversight of avoidable mortality and identify outliers?
- Are there any specialities, sub-specialties, diagnostic codes or times of the week for which the data suggest elevated mortality levels? What further analysis and actions are you taking?
- How will the MSG keep the Board informed about the work it does?
- What steps is the Trust taking to implement the advice from the Academy of Medical Royal Colleges regarding daily senior review and 7 day working in the Hospital?
- Is support from Critical Care outreach available 24/7?

3) In order to understand the standard of care being delivered to those who die there needs to be a high level assessment of all deaths

This is quite achievable if the responsibility is distributed amongst all consultants in those specialties with large numbers of deaths (e.g. acute medicine). It is the responsibility of all registered medical practitioners to understand the outcomes of their clinical practice so this should form a core element of SPA time. In specialties with fewer deaths (e.g. orthopaedics), case note review can be undertaken by a nominated individual. For those patients on a supportive care pathway where death should be judged unavoidable, assessment is still necessary in order to provide assurance of appropriateness and standard of care delivered.

The national RCRR methodology will include a standard review proforma and two-staged review process. Until rolled out, local mortality review templates (ideally electronic) may be used for this initial assessment of all deaths and include: demographic details, mode of admission, initial clinical assessment, on-going management including investigations and interventions, issues around infection and venous thromboembolism (VTE), nutrition and hydration, recognition of deterioration, use of critical care services, end of life care and appropriateness of cardiorespiratory resuscitation (DNAR) assessment. This is not an exhaustive or exclusive list. In order to improve clinician engagement it is worth considering, in collaboration with the clinical teams, developing bespoke templates for different groups of patients e.g. acute medicine, acute abdomen, stroke, fractured neck of femur, end of life care as these patients will have different needs and their care should be informed by the relevant guidance from NICE, royal college or specialist association.

Standards from these guidance documents should be embedded into these review templates along with generic Trust standards for care. Please note: the national methodology will also include scope for local, specialist adaption to the review form.

If there is a desire to understand the level of avoidable mortality then deaths can be categorised using a stratification tool such as the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categorisation (see “Process for responding to a mortality alert” below). This is largely a subjective judgement which will also be supported by the national methodology, based on the PRISM studies.

If there are found to be concerns about the standard of care then the case must be reviewed in-depth by a multidisciplinary team. This should be at a regular departmental morbidity and mortality meeting with representation from senior and junior doctors and nurses, and other AHPs as appropriate for that specialty. These meetings should have equivalent priority, administrative support and governance as other MDT meetings that exist to decide care in for example all cancer disciplines. The outputs from these meetings need to be recorded, especially conclusions about outstanding care and suboptimal care, both of which should be captured and sent on to provide data for the MSG.

Furthermore it might also be prudent to undertake a case note review as described in a selection of high risk diagnostic groups (typically for most acute trusts pneumonia, heart failure, sepsis, stroke, AKI, #neck of femur) at least annually in order to provide on-going assurance. Redesign of the pathway of care for the group

of patients concerned should be considered making use of care bundles and including advice from NICE, Royal Colleges and other professional groups on current best practice.

Given the known association between staffing levels (doctors and nurses) and clinical outcomes including mortality rates the MSG should pay particular attention to these issues at all times when reviewing a service or circumstance where concerns have been raised.

4) Process for responding to a mortality alert

In summary if there are concerns about mortality in any particular patient group then it is necessary to undertake an in depth case note review. It is important to identify the correct cohort of patients. This may be obvious depending upon the source of the concern (e.g. CQC alert or elevated SMR for a particular diagnostic group) or may require further investigation (e.g. global high weekend mortality). Once this has been established then a review of the case notes for a reasonable consecutive sample of the patients who died (say 30 – 40) by a relevant multidisciplinary group should be undertaken in order to establish whether the clinical care those patients received was appropriate or not. The review group should decide the criteria to be used for judging the standard of care much in the same way as the high level template described above although in this situation more detail may be required. This group will need adequate time and administrative support. There should be a lead person identified who will be responsible for the review and writing up the result.

The care should be categorised. The standardised RCRR methodology will include direction on categorisation, but in the interim, a useful approach is to employ the Confidential Enquiry into Stillbirths in Infancy (CESDI) mortality classification bandings. Deaths are classified according to CESDI as follows:

- Grade 0- Unavoidable Death, No Suboptimal Care,
- Grade 1- Unavoidable Death, Suboptimal care, but different management would not have made a difference to the outcome.
- Grade 2- Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)
- Grade 3- Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death).

Alternatively, the NCEPOD grading of care can be used:

- 1 = Good practice: A standard that you would accept from yourself, your trainees and your institution.
- 2 = Room for improvement: Aspects of clinical care that could have been better.
- 3 = Room for improvement: Aspects of organisational care that could have been better.
- 4 = Room for improvement: Aspects of both clinical and organisational care that could have been better.
- 5 = Less than satisfactory: Several aspects of clinical and/or organisational care that
  were well below that you would accept from yourself, your trainees and your institution.

In this way it is straightforward to determine if there is a problem. Assessment of coding should be part of the case note review but the primary focus should be to provide assurance on the quality of care. It is entirely possible that good care was provided to all patients and that all the deaths in the “alert” were unavoidable but experience in several Trusts shows 10-15% of cases will have elements of sub-optimal care. In any event following this approach will provide assurance to the Board that there is a formal process in place underpinned by sound documentary evidence.

5) Coding

Accurate clinical coding is essential in order that the correct information is collected in terms of activity and outcomes. This is necessary for a host of reasons not least that this constitutes the raw data upon which decisions are made about the Trust’s income. Clinicians need to be educated about how coders extract information from the hospital notes and how the way they record clinical findings and opinions support or hinder that process. Meetings and educational events between clinicians and coders can help build mutual understanding between these groups.

6) Feedback to the frontline

Clinicians need to be kept informed of the outcomes of their work if they are to learn and improve. It is essential that there is a mechanism for the outputs of the mortality governance process to be fed back to clinical staff as well as plans for improvement, lessons learnt and pathway redesign.

Dashboards depicting outcomes at individual / team / ward / department level can be used for these processes and are best devised in conjunction with the individuals concerned. Other vehicles such as safety lesson of the week email alerts, cascading through governance groups using this data as part of appraisals should be considered.

Mortality Surveillance Group

Suggested Composition

Chairman – Medical Director Information

Department Representation

Director of Nursing or Deputy

Senior Nurse

Doctor-Anaesthetist

Doctor-Acute Physician

Doctor – Care of the Elderly

Doctor – Respiratory /Cardiology

Doctor – Accident & Emergency

Doctor – General Surgery

Governance Representation Junior

Doctor Representation

NHSE LAT or CCG representative

Public representative

Governance representative

Administrative person

Quorum

Four members plus the Chairman (one nurse, two doctors and a governance representative).

Frequency of Meetings

The Committee will meet monthly.

Operational functions

To work towards the elimination of all avoidable in-hospital mortality.

1. To review on a monthly basis, the benchmarked mortality rates of the Trust.
2. To consider the mortality data in conjunction with other qualitative clinical data and identify areas for future investigation. To facilitate the increased use of Clinical databases, run by various bodies including professional societies in the fuller

assessment of in-hospital mortality.

3. To investigate any alerts received from the Care Quality Commission (CQC) or identified by the Mortality monitoring information systems e.g. Dr Foster, HED, etc.
4. To develop data collection systems to ensure the Trust's mortality data is timely robust and in line with national and international best practice.
5. To ensure mortality information linked to consultant appraisals is accurate, contextual and engenders a culture of clinical excellence.
6. To develop an annual mortality clinical coding improvement plan and receive regular reports on its implementation.
7. To assign clinical leads to address raised mortality in particular clinical areas by the deployment of strong evidence based interventions such as care bundles. The MC will receive regular reports on implementation and the measurable impact of these interventions on hospital mortality.
8. To work with established groups to ensure each junior doctor intake receives the latest guidelines on care protocol implementation and clinical coding best practice.
9. To review and monitor compliance with other Hospital policies including DNAR and Death Certification Policy.
10. To monitor and consider the information from the electronic review of all in hospital deaths.

Strategic functions

1. To act as the strategic hospital mortality overview group with senior leadership and support to ensure the alignment of the hospital departments for the purpose of reducing all avoidable deaths.
2. Strategic oversight of extant mortality review committee(s).
3. To produce a Mortality Reduction Strategy that aligns hospital systems such as audit, information services, training and clinical directorates. This strategy will be reviewed
   on an annual basis by the Medical Director
4. Sign off of action plans and methodologies that are designed to reduce morbidity and mortality across the trust.
5. Sign off of all regulatory mortality responses.
6. To report on Mortality performance to the Board.

Accountability

The MSG would be formally accountable the Trust Board and will report to Quality Committee.

Proposal for Arrangements at STHK

See below.

Mortality Surveillance Group
NED Chair (public representative)
MD (Vice Chair)
DMD (as RO)
Assistant Director of Nursing (Safety)
Governance Leads for MCG & SCG
A&E Consultant
AMU Consultant
SAU Consultant
T&O Consultant
General Surgeon Consultant
Critical Care Consultant
COE Consultant
Chair of Hospital Ethics Committee
Sepsis Lead (Consultant)
AKI Lead (Consultant)
Palliative Care Consultant
Clinical coder
Trainee doctor (STR)
Lead CCG Safety & Quality Nurse
CCG GP representative
MD Exec Assistant

Frequency: Monthly meetings (replacing RCRR meeting)
Quorum: Chair or MD/ DMD, 3 other Consultants, 1 Governance lead
Venue: Board Room or Executive Committee Room
Replacing: IOG (CRAB), RCRR Meeting, Clinical Outcomes Group,
Reporting to: Quality Committee, Quarterly
Minimum attendance: 50%

Functions

Aims: To reduce avoidable mortality & improve clinical care

Objectives: To monitor SHTK benchmarked mortality statistics and mortality data in national and other audits and reports, to guide and review RCRR, to share learning and best practice, to provide feedback to frontline clinicians and others and to share learning via CCG leads with primary and community care and the local authority to reduce mortality and improve care across the entire (integrated) health and care pathway.

Sources: To include, but not be restricted to: Crude Mortality rates, HSMR (broken down), SHMI (broken down), CQC reports and alerts, Dr Foster or other data provider information and alerts, ICNARC, TARN, NHFD, NJR, SSNAP, MINAP, NCAA, AQuA Mortality Reports, NHSI Reports, relevant Royal College Reports, CRAB, NCEPOD reports, NELA, NDIS, National Heart Failure Audit, Cancer Services Reports, GIRFT, National COPD Audit, National Sepsis Data, NBOCAP, NLCA, NAOGC, MET, National Seven Day Services Reports & RCRRs; local information on mortality from Sepsis, Pneumonia, Stroke, AMI, Heart failure, AKI and #NOF.

Functions:

1. Produce Mortality Reduction Strategy (MRS) with annual progress report to board.

2. Monitor MRS through KPIs tailored to Strategic SMART objectives from in Monthly Mortality Report (MMR).

3. Monitor mortality KPIs in MMR in the context of relevant other quality indicators, coding, workforce levels….etc.

4. Monitor and investigate where necessary national performance reports, alerts etc (list above) as and when they are published.

5. Sign off regulatory mortality responses.

6. Establish and evolve a supporting infrastructure to ensure timely RCRR and MDT deep dive review (using national electronic template), and learning and sharing of lessons from MSG work.

7. Ensure annual deep dive into the following in the absence of this happening through RCRR processes or national returns: Sepsis, Pneumonia, Stroke, AMI, Heart failure, AKI and #NOF.

8. Ensure, where appropriate, mortality information is linked to consultant appraisal and job planning to ensure delivery of 5* care.

9. Establish & deliver appropriate educational meetings and programmes as necessary to deliver improvements aimed at reducing mortality, including events bringing together clinicians and coders.

10. Assign clinical leads and to undertake focussed investigative and improvement work (must be SMART) to improve mortality as informed by RCRR and MDT review and data surveillance.

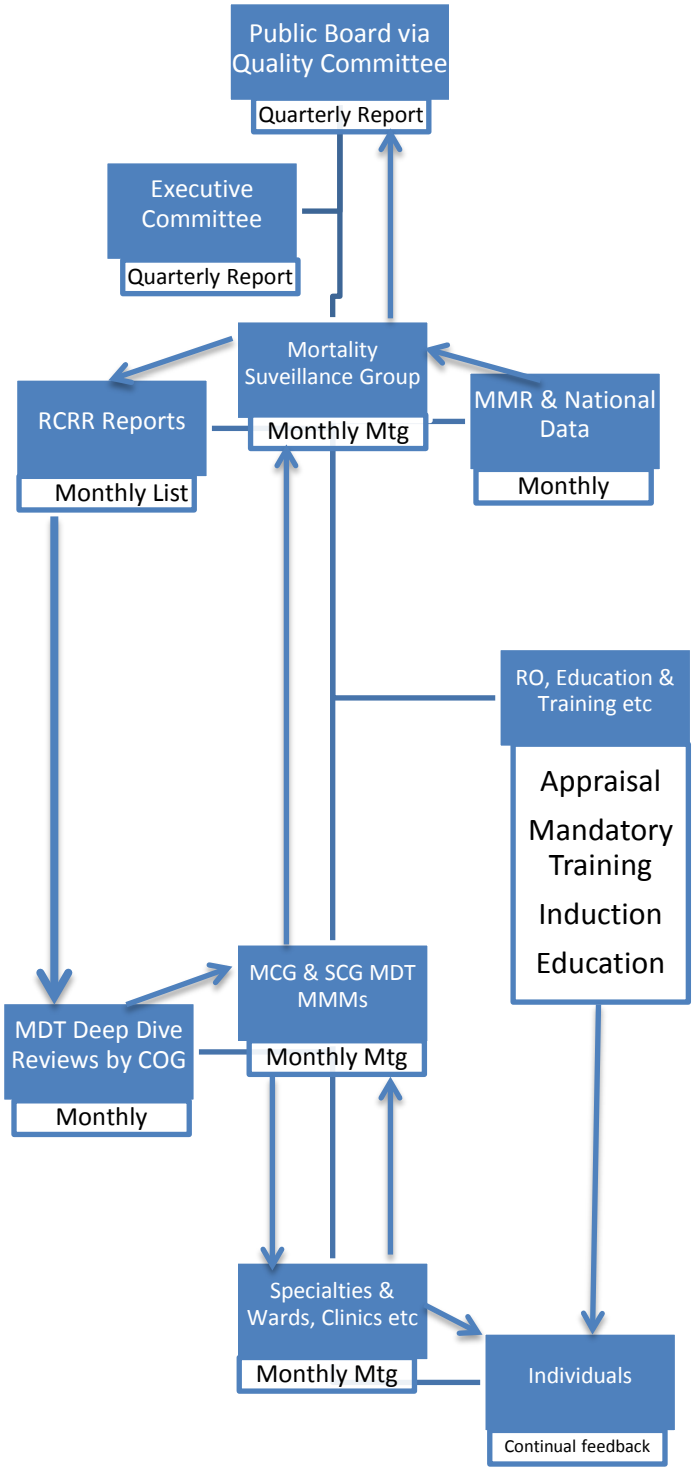
11. Ensure mandatory training, education & training and induction for all staff, including rotating trainee doctors is informed by MRS work to deliver evidence-based, effective care.

12. Liaise with End of Life Steering Group and others to ensure best practice in EOL care, palliative care, DNACPR and Death Certification.

13. Produce a quarterly news leaflet (possibly electronic) for all staff to keep those at the frontline and others up to date with best practice as understood by MRS.

14. Ensure staff are given sufficient core SPA time in their job plans (and nursing equivalent) to deliver MSG and related functions effectively.

Governance Structure



Mortality Surveillance & Review Process

1. Monthly list of deaths produced by 'Information' and sent to MD PA who will assign a named reviewer for each death, on or about 8th day of each month.

2. MD PA will send email to all reviewers advising them if they have a review (or not) for that month.

3. Attached to the email will be the national RCRR form (local form until national form issued).

4. Consultant will undertake the review within 4 weeks and will submit review to central repository held by MSG (held by MD PA).

5. Reviews were no concern or care shortfalls have been raised will be filed ('Closed File'.

6. Where any concern has been raised, they will appear on MSG agenda and MSG will either commission a more detailed MDT (MDTR) review (using the national RCRR template/local form until this is available) by Clinical Outcomes Group (COG) for AMBER reviews or refer to DoN for Level 3 RCA (with or without STEIS reporting) for RED reviews.

7. MDTR will identify specific learning and an action plan that will be shared through Care Group Governance Meetings with wards, departments, teams etc. The Care Group Governance Meetings (Divisional Director) will be responsible for ensuring delivery of the actions in the SMART action plan within an agreed timeframe and will provide quarterly reports to MSG. RCAs will be managed in the usual way.

8. MSG will keep a register of the status of all cases sent for MDTR or RCA and will ensure that Care Groups report on action plans in a timely manner.

9. Each month, MSG will review a Monthly Mortality Report (MMR) and the results of any national or other reports (list specified above). MSG will commission appropriate action plans from the relevant CD/DD or others and will ensure that these are returned within an appropriate timeframe (responsibility will rest with relevant CG DD).

10. MSG will be responsible for signing off national returns of these action plans after appropriate consultation with relevant Executives.

11. MSG will produce quarterly report to Quality Committee (and thus Board) detailing performance against specified mortality KPIs and a summary of the findings, actions and loop closure of MDTRs and RCAs.

12. MSG will share issues and learning with RO (and equivalents for other professionals) who will ensure that the issues and any learning are discussed and recorded at annual appraisal.

13. MSG will use lessons to be learned to commission education events, for example joint events with coders and EOL steering group etc. and will produce a quarterly electronic newsletter and ensure finding inform mandatory training where

appropriate.

14. MSG will use understanding from MMR and RCRR to devise an annual mortality reduction strategy (MRS) and will report the annual strategy and progress to board in an annual report.

Next Steps – Draft Timetable of Actions

No.	Action	Body/Group	Lead	Timeframe
1.	This paper to Execs for Discussion	Execs	KH	5/16
2.	This paper to Board for Approval	Board	KH	5/16
3.	Information to work with MD to devise KPIs and MMR.	Information Team	DH	5/16
4.	General paperwork for MSG to be devised and approved by Execs	MD PA	KH	5/16
5.	Trust RCRR form to be revised to accommodate new process	MD PA	KH	5/16
6.	Groups to be established and timetable for meetings produced	MD PA	KH	6/16
7.	TORs of relevant other meetings and councils to be amended	MD PA	KH	6/16
8.	Relevant other meetings to be closed down.	Relevant Groups	KH	7/16
9.	Final Full Proposal to Board for sign off	Board	KH	7/16
10.	New process to start	MSG	KH	8/16

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)061

Title of paper: Corporate Objectives Review.

Purpose: To advise Trust Board members of progress against Trust 2015/16 objectives.

Summary:

1. The Trust agreed twenty-seven objectives for 2015/16, and the following paper provides outturn performance for the year against each one.
2. In addition, performance has been RAG rated. Whilst the rating is subjective the results show:
   - 2.1. 19 objectives or 70.4% of objectives are rated as green signifying the criteria were fully met.
   - 2.2. 6 objectives or 22.2% of objectives are rated as amber signifying the criteria were partially met and good progress was being made.
   - 2.3. Only 2 objectives or 7.4% of objectives are rated as red signifying the criteria failed to be met or insufficient progress was made. These were:
     - *"To work with commissioners and other partner organisations to develop alternative services and pathways of care that will reduce AED attendances and emergency admissions.*" Whilst there were some successes with A&E avoidance schemes, and the GPAU and ambulatory care workstreams increased same-day discharges, the bottom line was that insufficient alternatives to A&E were created meaning attendances and emergency admissions rose.
     - *"To reduce complaints related to staff attitude and behaviour, and improve the timeliness of responding to complaints."* Whilst timeliness of responses improved, this was not to the required level, and despite initiatives to address staff attitude the proportion of complaints in this category increased.
3. In summary, general achievement against 2015/16 objectives was extremely good.

Corporate objective met or risk addressed: Contributes to the Trust's Governance arrangements, and its short and longer-term plans.

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff and all stakeholders.

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

Presenting officer: Ann Marr, Chief Executive.

Date of meeting: 25th May 2016.

ACHIEVEMENT AGAINST 2015/16 TRUST OBJECTIVES

The following report summarises progress against the Trust's five key objectives linked directly to patient care, and four associated and supporting objectives. A RAG rating has been provided against each objective on the basis of:

- Fully met criteria
- Partially met or good progress made
- Failed to meet or insufficient progress made

	5 STAR PATIENT CARE – Care *We will deliver care that is consistently high quality, meets best practice standards and provides the best possible experience of healthcare for our patients and their families*
1	Enrich the patient experience by continued improvements in clinical care and timeliness of discharges and transfers • *Clinical care continues to be of a high quality as is evidenced by the performance standards captured in the Trust's Integrated Performance Report, and the outstanding care rating resulting from the CQC's Chief Inspector of Hospitals report.* • *A Rapid Improvement event produced new processes to improve the timeliness of discharges.* • *Discharge data by time of day has significantly improved to support remedial actions.* • *An Executive Operational Turnaround Group (EOTG) is meeting weekly and overseeing work-streams aimed at improving discharges before 1:00pm.Whilst progress has been slow the latest evidence indicates that improvement is now occurring.* • *Protocols have been agreed with the major trauma centers to improve the timeliness of transfers.*
2	Continue to standardise high-quality clinical care across each day of the week • *Investments into seven-day working have resulted in a substantial reduction in LoS releasing beds which have been essential for meeting the increases in non-elective admissions.* • *The operation of the Medical Emergency Team (MET) has improved with better defined roles & responsibilities and a clear escalation policy. The recent introduction of eMEWS has further improved the effectiveness of the Team.* • *Whilst all medical wards have consultant presence across the week, the volumes of discharges at weekends have not risen significantly but this issue is actively addressed through the EOTG.*
3	Ensure adequate nurse staffing levels are in place, and maximise the time nursing staff spend on clinical duties. Extend the ward accreditation programme and continue to improve clinical training and research to further develop skills, knowledge and competencies of staff • *The Trust continues to monitor and report safer staffing data, and achieved a qualified nursing fill rate of 96.8% for the year.* • *The impact of staffing levels is routinely assessed, whilst recognising vacancy, bank and agency figures. The 3rd Shelford acuity and dependency audit was completed in October and demonstrated that the current ward establishment met the appropriate requirements.* • *The Quality Care Assessment Tool (QCAT), developed to meet objectives from the Nursing Midwifery Strategy, was rolled out to all appropriate wards, and in 2016/17 will be extended to Outpatient departments.* • *The ward manager and matrons are participating in development programmes.* • *"Time to care" has been successfully rolled out to all assessment and rehabilitation areas.*

5 STAR PATIENT CARE - Safety *We will embed a learning culture that reduces harm, achieves good outcomes and enhances the patient experience*	
4	Increase harm-free care; prevent 'never events' and further reduce medication errors Implement the "sign-up for safety" key indicators to improve safety and clinical outcomes • *The Trust continues to achieve above 98% new Harm free care outperforming neighboring Trusts.* • *There have been no never events since May 2013.* • *Incident reporting, seen as a positive measure of staff's confidence in raising concerns, increased by circa 10%.* • *The Trust's Medicine's Optimisation Strategy & Action Plan, monitored by QC. includes clear actions to further increase error reporting and reduce medication errors including: the introduction of a system of electronic prescribing; changes to the existing medicines kardex; education for all prescribing clinicians and a PhD research project investigating the best ways to reduce prescribing errors. A highly successful intervention has seen an excellent increase in prescribed enoxaparin being administered, where previously this was suboptimal.*
5	Make further improvements with respect to avoidable hospital acquired infections, pressure ulcers, VTE screening, and the treatment of acute kidney injury and sepsis • *There were no cases of MRSA bacteraemia in 2015/16.* • *C.Difficile data has yet to be finalized due to the appeal process but rates were well within the Trust-specific control total. Hand-washing and timeliness of samples have improved and remain the key targets for further improvement.* • *.There has been a 48% reduction in falls resulting in moderate or severe harm following implementation of the falls strategy action plan.* • *There has been a 50% reduction in grade 3 pressure ulcers and no grade 4 cases.* • *The eMews electronic observation and escalation system has been rolled out and will improve recognition and speed of response to deteriorating patients.* • *The trust has performed poorly on VTE assessment. A new electronic system that allows assessment even in patients not on ADT has been introduced and there is a drive to improve VTE assessment, particularly in ED and on the assessment units where most breaches occur.* • *The Trust has funded initiatives to improve the management of AKI and sepsis to reduce mortality and meet the new national targets and is monitoring outcomes (too early to assess yet).*
6	Maintain in-hospital mortality below the north west average and continue to close the gap between outcomes for weekend and weekday admissions. • *HSMR and SHMI have both improved substantially (as predicted) following resubmission of assessment unit attendances. HSMR is better than the national and NW averages and SHMI is consistently better than the NW average. Mortality for weekend admissions has improved materially in the last 5 months. Co-morbidity documentation has improved and is now better than NW and national averages and there is a focus on Palliative care coding with the recent consultant appointment; work to minimize use of 'R' codes is now a major focus, particular use of the r69 code for missing records. The impact of implementing the business cases for Sepsis and Acute Kidney Injury will improve observed mortality.*

5 STAR PATIENT CARE – Pathways *Embed clear pathways which reduce variations, whilst recognising the needs of patients for personalised planned care*	
7	Work with commissioners and other partner organisations to develop alternative services and pathways of care that will reduce AED attendances and emergency admissions • *Achievement of this objective was always going to be highly dependent upon the work of partner organisations and unfortunately this was less successful than originally anticipated.* • *A&E attendances increased by circa 2.7% with a further 0.6% increase redirected to alternative Trust initiatives thereby avoiding A&E.* • *A GP sub-acute service was established linked to physical accommodation changes, which effectively dealt with circa 9% of A&E attenders and improved flows.* • *Ambulatory care facilities became further established leading to smoother patient journeys and an enhanced patient experience.* • *The effectiveness of the GPAU meant that increased numbers of patients could be reviewed and discharged on the same day, avoiding overnight stay.* • *Going forward, agreement by Knowsley CCG to invest in a Community Assessment Facility should provide further benefits.*
8	Work in collaboration with neighbouring health and social care partners to explore opportunities for joint working that will improve patient care, and simplify the patient journey • *Joint working initiatives with local providers continue to be explored and picked-up towards the end of the year with the national drive for efficiencies across a wider footprint.* • *In particular, collaboration discussions with Southport and Ormskirk, and Warrington and Halton provider units have progressed.* • *Proposals for further alliance with Warrington Trust regarding the management of their acute stroke cases are soon to be implemented.*
9	Use benchmarking data intelligence to reduce variation and improve outcomes • *There is evidence of a range of services actively using benchmarking data to reduce variation and improve outcomes.* • *The Project Management Office is actively reviewing such data with care groups to drive improvements by learning from the best.* • *One of the major successes was with regards to the performance of stroke services which went from relatively poor to an exemplar service.* • *Other examples include Orthopaedic surgery where benchmarks have assisted in reducing the fractured neck of femur length of stay, whilst radiology and gastroenterology have used comparative information to enhance the overall quality of services.*
5 STAR PATIENT CARE – Communication *We'll be open and inclusive with patients providing them with timely information about their care. We will be courteous in communications and actively seek the views of patients and carers*	
10	Continue to work with patient focus groups to enable a fuller understanding of the patients' and carers' views and experiences. Continue to improve response rates and outcomes from the Friends and Family Test • *Patient / carer representation and engagement at focus groups is increasing and continues to have a positive impact. Recent initiatives have seen the development of spiritual care volunteers and dining room companions.* • *Excellent feedback was received from patient groups as part of the CQC inspection.* • *Achievement of the family and friends response rates has been challenging, however 96.4% of inpatients would recommend the Trust for treatment.* • *Response rates for the pilot outpatient clinics are extremely good.*

11	Reduce complaints related to staff attitude and behaviour, and improve the timeliness of responding to complaints • *The overall number of complaints in 2015/16 at 292 showed a slight increase of 3.9% from the previous year.* • *From 1St April revised recording categories have provided improved data on complaints. Those related to staff attitude have unfortunately increased by over 30% from the previous year.* • *Initiatives to address staff attitude include reflective practice, customer care training and discussion as part of the appraisal process. ACE behavioral standards have been reiterated to all staff.* • *Timeliness of complaint responses continues to be a challenge and a focus of management attention, with only 61.4% meeting the target.* • *Measures to improve the timeliness of responses and for the past 3 months have achieved 100% within target and YTD 67.4%.*
12	Continue to review and improve patient information both verbal and written • *A major initiative in 2015/16 ensured that the vast majority of patient information was reviewed and where appropriate revised.* • *In addition, ensuring that adequate stocks are routinely available was addressed.* • *Improved verbal and written communication is being addressed through a range of staff training modules and monitored through appraisal systems.* • *The Trust overhauled its internet site ensuring that patient information was accurate, in date and appropriate.* • *The Trust has made good progress in its preparation for the launch of "accessible information" in July, to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.*
5 STAR PATIENT CARE – Systems *We will improve Trust systems and processes, drawing upon best practice to ensure they are efficient, patient-centred and reliable*	
13	Implement the next phase of IT systems including: a clinical portal, electronic prescribing, electronic medical early warning system and electronic staff rostering • *Good progress was made with implementation of new IT systems.* • *The roll-out of eMews was completed in May 2016 with 1,800 clinical staff trained in its use. This allows for electronic capture of patient observations, improving accuracy, enabling quicker sharing of data, saving time and reducing paperwork.* • *An electronic staff rostering system was introduced into 47 clinical units with 1,400 nursing staff having their off duty created using the e-Rostering System. Plans are ongoing to introduce the e-Rostering system across other staff groups including junior doctors* • *Work on the Clinical Portal and systems for drug prescribing and theatres progressed, and the development of a three-year IT Strategy has commenced linked in to strategic plans.*
14	Continue to achieve improvements in data quality • *The Trust continues to benchmark itself using the Information Governance Toolkit, which allows NHS organisations to assess themselves against Department of Health information governance policies and standards.* • *The IG Assessment Report overall score for 2015/16 was 80%. This means that the Trust was rated 'Green' and is compliant in all sections of the Information Governance Toolkit. Plans are already in place to continue to improve this score for the 2016/17.*
15	Improve systems for scheduling out-patient appointments • *Out-patient clinic templates have been significantly improved.* • *Room utilisation rates are being monitored, and room scheduling processes are under development.* • *A paper-based scheduling system is still in place but it is hoped that an IT based system can be considered for the medium term.*

DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE *We will nurture a committed workforce who feel valued supported and developed to care for our patients, and encourage an open management style that inspires staff to speak up*	
16	Identify innovative approaches to the recruitment and retention of staff to ensure the Trust remains an employer of choice. Attract, develop and retain high quality leaders • *A 5 year Recruitment & Retention Strategy and year one action plan has been developed.* • *An international recruitment campaign to employ up to 120 qualified nurses is ongoing.* • *Collaboration with junior doctor training in the Czech Republic has resulted in the international recruitment of 6 junior doctors.* • *Plans to increase the pool of volunteers (currently 374 active volunteers) are ongoing. A volunteer strategy is being developed which extends the range of volunteer roles to include Dementia Friends dining companions and Prevention of Delirium volunteers.* • *Two programmes of leadership development for Ward Managers and Matrons to ensure they are equipped with the skills to deliver high standards of patient care are nearing completion.* • *The Trust continues to support leaders at all levels of the organisation with coaching and mentorship aligned to their personal development plans. A bespoke senior leadership course is being developed specifically for operational and corporate leaders to support collaborative working, driving productivity, efficiency and transformational change.* • *The development of Speciality specific OD plans will provide a focus to improve the effectiveness of the workforce, improve staff engagement and ultimately improve retention rates e.g. via succession planning for future staffing requirements.* • *A revised Preceptorship Programme for newly recruited Nursing staff has been launched supported by a coordinator role to ensure each receives the appropriate help and development they require in the clinical area.* • *An 11 week return to work programme was delivered in conjunction with the Skills Academy for Health and Job Centre Plus to support long term unemployed, resulting in 100% of all those the Trust supported entering employment.* • *Delivery of 47 Apprenticeships in a range of subject areas including Healthcare, Business Administration and Customer Service.*
17	Continue to embed a safety culture, and empower staff to feel confident to raise concerns and understand how to access support • *The Trust has delivered actions plans addressing the recommendations from both the Francis and Savile reports with ongoing monitoring to provide assurance that the actions are embedded.* • *The Trust continues to develop a culture of "speaking out safely", and strives to embed the principles of human factors in areas such as theatres.* • *Staff are encouraged to raise concerns through the Trust's Raising Concerns Policy.* • *Training in Human Factors continues to be rolled out to all clinical staff groups to improve understanding of the contributory elements to errors and how these might be addressed.*
18	Continue to raise the profile of the Trust's ACE Behavioural Standards and maintain positive staff Friends and Family test outcomes • *Awareness raising of the ACE Behavioural Standards is ongoing through induction and mandatory training and is championed through line managers.* • *The Trust's SFFT outcomes remain within the top quartile of responses nationally. The average response across the 3 quarters surveyed for staff recommending the Trust to friends and family if they needed care or treatment was 94% compared to a national average of 79%. The average response across the 3 quarters surveyed for staff recommending the Trust to friends and family as a place to work was 84% compared to a national average of 62%.* • *Excellent results in the National Staff Survey with a response rate of 55% compared to a national average of 41% placing us in the best 20% of Acute Trusts nationally. Improved scores across the majority of Key Findings including the overall score for staff engagement above the national average.* • *Cultural surveys are ongoing as part of the development of OD plans which will provide a 'pulse' check of the existing cultural style and whether or not ACE behavioural standards are prevalent or if further actions are needed. Part of this is being facilitated by professional coaches.*

OPERATIONAL PERFORMANCE *We will meet and where possible improve upon national and local performance standards which in turn will help deliver 5 star patient care*	
19	Achieve all clinically based performance indicators related to the quality of services provided; the timeliness of diagnosis and treatment, and the quantity of activity undertaken • *The Trust continues to monitor performance across many hundred parameters which are captured in the monthly Integrated Performance Report.* • *The Trust achieved every national access standard with the exception of 4-hour A&E wait, which represents a significant achievement given the picture nationally.* • *Stroke, elective access and critical care access have all improved.*
20	Use benchmark data and the comparative indicators to improve performance standards • *Continues to be good. Please also see the response to objective 9.*
21	Monitor trends in performance, and take appropriate remedial action to improve outcomes and results • *Continues to be good. Please also see the response to objective 9.*
FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY *We will at all times demonstrate robust financial governance, delivering improved productivity and value for money*	
22	Achieve all statutory financial duties • *In 2015/16 the Trust achieved its financial duties with respect to capital cost absorption; external finance limit and capital resource limit.* • *As predicted the Trust did not achieve the break even duty due to the YE deficit, although the final outcome of £9.55m was an improvement on the £9.79 original forecast.* • *The Better Payment Practice Code requires us to aim to pay 95% of all invoices within 30 days. We achieved 95.58% in terms of invoice value, but marginally failed in terms of invoice number, at 94.34%.*
23	Continue to refine the financial systems to improve service and patient level costing information to support decision making • *The areas we have set out for improvement this year are: Pathology at test level (awaiting upgrade); Bar coding of all equipment used (3 year project); Medical Job plans (awaiting completion in e-rostering).*
24	Deliver the cost and productivity improvement programme and establish a Project Management Office to work with operational managers on organisation sustainability. Utilise benchmarking data to identify efficiency improvements in areas such as theatre, outpatient and inpatient activity, and optimise space utilisation • *The CIP target of £13m was fully achieved.* • *The PMO was in place at the beginning of December, assisting operational managers with in-depth system and process reviews and achievement of CIP initiatives.* • *Early work has included exploring key lines of enquiry arising from the Lord Carter review especially regarding processes and practices within A&E and ICU.* • *The PMO are active members of Executive Operational Turnaround Group and the CIP Council.*

FT TRANSITION PLAN *We will work closely with the relevant regulators, commissioners and local authority partners to achieve Foundation Trust (FT) status*	
25	Progress the Trust's 5-year integrated business plan to demonstrate the organisation's readiness for FT status and long-term sustainability • *The Trust has developed short and long-term plans as required by commissioners and regulators and met all the required deadlines.* • *In late 2015/16 existing planning requirements were superseded by the national Sustainability and Transitional Planning guidance. As a result the Trust is contributing towards the plans for the Cheshire and Merseyside footprint, and undertaking detail planning with the acute provider alliance including Halton, Ormskirk, Southport and Warrington hospitals.* • *Governance arrangements are in place and initial plans are required in June 2016.*
26	Develop working relationships with commissioners and other health economy partners to explore collaboration where benefits on a wider footprint can be achieved • *The Trust continues to contribute in wider strategic planning discussions with commissioners, providers and other relevant stakeholders as captured in 25 above.* • *Executive Team to Team meetings have been held with commissioners and providers during the year, and the regular monthly meeting with the TDA has been maintained.* • *Evidence of the robust relationship with our key commissioner was the amicable close-out of the 2015/16 financial year, and agreement of 2016/17 contracts without the need for mediation.*
27	Continue to deliver the communication and engagement strategy to ensure that staff, patients and visitors are kept informed of the Trust's future organisational plans • *Progress has been made against the existing strategy and this will be updated after July to reflect the outcome of the STP plans as detailed in 25 above.* • *Staff engagement through the delivery of regular 'Team Talks' events continues to be seen by staff as a positive process with staff feedback and suggestions being used to make improvements to patient and staff experience.* • *Two 'Little Big Conversation' events were used to engage with large groups of staff in the development and implementation of the revised Trust Values and 'Speak out safely'.* • *The Trust successfully re-launched its internet site, and extended its social media presence, and the new Intranet site is soon to be unveiled.* • *The Trust general charity appeal was actively promoted with great success.*

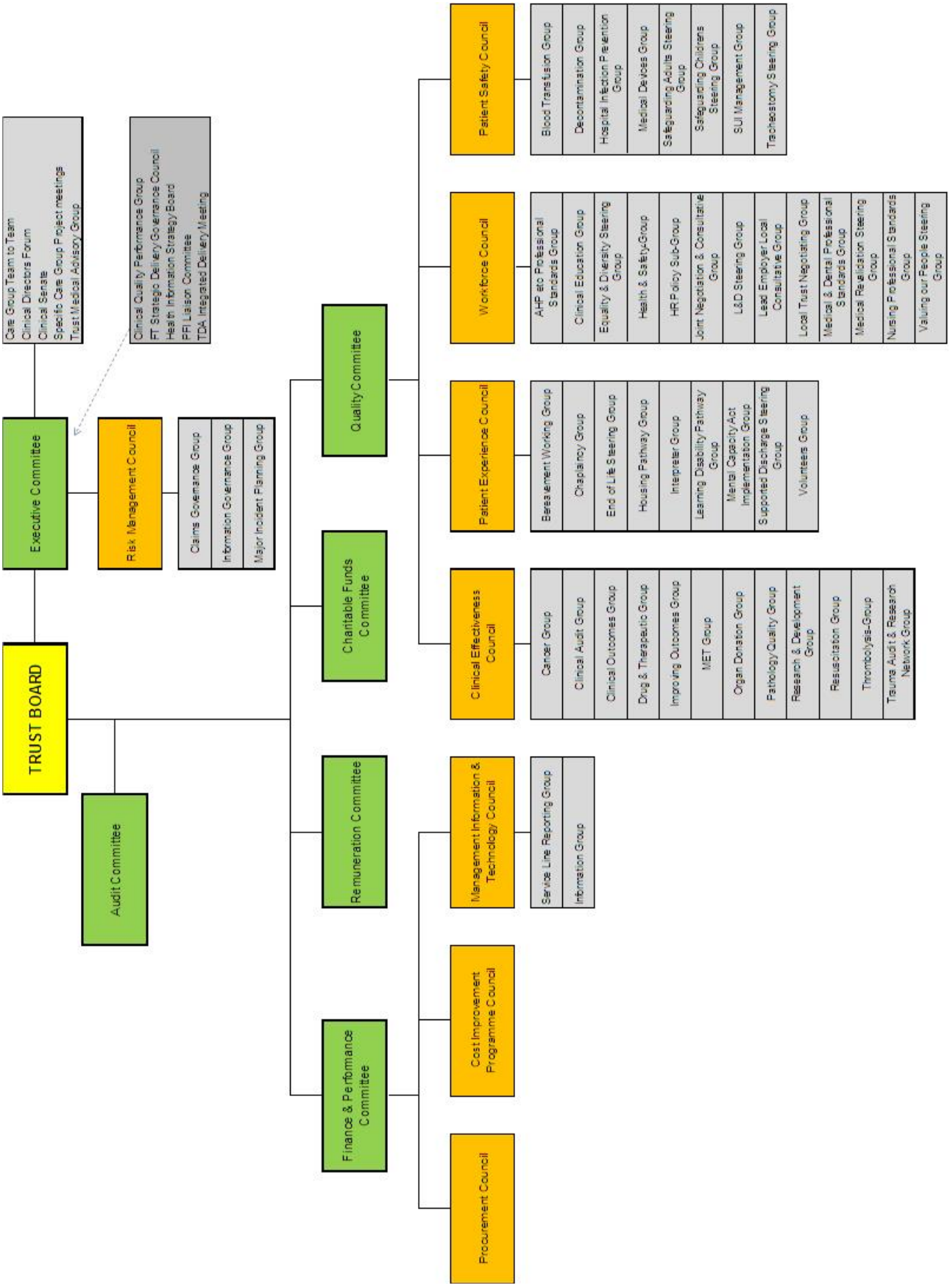
ENDS

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

TRUST BOARD PAPER

Paper No: NHST(16)062
Title of paper: Board effectiveness review – Revised Terms of Reference (ToR).
Purpose: To provide the Board with a pack of revised Board and Committee ToR that reflect the outcomes of the 2015/16 meeting effectiveness review process.
Summary: 1. From February through to April the effectiveness of the Trust Board and its Committees has been undertaken with regular updates provided to the Board. 2. The conclusion of the reviews is that the purpose, remit and organisation of the Trust Board and its Committees remains appropriate and provides the necessary assurance that the Trust is effectively and appropriately managed. 3. This conclusion is supported by the MIAA Audit Report on Board Reporting, published in April 2016 and providing Significant Assurance. 4. The final part of this review is the issuing of revised ToR for each forum incorporating agreed changes. 5. In general the ToR have been updated to address any omissions or ambiguities with only two material changes as detailed below. <u>Quality Committee</u> 6. The NED compliment of the core membership is to increase to 3 with the inclusion of Sarah O'Brien. <u>Charitable Funds Committee</u> 7. The core membership is to be reduced by removing the Trust finance staff that facilitate the meetings and making them attendees.
Corporate objective met or risk addressed: Contributes to the Trust's Governance arrangements.
Financial implications: None directly from this report.
Stakeholders: The Trust, its staff and all stakeholders.
Recommendation(s): The Board are asked to approve the attached ToR which reflect agreed changes resulting from the meeting effectiveness reviews.
Presenting officer: Peter Williams, Director of Corporate Services.
Date of meeting: 25th May 2016.

GOVERNANCE STRUCTURE AND TERMS OF REFERENCE



TRUST BOARD – Terms of Reference	
Authority	St Helens and Knowsley Teaching Hospitals NHS Trust (the Trust) is a body corporate which was established under the St Helens and Knowsley Hospital Services National Health Service Trust (Establishment) Order 1990 (SI 2446) amended by 1999 (No 632) (the Establishment Order). The principal place of business of the Trust is the address as per the establishment order. The terms under which the Trust Board operates are described in the Standing Orders section of the Corporate Governance Manual (section 7.3).
Delegated Authority	The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, and their specific executive powers shall be approved by the Board, and appended within the Corporate Governance Manual. The Board has delegated authority to the following Committees of the Board i) Audit Committee ii) Remuneration Committee iii) Quality Committee iv) Finance & Performance Committee v) Charitable Funds Committee vi) Executive Committee
Agendas	The Board will have a forward work programme for the ensuing year that provides an outline plan for reporting throughout the year. This will include items on quality, performance and statutory compliance as well as reports from the Trust's Committees where more in-depth scrutiny of items has occurred in the presence of both Non-Executive and Executive Directors. This does not prevent agenda items being added as required and may result in items being deferred to another month if the agenda becomes too congested. A Board member desiring a matter to be included on an agenda shall make their request to the Chairman at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman. Where a petition has been received by the Trust the Chairman of the Board shall include the petition as an item for the agenda of the next Board meeting.
Accountability and reporting	All ordinary meetings of the Board are open meetings which members of the public can attend to observe the decision-making process of the Trust. They are not open meetings where the public have a right to contribute to the debate, however, contributions from the public at such meetings can be considered at the discretion of the Chairman. Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers. Exceptionally, there may be items of a confidential nature on the agenda of these ordinary meetings from which the public may be excluded. Such items will be business that: i) relate to a member of staff, ii) relate to a patient,

	iii) would commercially disadvantage the Trust if discussed in public, iv) would be detrimental to the operation of the Trust.
Review	In March each year the Board will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the ToR.
Membership	**Core Members (voting)** Non-Executive Chairman (chair) 5 Non-executive Directors (one of which will be appointed Vice Chair, and one appointed Senior Independent Director) Chief Executive 4 Executive Directors (to include Director of Finance, Medical Director, Nursing Director plus one other. One to be nominated Deputy Chief Executive) Collective Responsibility - Legally there is no distinction between the Board duties of Executive and Non-Executive Directors; both share responsibility for the direction and control of the organisation. All Directors are required to act in the best interest of the NHS. There are also statutory obligations such as quality assurance, health and safety and financial oversight that Board members need to meet. Each Board member has a role in ensuring the probity of the organisation's activities and contributing to the achievement of its objectives in the best interest of patients and the wider public. <u>In attendance</u> The Board shall be able to require the attendance of any other Director or member of staff.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year.
Quorum	50% of the core membership must be present including at least one Executive Director and one Non-Executive Director.
Meeting Frequency	The Trust Board will meet monthly (with the exception of August and December). All meetings will have public and private elements.
Agenda Setting and papers	Minute production and distribution is via the office of the Director of Corporate Services. Documents submitted to the Trust Board should be in line with the corporate standard.

AUDIT COMMITTEE – Terms of Reference	
Delegated Authority	The Trust shall establish a Committee to be known as the Audit Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Board may request the Committee to review specific issues where the Board requires additional scrutiny and assurance.
Role	The Committee shall review the establishment and maintenance of an effective system of integrated governance internal control and risk management across the whole of the organisations activities, clinical and non-clinical that support the achievement of the Trust's objectives.
Duties	The Committee will undertake the following duties: <u>Internal Control and Risk Management</u>

	1. In particular the Committee will review the adequacy of: - All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board. - The structures, processes and responsibilities for identifying and managing key risks facing the organisation. - The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any other reporting and self-certification requirements. - The operational effectiveness of policies and procedures - The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Directorate of Counter Fraud Services. 2. The Committee will: - Provide an overview of the effectiveness of the assurance framework; - Provide an oversight role in respect of the governance structure and the linkages with other committees; - Consider the findings of other significant assurance functions (e.g. regulators, professional bodies, external reviews); - Review the arrangements and their effectiveness for which staff may raise, in confidence, any concerns; - Ensure there is a clear policy for the engagement of internal and external auditors to supply non-audit services, to ensure auditor independence and objectivity; - Review the work of other Trust Committees whose work will provide relevant assurance to the Audit Committee's own areas of responsibility; - Request and review reports, evidence and assurances from Directors and managers on the overall arrangements for governance, risk management and external control. <u>Internal Audit</u> 3. To consider the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal. 4. To review the internal audit programme, consider the major findings of internal audit investigations (and management's response), and ensure coordination between the Internal and External Auditors. 5. To ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation. <u>External Audit</u> 6. Establish an auditor panel with formal terms of reference to consider the appointment of the External Auditor and to ensure the on-going independence of the Auditor, making recommendations to the Trust Board. (See Appendix A.) (The Audit Committee should assess a prospective auditor panel member's independence by considering whether his or her circumstances could affect his or her judgement and by a number of factors – for example, recent employment with the Trust, close family ties to its directors, members, advisors or senior employees or a material business relationship with the Trust.) 7. Consider the audit fee, as far as the rules governing the appointment permit, and make recommendation to the Board when appropriate. 8. Discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with other External Auditors in the local health community.

	9. Review External Audit reports, including value for money reports and annual audit letters, together with the management response. 10. Review the adequacy and effectiveness of statements within the quality account together with the external audit assurance. 11. Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-statutory audit work including the pre-approval by the Audit Committee's Auditor Panel for this work. <u>Financial Reporting and Governance</u> 12. Review the annual report and financial statements before submission to the Board, focusing particularly on: - The Annual Governance Statement; - Changes in, and compliance with, accounting policies and practices; - Unadjusted mis-statements in the Financial Statements; - Letters of representation; - Major judgemental areas, and; - Significant adjustments resulting from the audit. 13. Consider any proposed changes to Standing Orders and Standing Financial Instructions and to the Scheme of Reservation and Delegation of Powers including delegated limits and make recommendations to the Trust Board. (NB. All of these are incorporated within the Trust's Corporate Governance Manual.) 14. Consider any proposed changes to the Trust's Standards of Business Conduct Policy and Anti-Fraud, Bribery and Corruption Policy and make recommendations to the Trust Board. 15. Review responsibilities in respect of the appropriate processes and compliance with Standing Orders for the use of the seal (delegated from the Board), tender waivers, losses and special payments, and aged debt, gifts and declarations of interests.
Review	Terms of reference and effectiveness of the Committee will be reviewed annually each February and included in the report to the Board.
Membership	<u>Core Members</u> The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than 3 members. <u>In attendance</u> The Director of Finance, the Head of Internal Audit and a representative of the External Auditors shall normally attend meetings. However at least once a year the Committee may wish to meet with the External and Internal Auditors without any Executive Board Director present. The Committee shall be able to require the attendance of any other Director or member of staff. Specifically, the Committee should consider inviting the Chief Executive to attend the Audit Committee to discuss the Annual Governance Statement and Internal Audit Plan.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible, - Contribute fully to discussion and decision-making, - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.

Quorum	A quorum shall be 2 members.
Accountability & Reporting	The council reports to the Trust Board and a written summary of the latest meeting is presented to the next Board meeting by the Audit Committee Chair.
Meeting Frequency	Meetings shall be held not less than three times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Director of Finance and Information. Documents submitted to the Committee should be in line with the corporate standard.

CHARITABLE FUNDS COMMITTEE – Terms of Reference	
Delegated Authority	The Trust shall establish a Committee to be known as the Charitable Funds Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee has no executive powers other than those specifically delegated in these terms of reference.
Terms of Reference	The Committee will oversee the administration of charitable funds in line with the Charities Commission requirements and relevant legislation. The Committee will undertake the following duties: • To manage the affairs of the St Helens and Knowsley Hospitals Charitable Fund within the terms of its declaration of Trust. • Develop policies in respect of the management of charitable funds including investments, donated income, spending, fundraising, use of reserves and other relevant matters. • Appoint an investment advisor to advise on investment arrangements for Charitable Funds. • Approval of expenditure requests in accordance with charitable funds expenditure approval procedures reviewing the financial position of charitable funds on at least a four monthly basis. • To ensure funding decisions are appropriate and are consistent with the St Helens and Knowsley Hospitals Charitable Fund objectives, to ensure such funding provides added value and benefit to the patients and staff of the trust, above those afforded by the Exchequer funds. • To implement as appropriate, procedures and policies to ensure that accounting systems are robust, donations received and coded as instructed and that all expenditure is reasonable, clinically and ethically appropriate. • To approve the annual accounts and report and to ensure that relevant information is disclosed.
Review	In February each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	<u>Core Membership</u> Core membership will comprise a Non-Executive Director who will chair meetings of the Committee; the Director of Finance or his nominated officer, two Trust senior officers (preferably clinical). <u>In attendance</u> The Charitable Funds Financial Accountant and Charitable Funds Officer will be in attendance. The Chairman and Chief Executive are invited to attend the Charitable Funds

	Committee at any time. Representatives of Internal and External Audit and other Trust Senior Managers may be invited to attend meetings in an ex-officio capacity. In addition, the Committee may establish appropriate working groups to consider specific issues on a project basis. The terms of reference of such groups will be agreed by the Committee with minutes of such groups presented to the Committee.
Attendance	Core Members are expected to attend a minimum of 60% of meetings per year. Members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible, - Contribute fully to discussion and decision-making, - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	The Committee would be considered quorate with 50% attendance.
Accountability & Reporting	The Committee reports to the Trust Board and will provide a written report setting out the basis of recommendations made.
Meeting Frequency	The Committee will meet at least three times per year. Meetings may be convened with the agreement of all members at any time.
Agenda Setting and papers	The Director of Finance will be responsible for all administrative arrangements.

EXECUTIVE COMMITTEE – Terms of Reference	
Delegated Authority	The Trust shall establish a Committee to be known as the Executive Committee which will formally be constituted as a Committee of the Board.
Role	The Executive Committee meeting is established as the most senior executive forum within the Trust. This forum will be the final arbiter on all operational issues. The prime role of meetings is to consider the operational issues within the Trust along with the coordination of work programmes required to deliver the strategic objectives of the organisation.
Duties	Duties of the Committee will include: 1. To review and approve business cases for the appointment of consultants and key Trust staff, or the creation of such posts 2. To review and approve business cases for new service developments, material expansion or reduction of existing services including capital developments, arising within year that cannot be accommodated within the annual planning process 3. To review and approve significant Tender documents submitted by the Trust 4. The management of issues with reputational and relationship management significance 5. The monitoring of Trust performance against all objectives, standards and targets including the development of any remedial actions 6. Receiving and considering the chair's report from the Risk Management Council and other appropriate supporting groups 7. Governance matters including preparation and arrangements for regulatory review

Review	In February each year the Committee will undertake an Annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	Core membership of the meeting will comprise: - Chief Executive (chair) - Director of Human Resources (vice chair) - Medical Director - Director of Nursing & Midwifery - Director of Finance - Director of Operations & Performance - Director of Corporate Services - Director of Informatics. The attendance of deputies will not routinely be permitted, however attendance by other staff of the Trust and stakeholders is envisaged for specific agenda items.
Attendance	Members are expected to attend a minimum of 70% of meetings. Members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making.
Quorum	A quorum will be 50% attendance. Where a decision is to be taken with financial consequences, the delegated authority for expenditure as contained in the Trust's Standing Financial Instructions must be adhered to.
Clinical Senate	On a monthly basis the meeting will be enhanced by the addition of the following members to create the Clinical Senate: - Deputy Medical Director - Assistant Medical Director - Divisional Medical Director (Medicine) - Divisional Medical Director (Surgery) - Divisional Medical Director (Clinical Support Services)
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	Meetings will be scheduled weekly on a Thursday.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the Trust office secretariat under the direction of the PA to the Chief Executive. Documents submitted to the Committee should be in line with the corporate standard.

FINANCE & PERFORMANCE COMMITTEE – Terms of Reference	
Delegated Authority	The Trust shall establish a Committee to be known as the Finance and Performance Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to financial and operational performance and subsequent risk of the Trust. In

	establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported for approval before action. The Board may request the Committee to review specific aspects of financial or operational performance where the Board requires additional scrutiny and assurance.
Role	To enable the Board to obtain assurance that the Trust has robust activity and financial plans in place to meet both short and long-term sustainability objectives, and maintain the Trust as a going concern. To contribute to the overall governance framework, and support the development and maintenance of effective financial and performance governance arrangements throughout the Trust to promote the efficient and effective use of resources and identify, prioritise and manage risk from Trust activities.
Duties	The Committee will undertake the following duties:- 1. To review and make recommendations to the Board on the annual financial and business plan and the assumptions which underpin it, and the Trust's longer-term financial and operational strategies 2. To review the performance of the Trust against all elements of the Trust finance and activity objectives via the monthly Finance and Performance Report. To make recommendations to the Board on key risks, and actions to ensure the Trust performs to the optimum level and operates within the resources available 3. To oversee the Trust's commercial strategy and oversee the further development of Service Line Management to contribute towards effective decision making underpinning service developments and market strategy 4. To review proposed cost improvement programme and to monitor implementation and report, to the Board, proposals for corrective actions considered if required 5. To approve policies and procedures in respect of finance and performance and if necessary make recommendation to the Board 6. Based on forecast resources available, to review the capital programme and to monitor progress against it 7. To review and monitor progress with annual contract negotiations and the impact on Trust sustainability; escalating any concerns to the Board 8. To consider relevant central guidance, benchmarking reports, reference costs or consultations and where appropriate make recommendations to the Board 9. To set the ToR including the annual work programme for the reporting Councils, ensuring that the governance of all relevant aspects of finance and performance is delegated appropriately 10. To receive assurance reports from the Council chairs following each meeting of the councils and to request in-depth reviews or commission independent audits where necessary. In addition, to receive annual reports prior to submission to the Board, e.g. Annual Accounts, and Strategic Plans 11. To undertake any reasonable finance and performance related reviews as directed by the Board or initiated from work of the Committee or its Councils 12. To provide assurance that appropriate governance structures, processes and controls are in place through reviewing relevant internal and external reports (including Lord Carter recommendations) and assessing the Trust's performance against each

Review	In February each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	**Core Members** Non-Executive Director (chair) Non-executive Director x 2 Director of Finance Medical Director Director of Operations & Performance The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. <u>In attendance-</u> In addition to formal members the Deputy Director of Finance, Assistant Director(s) of Finance and nominated deputy to the Director of Ops may be in attendance. The Committee shall be able to require the attendance of any other Director or member of staff. Members are selected for their specific role or because they are representative of a professional group or Department. As a result members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making, and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and one Non-Executive Director.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet monthly each year with the exception of August and December.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Director of Finance and Information. Documents submitted to the Committee should be in line with the corporate standard.

QUALITY COMMITTEE – Terms of Reference	
Delegated Authority	The Trust shall establish a Committee to be known as the Quality Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to quality of services and subsequent risk to patients and the Trust. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported to the Board for approval before action. The Board may request the committee to review specific aspects of quality performance where the Board requires additional scrutiny and assurance.

Role	To enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to: 1. Promote safety and excellence in patient care 2. Identify, prioritise and manage risk arising from clinical care 3. Ensure the effective and efficient use of resources through evidence-based clinical practice 4. Protect the health and safety of Trust employees 5. Ensure compliance with legal, regulatory and other obligations.
Duties	The Committee will undertake the following duties:- 1. To provide assurance to the Board on the delivery of the Trust's Clinical and Quality Strategy, based on the Trust's vision for 5-star patient care, through scrutiny of relevant quality indicators in the IPR 2. To monitor the Trust's performance against other internal and external quality targets via the IPR and to advise the Board of relevant actions if performance varies from agreed tolerances 3. To take appropriate action to address any under-performance, initiating and monitoring quality improvement programmes, and where necessary escalating issues to the Board 4. To oversee the production of the Annual Quality Account and review the final draft prior to submission to the Board for approval 5. To provide assurance on the delivery of the agreed Annual Quality Account priorities through Council reports 6. To approve policies and procedures in respect of quality and if necessary make recommendation to the Board 7. To set the ToR including the annual work programme for the reporting Councils, ensuring that the governance of all relevant aspects of quality is delegated appropriately 8. To receive assurance reports from the Council chairs following each meeting of the Councils and to request in-depth reviews or commission independent audits where necessary. In addition, to receive annual reports prior to submission to the Board, e.g. complaints, infection control, safeguarding, medicines management, mixed-sex declaration, clinical audit programme, and medical revalidation 9. To undertake any reasonable quality related reviews as directed by the Board or initiated from work of the Committee or its Councils 10. To provide assurance that appropriate governance structures, processes and controls are in place through reviewing relevant internal and external reports (including CQC recommendations and compliance) and assessing the Trust's performance against each.
Review	In February of each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	**Core Members** Non-Executive Director (chair) Non-Executive Directors x 2 Chief Executive Director of Human Resources

	Director of Finance Medical Director Director of Nursing & Midwifery Director of Operations & Performance Divisional Medical Directors The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. <u>In attendance-</u> In addition to formal members the Divisional Quality Leads, Deputy Medical Director, the Deputy Director of Nursing & Quality, the Deputy Director of Human Resources and any Assistant Director of Ops, may be in attendance. The Committee shall be able to require the attendance of any other Director or member of staff. Members are selected for their specific role or because they are representative of a professional group or Department. As a result members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making, and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and one Non-Executive Director.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet monthly each year with the exception of August and December.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Director of Nursing, Midwifery and Governance. Documents submitted to the Committee should be in line with the corporate standard.

REMUNERATION COMMITTEE – Terms of Reference	
Delegated Authority	The Trust shall establish a Committee to be known as the Remuneration Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee is authorised to make recommendations to the Trust Board on the appropriate remuneration and terms of service for the Chief Executive and Executive Trust Directors and Associate Directors with due regard to market rates, NHS wide guidance, affordability and equal value.
Terms of Reference	The Committee will undertake the following duties: 1. To receive and consider information and advice from the Chief Executive on the levels of remuneration for individual Directors taking into account internal relativities, the particular contribution and value of individual Directors and affordability. 2. To consider the level of remuneration for the Chief Executive taking into account the above factors. 3. To receive and consider external information on the wider pay scene

	including: - Guidance on Executive remuneration from the Department of Health. - The levels of Executive remuneration offered by similar NHS organisations. - Consideration of the environment in which the organisation is operating. 4. To advise and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate including the approval process for: - Redundancy payments made to Chief Executives and Directors. - Redundancy payments in excess of £50,000 made to all other staff. - Special payments, i.e. any severance payments exceeding contractual obligations (or exceeding 3-months pay in lieu of notice).
Review	In March each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	<u>Core Members</u> Membership will comprise the Chairman and all Non-Executive Directors. <u>In attendance</u> The Chief Executive (except during discussions about his /her remuneration or terms of service) shall normally attend meetings. The Director of Human Resources shall be Secretary to the Committee and shall attend to take minutes of the meeting. The Chairman may co-opt other members, such as the Director of Finance, as appropriate, in order to assist the Committee in meeting its objectives.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible, - Contribute fully to discussion and decision-making, - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	The Remuneration Committee would be considered quorate when the Trust Chair or Vice Chair plus 3 Non-Executive Directors are in attendance.
Accountability & Reporting	The Committee reports to the Trust Board and will provide a written report setting out the basis of recommendations made.
Meeting Frequency	The Committee will meet at least once a year. Meetings may be convened with the agreement of all members at any time.
Agenda Setting and papers	The Director of Human Resources will be responsible for all administrative arrangements.

St Helens and Knowsley Teaching Hospitals NHS
NHS Trust

BOARD PAPER

Paper No: NHST(16)063

Title of paper: 2015-16 Quality Account

Purpose: To provide the Board with the opportunity to review and comment on the final draft of the Quality Account, following its review at May's Quality Committee and to seek delegation to the Chief Executive and Director of Nursing to approve the addition of the three outstanding items prior to publication.

Summary:

The final draft of this year's Quality Account has been completed subject to the outstanding information being inserted, that is, national VTE figures (due to be published 3rd June), finalisation of the Clostridium difficile figures following the outcome of appeals and written comments from Halton and Knowsley Clinical Commissioning Groups (CCGs) and St Helens Healthwatch and Knowsley Healthwatch.

Grant Thornton have received the draft version and are in the process of completing their limited assurance report, having reviewed the content of the Quality Account and undertaken an audit of incident management and reporting and Clostridium difficile.

The Director of Nursing and Assistant Director of Governance have discussed the draft Account with a number of external partners at external presentations made to:

- Halton Borough Council, Health Policy and Performance Board (13th April)
- Halton CCG (19th April)
- St Helens CCG (6th May)
- Knowsley CCG (6th May)

The feedback from these presentations has led to some minor amendments and additional information on the work undertaken by the Trust in the following areas:

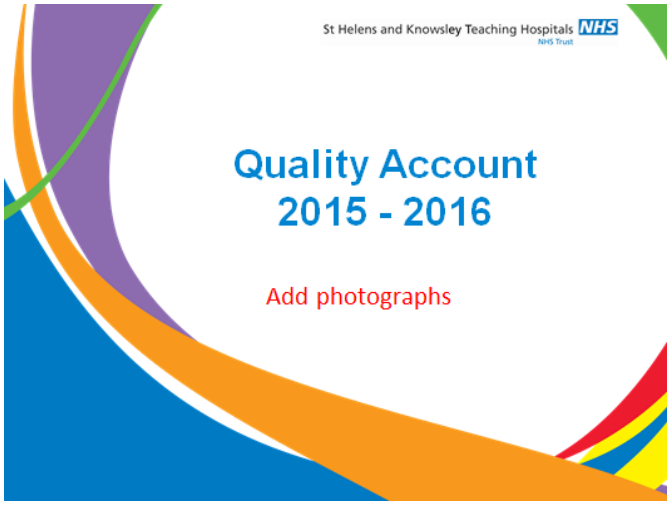
- Actions taken to meet the challenges within nursing recruitment (section 2.2)
- Delivering actions following the recommendations in the CQC report for meeting access targets in the Emergency Department and improvements in Maternity Services (section 2.4.5.1)
- Actions being taken to improve VTE risk assessment (section 2.4.10)
- Complaints management (section 3.6.2)
- Dementia care (section 3.1.2)
- Promoting health (section 3.5.2)
- Local employment opportunities (section 3.3)
- Safeguarding (section 3.4.5)

In addition, the summary of performance against last year's quality priorities was moved to earlier in the document, to section 2.2.
The final information will be inserted as soon as it has been received and the Quality

Account will be provided to the Communications Team for layout and design purposes. We remain on track to ensure that the final version is ready for upload to NHS Choices by the national deadline of 30th June 2016. The latest version is attached as Appendix 1.
Corporate objectives met or risks addressed: Care, safety, communication
Financial implications: There are no additional resource requirements arising directly from this report.
Stakeholders: Trust Board, patients, carers, staff, regulators, commissioners, Healthwatch
Recommendation(s): Members are asked to comment on the final draft version of the Quality Account. The Board is asked to delegate final approval of the remaining items for inclusion to the Chief Executive and Director of Nursing prior to publication.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 25th May, 2016

Draft Quality Account 2015 – 2016

Front cover - DN: Maintain previous year's design for the front cover



DN: Contents page to be reduced to main section headings only – left in draft for ease of navigation

Contents

1. Section 1

1.1. Summary of quality achievements in 2015-16

CQC comments

"Patient safety and positive experiences were key priorities for the Trust and underpinned all aspects of service planning and delivery."

"Care and treatment was delivered by caring, committed, and compassionate staff. Staff at all grades treated people with dignity and respect.

"Staff were open, friendly and helpful, many went out of their way to help and support patients"

"Treatment was delivered by skilled and committed staff."

"Staff were passionate about delivering high quality care and went above and beyond their usual duties to ensure children and young people experienced high quality care."

DN: Display as call out boxes?

Quality of services overall

- Caring rated as **outstanding** across the Trust, **the best rating possible**, by the Care Quality Commission (CQC)
- St Helens Hospital rated as **outstanding**
- Outpatients and Diagnostic Imaging Services rated as **outstanding overall**
- Trust rated as good overall
- Ward quality accreditation tool rolled out across all general inpatient areas, namely the Quality Care Assessment Tool (QCAT)

Patient safety

- No never events since May 2013
- Patients consistently received above 98% new harm-free care, that is harm that has occurred whilst an inpatient in the Trust in 2015-16 reported via the NHS Safety Thermometer - outperforming neighbouring Trusts in this safety measure
- 48% reduction in falls resulting in moderate or severe harm, following the implementation of the falls strategy action plan in October 2015
- Reduced the number of hospital acquired pressure ulcers compared to last year, with a 50% reduction in grade 3 and no grade 4 pressure ulcers
- Reduced the number of Clostridium difficile infections, performing better than the target
- No hospital acquired methicillin-resistant staphylococcus aureus (MRSA) bacteraemia since September 2014
- 96.8% fill rate for registered nurses/midwifes

Patient experience

- Best in the UK for patient experience and shortlisted again for the forthcoming awards by CHKS Top Hospitals
- Best acute NHS Trust in England for the second year running in the Patient Led Assessments of the Care Environment (PLACE)
- 96.4% of inpatients would recommend our services as recorded by the Friends and Family Test

Clinical effectiveness

- 3rd best performer in England in the Sentinel Stroke National Audit Programme following transformational changes to the service
- Electronic modified early warning score (eMEWS) system went live to electronically record patient observations ensuring more effective treatment for patients at risk of deterioration
- Cancer services seen as champions of the Electronic Holistic Needs Assessment (eHNA), for staff sharing best practice examples with other cancer hospitals nationally to improve individualised care plans for patients
- First Department of Anaesthesia in the North West and 8th nationally to be awarded accreditation status by the Royal College of Anaesthetists

Well-led

- Ranked in the top 100 places to work in the NHS in the Health Service Journal's independent assessment in 2014 and 2015
- Rated as the best acute Trust in the North West and the best non-Foundation Trust nationally in the latest staff survey
- Scored the highest score for any acute hospital nationally for the question, "Are you happy with the quality of care you are able to deliver?" in the staff survey

Summary of 2015-16 awards

DN: Display as call out boxes?

The following staff and teams were recognised by external bodies for their outstanding contributions in their own professional areas of work:

- Customer service excellence award for the Rheumatology Unit
- Midwife, Joanne Price, won the prestigious Johnson's Baby Mums' Midwife of the Year Award 2015 for the North England region, at the Royal College of Midwives (RCM) Annual Midwifery Awards
- Consultant, Tamara Kiernan, won the Liverpool and North West Surgical Society registrar prize for her work as Oncoplastic Fellow for Merseyside
- Gary Barker, Specialty Lead Nurse, Sexual Health, was named the Gilead Sciences HIV Nurse of the Year at the National HIV Nurses Association's 17th Annual Conference
- Jackie Burke, Healthcare Assistant, won the Michael McNally Mentor Award at the 12th Annual Cadet Award Ceremony
- Julie Sanderson, Bereavement Midwife, was named North West Nurse of the Year at this year's North West Pride Awards, after being nominated by a bereaved parent who believes "every hospital should have a Julie"
- Sexual Health team won first prize at the national Royal College of General Practitioners' conference for their poster presentation for services delivered to seldom heard communities, in partnership with the Addaction Service (drugs and alcohol service)
- Finalist in the category of Education and Training in Patient Safety, in the national Patient Safety Awards, following the work in theatres to introduce safer systems based on Human Factors training
- Maternity Bereavement Service shortlisted for the category of Best Hospital Bereavement Service Award at the Butterfly Awards
- Ward 3C (trauma & orthopaedics) received an award for being an outstanding clinical placement for nursing students from Liverpool John Moores University.

The Trust also celebrates success internally and hosted its 11th annual staff awards in July 2015 to celebrate the hard work and achievements of a number of staff and teams in providing excellent patient care. The annual awards and the employee of the month are important ways of recognising and rewarding the on-going dedication and commitment of staff throughout the year.

1.2. Statement on quality from the Chief Executive of the Trust

DN: CEO review/amend/approve

We are pleased to present the Trust's seventh annual Quality Account, which reviews our performance and achievements over the past year, as well as outlining our priorities for improving quality in the coming year.

Our mission is to provide high quality health services and an excellent patient experience. Our vision to provide 5-star patient care remains the Trust's primary objective so that patients and their carers receive services that are safe, patient-centred and responsive, achieving positive outcomes every time. This continues to be embedded in the everyday working practices of staff throughout the Trust and has been recognised by a number of external organisations.

The vision is underpinned by the Trust's values, five key action areas and the ACE behavioural standards of **a**ttitudes, **c**ommunication and the **e**xperiences we create. The vision and values are shown in the diagrams below:

St Helens and Knowsley Teaching Hospitals NHS Trust's Vision

St Helens and Knowsley Teaching Hospitals NHS Trust's Values

The Board, through its Quality Committee, oversees the delivery of the vision to achieve 5-star patient care by monitoring key performance indicators and by reviewing the delivery of the quality standards. One of the key ways of measuring the quality of services is through the regular inspections by the CQC, the independent regulator of health and adult social care services.

The CQC inspectors assess services against five key questions asking if services are:

- Safe
- Effective
- Caring
- Responsive to people's needs and
- Well-led

We are delighted to report that the Trust was rated as outstanding for caring, with St Helens Hospital and our outpatients and diagnostics services rated as outstanding by the CQC following their comprehensive inspection. These are great achievements and demonstrate that the Trust is performing exceptionally well. Overall, the Trust was rated as good and noted to be one of the best Trusts inspected so far.

The inspection took place during August and September 2015. A team of 52 inspectors, including doctors, senior nurses, pharmacists, trained lay members and CQC members visited the Trust, talked to patients, carers and staff and reviewed the services provided. The inspectors confirmed that patient safety and positive experiences were key priorities for the Trust and underpinned all aspects of service planning and delivery. In addition, they found that staff were fully engaged in the on-going development and implementation of the Trust's vision, values and behavioural standards.

The CQC reported that they saw several areas of outstanding practice including:

- The development of a pressure ulcer (PU) risk assessment tool used by the tissue viability nurses across the wards. This took into account the grade of the PU risk and a care plan was determined which included the equipment to be used for the patient
- A pathway and coordinated approach for patients with additional needs to reduce the need for repeat procedures and to enhance the patient's experience
- Staff were passionate about delivering high quality care and went above and beyond their usual duties to ensure children and young people experienced high quality care (Services for Children and Young People)
- Feedback from children, young people and parents about their care was exceptionally positive
- Excellent caring, respectful and compassionate interactions between staff, children, young people and their families, particularly in the outpatient clinics (Services for Children and Young People)
- Positive interactions when staff were seeking consent (Surgery)
- Improvements in the response times and access to timely treatment for a patient, by booking another follow-up appointment with the appropriate specialist if a critical or abnormal finding was detected on an X-ray by radiology staff

The CQC did highlight areas for improvement within the Trust's Emergency Department (ED) in the responsive domain, as the Trust was not meeting the four-hour access target or ambulance handover times, although, the Trust was amongst the best performing Trusts in the region. In Maternity Services some improvements were required in the safety, responsive and well-led domains. The CQC recognised

that action was being taken to address these. Further work is on-going to embed the improvements via a robust action plan, which is monitored internally and external to the Trust.

This year we have worked with our local Healthwatch organisations to improve accessibility and inclusivity of our services, particularly in respect of seldom heard groups within the community, shown in the progress achieved in meeting the agreed targets for the Equality Delivery System (EDS2) outcomes.

In addition, we have continued to work closely with patients and carers during the year to ensure that they are able to influence changes made to our services. The Trust hosts a number of patient focus groups and has patient representatives on several Trust councils and steering groups. Healthwatch representatives are key members of the Patient Experience and the Patient Safety Councils which report to the Board's Quality Committee, ensuring effective representation in the oversight and governance structure of the Trust.

Patients are able to present their experiences of the care received, in their own words, as a patient story at the start of our public Board meetings.

This Quality Account details the progress we have made with delivering the priorities agreed last year and our achievement of national and local performance indicators, highlighting any challenges and the initiatives undertaken to work towards realising our vision of 5-star patient care. It also includes progress in delivering the plans set out in our Clinical & Quality and Nursing & Midwifery Strategies. It outlines our quality improvement priorities for 2016-17, which were widely consulted on seeking the views of staff, patient representatives and our commissioners.

I am pleased to confirm that the Board of Directors has reviewed the Quality Account for 2015-16 and confirm that it is a true and fair reflection of our performance and that, to the best of my knowledge, the information contained within it is accurate. We hope that it provides you with the confidence that high quality patient care remains our overarching priority and that it clearly demonstrates the progress we have made.

We recognise that our staff are our greatest asset and we acknowledge their professionalism, commitment and dedication as they work tirelessly to provide excellent care for our patients and their carers. On behalf of the Trust Board I would like to thank all staff who have contributed to what has been another successful and challenging year.

Ann Marr
Chief Executive
St Helens and Knowsley Teaching Hospitals NHS Trust
May 2016

2. Section 2

2.1. About us

2.1.1. Our services

St Helens and Knowsley Teaching Hospitals NHS Trust is a medium-sized NHS Trust. It provides a range of acute and specialist healthcare services including inpatient, outpatient, maternity and emergency services. In addition, the Trust hosts the Mersey Regional Burns and Plastic Surgery Unit providing services for around four million people living in the North West of England, North Wales and the Isle of Man.

The Trust has just over 780 inpatient beds and provides the majority of its services from two main sites at Whiston and St Helens Hospitals, both of which are new state-of-the-art, purpose built modern facilities that are well-maintained. Whiston Hospital houses the Emergency Department, the maternity unit, children and young people's service and all acute care beds. St Helens Hospital houses day-case and elective surgery, outpatients, diagnostic facilities, as well as rehabilitation beds and the dedicated cancer unit. The Trust provides outpatient and diagnostic services in a small number of other settings.

The Trust Board is committed to continuing to deliver safe and high quality care. The Trust has had another successful year, despite the current financial challenges facing the NHS. There has been a significant increase in demand for its services, as the Trust continues to be one of the busiest acute hospital trusts in the North West of England. It has a good track record of providing high standards of care to its population of approximately 350,000 people across St Helens, Knowsley, Halton and South Liverpool, as well as further afield, which was recognised by the CQC.

The number of patients attending the Emergency Department (ED) has continued to increase along with elective referrals from General Practice, patients attending the outpatients department and those receiving treatment as a day case patient.

In the past year, the Trust saw:

- 65,782 inpatient admissions (an increase of 0.7%) (this is elective and non-elective admissions, excluding well babies)
- 3,902 births (an increase of 0.6% compared to the previous year's increase of 7.1%)
- 38,514 day-case patients (an increase of 10.8%)
- 103,940 ED attendances (an increase of 2.7%)
- 438,330 total outpatient attendances (an increase of 5.6%)

2.1.2. Our staff and resources

The Trust's annual total revenue income for 2015-16 was £313 million. We employ more than 4,000 members of staff and we are the lead employer for the Mersey Deanery, responsible for 2,000 trainee specialty doctors, based in hospitals and general practice (GP) placements throughout Merseyside and Cheshire. The average staff turnover rate in the Trust for 2015-16 was 9.34%, which is lower than the national rate of 9.46%. However, this overall rate masks variations between

disciplines and the significant recruitment challenges within specific specialties and for specific roles, in particular: medical, nursing and scientific staff. The Trust is proactive in addressing these challenges, holding regular recruitment events and using international recruitment to ensure vacancies are filled.

The Trust strives to meet the best standards of professional care whilst being sensitive and responsive to the needs of individual patients. Clinical services are organised within three care groups; surgery, medicine and clinical support, working together to provide integrated care. A range of corporate support services including human resources (HR), education and training, informatics, research and development, finance, governance, facilities, estates and hotel services, all contribute to the efficient and effective running of the two hospitals.

2.1.3. Our communities

The local population is generally less healthy than the rest of England, with a higher proportion of people suffering from a long-term illness. Many areas suffer high levels of deprivation. This has contributed to significant health inequalities among residents, leading to poorer health and a greater demand for health and social care services. Rates of obesity, smoking, cancer and heart disease, related to poor general health and nutrition, are significantly higher than the national average.

2.1.4. Our partners

We are continuing to work with stakeholders across the health economy to secure sustainable health care services for our local population. The Trust is working with its commissioners and provider partners to develop a five year Sustainability and Transformation Plan (STP) in accordance with the NHS national planning guidance. This plan will be submitted in June 2016.

The Commissioners within the Liverpool City Region have formed a collaborative partnership and a Committee in Common to support decision-making. The Liverpool City Region is, therefore, the overarching STP footprint, but within this there will be more localised plans covering four Local Delivery Systems.

Mersey health and social care economy are broadly aligned, in that all partner organisations aspire to reduce urgent care demand and provide more services outside of hospitals. The Trust is working with partners within the economy to develop long term transformation programmes to deliver this aspiration, whilst at the same time securing sustainable and viable services. One of the key areas for attention is consolidating and integrating services, in particular care pathways for frail elderly patients across primary, secondary and social care, which are designed to reduce Emergency Department (ED) attendances and non-elective hospital admissions.

The Trust is part of the Cheshire and Merseyside Paediatrics, Neonatal and Maternity Services Vanguard programme which is exploring new ways of working across the wider health economy. This will enable the sharing of best practice and resources, as well as leading to a reduction in the variation in outcomes between

different units. This is an exciting new way of working to support the delivery of the NHS Five Year Forward View to achieve both clinical and financial long term sustainability for services. It is based on collaboration and integration of service models across traditional boundaries, where this will help to promote higher quality care.

The Trust actively participates in the mid-Mersey patient safety and healthcare associated infection collaboratives. This includes working in partnership with primary care, local authority and commissioners to ensure the services we provide meet the needs of our local population and to share lessons learned as widely as possible.

2.1.5. Technology and information

This year the Trust has continued to deliver a portfolio of technological advancements to enhance patient safety and care.

Working closely with teams of clinicians and nurses across the Trust, the Informatics Department have deployed an electronic modified early warning score (eMEWS) system. This system has replaced paper charts that required manual calculations of patients' observations with an automatic system, using iPads instead of paper. The system is faster and safer for patients with an automatic referral of a patient in the event of deterioration in their condition. It has already delivered significant time-saving benefits for clinical users of the system. This time can be re-invested back into patient care.

The Informatics Department have also developed the eHandover application, to ensure the medical on-call referral process for patients admitted to the trust via emergency department (ED) is efficient, safe and transparent. Working closely with a team in the ED to develop the application, eHandover has replaced the manual process and is already proving to be an extremely useful tool for all teams involved in this handover process, improving the efficiency of the medical on-call referral process and minimising bleeps from ED to medical specialist-trainees and registrars.

Informatics have also upgraded a number of existing Trust systems, including:-

- Critical Care information system – to give better resilience of the system
- Mortuary system – allowing the Trust to exchange information with Warrington Hospital
- Trust-wide pager system - to enable more advanced monitoring and higher availability

Trust systems and applications can only function effectively if the underlying infrastructure is secure, available and resilient. During 2015-16, the Informatics Department have also made significant improvements to the infrastructure that ensures staff and patients can access the right systems and information at the time they need it. We have:

- Replaced the Storage Area Network (SAN) – enabling increased performance and capacity and higher availability of systems and data

- Commenced a project to deploy a new version of internet explorer web browser across the Trust – this is required for future projects in plan
- Deployed Patient Wi-Fi – across a number of patient locations at St Helens Hospital
- Developed the new Trust website – in collaboration with the Trust Communications Team, resulting in a more user friendly and up to date public website

2.2. Summary of how we did against our 2015-16 Quality Account priorities

Every year the Trust identifies its priorities for delivering high quality care to patients, which are set out in the Quality Account. The section below provides a review of how well the Trust did in achieving the targets set last year.

2015-16 Progress in achieving quality goals

Quality Improvement Goal	Outcome delivered	Progress
Priority 1: Reduce avoidable harm by 50% in the next 3 years (falls, pressure ulcers, medication incidents)	On track	• 2015-16 figures demonstrate a 50% reduction in grade 3 & and no grade 4 pressure ulcers and a 16% reduction in grade 2 pressure ulcers. Grade 1 pressure ulcers have remained the same. Overall there has been a 15% reduction in all pressure ulcers. • The year one target for reducing prescribing errors was to increase the reporting of prescribing errors by 50%. This target was achieved in January 2016. It is essential to fully understand the causes of prescribing errors and the plan for this year is to optimise all potential reduction strategies. These are included in the medicines optimisation plan, which is reported through the Medicines Safety Group. This work will be further supported by the introduction of a Trust wide e-prescribing system in 2016 and the presence of ward-based pharmacy staff. The data demonstrates a 30% reduction in harm related to prescribing errors in 15-16 compared to 14-15. • The early recognition and response to deteriorating patients is progressing well, with the introduction of an electronic vital signs recording and escalation system. The system began roll out in December 2015 and it is anticipated it will be operating across all Trust areas by summer 2016. • The Trust had maintained its impressive record of zero never events since May 2013. Annually the NHS reports over 300 never events nationally which highlights this as a significant achievement by the Trust for over almost three years. • The Trust continues to pilot new and innovative ways of reducing harm from inpatient falls. The Trust's new falls prevention strategy and associated actions have seen a significant decrease in harm from falls since its implementation in

Quality Improvement Goal	Outcome delivered	Progress
		October 2015. A 13% decrease in the overall harm from falls and a 48% decrease in falls resulting in moderate harm or above has been demonstrated from October 2015 to March 2016, compared to the first half of the financial year. • The Trust is currently piloting safety briefings as part of ward handovers between staff. The final safety huddle tool will be rolled out Trust wide in Spring 2016, following a period of refinement.
Priority 2: To further embed the process for learning from incidents and complaints	Partially achieved	• Evidence of learning from complaints is provided via reports to the Board, the Quality Committee and the Patient Experience Council. • Improvements have been made to the electronic system, Datix, in order to better capture the actions taken, lessons learned and outcomes of complaints investigations. The Central Complaints Team have developed a short course for staff to use the investigations section and the actions module, which will be rolled-out across all Care Groups from April 2016. • 10% increase in incident reporting & key lessons cascaded through Patient Safety Newsletter, team meetings, safety huddles • There is a continued focus on increasing the quality of investigations to ensure that the key factors causing incidents are identified and then the relevant action plans delivered to mitigate the future risk of same types of harm. This includes involving patients and families in the investigation process to ensure that all available information pertaining to the episode of harm is captured and all causation factors full understood and mitigated against. Additional focus will be placed on the timeliness of completing investigation reports during 2016-17 to ensure that these are undertaken within the required deadlines.
Priority 3: Ensure safer staffing levels are achieved	Achieving	• Monthly safer staffing reports are provided to the Board and Quality Committee, which note high levels of compliance in the majority of areas. On-going recruitment days are in place for areas with lower staffing levels due to vacancies. In addition, staff from other wards are reallocated to ensure safe staffing across the hospital. This is proactively managed through the Trust's risk management processes.

Quality Improvement Goal	Outcome delivered	Progress
		• Staffing levels are reviewed throughout the day with daily safer staffing huddles undertaken by the Matrons. • More detailed reports are provided twice yearly and include the use of the Shelford tool to assess staffing requirements in response to changing patient dependency and acuity which are reported to the Board. • In recognition of the challenges to maintain safe staffing levels, including the national shortage of registered nurses and other specialist roles, the Trust has undertaken international recruitment to increase the overall number of clinical staff within the Trust. • The Trust proactively manages the use of temporary staff including agency staff, mindful of the requirement to remain within the national spending restrictions.
Priority 1: Further reduce mortality of weekend admissions.	Off trajectory	Progress in reducing mortality in people admitted at weekends has fallen short of plan and intensive focus will be given to this area in 2016-17.
Priority 2: Reduce variations in care to improve outcomes	Achieving	The Trust has received assurance from internal work and externally from the CQC and internal audit that its systems and processes for incorporating evidence-based clinical care based on national guidance is effective
Priority 3: Improve pathways of care for people with long term conditions including frailty	Partially achieved	Good progress has been made in improving integration between specialist community and primary care delivered for people with long-term conditions. The Trust, together with other speciality and community providers and all the local CCGs, has signed up to increased vertical and horizontal integration as part of the local delivery system and the sustainability transformation plan.
Priority 1: To improve the timeliness of complaint responses.	Partially achieved	61.5% Stage 1 complaints received in 2015-16 and resolved within agreed timescales compared to 35.5% in 2014-15
Priority 2: Enhance the discharge planning process	Partially achieved	Discharge processes continue to be the focus of the Trust's rapid improvement work. Improvements have been made to the electronic discharge planning report, which is accessed by the multidisciplinary team to ensure timely effective discharges. It is also a tool to highlight the needs of the patient to reduce any delays

Quality Improvement Goal	Outcome delivered	Progress
		in discharge planning and identify social care needs. Work is continuing with the Medical Directors to ensure that all patients have a documented workable estimated date of discharge. This along with an agreed Standard Operation Procedure is being embedded in all ward areas with all grades of staff. Weekly length of stay meetings with a representative from the Local Authority and the CCG discuss any patients with a stay of more than 14 days. Ward-based Discharge Coordinators expedite any delays and they ensure effective discharge planning in a timely manner with a plan of care in place that will prevent re-admission. The Integrated Discharge Team, which includes social services, ensure that through holistic working the patients' needs are identified and met prior to discharge. Closer liaison with community teams is undertaken for patients with complex needs. There is an on-going project to encourage the ward staff to utilize the ward based pharmacy teams, which should improve the timing of discharge medication being processed through the dispensary.

2.3. Quality priorities for improvement for 2016-17

The Trust's quality priorities for 2016-17 are listed below with the reasons why they are important areas for quality improvement. The views of a wide number of stakeholders and staff were considered prior to the Board's approval of the final list. The consultation included a survey that was circulated to staff, commissioners and patient representatives, as well as placed on the Trust's website for public participation. Also, Healthwatch members of the Trust's councils and our commissioners were asked for their views on what should be included in the list of priorities.

1. Reduce avoidable harm from falls, pressure ulcers and medication incidents by 50% in the next 3 years

Rationale:

Patient safety remains a key priority for the Trust.
2016-17 will be the second year of the Trust's commitment to the three year Sign up to Safety Campaign and the Trust remains focussed on continuing to reduce avoidable harm to patients, with the aim to 'get it right for every patient, every time'.

The key measures will be:

- Reducing the number of falls which result in moderate to severe harm by 50% from 2013-14 baseline data
- Maintaining a 50% reduction in theatre-related episodes of avoidable harm (measured against 2012-13 Human Factors service redesign data)
- Reducing the incidence of Clostridium difficile and avoidable MRSA infections
- Having zero tolerance to hospital acquired grade 4 pressure ulcers and continue to seek to further reduce harm from pressure ulcers at all grades by 5% in year
- Reducing the incident of prescribing errors by 50% from 2013-14 baseline data
- Improving the recognition and treatment of the deteriorating patient through technology and education
- Introducing patient safety briefings at ward level

This will be monitored by the Patient Safety Council and reported to the Quality Committee.

2. To further embed the process for learning from incidents and complaints

Rationale:

Patients sometimes experience unintended physical or emotional harm, despite the hard work of healthcare staff. The Trust remains committed to reducing harm by strengthening Trust-wide and local learning from incidents and complaints and is proposing to keep this as a priority for the next year.

This will be measured by:

- Demonstrate a learning safety culture through increased reporting of incidents by 30%
- Improve on the timeliness of investigating and reporting serious incidents
- Be in the top 20% nationally for reporting incidents within the reporting cohort in the national reporting and learning system (NLRS)

- Improve timeliness of responding to complaints to meet the Trust target of 90% of complaints responded to within the agreed timescale
- Implement a lessons learnt framework Trust-wide to increase the sharing of lessons learnt from incidents, complaints and claims

This will be monitored by both the Patient Safety and Patient Experience Councils and reported to the Quality Committee.

3. Further reduce mortality of weekend admissions

Rationale:

In line with other trusts nationally, St Helens and Knowsley Teaching Hospitals NHS Trust continues to experience higher than expected numbers of deaths for patients admitted at the weekend and continues to strive towards reducing differences in care across the days of the week.

This will be measured through hospital standardised mortality ratio (HSMR) data from Dr Foster. Our first action to address this issue is to undertake detailed analysis of the data to help identify the issues and to support the establishment of targets for improvement going forward and help to determine a trajectory and timeframe for achievement.

This will be monitored by the Clinical Effectiveness Council and reported to the Quality Committee.

4. Earlier identification and initiation of appropriate treatment thus reducing mortality due to sepsis for patients attending St Helens and Knowsley Teaching Hospitals NHS Trust

Rationale:

Sepsis is a common condition associated with infection which, if not identified and managed early, can lead to serious complications and death. Sepsis Trust quotes that annually 37,000 patients die as a consequence of sepsis in UK alone. Sepsis is one of the leading causes of death across all acute trusts in the country and at St Helens and Knowsley Teaching Hospitals NHS Trust we are also faced with a similar challenge. We admit between 15-30 patients every day with sepsis. The Trust is determined to improve the management of sepsis and to reduce the number of avoidable deaths due to sepsis.

This will be measured by:

- Increase screening from 30% of patients to 60% in next 12 months for all acute admissions including paediatrics
- Increase antibiotic administration within first hour of presentation from 30% to 60% in next 12 months
- Reduce length of stay by one day in next 12 months

This will be monitored by the Clinical Effectiveness Council and reported to the Quality Committee.

5. To deliver 5-star care to patients admitted to hospital with an Acute Kidney Injury

Rationale:
Acute Kidney Injury (AKI) is a sudden reduction in kidney function. In England, over half a million people sustain AKI every year with AKI affecting 5-15% of all hospital admissions. It is responsible for 40,000 excess deaths every year. Patients with AKI are also subject to longer, more complex hospital stays with the annual cost of AKI in England at more than £1billion.

This will be measured by:

- Delivery of a 4.7 day length of stay reduction for 25% of hospital-acquired AKI population within two years using 2014-15 as a baseline
- Delivery of the local Commissioning for Quality and Innovation (CQuIN) target for effective discharge communication for patients with AKI

This will be monitored by the Clinical Effectiveness Council and reported to the Quality Committee.

6. **Increase the percentage of e-discharge summaries sent within 24 hours to 90%**

Rationale:
In order to communicate the on-going treatment plan when patients are discharged it is essential to share the relevant information in a timely and efficient manner, particularly for patients with complex needs. This will ensure that patients' on-going clinical care is provided effectively and will reduce the potential for readmission into hospital.

This will be monitored by the Clinical Effectiveness Council and reported to the Quality Committee.

In addition to the above agreed quality priorities, the Trust will continue to work on areas for improvement, as outlined in other sections of the quality account, including emergency care access, maternity services, complaints and serious investigation report response times and venous-thromboembolism risk assessments.

2.4. Statements relating to the quality of the NHS services provided by the Trust in 2015-16

The following statements are required by the regulations and they will enable comparisons to be made between organisations, as well as providing assurance that the Board has considered a broad range of drivers for quality improvement.

2.4.1. Review of services

During 2015-16 the St Helens and Knowsley Teaching Hospitals NHS Trust provided and/or sub-contracted £261m NHS services.

The St Helens and Knowsley Teaching Hospitals NHS Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2015-16 represents 100 per cent of the total income generated from the provision of NHS services by the St Helens and Knowsley Teaching Hospitals NHS Trust for 2015-16.

2.4.2. Participation in clinical audit

During 2015-16, 43 national clinical audits and 2 national confidential enquiries covered NHS services that St Helens and Knowsley Teaching Hospitals NHS Trust provides.
Please note: some audits are listed with one heading, however several individual audits have been undertaken under each heading, as noted below:

- **National Confidential Enquiry into Patient Outcome and Death (NCEPOD)** - 4 individual audits
- **Blood Transfusion Programme** – 3 individual audits (participated in 2 audits)
- **Falls And Fragility Fractures Programme (FFFAP)** – 2 individual audits

During that period St Helens and Knowsley Teaching Hospitals NHS Trust participated in 97% (28/29) national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that St Helens and Knowsley Teaching Hospitals NHS Trust participated in, and for which data collection was completed during 2015-16, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

2.4.2.1. Quality account audits/ascertainment rate

National Audits 2015-16	Participation	Status	Rate Of Case Ascertainment
Diabetes (Paediatric) (Paediatric National Diabetes Audit (PNDA))	Yes	Completed	100%
Procedural Sedation In Adults (Care In ED) (College of Emergency Medicine (CEM))	Yes	Completed	100%
Vital Signs In Children (Care in ED) (CEM)	Yes	Completed	300%
VTE Risk in Lower Limb (Care in ED) (CEM)	Yes	Completed	125%
Inflammatory Bowel Disease 4th Round UK	Yes	Completed	100% For Main Audit 100% Biologics Audit
BRS Rheumatoid and Early Inflammatory Arthritis	Yes	Completed	All Data Submitted for 2015
Parkinson's UK	Yes	Completed	100%

National Audits 2015-16	Participation	Status	Rate Of Case Ascertainment
Emergency Use in Oxygen BTS	Yes	Completed	100%
Paediatric Asthma British Thoracic Society (BTS)	Yes	Completed	100%
National Emergency Laparotomy Audit (NELA)	Yes	Active	-
Diabetes (Adult) (National Diabetes Audit (Adult) (NDA (A))	Yes	Completed	13-14 Data 47% 14-15 Data 67%
National Comparative Audit of Blood Transfusion Programme (X3)			
• Blood Transfusion in Scheduled Surgery Audit • Audit of Red Cell • Lower GI Bleed Audit: Use of Blood	Yes	Completed Completed Did not participate	100% 100%
National Prostate Cancer Audit (NPCA)	Yes	Active	-
National Ophthalmology Audit	Yes	Active	-
Bowel Cancer (National Bowel Cancer Audit Programme (NBOCAP))	Yes	Continuous Monitoring	Awaiting figures from national centre
Oesophago-Gastric Cancer (National Audit Oesophago-Gastric Cancer (NAOGC))	Yes	Continuous Monitoring	Awaiting figures from national centre
Lung Cancer (National Lung Cancer Audit (NLCA))	Yes	Continuous Monitoring	Awaiting figures from national centre
Adult Critical Care (Case Mix Programme) (Intensive Care National Audit & Research Centre (ICNARC))	Yes	Continuous Monitoring	100%
Severe Trauma (Trauma Audit & Research Network (TARN))	Yes	Continuous Monitoring	100%
Acute Coronary Syndrome or Acute Myocardial Infarction (Myocardial Ischaemia National Audit Project (MINAP))	Yes	Continuous Monitoring	100%
National Cardiac Arrest Audit (NCAA)	Yes	Continuous Monitoring	100%
National Heart Failure (HF)	Yes	Continuous Monitoring	2013-14 94% (Awaiting 2014-15 national figures)
Sentinel Stroke National Audit Programme	Yes	Continuous Monitoring	100%

National Audits 2015-16	Participation	Status	Rate Of Case Ascertainment
Falls And Fragility Fractures Programme (FFFAP) • Includes National Hip Fracture Database	Yes	Continuous Monitoring	91.6%
• Fracture Liaison Service Database (FLS-DB) Facilities Audit	Yes	Completed	Took part In organisational audit and not eligible for main audit
National Joint Registry (NJR)	Yes	Continuous Monitoring	98.4%
Neonatal Intensive and Special Care (National Neonatal Audit Programme (NNAP))	Yes	Continuous Monitoring	Jan – Dec 15 100%
Elective Surgery (National patient-reported outcomes measures (PROMS) Programme)	Yes	Continuous Monitoring	April 15 – Feb 16 79.6% (Provisional)
Cystic Fibrosis Registry	Yes	Continuous Monitoring	100%
National Complicated Diverticulitis (CAD)	No	Did Not Participate	

National Confidential Enquiries			
2015-16	**Participation**	**Status**	**Rate Of Case Ascertainment**
Gastro-Intestinal Haemorrhage	Yes	Completed	100%
Sepsis	Yes	Completed	100%
Acute Pancreatitis	Yes	Completed	100%
Mental Care Health in Acute Hospitals	Yes	Completed	100%
Confidential Enquiries across the UK (MBRRACE-UK)) Maternal, Infant and Newborn - Clinical Outcome Review Programme (Mothers and Babies - Reducing Risk through Audits	Yes	Continuous Monitoring	100%

*The Diabetes National audit relies on direct data capture from electronic systems but St Helens and Knowsley Teaching Hospitals NHS Trust systems are currently paper based and therefore we have to submit a labour-intensive sample audit.

2.4.2.2. Trust participation in other national audits

Audit Title	Participation	Data collection completed

Audit Title	Participation	Data collection completed
National End of Life Care	Yes	Completed
Society For Acute Medicine Benchmarking Audit (SAMBA)	Yes	Completed
Audit Of Enhanced Recovery Programmes in Lower Limb Joint Replacement	Yes	Completed
1st National Audit Of Inpatient Falls 2015	Yes	Completed
Bliss Baby Charter Audit Tool	Yes	Completed
National Diabetes Foot Care Audit (NDFA)	Yes	Completed
National Audit Of Dementia: Pilot Project Of Feasibility For Community Hospital	Yes	Completed
Mastectomy Decisions Audit: A Multi-Centre, Population Based Audit	Yes	Active
National Audit Of Dementia	Yes	Active
Recording The Impact of Acute Kidney Injury Following Major Gastro-intestinal Surgery (STARSURG)	Yes	Active
Implant Breast Reconstruction Audit (IBRA)	Yes	Active
National 3rd Corrective Jaw Treatment Audit	Yes	Active
Head and Neck Oncology	Yes	continuous monitoring
RACPC Audit Programme	Yes	continuous monitoring

The reports of 30 national clinical audits were reviewed by the provider in 2015-16 and St Helens and Knowsley Teaching Hospitals NHS Trust has taken and intends to take the following actions to improve the quality of healthcare provided:

Inpatient Falls Audit
Following recommendations from this audit an extensive action plan has been produced which includes the implementation of a revised Falls Prevention Strategy; a Strategic Falls Group has been formed to oversee the implementation of this strategy and to performance manage the associated actions contained in the action plan.

End of Life Care Audit
The results of the audit report will be discussed at the EOLC Steering Group and a formal action plan will subsequently be produced.

Parkinson's UK Audit
The Trust will review the advanced care planning pack, give advice regarding financial benefits available for patients, review the Parkinson's clinic assessment questionnaires and establish the support available from Speech & Language Therapy Team (SALT).

National Dementia Audit: Following first and second audit

The pathway for patients with suspected dementia forms part of the Dementia Commissioning for Quality and Innovation (CQuIN) target and, therefore, this standard is monitored and reported to the commissioners. The Trust's Datix system is now set up to allow for identification of patients with cognitive impairment. In addition, the Trust is developing the frailty service, which includes patients with dementia. A Frailty Unit was established in November 2014 and the frailty nurses now see patients in the Emergency Department (ED) and the Medical Assessment Unit (MAU).

A prompt for mental health diagnosis is included in the discharge summaries for the Frailty Unit and Intermediate Care Unit and the frailty discharge summary will be implemented across the Older People's wards over the next 12 months.
Carer Support workers proactively identify carers of inpatients in Whiston and St Helens hospitals. The Carer Policy ensures there are clear guidelines regarding involvement of carers and information sharing.

Therapy assessments are available on request for all patients and referrals can be made for geriatric and psychiatric assessment. The assessment of nutritional status includes recording of weight. In an effort to improve social interaction at meal times and during the day, some wards encourage patients to eat their lunch at a table with other patients in their bay. The volunteer project on 3alpha improves social interaction for patients who have had a hip fracture.

The Trust has a delirium prevention care plan in place.

All the Older People's wards on the 5th floor of Whiston hospital have been adapted and are dementia-friendly. Dementia-friendly cubicles have been established within the ED. A capital bid has been submitted for dementia-friendly adaptations to the Frailty Unit.

Dementia awareness training is mandatory in the Trust and Mental Capacity Act training is soon to be mandatory. The Trust is meeting all the training levels required by the Dementia CQuIN.

UK Inflammatory Bowel Disease Audit (IBD) - 4th Round
Appointment of 2 new IBD Nurse Specialists since round 4 of IBD audit, all inpatients are being reviewed by IBD nurse specialists. Parenteral iron therapy offered for patients with iron deficiency anaemia who are intolerant or nonresponsive to oral iron. Endoscopy treatment unit receives all referrals for the same and is able to action, as per patient choice.

Initial Management of the Fitting Child Audit (CEM)
Epilepsy advice leaflets reviewed and sourced, which are now available in Paediatrics & ED and given out on discharge.

Sepsis Audit (CEM)
Sepsis Pathway has been implemented, Stretcher Triage and Triage Nurse Training has been completed.

Paracetamol Overdose Audit (CEM)

Following the audit 2 new pro forma have been introduced; for use in initial assessment by nursing staff and Medical staff. Teaching sessions have been completed.

National Audit of Seizure Management in Hospitals (NASH2) - Emergency Department
New epilepsy referral pathway should improve follow-up for all patients presenting with seizures.

National Paediatric Diabetes Audit (NPDA) 2012-2013
Issues around child and adolescent mental health services (CAMHS) identified and a Clinical Psychologist is now employed and in place. Data capture has been improved and International Classification of Diseases (ICD) codes are now within the system, with patients identified and the data updated. Monthly validation is undertaken to ensure data accuracy prior to submission. The Trust participates in this National Audit annually.

Trauma Audit Research Network (TARN)
There has been an increase in our data quality and submission efficiency rates as a result of new systems. The use of the Trauma Team has increased again since 2015 with 30 Trauma Team activations for the first quarter of 2016, compared to 19 in the same time period in 2015. Whiston was again re-accredited as a trauma receiving unit in 2015 and will undergo further re accreditation in 2016.

TARN data shows a reduction in the time from arrival to CT scan time for major trauma patients who require an urgent CT, under NICE Head Injury Guidance. TARN data shows that >50% of trauma teams are being led by a senior doctor and that in the majority of cases a full trauma team responds to every trauma call alert. TARN data shows that patients requiring blood products or tranexamic acid after trauma are being managed appropriately and according to clinical guidance. Any cases suggested by TARN for review are reviewed locally by a clinical team. Any trauma deaths go through the Cheshire & Mersey Major Trauma Network clinical governance mortality review process and lessons learnt are fed back locally.

Confidential Enquiries

Confidential Enquiry into Maternal Deaths - MBRRACE – UK, December 2014
The guideline for the Management of Maternal Collapse in Pregnancy and Puerperium (including amniotic fluid embolism and uterine rupture) has been updated with the recommendations from MBRRACE-UK. Presentations have been updated to reflect recommendations for the Multidisciplinary Obstetric Drills, Skills, and Simulation (MODSS) Emergency Study Day.

NCEPOD (National Confidential Enquiry into Patient Outcome and Death)/ Child Heath Programme
The Trust has participated in all eligible studies during 2015-16. Completed study reports have been disseminated and reviewed with report recommendations implemented or planned.

NCEPOD Sepsis study

Examples of implemented actions include a designated Consultant lead for Sepsis and the implementation of a sepsis pathway and screening tool. Sepsis Nurses providing a sepsis team approach are helping to ensure that appropriate treatment is administered within one hour of presentation of severe sepsis. This is monitored via CQuIN measures.

NCEPOD Subarachnoid Haemorrhage (SAH) study
A protocol for suspected SAH has been designed with planned implementation during 2016. A local audit on confirmed SAH has been undertaken, the results of which will be disseminated at the next Trust protected time audit session (May 16).

Reports to be published later in 2016:
- Acute Pancreatitis study
- Care of Patients with Mental Health Problems

Current NCEPOD/Child Health studies due for completion in 2017:
- Non-Invasive ventilation
- Young Persons Mental Health Study
- Chronic-Neurodisability (Cerebral Palsy)

The reports of 148 local clinical audits were reviewed by the provider in 2015-16 and St Helens and Knowsley Teaching Hospitals NHS Trust has taken and intends to take the following actions to improve the quality of healthcare provided

Annual Audit Care of the Dying Patient
The Individualised Care and Communication Record was rolled out Trust-wide. The audit findings demonstrate a dramatic increase in compliance with end of life care standards and documentation when this record was in use.

Audit of the Paediatrics Epilepsy Services
A new pro forma has been implemented, which includes confirmation of what information has been given to families. An evidence-based web site: www.epilepsy.org.uk is used to signpost parents to information about epilepsy and all information given out in clinic is from this web site. Parents also receive information in clinic on how to contact the epilepsy team.

Audit of the Neonatal Admission Proforma
A new neonatal admission pro forma is currently in use.

Quality & Safety of Percutaneous Endoscopic Gastrostomy (PEG) Tube Insertion
Guidelines have been reviewed and are available on the intranet.

Diabetic Ketoacidosis Audit
An electronic form has been devised (which incorporates a plan of care) and will be added to the discharge paperwork following training. Every patient admitted with a primary diagnosis of diabetes will have this, which will be shared with everyone involved in their care, including community staff.

Assessment & Management of Delirium in Medical Inpatients
The Frailty Discharge has been implemented on all the Older People wards; the discharge summary template has been amended to prompt users to check if delirium has resolved.

Audit on Reporting Cervical Cancer
The audit found good compliance with completing the relevant dataset. An electronic system to report cervical loop specimens has been implemented.

Audit of Diagnosis and Management of Bacterial Meningitis & Meningococcal Septicaemia in Adults
The Trust policy has been reviewed and implemented.

Trust Antibiotic Audit of Performance
Audit information is incorporated into Trust inductions. The online antibiotics policy and the Mersey Micro app have been updated as per the review and a re-launch of the antibiotic guideline has taken place.

Decompensated Chronic Liver Disease
Decompensated chronic liver disease care bundle has been launched. Training of nurses to do ascitic tap and delivery of education/awareness of care bundle has been completed.

Clexane in Lower Limb Plaster of Paris
ED pathway for lower limb plaster of paris has been implemented.

Re-Audit of DC Cardioversion for AF/ Flutter
The referral form has been updated and implemented in order to streamline the referral process for Cardioversion.

Management of Ectopic Pregnancies
A discharge checklist has been created to ensure that the patient has appropriate follow up in place. Continued counselling on the various management options is offered.

Induction of Labour 2014
The guideline has been updated**.** Alternative management for women who have failed induction of labour following a 4th Prostin is being discussed.

Audit of Vulval Cancer: for existing Vulval Disorders
The Vulval Clinic is successfully managing vulval disorders in accordance with guidelines.

Primary Total Hip Replacement-Transfusion Rates/Length of Stay
An orthopaedic pathway is underway. Tranexamic acid is now used routinely, as per the guideline and at the discretion of the team performing the anaesthetic/surgery.

Audit reviewing the offer of HIV Testing: In an Integrated Sexual Health Service

Introduction of either oral swabs or dry blood spot testing to increase the uptake of HIV has been implemented. Kits have been purchased and are currently used in clinics for patients who are needle-phobic. Leaflets have been disseminated and groups held for young people to better understand HIV and its transmission, in order to raise awareness among young people to get HIV tested, as well as displaying posters in clinic waiting rooms.

Audit of Compliance against the Clinical Audit Policy
Continuous monitoring of actions to be taken following audit is required, with progress reported in the quarterly audit reports, which are provided to the Clinical Effectiveness Council

Consent Audit Programme
Changes to the consent audit programme were undertaken during 2015-16 as a result of new guidance and the Trust's revised Consent Policy, with 2 audits undertaken by the individual specialties during the audit year. The initial audits have been undertaken with a timelier re-audit to follow, to ensure that areas of poor practice were highlighted and actioned quickly in order to maintain high standards across the Trust. All results have been disseminated and discussed and some individual specialities have delivered further training in this area.

Record Keeping Audit Programme
The Trust-wide record keeping programme continues to be undertaken annually. Improvements have been demonstrated with a large number of record keeping standards being consistently met in all specialties. The Trust record keeping policy has been reviewed and amended and changes to the generic audit tool have been made to streamline the content and to make the tool more user friendly, with implementation planned from April 2016.

Identification & Management of Acute Kidney Injury (AKI)
Planned actions include continued encouragement in the use of AKI bundle, with links to bundle tool available via the hospital intranet. Additional actions will be to review the possibility of including AKI investigation & management fields on general Acute Medical Unit (AMU) documentation. Further teaching is planned as earlier identification and timely interventions for AKI significantly reduce the risk of complications and morbidity/mortality.

HIV Testing in the Acute Medical Unit
Following the initial audit, posters showing HIV test indicator conditions were put up around AMU. Raising awareness of indicators for HIV testing teaching sessions are also planned for junior doctors.

Diagnosis & Stratification of patients with Myelodysplastic Syndromes (MDS)
Planned actions are for the inclusion of a 'Diagnosis Summary Box' located at the start of every clinic letter and to produce a specific MDS pro forma.

Audit of the Rheumatology Nurse Advice Line
All helplines have now been merged on to one number only and patients have been informed of the changes.

MRSA suppression therapy audit
Planned actions include the implementation of a daily ward audit on MRSA prescriptions. 'Decolonisation therapy' education sessions are planned for 2016.

Sepsis in Pneumonia
Sepsis specialist nurses have now been recruited and are in post. The use of B U F A L O scoring system in patients with pneumonia is encouraged.

Adequacy of Clinical Information on X-Ray Requests from the ED
A new pro forma is to be developed.

Annual Audit of Compliance with Good Clinical Practice Regulations and the Research Governance Framework
Auditing of essential standing operating procedures has been added to the annual audit plan for 2016-17.

Early Morning Medical Emergency Team Calls to High Volume Areas
Audit findings have been disseminated to senior nursing and medical forums. Implementation of electronic track and trigger has been completed. Escalation issues are highlighted for high volume areas and local systems have been put in place to address this.

Supracondylar Fractures of the Humerus in Children
An upper nerve assessment sheet is in final revision before distribution. Recommendation of 2.0 mm k wire is in use and due to be re-audited in 2016 to assess compliance.

Outcomes of DIEP Breast Reconstruction in Patients More Than 60 Years Old
Trainees to be instructed to update the DIEP database regularly following each case.

Re-audit Patient Identification/Alert Wrist Bands
A daily wrist band check is undertaken on each patient in every applicable clinical area in the Trust as part of a daily continuously monitored audit. The quality of the current identification bands has also been reviewed.

2.4.3. Participation in clinical research

Clinical research is a vital part of the work of the NHS, helping improve treatments for patients now and in the future. Indeed, there is a strong link between research and improved patient outcomes.

The Trust's Research Development and Innovation (RDI) Strategy resonates with the Board objectives, vision, values and goals and ensures that we have robust systems to facilitate high quality research. We are committed to ensuring that our patients are given the opportunity to participate in safe research.

During 2015-2016 STHK was involved in 151 studies of which 132 were supported by the National Institute for Health Research (NIHR). We have supported 19 Non-NIHR studies.

The number of patients receiving NHS services provided or sub-contracted by St Helens and Knowsley Teaching Hospitals NHS Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 535.

The total recruitment (N767) was made up of:

- 535 patients recruited to NIHR adopted studies, all of which were approved by a research ethics committee.
- 232 participants recruited to non-NIHR adopted studies i.e. local and student. Of these, 57 were patients and 175 were staff members.

The Trust has successfully recruited 535 participants against the proposed NIHR Clinical Research Network (CRN) target of 500, similar to previous years. During 2015-16, the Trust continued to improve the quality, speed and co-ordination of clinical research by unifying systems, improving collaboration with industry and streamlining administrative processes. We have consistently achieved 100 % against the NIHR target of issuing RDI approval within 15 days.

The Trust has impressive research activity across a wide range of clinical specialities. Since 1st April 2015 we have approved 31 NIHR studies in the following areas:

Speciality	Number of Studies
Anaesthetics	1
Cancer	6
Cardiology	1
Critical Care	1
Dermatology	2
Diabetes	3
Gastroenterology	1
Mental Health	1
Paediatrics	2
Pathology	2
Rheumatology	2
Stroke	2
Surgical	3
Urology	2
Woman & Child Health	2

2.4.3.1. Performance in initiation and delivery of research (PID data)

We report quarterly to the Department of Health on the following performance measures (for clinical trials only):

- Non-commercial studies: meeting a 70-day benchmark to recruit the first patient following RDI permission.

- Commercial studies: recruiting to time and target for closed studies.

St Helens and Knowsley Teaching Hospitals NHS Trust met the 70-day benchmark in 78% (n14) of the trials submitted in the data collection period for quarter 4 in 2015-16 (looking at the preceding 12 months from 01/04/2015 to31/03/2016. The 70-day benchmark was not achieved in four studies, where the patients were approached but declined to take part. The Trust did however meet the recruiting to time and target for all three commercial studies.

2.4.3.2. Commercially sponsored studies

We continue to increase our participation in commercially sponsored studies, with 8 commercial studies active within the Trust (4 last year) in diabetes, dermatology, gastroenterology, cancer and, rheumatology and more are planned for other areas including Cardiology and Emergency Department.

The following are examples of how St Helens and Knowsley Teaching Hospitals NHS Trust has continuously strived to improve the quality of services provided through research:

- Cancer research at the Trust has made excellent progress in 2015-16. Cancer research plays an essential role, not only in developing new approaches to managing disease, but also in improving the effectiveness of existing treatments. At present there are 17 open studies actively recruiting across all tumour groups. This year 139 patients diagnosed with cancer have participated in a cancer research study.
- The stroke unit is taking part in an international nursing study looking at positioning after stroke, the HeadPoST study. This study aims to compare the different practices used in different countries in order to better identify which components of care may benefit individual patients.
- In September 2015, diabetes patients in St Helens were invited to be among the first in the world to trial a drug aimed to relieve pains associated with the condition. The clinical trial is taking place at St Helens Hospital and aims to investigate the potential of an innovative drug for chronic pain conditions such as diabetic neuropathy, a complication of the condition.

2.4.3.3. Key achievements

- The Trust was the first site in the UK to reach the GRACE study recruitment target. This is a study treating patients with idiopathic overactive bladder with urine incontinence.
- In the month of December 2015, St Helens Hospital was the highest recruiter to the British Society for Rheumatology Rheumatoid Arthritis Register study set up to monitor the safety of treatments for ankylosing spondylitis.
- In January 2016, the Trust was the top recruiter to the provision of psychological support to people in intensive care study, which aims to improve patients' well-being after a stay in the intensive care unit.
- Also in January 2016, our Research Team helped recruit the 1000th patient to the PRISM trial. This is a multi–centre study that investigates whether

progesterone, a natural pregnancy hormone, could help to reduce the risk of miscarriage for women with bleeding in early pregnancy.

These achievements have only been made possible by the continued support from the committed Consultants, who take the role of Chief and Principal Investigators, the research teams, support services and most importantly the patients who give up their time to take part in clinical trials.

We are a partner organisation in the North West Coast (NWC) CRN. This partnership working helps the Trust to support national commitments to research. On the 29th February 2016 we hosted a roadshow run by the NWC CRN. This was a practical work based event focussing on sharing best practice and engagement with research colleagues.

131 publications (research and academic) have resulted from our involvement in both NIHR and Non-NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

2.4.3.4. Research aims for 2016-17

Our aims for 2016-17 are to continue to:

- Work in partnership with the CRN to meet the NIHR high level objectives
- Generate research funding by increasing the number of commercially sponsored studies in our portfolio
- Ensure high quality delivery of studies, to time and on target
- Maintain research governance and assurance for staff undertaking research
- Develop a culture that adopts new evidence based interventions and learns from innovative good practice

2.4.4. Goals agreed with commissioners

A proportion of St Helens and Knowsley Teaching Hospitals NHS Trust's income in 2015-16 was conditional on achieving quality improvement and innovation goals agreed between St Helens and Knowsley Teaching Hospitals NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2015-16 and for the following 12 month period are shown in the tables below:

Type	CQUIN Ref 2015-16	CQUIN summary for 2015-16
Clinical Commissioning Group Commissioner CQUINS		
National	Acute Kidney Injury)	Acute kidney injury treatment and diagnosis in hospital, including stage of acute kidney injury, evidence of medicines review having been undertaken, type of blood tests required on discharge for monitoring and frequency of blood tests required on discharge for monitoring
National	Sepsis	Sepsis patients who meet criteria of local protocol. The total proportion of patients presenting to emergency departments and other units that directly admit emergencies who met the criteria of the local protocol and were screened for sepsis
		Patients with severe sepsis, Red Flag Sepsis or septic shock. The proportion of patients who present to emergency departments and other wards/units that directly admit emergencies with severe sepsis, Red Flag Sepsis or Septic shock (as identified retrospectively via case note review of patients with clinical codes for sepsis) and who received intravenous antibiotics within 1 hour of presenting
National	Dementia	The proportion of patients aged 75 years and over to whom case finding is applied following an episode of emergency, unplanned care to either hospital or community services
		The proportion of those identified as potentially having dementia or delirium who are appropriately assessed
		The proportion of those identified, assessed and referred for further diagnostic advice in line with local pathways agreed with commissioners, who have a written care plan on discharge which is shared with the patient's GP
		To ensure that appropriate dementia training is available to staff through a locally determined training programme
		To ensure carers of people with dementia and delirium feel adequately supported
National	Urgent & Emergency Care	Reducing the proportion of avoidable emergency admissions to hospital. Increased use of other emergency referral methods
		Reducing the proportion of avoidable emergency admissions to hospital. Improving recording of diagnosis in Emergency Department

Type	CQUIN Ref 2015-16	CQUIN summary for 2015-16
		Reducing the proportion of avoidable emergency admissions to hospital. Reduction in Emergency Department mental health re-attendances
Local	Advancing Quality	Heart Failure
		Pneumonia
		Hip Fracture
		Sepsis
		Acute Kidney Injury
		Chronic obstructive pulmonary disease gap analysis
		Alcohol Liver Disease gap analysis
Local	Integration	Chronic obstructive pulmonary disease
		Heart Failure
		Diabetes
Local	Stroke	Total patients referred to the stroke service from the emergency department with a median time of 30 minutes
		Proportion of patients diagnosed with stroke who are referred to the Stroke Specialist Nurse
		Sentinel Stroke National Audit Programme (SSNAP) Domain 5 Occupational Therapy assessment
		Median number of minutes per day on which occupational therapy is received
		Median percentage of days as an inpatient on which occupational therapy is received
		Compliance (%) against the therapy targets
		SSNAP Domain 8 Multidisciplinary team working
		SSNAP Domain 9 standards by discharge
		Proportion of applicable patients who have a continence plan drawn up within 3 weeks of clock start
		Proportion of applicable patients who have mood and cognition screening by discharge
		Transient ischaemic attach - from receipt of referral - 36 hrs to assessment and scanning
		Numbers of patients seen and assessed within 36 *hours from receipt of referral*
		Numbers of patients appropriately scanned within 36 hours from receipt of referral
		Quarterly report containing: Number of referrals received, breakdown of referring practices, Time of the patient's first contact with a clinician to time of referral to the Acute Trust
Specialised Commissioning CQUINS		
National	HIV	HIV: Reducing unnecessary CD4 monitoring
National	Neonatal	Neonatal Critical Care – Reducing clinical variation and identifying service improvement requirements by ensuring data completeness in the 4 National Neonatal Audit Programme audit questions identified

Type	CQUIN Ref 2015-16	CQUIN summary for 2015-16
		Neonatal unit admissions. Reduce separation of mothers and babies and reduce demand on neonatal services by improving learning from avoidable term admissions (≥37wk gestation) into neonatal units.

Type	CQUIN Ref 2016/17	CQUIN summary for 2016-17
CCG Commissioner CQUINS		
National	HWB	Healthy food for NHS Staff, visitors & patients
National	Flu	Improving the uptake of flu vaccinations for front line clinical staff
National	Sepsis	Timely identification & treatment of sepsis in Emergency Departments and acute inpatient settings, including screening, administration of intravenous antibiotics and review.
National	Cancer	Cancer 62 Day Waits - urgent GP referral for suspected cancer to first treatment within 62 days and root cause analysis on all long waiter and a clinical harm review for a positive diagnosis.
National	Antimicrobial resistance	Antimicrobial resistance & antimicrobial stewardship, including, submission of consumption data, 1% reduction in total antibiotic consumption per 1000 admissions from 2013/14 baseline, 1% reduction in carbapenem per 1000 admissions from 2013/14 baseline, 1% reduction in piperacillin-tazobactam consumption per 1000 admissions from 2013/14 baseline and empiric review of antibiotic prescriptions
Local	Acute kidney injury	Acute kidney injury treatment and diagnosis in hospital.
Local	Fetal monitoring training	Fetal monitoring training, including all Midwives annual training in antenatal cardiotocography, errors & limitations of fetal monitoring using K2, acid base & physiology and cardiotocography K2 training
Specialised Commissioning CQUINS		
National	Dose band	Cancer: chemotherapy (adult) dose banding - dose banding adult intravenous systemic anticancer therapy
National	Neonatal Critical Care	2 Year Outcomes <30 Weeks Gestation, prevention hypothermia preterm babies - babies <34 weeks - 1st temperature taken <1hr and prevention hypothermia preterm babies - babies <34 weeks - 1st temperature taken <1hr range >=36^{o}C

2.4.5. Statements from the Care Quality Commission (CQC)

The CQC is the independent regulator for health and adult social care services in England. The CQC monitors the quality of services the NHS provides and takes action where these fall short of the fundamental standards required. The CQC uses a wide range of regularly updated sources of external information, as well as its own observations during planned and unplanned inspections to assess the quality of care a Trust provides. If it has cause for concern, it may undertake special reviews/investigations and impose certain conditions.

The Trust's Chief Inspector of Hospitals CQC planned inspection of St Helens and Knowsley Teaching Hospitals NHS Trust took place in the week commencing 17th August 2015. A large team of inspectors visited both Whiston and St Helens hospitals during that week to talk to patients, carers and staff about the quality and safety of the care we provide. They reviewed care records and observed care being delivered. The Trust was able to demonstrate to the inspection team the high standard of work that is undertaken on a daily basis to ensure patients receive excellent care.

St Helens and Knowsley Teaching Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against St Helens and Knowsley Teaching Hospitals NHS Trust during 2015-16.

St Helens and Knowsley Teaching Hospitals NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

St Helens and Knowsley Teaching Hospitals NHS Trust is subject to periodic reviews by the Care Quality Commission and the last review was in August/September 2015. The CQC's assessment of the St Helens and Knowsley Teaching Hospitals NHS Trust following that review was good. St Helens Hospital was rated as outstanding and the Trust was rated overall as outstanding for the care it provides to patients, with the Outpatients and Diagnostic service also rated as outstanding on both sites. The Trust's maternity services were rated as requires improvement for responsive, safe and well-led, with the emergency department also rated as requires improvement for the responsive domain. Action plans are in place to deliver the required improvements, with key actions noted in the section below.

2.4.5.1. CQC ratings table for St Helens and Knowsley Teaching Hospitals NHS Trust January 2016

Safe	Effective	Caring	Responsive	Well-led
Good	Good	☆ Outstanding	Good	Good

St Helens and Knowsley Teaching Hospitals NHS Trust intends to take the following action to address the points made in the CQC's assessment:

- Continue to work with our health economy partners to improve access to urgent and emergency care, which includes participation in a rapid improvement workshop in May 2016 and an internal review of the systems and process across the Trust to improve patient flow. An action plan has been developed as part of the System Resilience Group that will address factors impacting on the Trust's performance in this area.
- Continue to strengthen the processes to further reduce risks within maternity services
- Development of a specific Maternity Strategy
- Maintain robust systems for the storage of medications
- Continue to ensure the appropriate skill mix of staff and that the privacy and dignity of patients in coronary care unit is maintained at all times

St Helens and Knowsley Teaching Hospitals NHS Trust has made the following progress by 31st March 2016 in taking such action:

- Comprehensive action plan agreed with health economy partners to drive improvements in access to urgent and emergency care, including increasing the capacity within intermediate care in the community and reviewing and developing community services
- Improved the ambulance turnaround times within the Emergency Department by putting in place 7 day/week ambulance clinical coordinators to promote the use of alternative destinations for patients as appropriate and providing a 12 hour day coordination service.
- Reviewed and improved the systems for managing and responding to serious incidents within maternity services, ensuring effective processes for implementing lessons learnt. This includes the introduction of daily safety huddles at each shift hand-over, patient safety boards and safety briefings to share lessons learnt. In addition, an organisational development plan has been implemented, following a series of staff listening events.
- Adaptations to the Maternity Unit bereavement rooms to enhance patient experience
- Regularly auditing the safe storage of medications
- Firmly embedded processes for reviewing staffing levels across the Trust on a daily basis to ensure safe staffing in all areas, with monthly reporting to the Board
- Installed permanent screen in coronary care unit to ensure the privacy and dignity of patients is maintained at all times

2.4.6. Information governance and toolkit attainment levels

Information Governance is the term used to describe the standards and processes for ensuring that organisations comply with the laws and regulations regarding handling and dealing with personal information. Within our organisation we have clear policies and processes to ensure that information, including patient information, is handled in a confidential and secure manner.

The designated individual within the Trust who is responsible for ensuring confidentiality of personal information is the Caldicott Guardian. This position is

currently held by the Assistant Medical Director, who is Caldicott trained, registered and accredited. The Trust also has a Senior Information Risk Owner (SIRO), who is responsible for reviewing and reporting on information, as well as providing assurance on the management of information risk to the Board. This role is held by the Director of Informatics, who is SIRO trained, registered and accredited.

The Trust continues to benchmark itself against the Information Governance Toolkit (IGT). The toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health information governance policies and standards. It also allows members of the public to view our commitment to information governance standards.

St Helens and Knowsley Teaching Hospitals NHS Trust Information Governance Assessment Report overall score for 2015-16 was 80% and was graded 'green'.

This indicates that the Trust is compliant in all sections of the IGT and indicates that there are effective data systems, standards and processes across the Trust to protect information.

2.4.7. Clinical coding error rate

St Helens and Knowsley Teaching Hospitals NHS Trust was subject to the Payment and Tariff Assurance Framework Audit for gastro-intestinal (GI) and urology services during the reporting period and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

2014 data reported in April 2015				
Measure	Primary diagnosis incorrect	Secondary diagnosis incorrect	Primary procedure incorrect	Secondary procedure incorrect
External PbR Audit	3.5%	1.7%	4.6%	16.3%

2.4.8. Data quality

The Trust continues to be committed to ensure accurate and up-to-date information is available to communicate effectively with GPs and others involved in delivering care to patients. Good quality information underpins effective delivery of patient care and supports better decision-making, which is essential for delivering improvements.

The data quality framework is fully embedded within the organisation. Robust governance arrangements are in place to ensure the effective management of this process. Audit outcomes are monitored by the Information Steering Group and the Management of Information and Technology Council to ensure that the Trust continues to maintain performance in line with national standards. The data quality framework is reviewed on an annual basis to ensure new requirements are reflected in the audit plan. The standard national data quality items that are routinely monitored are as follows:-

- Blank/invalid NHS Number

- Unknown or dummy practice codes
- Blank or invalid registered GP practice
- Patient postcode

St Helens and Knowsley Teaching Hospitals NHS Trust will be taking the following actions to improve data quality:

- Continuing to run regular reports by the Data Quality Team to monitor data quality throughout the Trust
- Liaising with line managers and end users to address issues
- Identifying training needs
- Providing data quality awareness sessions about the importance of good quality patient data

2.4.9. NHS number and general medical practice code validity

St Helens and Knowsley Teaching Hospitals NHS Trust submitted records during 2015-16 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data which:

- Included the patient's valid NHS number was:
    - 99.3% - Admitted patient care
    - 99.4% - Outpatient care
    - 99.1% - Accident and Emergency care

- Included the patient's valid General Medical Practice Code was:
    - 100% - Admitted patient care
    - 100% - Outpatient care
    - 99.9% - Accident and Emergency care

(Source: SUS Data Quality Dashboard latest published report: April 2015 – November 2015)

In all cases, the Trust performs better than the national average, with percentages greater than the national percentage, demonstrating the importance the Trust places on data quality.

2.4.10. Benchmarking information

The Department of Health specifies that the Quality Account includes information on a core set of outcome indicators, which the NHS should be aiming to improve against. All trusts are required to report against these indicators using a standard format. The following data is made available to NHS trusts by the Health and Social Care Information Centre (HSCIC). The Trust has more up-to-date information for some measures, however, only data with specified national benchmarks from the central data sources can be reported. Therefore, some information included in this report must out of necessity be from the previous year or earlier and the timeframes are included in the report. It is not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.

Benchmarking Information

Please note the information below is based on the latest nationally reported data with specified benchmarks from the central data sources. Data highlighted in purple text provides local data on the Trust's most recent performance.

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
		Latest reporting period						
1.	Value of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	Oct-14 to Sep-15 1.029 (no local data available)	Oct-14 to Sep-15 1.000	Oct-14 to Sep-15 0.652	Oct-14 to Sep-15 1.177	The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: • The Trust's performance remains amongst the best in the North West • Information relating to mortality is monitored monthly and used to drive improvements • The mortality data is provided by an external source (Dr	Jul-14 to Jun-15	1.031
							Apr-14 to Mar-15	1.025
2.	Banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	Oct-14 to Sep-15 Band 2 as expected (no local data available)	Oct-14 to Sep-15 Band 2 as expected	Oct-14 to Sep-15 Band 1 better than expected	Oct-14 to Sep-15 Band 3 worse than expected		Jul-14 to Jun-15	2
							Apr-14 to Mar-15	2
3.	Percentage of patient deaths with palliative care* coded at either diagnosis or specialty level for the Trust for the reporting period *This is a contextual indicator used to help interpret the above indicator, as	Oct-14 to Sep-15 24.8%	Oct-14 to Sep-15 26.6%	Oct-14 to Sep-15 53.5%	Oct-14 to Sep-15 0.2%		Jul-14 to Jun-15	24.3 %
							Apr-14 to Mar-15	24.1 %

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
	the SHMI methodology does not make any adjustments for patients recorded as receiving palliative care, because there is wide variation in how these are coded between Trusts.					Foster) The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve the indicator and percentage in (a) and (b), and so the quality of its services, by: • Monthly monitoring of available measures of mortality • Embedding mortality and morbidity reviews in all directorates for inpatient deaths, with detailed, multi-disciplinary review of selected cases to ensure patients have received appropriate care		

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
						and lessons learnt are disseminated to further improve the care provided.		
4.	Patient reported outcome measures (PROMs) scores for groin hernia surgery	April 15-Sept 15 (provisional) 0.049	April 15-Sept 15 (provisional) 0.088	April 15-Sept 15 (provisional) 0.135	April 15-Sept 15 (provisional) 0.008	The St Helens and Knowsley Teaching Hospitals NHS Trust considers that the outcome scores are as described for the following reasons: • The questionnaire used for PROMs is a validated tool and administered for the Trust by an independent organisation, Quality Health The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these outcome scores,	Apr-14 to Mar-15 (provisional)	0.077
5.	PROMs scores for varicose vein surgery Due to reasons of confidentiality, the Information Centre has suppressed figures for those areas highlighted with an '*' (an asterisk). This is because the underlying data has small numbers (between 1 and 5)	April 15-Sept 15 (provisional) *	April 15-Sept 15 (provisional) 0.104	April 15-Sept 15 (provisional) 0.130	April 15-Sept 15 (provisional) 0.037		Apr-14 to Mar-15 (provisional)	*
6.	PROMs scores for hip replacement surgery	April 15-Sept 15 (provisional) -	April 15-Sept 15 (provisional) 0.454	April 15-Sept 15 (provisional) 0.520	April 15-Sept 15 (provisional) 0.359		Apr-14 to Mar-15 (provisional)	0.393
7.	PROMs scores for knee replacement surgery	April 15-Sept 15 (provisional) -	April 15-Sept 15 (provisional) 0.334	April 15-Sept 15 (provisional) 0.412	April 15-Sept 15 (provisional) 0.207		Apr-14 to Mar-15 (provisional)	0.276

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
						and so the quality of its services, by: • Delivering a number of actions to improve patient experiences following hip replacement surgery, including increasing the numbers of patients attending joint school prior to surgery to increase awareness of what to expect • Monitoring the PROMs data at the Clinical Effectiveness Council		
8.	Percentage of patients aged 0 to 15 readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which	Apr-11 to Mar-12 11.39	Apr-11 to Mar-12 10.01	Apr-11 to Mar-12 0.00	Apr-11 to Mar-12 14.94	The St Helens and Knowsley Teaching Hospitals NHS Trust considers that these	Apr-10 to Mar-11	10.66

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
	forms part of the Trust.					percentages are as described for the following reasons: • The data is consistent with Dr Foster's standardised ratios for re-admissions • The data is monitored monthly by the Board The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these percentages, and so the quality of its services, by: • Working to improve discharge information as a patient experience		
9.	Percentage of patients aged 16+ readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust.	Apr-11 to Mar-12 12.73	Apr-11 to Mar-12 11.45	Apr-11 to Mar-12 0.00	Apr-11 to Mar-12 17.15		Apr-10 to Mar-11	12.60

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
						priority (see section 2.2) • Reviewing and improving discharge planning		
10.	Trust's responsiveness to the personal needs of its patients during the reporting period (CQC national inpatient survey score).	2014-15 71.3	2014-15 68.9	2014-15 86.1	2014-15 59.1	The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: • The Trust's vision and drive to provide 5-star patient care ensures that patients are at the centre of all the Trust does • The Trust was rated outstanding overall for caring by the CQC following	2013-14	72.5

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
						their inspection in 2015 • The survey is conducted by an independent and approved survey provider (Quality Health), with scores taken from the CQC website The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this data, and so the quality of its services, by: • Promoting a culture of patient-centred care • Responding to patient feedback through patient forums, national and local surveys, friends		

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
						and family test results, complaints and Patient Advice and Liaison Service (PALS) • Working closely with Healthwatch colleagues to address priorities identified by patients, including improving discharge planning		
11.	Percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	2015 81.7%	2015 69.2%	2015 85.4%	2015 46.0%	The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this percentage is as described for the following reasons; • The Trust provides a positive working environment for staff with a proactive Health, Work and Well-	2014	77.7%

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
						being Service • The data is provided by an independent provider, Quality Health. The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this percentage, and so the quality of its services, by: • Embedding a positive culture with clear visible leadership, clarity of vision and actively promoting behavioural standards for all staff • Engagement of staff at all levels in the		

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
						development of the vision and values of the Trust • Honest and open culture, with staff supported to raise concerns via Speak Out Safely champions		
12.	% experiencing harassment, bullying or abuse from staff in last 12 months	2015 21%	2015 26%	2015 16%		The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: • The survey is conducted by an independent provider • The Trust actively promotes an open and supportive culture The St Helens and Knowsley Teaching	2014	21%

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
						Hospitals NHS Trust has taken the following actions to improve this percentage, and so the quality of its services, by: • Implemented Speak up Safely guardians and champions to support staff in raising concerns • Letters sent to all staff regarding Raising Concerns and Speak up Safely • Utilise the Valuing Our People Steering Group to identify the location of spikes in incidents and take appropriate action • Continued engagement with St Helens		

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
						HealthWatch regarding raising concerns • Two large staff engagement events for staff, spanning all roles and professionals, to bring different perspectives to the following workshops 'Realising the Trust values' and 'Speak out Safely.'		
13.	% believing the organisation provides equal opportunities for career progression / promotion	2015 92%	2015 87%	2015 96%		The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: • The survey is conducted by an independent provider • The Trust actively	2014	93%

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
						promotes equality within the workplace and reports this annually to the Board The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this percentage, and so the quality of its services, by: • Developed an action plan with the Equality, Diversity & Inclusion Steering Group which includes obtaining the Navajo charter mark, completing EDS2 objectives including a representative workforce at all levels		

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
						• Published the baseline workforce race equality scheme report for 2015 together with an action plan that includes the indicator *'Relative likelihood of black and minority ethnic staff accessing non-mandatory training and continuing professional development as compared to white staff.'*		
14.	Percentage of patients who would recommend the Trust as a provider of care to their family or friends.					The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this percentage is as described for the following reasons: • The Trust's vision and drive		

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period
						to provide 5-star patient care ensures that patients are at the centre of all the Trust does • The Trust was rated outstanding overall for caring by the CQC following their inspection in 2015 • The survey is conducted by an independent provider The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this percentage, and so the quality of its services, by:	

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
						• Striving to provide the highest quality of care, through the 5-star patient care vision and the Trust values • Identifying lessons learnt and implementing actions to ensure improvements to care to ensure that patients have a positive experience		
15.	Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE)	Quarter 4 2015-16 89.3%	Quarter 4 2015-16 National figures not available	Quarter 4 2015-16 National figures not available	Quarter 4 2015-16 National figures not available	The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this percentage is as described for the following reasons: • Data on VTE risk assessments are submitted	Quarter 3 2015-16	93.2%
							Quarter 2 2015-16	94.3%
							Quarter 1 2015-16	95.0%

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
						to NHS England each month • Root cause analysis (RCA) undertaken on VTEs recorded on Datix to ensure best practice is followed The St Helens and Knowsley Teaching Hospitals NHS Trust is taking the following actions to improve this percentage, and so the quality of its services, by: • Overarching improvement plan in place • Maintaining focus with increased monitoring (weekly) of the rate of risk		

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
						assessments to improve performance to achieve the national target, with monthly reporting to the Board. • Undertaking audits on the administration of appropriate medications to prevent blood clots • Completing RCA investigations on all patients who develop a hospital acquired venous thrombosis to ensure that best practice has been followed • Sharing any learning from these reviews		

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
						• Providing on-going training for clinical staff. • Implementation of an electronic recording system across all relevant departments. • Working closely with clinicians across all departments through which patients are admitted to improve compliance.		
16.	Rate per 100,000 bed days of cases of Clostridium difficile (C. difficile) infection reported within the Trust amongst patients aged 2 or over.	The Trust reported 30 C. difficile cases from April 15 – March 16, which is a rate of 11.76 per 100,000 bed days	Apr-14 to Mar-15 15.1	Apr-14 to Mar-15 0	Apr-14 to Mar-15 62.2	The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this rate is as described for the following reasons: • Infection prevention and control remains a priority for the	Apr-13 to Mar-14	11.1

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
		*however 3 of these 30 cases are subject to appeal Apr-14 to Mar-15 18.6				Trust • All new cases of C. difficile infection are identified by the laboratory and reported to the Infection Prevention and Control Team, who co-ordinate mandatory reporting to Health Protection England • The Trust is maintaining compliance with the national guidance on testing stool specimens in patients with diarrhoea • All cases are thoroughly investigated using RCA,		

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
						which is reported back to a multidisciplinary panel chaired by an Executive Director to ensure appropriate care was provided and lessons learnt are disseminated across the Trust. The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by: • Ensuring that all staff are compliant with mandatory training for infection		

	Indicator	StHK	National average	Best Performer Where applicable	Worse Performer Where applicable	Trust Statement	StHK data for previous reporting period	
						prevention and control • Actively promoting the use of hand washing and hand gels to those visiting the hospital • Providing a proactive and responsive infection prevention service to increase levels of compliance • Ensuring comprehensive guidance is in place on antibiotic prescribing		

17.	Rate of patient safety incidents reported within the Trust per 1000 bed days* *High reporters should be shown as better Based on acute (non-specialist) trusts with complete data. The data on HSCIC website for this indicator is 7 months old; our local data for this indicator for performance up to 31/03/16 is 4427 incidents for the period of April 15 - September 15. This equates to 38.10 incidents per 1,000 bed days. We believe the local data is a more meaningful measure of performance because incident management and investigation is a fluid process and subject to change as noted in our local figures. In addition data not yet published by the NRLS indicates our performance to be 4458 for the period of October 15 – March 16, this equates to 34.52 incidents per 1,000 bed days.	Oct 15 – March 16 34.52 (number of incidents = 4458) April 15 – Sep 15 37.73 (number of incidents = 4384)	National data not yet available April 15 – Sep 15 38.35 (number of incidents = 4718)	April 15 – Sep 15 74.67 (number of incidents = 12080)	April 15 – Sep 15 18.07 (number of incidents = 1559)	The St Helens and Knowsley Teaching Hospitals NHS Trust considers that these numbers and rates are as described for the following reasons: • The Trust actively promotes a culture of open and honest reporting within a culture of fair blame. • The data has been validated against National Reporting and Learning System (NRLS) and HSCIC figures. The latest data to	Oct 14 – Mar 15 35.34 (number of incidents = 4213)
18.	Rate of patient safety incidents reported within the Trust resulting in severe harm or death per 1000 bed days* *High reporters should be shown as better	Oct 15 – March 16 0.12 (number of incidents = 16) April 15 – Sep 15	National data not yet available April 15 – Sep 15	April 15 – Sep 15	April 15 – Sep 15		Oct 14 – Mar 15 0.24 (number of incidents = 29)

	The data on HSCIC website for this indicator is 7 months old; our local data for this indicator for performance up to 31/03/16 is 20 incidents for the period of April 15 - September 15. This equates to 0.17 incidents per 1,000 bed days. We believe the local data is a more meaningful measure of performance because incident management and investigation is a fluid process and subject to change. In addition data not yet published by the NRLS indicates our performance to be 16 for the period of October 15 – March 16, this equates to 0.12 incidents per 1,000 bed days.	0.18 (number of incidents = 21)	0.16 (number of incidents = 20)	0.74 (number of incidents = 89)	0.03 (number of incidents = 2)	be published is for 2014-15. The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this number and rate, and so the quality of its services, by: • Committing to the Sign up to Safety campaign to reduce avoidable harm by 50% by 2018 • Undertaking comprehensive investigations of incidents resulting in moderate or severe harm • Delivering Human Factors training to enhance team working in clinical areas • Providing staff	
19.	Percentage of patient safety incidents that resulted in severe harm or death The data on HSCIC website for this indicator is 7 months old; our local data for this indicator for performance up to 31/03/16 is 20 incidents for the period of April 15 - September 15 which is 0.5% of total incidents (4427). We believe the local data is a more meaningful measure of performance because incident management and investigation is a fluid process and subject to change. In addition data not yet published by the NRLS indicates our performance to be 16 incidents for the period of October 15 – March 16, which is 0.4% of total incidents (4458). Local data for the full year (April 2015 – March 2016) shows a total of 36 incidents, which is 0.4% of total incidents (8885).	Oct 15 – March 16 0.4% (16 severe harm or death/4458 total) April 15 – Sep 15 0.5% (21 severe harm or death/4384 total)	National data not yet available April 15 – Sep 15 0.4% (2380 severe harm or death/575583 total)	April 15 – Sep 15 2.0% (89 severe harm or death / 4519 total)	April 15 – Sep 15 0.1% (2 severe harm or death / 3062 total)		Oct 14 – Mar 15 0.7% (29 severe harm or death/4213 total)

						training in incident reporting and risk management • Monitoring key performance indicators at the Patient Safety Council • Continuing to promote an open and honest reporting culture to ensure incidents are consistently reported	

2.4.11. Performance against national targets and regulatory requirements

The Trust aims to meet all national targets and priorities and our performance against the key indicators for 2015-16 is shown in the table below:

Performance Indicator	2014-15 Performance	2015 -16 Target	2015-16 Performance	Latest data
Cancelled operations (% of patients treated within 28 days following cancellation)	Achieved	100%	100.0%	Apr-15 to Feb-16
Referral to treatment targets (% within 18 weeks and 95th percentile targets) - Admitted	Achieved	N/A	90.7%	Apr-15 to Mar-16
Referral to treatment targets (% within 18 weeks and 95th percentile targets) - Non-admitted	Achieved	N/A	98.0%	Apr-15 to Mar-16
Referral to treatment targets (% within 18 weeks and 95th percentile targets) – Incomplete pathways	Achieved	92%	95.5%	Apr-15 to Mar-16
Cancer: 31-day wait from diagnosis to first treatment	Achieved	96%	97.8%	Apr-15 to Feb-16
Cancer: 31-day wait for second or subsequent treatment:				
- surgery	Achieved	94%	98.6%	Apr-15 to Feb-16
- anti-cancer drug treatments	Achieved	98%	98.4%	Apr-15 to Feb-16
Cancer: 62-day wait for first treatment:				
- from urgent GP referral	Achieved	85%	88.5%	Apr-15 to Feb-16
- from consultant upgrade	Achieved	85%	89.5%	Apr-15 to Feb-16
- from urgent screening referral	Achieved	90%	100.0%	Apr-15 to Feb-16

Performance Indicator	2014-15 Performance	2015 -16 Target	2015-16 Performance	Latest data
Cancer: 2 week wait from referral to date first seen:				
- urgent GP suspected cancer referrals	Achieved	93%	94.8%	Apr-15 to Feb-16
- symptomatic breast patients	Achieved	93%	94.1%	Apr-15 to Feb-16
Emergency Department waiting times within 4 hours - Type 1 only	Not achieved	95%	85.0%	Apr-15 to Mar-16
Percentage of patients admitted with stroke spending at least 90% of their stay on a stroke unit	Achieved	83%	92.0%	Apr-15 to Mar-16
Clostridium Difficile	Not achieved	41	Achieved To date 30 hospital acquired cases though this may change as 3 of these 30 are subject to appeal	April-15 to March-16
Methicillin-resistant staphylococcus aureus (MRSA)	Not achieved	0	0	April-15 to March-16

3. Section 3 – Quality of care provided

This section of the Quality Account reviews the Trust's performance for quality and quality improvement indicators not covered in the report so far. It includes an update on progress in delivering the Trust's own strategies and in meeting the targets identified in last year's Quality Account.

3.1. Summary of how we did in achieving our strategies

3.1.1. Clinical and Quality Strategy 2014-18

The Trust's vision to provide 5-star patient care encapsulates the Trust's approach to quality in striving to achieve the best possible care for patients. The Clinical & Quality Strategy 2014-18 presents the clinical and quality priorities that will support the achievement of the vision, set within the context of the strategic priorities for the wider NHS and our local health and social care community. It reiterates the Trust's commitment to provide the best quality of care. The latest review of progress in delivering the Strategy was undertaken in January 2016 and reported to the Board. It indicated that the Trust was achieving many of the key performance indicators set out in the Strategy and was making good progress in the majority of areas, with action plans in place to address under-performing areas.

Progress in delivering a number of the priorities is provided throughout the Quality Account, including sections 2.3.10 and 2.3.11.

The Trust is currently re-writing the strategy in light of the changing external context and following agreement of this year's Trust objectives.

3.1.2. Nursing and Midwifery Strategy 2014-18

The five year strategy outlines an ambitious plan for developing and sustaining a flexible, well-educated, confident, competent, caring and compassionate nursing and midwifery workforce to enable the Trust to deliver its corporate objectives. It is structured around the Chief Nursing Officer's six enduring values and behaviours that underpin compassion in practice, the six Cs. These are care, compassion, communication, competence, courage and commitment.

The following outlines the key achievements in 2015-16:

Care

- Rated as outstanding by the CQC inspection in the caring domain
- Continued progress in the reduction of avoidable harm in line with the Trust's sign up to safety pledge, including achievement of the target for MRSA bacteraemia and Clostridium difficile
- Introduction of standard operating procedure for reviewing daily staffing levels in clinical areas, with average ward staffing levels demonstrating fill rates for registered and unregistered staff higher than the target of 90% against expected staff

- Updated the Safeguarding Adults and Children Training Needs Analysis and training competencies in line with updated national guidance
- Implemented Malnutrition Universal Screening Tool (MUST) risk assessment across the trust

Compassion

- Provision of good dementia care by:
    - Adapting the hip fracture ward and four of the wards of the Department of Medicine for Older People to become dementia-friendly environments. This includes dementia-friendly signage, paintwork, flooring and reminiscence rooms.
    - Four specially designed cubicles in the Emergency Department to support patients with dementia. On-going work to create a quiet space in the waiting area continues.
    - Strengthening links with the local community as our Nurse Consultant is a trustee of the Hargreaves Dementia Trust. This local charity supports families and carers of people with dementia
    - Regularly meeting with our local partners in health and social care with the aim of improving the care we provide to people who access our services.
    - Engaging Volunteers, with “Well Being” volunteers receiving dementia and delirium specific training
    - Training a sub-group of selected volunteers, who after meeting agreed competencies are able to assist patients with meals and drinks. These “dining assistants” are currently working on two wards with plans to roll this out following evaluation of the outcomes from this first cohort
    - Meeting National Standards, through compliance with the National Institute for Health and Care Excellence has produced quality statements for dementia.
    - Participating in the first two rounds of the National Dementia Audit, a regional audit of dementia care and our own audits. These are used to assess our progress to date and inform our action plan for the future. We will take part in the third round of the National Dementia Audit. This is due to start in April 2016.
    - Our Intermediate Care unit participating in a pilot study of the use of the National Dementia Audit in community hospitals.
    - Supporting John’s Campaign which calls for families and carers of people with dementia to have the same rights as the parents of sick children and to be allowed to remain with them in hospital for as many hours as they are needed and as they are able to give. This campaign is also endorsed by our partners, Medirest services, who are allowing the main carer of the person in hospital to have the same concessions that staff receive in the restaurant. Carers need to be recognised as equal partners in care and by committing to this campaign we are demonstrating this. This campaign is currently being trialled on a number of wards.
    - Providing a Carer’s Focus Group, which meets monthly and allows carers to share their experiences of recent hospital stays. We recognise that carers provide invaluable support to some very vulnerable people and this

contribution needs to be valued, acknowledged and respected. We need to learn what we did right and what we can do better.

- Enhanced end of life care provided for patients by appointing a Consultant in Palliative Medicine, provision of comprehensive education programme, provision of ward information boards for end of life carer and rolling out the individualised care and communication record for the care of the patient in the last hours/days.

Courage

- Embedded the use of the HALT tool across the Trust. The tool is a hierarchy flattening tool that supports colleagues to challenge each other to ensure safe practice.
- Implementation of a quality accreditation tool for all general wards, with wards receiving a bronze, silver or gold award based on the results of a comprehensive assessment of the quality of care and leadership provided. Action plans are produced for each element that requires improvement. Ward 4D, our burns ward was the first ward to receive the gold award.
- Ward performance indicators displayed on each ward, providing an overview of the quality of the care provided.

Commitment

- Implementation of Care Certificate for health care assistants
- Health care assistant development programme and competency framework in place
- Practice Education Facilitators continue to meet the quality standards for practice placements for students
- Local and international recruitment drive leading to the appointment of a significant number of nursing staff

Competence

- Reviewed and extended the preceptorship programme for newly qualified nurses to offer a 12 month preceptorship programme that incorporate the band 5 competency framework
- Developed a new programme that offers 3rd year student nurses the opportunity to gain competence in clinical skills during their training that they can use once qualified and employed by the Trust to improve the quality of patient care
- On-going support for qualified nurses and midwives to complete post-registration education modules at degree and masters level as part of the continuous professional development (CPD)-apply process to develop the competencies of staff and improve the quality of patient care.
- Implementation of a nursing and midwifery staff revalidation programme to ensure all relevant staff were supported to complete the revalidation requirements introduced by the Nursing and Midwifery Council for registered nurses and midwives
- Leadership development programme commenced for the ward managers, lead nurses and matrons, with four cohorts due to complete in May 2016 and further cohorts commencing in April
- Care certificate programme in place for health care assistants

Communication

- Improvements made to the timeliness of complaints' responses
- Implemented a revised process for general nursing documentation, following consultation with staff
- Developed a combined risk assessment e-form that incorporates delirium, falls, tissue viability, moving and handling and malnutrition 'MUST' assessments that will form part of the patient track package and lead to improved care for patients

3.1.3. Communications and Engagement Strategy 2013-16

The strategy sets out the overall framework for how the Trust intends to communicate and engage with all of its stakeholders and audiences in a number of ways. It reiterates the Trust's commitment to improving engagement and the importance of clear, honest, timely and relevant communications, delivered in a way everyone understands. Good communication is essential for the effective functioning of the organisation and to maintain a good reputation for delivering good quality care.

Key achievements in improving communications during 2015-16 include:

- Active promotion of the Trust's vision for 5-star patient care
- Launch of the Trust's new website, which was tested prior to its launch by a specially chosen patient group with varied experience of web use from first time users to experienced users. The website is increasingly used by patients and the public to find information about the Trust, including the range of services provided and how well the Trust is performing.
- Continued use of social media, with a rise in the number of people accessing information through the Trust's Facebook, Twitter and YouTube accounts.
- New, standardised ward entrance and department noticeboard information, with all patient facing communication materials on display reviewed and updated
- Work on the new intranet site for staff

The current Communications and Engagement Strategy comes to an end in 2016 and the Trust is working on an updated Strategy, scheduled for approval in April.

3.2. Equality, Diversity and Inclusion Strategy

The Trust's Equality, Diversity and Inclusion Strategy outlines the Trust's commitment to promoting equality in all its functions and to valuing the diversity of staff and service users. The principles of equality, diversity and human rights are intrinsic to the Trust's core business. We are committed to delivering high quality services that are accessible, responsive and appropriate to meet the needs of all our patients. In this respect, patient pathways have been designed to reduce variations in care and improve outcomes, whilst recognising the needs of individual patients. In addition, we aim to be an employer of choice and ensure that all our staff have equality of access to jobs, to promotion and to training opportunities.

The Trust is committed to creating an environment where everyone is treated with dignity, fairness and respect and to developing a culture of support and inclusion for all our employees and for those patients who access our services.

The Trust has continued to utilise the Equality Delivery System (EDS) to measure its equality progress. The EDS is a toolkit, designed to support NHS organisations to deliver better outcomes for patients and a better working environment for staff. The Trust has published the EDS2 Summary Report which details its progress against all eighteen of the equality outcomes.

The Trust met the agreed targets for 2015-16 in respect of the refreshed Equality Delivery System (EDS2) by reaching a level of 'achieving' across five outcomes independently assessed by its Healthwatch partners. This provided a solid foundation for the period. The agreed targets are shown in the table below:

1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse
2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
2.3	People report positive experiences of the NHS
3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives.

The Trust's Equality and Diversity Steering Group continues to meet quarterly, ensuring that the Trust complies with externally set standards and establishes, monitors and reviews content and methods of providing assurance to the Patient Experience Council and the Workforce Council in relation to all areas of equality and diversity. The Steering Group is composed of a range of staff from all disciplines: clinical, non-clinical, staff-side, Healthwatch representatives and independent service users. Work is in progress to develop the Group's function in providing an effective challenge to the Trust where necessary and appropriate.

The Workforce Council, for example, has supported an initiative emanating from the Steering Group to work towards achieving the locally-based Navajo Charter Mark in respect of good practice in working with its lesbian, gay, bisexual and transgender (LGBT) population, both staff and patients. A task and finish group has been set up and is developing a work programme around this particular protected characteristic, which, whilst focused on the achievement of the standard, is developing robust and sustainable processes supporting inclusivity and accessibility for all patients.

The following initiatives are examples of the Trust's determination to achieve this:

- The Care Quality Commission's findings, from their inspection in August 2015, that the work being undertaken around pathways for people with additional needs was outstanding. This is a very positive judgement confirming the work that the Trust has been undertaking to promote accessible services to those who are most vulnerable.

- The Trust's successful bid for funding from Health Education North West to establish, implement and publicise an integrated pathway that enables access for a highly significant and often excluded group to acute services (such as imaging, endoscopy, orthodontics etc.) led to the production of a toolkit with guidance and learning materials which were successfully showcased in November 2015 at a regional event.
- Work to distribute this across the primary and social care networks is in place and is expected to lead to the wider usage of accessible pathways for all patients with protected characteristics
- Establishment of a Steering Group and Task and Finish Group, inclusive of local Healthwatch and voluntary sector representatives to implement the Accessible Information Standard, to ensure that the information and communication needs of disabled patients, service users and carers are met
- Representation and contribution to the local learning disability agenda through both St Helens and Knowsley 'Healthcare for All' sub-group
- St Helens locality achieved a joint second place in the country for its submission to the Learning Disability Self-Assessment Process to which the Trust made significant submissions, thus achieving good assurance in those areas associated with the accessibility of people with a learning disability to acute care services
- The Trust has made significant contributions to the local St Helens and Knowsley Crisis Care Concordat Action Plan which is available on the concordat website
- The Trust has a monthly Mental Health Steering Group which has multi-agency and multi-professional representation including Merseyside Police and both St Helens and Knowsley Healthwatch members; this is the vehicle for managing activity relating to patients with mental health needs. Its current work programme involves its Mental Health Liaison partners and includes a mental health triage service, frequent attenders meeting and efforts to manage patients with medically unexplained symptoms;
- As part of its work internally, the Trust has produced its first Annual Report for Patients with Mental Health Needs (2014-15) published in November 2015 detailing the services available and setting actions for the following year
- As part of its contribution to achieving 'parity of esteem' the Trust has a Mental Health Training Sub-Group which is tasked with developing knowledge and awareness of training materials and resources to support Trust staff to meet the needs of patients with mental health needs in accessible and workplace friendly formats, such as handover and ward meetings rather than large classroom based events
- The Trust's use of interpreters in the periods 2013-14 and 2014-15 has increased by 83% for foreign language interpretation and 55% for British Sign Language interpretation reflecting a much greater awareness of need and the importance of obtaining interpreters to meet patient need and obtain improved health outcomes
- Merseyside Police have a monthly drop-in session within the main reception on the Whiston site to support initiatives on hate crime which have been very successful and have been extended as a result
- The Trust hosts a fully commissioned Carers' Support Service which operates within the Integrated Discharge Team supporting carers across all localities. The Trust is represented on and is a contributor to the St Helens Young Carers Board

and is working with individual young carers to understand their needs and to improve responses to the needs of young carers once identified within the Trust
- Well-established Dignity Champions Network in place, which meets bi-monthly with efforts being made in the coming year to expand this to include care home providers in the community building on our common purpose to support this vulnerable population
- The Trust has been allocated the resources and physical space to establish a 'Changing Places Facility' to ensure that any adult with changing needs who is a visitor to the Trust can manage their care in a dignified and appropriate manner.

Equal opportunities for those with disabilities are essential. The Trust is an equal opportunity employer and has control measures in place to ensure that all of the organisation's obligations under equality, diversity and human rights legislation are complied with. All of the above initiatives are reliant on developing and maintaining good working relationships across all sectors of the social and healthcare economy. This is a major part of the Trust's work in this area and is supported through the various multidisciplinary steering groups in place.

3.3. Human Resources and Workforce Strategy 2014-19

The Trust recognises that its staff are central to the provision of excellent services to our patients, their loved ones, commissioners and our local communities. Our five year HR and Workforce Strategy sets out our plans to develop a management culture and style that empowers, builds teams and recognises and nurtures talent through learning and development. We will be open and honest with staff, provide support throughout organisational change and invest in health and well-being. We will promote standards of behaviour that encourage a culture of caring, kindness and mutual respect. The delivery of the strategy will enable our staff to continue to provide 5-star patient care throughout the Trust. There are a number of supporting strategies to help achieve this:

- Health, Work & Well-Being Strategy 2016-21
- Recruitment & Retention Strategy 2015-20
- Equality, Diversity & Inclusion Strategy 2016-17
- Learning & Development Strategy 2016-21

The Trust is committed to providing employment opportunities for local people. In September 2015 we worked in collaboration with the Skills Academy for Health, St Helens College and Job Centre Plus to offer structured work placements to long term unemployed people from the local community in an effort to provide them with the skills to gain employment.

This work supported eight individuals back into the workplace in both administration and health care assistant roles. Seven of these went on to secure on-going employment, four in permanent posts at the Trust, another at a local Trust and a care home with the rest joining our bank. This was a great success and one that we are looking to repeat this year with up to 24 long term unemployed people.

3.3.1. Staff survey key questions

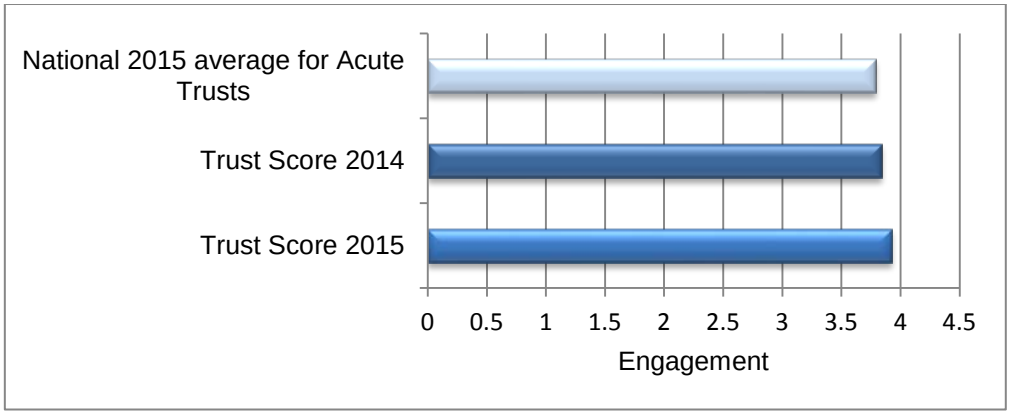
The Trust takes the national staff survey extremely seriously and uses the findings to both reinforce good practice and to identify areas for improvement. The Trust's response rate for the 2015 survey was 55%, which is 3% higher than last year and is amongst the highest response rates for acute trusts nationally.

The Trust has once again performed extremely well and scored in the top 20% of all acute trusts nationally for 22 of the 32 indicators, including:

- Staff recommending the organisation as a place to work and receive treatment
- Staff satisfaction with the quality of work and patient care they are able to deliver
- Staff looking forward to going to work and enthusiasm for their jobs

In addition, staff stated that care of patients is the organisation's top priority, with the percentage of staff confirming this in the top 20% of acute trusts nationally and improving from 79% last year to 83% this year. These measures can be used as further indicators that the care provided to patients is of a high quality.

The chart below shows how the Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating poorly engaged staff (with their work, their team and their trust) and 5 indicating a highly engaged workforce. The Trust's score of 3.92 was in the highest (best) 20% when compared with trusts of a similar type nationally and has improved since last year.



The table below highlights the scores for some of the areas where Trust was among the highest nationally:

Key Finding	StHK % score 2015	StHK % score 2014	Score compared to national acute average
Care of patients is the organisation's top priority	83	79	75
Organisation acts on patient concerns	80	82	73
Staff would recommend organisation as a	71	73	61

place to work			
If a relative needed treatment they would be happy with standard of care	82	77	70
Staff satisfaction with the quality of work and patient care they are able to deliver	76	74	72

Whilst the overwhelming majority of responses to the 2015 survey were positive, the following list highlights the areas where staff experience was not as positive as we would want:

- Whilst the overall result for the Trust is better than the national average for staff stating they had experienced discrimination at work in the last 12 months, a number of respondents from black and ethnic minority groups reported that they had experienced some form of discrimination. The Trust does not tolerate discrimination in any form and additional work is being undertaken to understand what led to this outcome and where it occurred to identify the actions that need be taken to prevent a reoccurrence
- The percentage of staff reporting good communication between senior management and staff has seen a marginal improvement since the 2014 survey and does place the Trust in the best 20% of acute trust nationally. However the results indicate that the majority of respondents feel that communication is not as effective as they would wish.
- Whilst the number of respondents experiencing physical violence from patients, relatives, the public and staff is very low this still continues to be a concern as it is greater than the national average for similar trusts
- 68% of staff stated they were able to contribute towards improvements at work which is slightly below the national average

In order to address these concerns the Trust is reviewing the detail of the responses to get a better understanding of which service areas are affected. This detailed analysis will enable the Trust to deliver appropriate corrective actions during 2016-17.

3.3.2. Health, work and well-being

The Boorman review (2009) stated that NHS organisations which prioritise staff health and well-being achieve enhanced performance and improve patient care. In recognition of the benefits of a healthy workforce, the Trust has a proactive Health, Work and Well-Being (HWWB) Service in place. The Trust scored in the top 20% of acute hospitals nationally in the latest staff survey for interest in and actions on health and well-being, demonstrating our commitment to staff welfare. The Service has worked alongside Human Resources and managers during the year to try to reduce sickness absence, including helping staff to remain healthy and supporting staff to return to work following absence.

Stress continues to be the main cause of absence and over the last twelve months there have been workshops developed by the Service to signpost staff to relevant support so that they can be proactive in managing their stress issues. These have

included ‘You and Your Well-Being’ and the ‘Letting Off Steam Initiative’ where staff could drop in and see a Counsellor without an appointment.

The HWWB Service has worked in partnership with the Health and Safety Team, performing a trend analysis to see where the highest number of incidents have occurred and then arranged roadshows to advise staff, for example, on the reduction of slips, trips and falls. The Service has also put on roadshows for general health promotion which encompass National Institute for Health and Care Excellence (NICE) Guidance.

The Flu Campaign for 2015-16 was launched at the HWWB annual open day in September. The Trust’s vaccination uptake for frontline staff was 78.6%, an overachievement of the target of 75%.

The HWWB Service successfully completed its annual self-assessment for Safe Effective Quality Occupational Health Services and was once again successful in reaching all of the required standards.

New systems have been put in place to work towards a paper-lite work area to deliver a more effective and efficient service. The new starter health assessment is now paperless and further developments will include the roll out of IT systems so that all management referrals and responses will be electronic and, therefore, more timely.

3.3.3. Education and training

The Clinical Education team have successfully implemented a number of new initiatives during the year including:

- Introduction of the Care Certificate, which defines a set of minimum standards that all social care and health support workers maintain in their daily working life. It defines the new minimum standards that should be covered for all new care support workers and forms part of redesigned induction training for our Healthcare Assistants.
- Increased the use of simulation and technology enhanced learning to support clinical competence and patient safety. In-situ simulation, already implemented across a number of areas, has been expanded with the introduction of paediatric simulation in the emergency department.

The Trust’s non-clinical development priorities are delivered by the Leadership & Organisational Development (L&OD) team, who provide a diverse range of programmes that support knowledge, skills and competency development, behavioural awareness and change for individuals and teams, across all staff groups. This supports our staff to deliver 5-star patient care. Over the past 12 months examples of the work the L&OD team have introduced and delivered are:

- **Apprenticeships**: over 100 staff are progressing through an apprenticeship in a range of level 2/3 qualifications, including Health - Maternity & Paediatric

Support, Health - Clinical Healthcare Support, Team Leading, Team Management and Business Administration.

- **Coaching Skills:** a range of workshops developed and rolled out to provide coaching skills for managers/leaders, from Supervisors, team leaders and managers up to Board members. The objectives of these workshops are to develop communication skills and support the use of coaching style conversations with team members and colleagues, with the wider aim of embedding a coaching culture within the Trust.
- **Little Big Conversations:** L&OD have developed and implemented these staff engagement and consultation events; the first being two half-day events held during 2015 that covered the subjects of 'Speak out Safely' and 'Realising the Trust Values'. A cross-section of around 40 Trust staff attended each event.
- **Ward Manager and Matrons Leadership Development**: initiated in 2015 this is a nine month programme that was developed in-house by L&OD; for Trust band 7 & 8 nursing leaders (80+ staff) across four cohorts. The programme is designed to support nursing staff in their roles as leaders of teams/departments; to reflect and build on their strengths, their role and abilities, to learn new skills and to learn more about themselves and how they can pro-actively take this learning back to the work-place to have even greater influence on care. They gain skills that will drive and sustain change, building a culture of patient-focused care at a departmental or functional level. They also gain greater business acumen and develop enhanced people management skills. The programme supports the Nursing and Midwifery Council's revalidation requirements including reflection and professional development discussions.

3.4. Patient safety

St Helens and Knowsley Teaching Hospitals NHS Trust was recognised for exceptional surgical safety and was selected as a finalist in the National Patient Safety Awards, in the category of Education and Training in Patient Safety. The successful project demonstrated the impact of a team-wide approach in Human Factors training. All members of the Trust's theatre teams were trained in Human Factors and the use of newly designed safe systems. The new systems were designed to enhance the overall safety of surgical procedures, whilst supporting the working needs of the clinical teams providing high quality patient care. Human Factors is the study of the interface between humans, equipment, the environment and each other. The project was measured over a three year period and demonstrated outstanding reductions in episodes of patient harm. Low harm was reduced by 58%, moderate harm by 70% and zero episodes of severe harm were recorded following the implementation of the project. This continuous work stream is just one of multiple projects currently enhancing the safety of each and every patient who enters the Trust and is a significant part of ensuring that the organisation provides 5-star patient care.

3.4.1. Patient safety improvement plan: sign up to safety campaign

The Trust's patient safety improvement plan includes our commitment to the 2015 Sign up to Safety plan which puts safety first by **c**ommitting to reducing avoidable harm by half and to publishing our goals and plans that have been developed locally. Our commitment is to:

- Reduce avoidable harm by 50% over three years (2015-18) - avoidable harm is harm that can be prevented
- Maintain a 50% reduction in theatre-related episodes of avoidable harm. Data for 2015-16 shows a 52% reduction in episodes of patient harm, measured against the project benchmark date from 2012-13.
- Reduce the incidence of Clostridium difficile and avoidable MRSA infections. There were no incidents of MRSA bacteraemia in 2015-16 and the incidence of Clostridium difficile was reduced from the previous year.
- Reduce prescribing error rates through the implementation of an error response and re-education system.
- Implement an Electronic Modified Early Warning Score (eMEWS) System to increase the efficiencies in the identification of the deteriorating patient, ensuring appropriate escalation and timely intervention. This was implemented in 2015-16 and its effectiveness will be implemented in 2016-17.
- Reduce to zero the number of never events reported in the organisation. There have been no never events since May 2013.
- The Trust will have zero tolerance on hospital acquired grade 4 pressure ulcers and will continue to seek to reduce harm from pressure ulcers at all grades by 50%. There has been a 15% overall reduction in all grades of pressure ulcers this year, with a 50% reduction of grade 3 and no grade 4s. The Trust proactively review all patients who are admitted with a pressure ulcer and liaises with the community tissue viability team to ensure findings and to ensure continuity of treatment for the patients.
- Continue to seek a reduction in harm from inpatient falls. There has been an overall 4% reduction in falls resulting in harm during 2015-16. However, following the implementation of the new falls prevention strategy and action plan in September there has been a significant improvement in the prevention of falls in the second half of the year. The actions have included fitting additional handrails on Older People's wards, use of non-slip anti-embolism stockings, refocus on staff training, increased surveillance and audit, investment in falls alarms and staff engagement via an open day.
- Introduce patient safety briefings to increase staff awareness of risk. Pilot studies have commenced to test the use of the patient safety briefing tool.

3.4.2. Duty of candour

The duty of candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have, or could have, led to significant harm (categorised as moderate harm or greater in severity).

The Trust promotes a culture of openness, honesty and transparency and our statutory duty of candour is delivered under the Being Open - A Duty to be Candid Policy, which sets out our commitment to being open when communicating with

patients, their relatives and carers about any failure in care or treatment. This includes an apology and a full explanation of what happened with all the available facts.

The Trust operates an open learning culture, within which all staff feel confident to raise concerns when risks are identified and then contribute fully to the investigation process in the knowledge that learning from harm and the prevention of future harm are the organisation's key priorities.

The Trust's incident reporting systems have been upgraded to record the information provided to the patient, family or carers to ensure that the Trust's ambition to be 100% compliant with this national statute is both measurable and delivered consistently in line with the Trust's policy. Every patient who suffers or is suspected of suffering an incident of harm categorised as moderate harm or above will receive an apology in person, followed by a letter of apology within 10 working days of the date that the incident was identified. The letter explains the investigation process and provides assurance that the organisation will learn lessons and implement change to ensure that the risk of any further episodes of avoidable patient harm is reduced.

3.4.3. Infection prevention and control

The Trust's infection prevention and control priorities are to:

- Reduce the incidence of Clostridium difficile infections by working collaboratively across the whole health economy
- Identify, monitor and prevent the spread of multi-resistant organisms throughout the Trust

The Trust had a Trust Development Authority (TDA) peer review infection control visit in June 2015. The TDA team consisted of infection control specialists, quality leads, chief nurses and GP representatives from the local Clinical Commissioning Groups and community and acute hospitals in the North West.

The team visited various clinical areas at the St Helens and Whiston hospital sites and interviewed staff, including consultants, junior doctors, matrons, nurses, housekeepers and domestics regarding infection control practice.

The feedback from the visit noted that the team was impressed with the engagement and ownership of staff at all levels on infection control issues and were assured that infection control is embedded within the Trust. The team highlighted the high standard of cleanliness in the hospitals, the bright and airy nature of the buildings and the ratio of individual side rooms to four-bedded bays within the hospital.

The areas for improvement highlighted have been addressed, including improving aseptic non-touch technique (ANTT) facilities in the Emergency Department and usage of personal protective equipment (PPE) by domestic staff.

Overall the experience was extremely valuable for both the Trust and members of the TDA team.

3.4.4. Safety Thermometer

The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care during hospital stays. This measures four key harms: pressure ulcers, falls, catheter acquired urinary tract infection and venous thromboembolism (VTE) (blood clots). The Trust has continued to achieve over 98% new harm free care, that is harm that has occurred whilst an inpatient.

Data for all inpatients is collected on one day every month. This identifies harms that patients are admitted with from home and harms which occurred whilst in hospital. The results from this audit are validated by specialist nursing staff. Once validated, the information is then submitted to the NHS Information Centre.

The Trust has consistently achieved new harm free care above 98% and is one of the best performing trusts in the region.

Overall, the Trust has made significant progress in embedding good practice in relation to the prevention of pressure ulcers, falls with harm and VTE.

This was achieved by:

- Ensuring education and training is available for all ward staff to enable them to complete and submit the NHS safety thermometer as required
- Establishing tissue viability link nurses within the ward areas
- Identifying trends and themes from the five most recent root cause analysis investigations of falls that resulted in harm
- Evaluating the performance of the implementation of the action plans and their effectiveness
- Formation of a monthly panel to review the Trust's moderate harmful falls with input from ward staff
- Formation of the strategic falls group to meet monthly to oversee the implementation of the revised falls strategy and performance manage the associated action plans
- Ensuring, when possible, a one-to-one staffing ratio is implemented when indicated by the risk assessment for falls
- All patients over the age of 65 having a lying and standing blood pressure performed as soon as practicable
- Replacing all anti-embolic stockings with non-slip versions
- Continuing to provide education for all clinical staff on VTE, resulting in increased compliance with the prescribing and administration of anticoagulants to prevent these occurring

3.4.5. Safeguarding

The Care Quality Commission made positive references to both safeguarding children and adult practice at the Trust and the knowledge and awareness of staff, in its report on the August 2015 inspection.

In February 2016 NHS England published safeguarding competences for those involved in caring for adults which is the equivalent of the longstanding set of competences for safeguarding children. This will require a review of the training needs analysis as a priority in the next year.

The Trust's safeguarding assurance framework has separate Safeguarding Children and Adult Steering Groups which meet quarterly to manage activity reporting, learning from experience and information sharing across the Trust.

Safeguarding adults

The Trust continues to work proactively with St Helens, Knowsley, Halton and Liverpool and Sefton Safeguarding Adult Boards either directly as Board Members or, as in the case of Liverpool and Sefton as a member of the Health Sub-Group. An increasing part of this work is contributing to potential Safeguarding Adult Reviews which are being identified in increasing numbers by localities in line with Care Act 2014 Guidance. This work entails reviewing all Trust activity relating to identified individuals and sharing relevant records where appropriate.

The new categories of abuse detailed in the Care Act 2014 include both modern slavery and self-neglect and have required the Trust to integrate them into its training packages and to begin to implement new processes, particularly the National Reporting Mechanism with Modern Slavery. Much work needs to be done with our partners in understanding these complex issues and how they will present to an acute trust.

A significant part of the Trust's Safeguarding Adult commitments are delivered through its work in supporting patients who have additional needs and who are potentially 'adults at risk'. Areas which have been targeted are patients with learning disabilities, mental health, patients with housing needs and those who may not have the mental capacity to make decisions about hospital and their care and treatment. This work powerfully promotes the prevention agenda.

Safeguarding children

The Trust continues to work proactively with St Helens, Knowsley and Halton Safeguarding Children Boards either directly as Board Members (St Helens) or, as in the case of Knowsley and Halton as a member of the Health Sub-Group. The Trust continued to be involved in action planning from the locality OFSTED Inspections of the previous year. This work is taking account of preparation for the new style inspection formats which will involve the Care Quality Commission coming into the Trust directly.

The Trust is working with all partners, both strategically and operationally to identify children and young people at risk of involvement in child sexual exploitation and to be alert to presentations at the Trust.

Domestic abuse

The Trust provides representation at both the St Helens and Knowsley Multi-Agency Risk Assessment Conferences (MARAC) and provides reports to other MARACs by

exception. The Trust provided input to two domestic homicide reviews and has fully reviewed its own actions and made recommendations in anticipation of formal reporting. All recommendations have been completed.

The Trust reviewed its Domestic Abuse Policy and training needs analysis to ensure its compliance with NICE guidance published in February 2014.

Mental Capacity Act
The Trust reviewed its Mental Capacity Act Policy in 2015-16 to ensure that it complied with recent case law and the developing knowledge base around deprivation of liberty safeguards. All areas have received additional training which has been very well received and staff have good awareness of the Mental Capacity Act framework, which was noted in the CQC Report (January 2016).

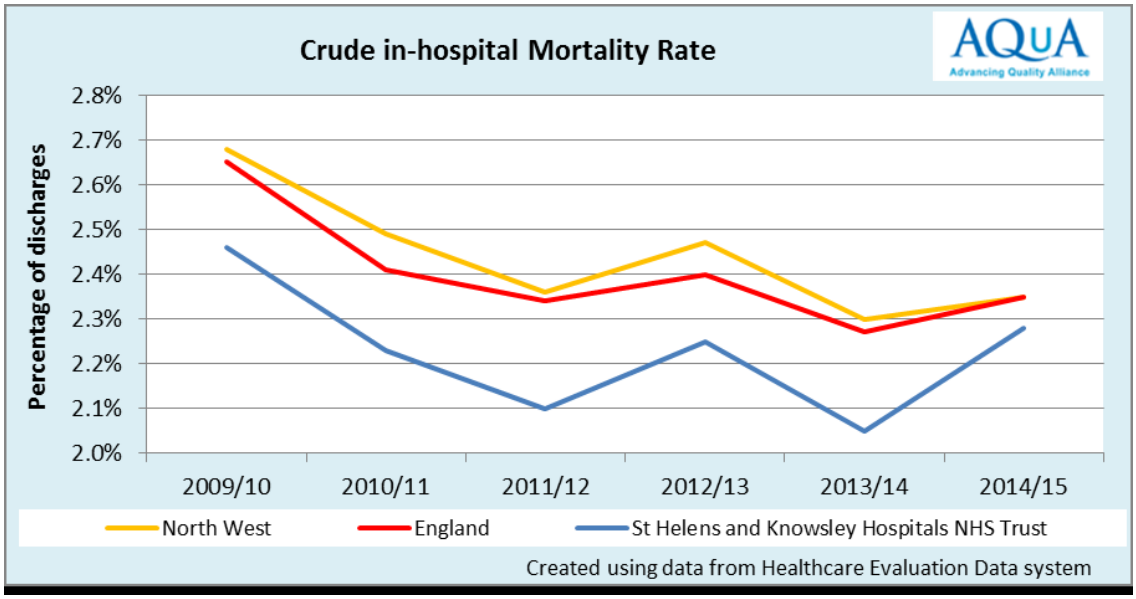
Deprivation of liberty safeguards
The Trust has continued to manage its deprivation of liberty safeguards authorisations through the safeguarding Team. The increased level of training and awareness has resulted in 190 applications being made in the period with 44 being declined. This is an increase from 69 from the previous year. The Trust meets on a regular basis with its 'Supervisory Authorities' to manage issues of concern and look into individual cases.

3.5. Clinical effectiveness

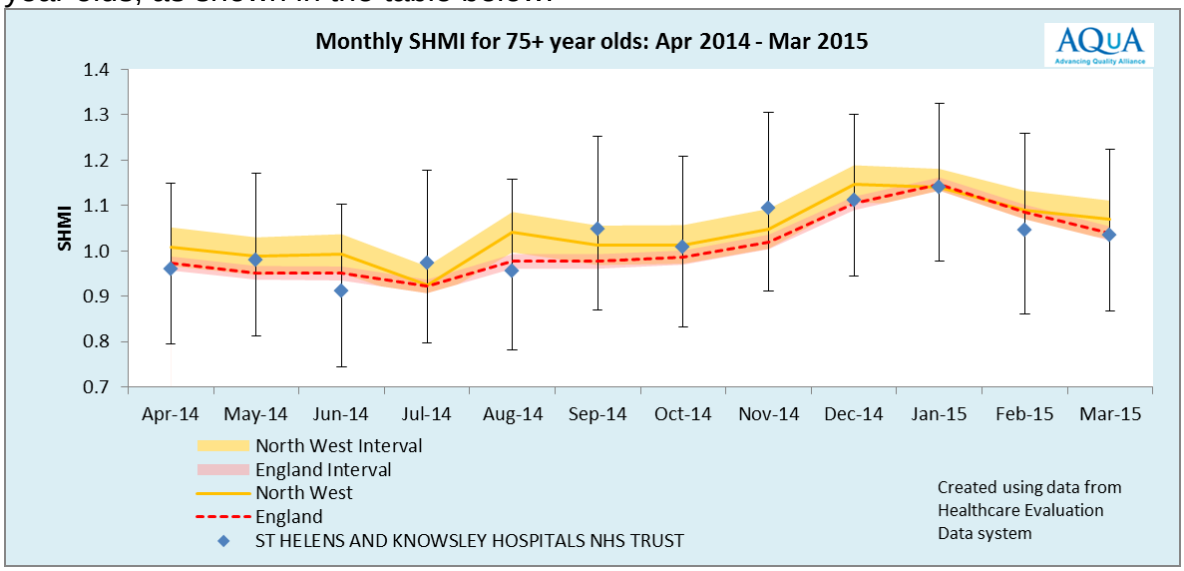
The Clinical Effectiveness Council meets monthly and monitors key outcome and effectiveness indicators, such as mortality, nationally bench-marked cardiac arrest data, critical care performance, hip fracture performance, readmissions, Advancing Quality, clinical audit and application of NICE guidance. Several areas reviewed by the Council are outlined in the sections below.

3.5.1. Mortality

The Trust benchmarks strongly in the North West for crude mortality and against the government's preferred measure, the Standardised Hospital Mortality Index (SHMI), where St Helens and Knowsley Teaching Hospitals NHS Trust is amongst the best in the North West as shown in the table below:



The Clinical Effectiveness Council examines mortality not only for the Trust as a whole, but also for a wide range of patient groups. For example, mortality in over 75-year olds, as shown in the table below:



In 2015-16, the Trust invited external review of its mortality processes by Mersey Internal Audit Agency and gained 'significant assurance' that the processes were robust.

3.5.2. Clinical microbiology

In 2014, the Trust introduced a full 24 hour, seven day on-site clinical microbiology service, the first in the region. This was enhanced in 2015-16, by increasing the number of staff on site during the night. From June 2015, our service has also provided clinical microbiology to Southport & Ormskirk Hospital NHS Trust and community users from the St Helens and Knowsley Teaching Hospitals NHS Trust site. This has led to a more effective and efficient service, with all urgent samples

being processed within an hour of arrival and approximately 125,000 (25% total workload) clinical specimens processed during the night with the results now available a day earlier for our patients. Further improvements mean that all positive blood cultures (usually about 10 per day) are dealt with when they flag positive. This has meant that the medical staff have far more information, up to five hours earlier, with which to target appropriate therapy.

3.5.3. Stroke performance

The Trust's stroke performance was subject to an internal improvement plan monitored by Clinical Effectiveness Council (discussed in last year's Quality Account). The Trust has seen transformational change and is now the 3rd best performer in England in the Sentinel Stroke National Audit Programme.

DN: Insert in call out box
The Therapies Service has seen steady improvement recently against the Sentinel Stroke National Audit Programme (SSNAP) and the Trust overall SNNAP performance is now at A (levels A-E, A being the highest); SNNAP has been used to drive quality improvement and an example is the introduction of the breakfast club.

This is a new initiative introduced by therapies on the stroke ward, where a room has been decorated to resemble a home dining room. The catering staff provide breakfast for a number of stroke patients in this designated area rather than at their bedsides. This group activity has a number of benefits for the patients, including delivering a number of activities of daily living, ensuring improved self-esteem through washing, dressing and combing of hair, improved mobility in transferring from the bedside to the dining room and improved posture through seating at a normal table. A key benefit is interaction with other patients, providing the opportunity to practice communication and cognition.

3.5.4. NICE guidance

The Trust's systems for reviewing and adopting NICE guidance (evidence-based best practice) were assessed internally and externally by the Care Quality Commission (CQC) and found to be high quality.

3.5.5. Intensive Care National Audit & Research Centre (ICNARC)

The Trust benchmarked favourably against this national audit, not least in terms of a transformation programme to improve timely transfer from Critical Care Unit to the wards, which has seen the Trust move from substantial delayed discharges to strong performance. Mortality against one of the two predictive models for critical care has risen and the Trust is undertaking work to understand the difference between the two mortality models.

3.5.6. Advancing quality (AQ)

This was presented in detail in the Quality Account for 2014-15.

3.5.7. Copeland risk adjustment barometer (CRAB)

CRAB monitors surgeon performance and provides assurance that individual surgeons are performing well in the spectrum of their individual practice. Performance of surgeons both individually and collectively is strong.

3.5.8. Never events

Never Events are serious incidents that are preventable due to national guidance or safety recommendations that healthcare providers should put in place. The Trust remains free from never events and has a Safer Surgery Collaborative that constantly looks for new ways to improve surgical safety. One of its developments, the HALT tool, has been proven to prevent never events and is being adopted elsewhere nationally.

3.5.9. Clinical audit

The Trust has an active clinical audit programme and is an active participant in required national audits where performance is strong. Our management of clinical audit was reviewed by Mersey Internal Audit Agency this year and found to provide significant assurance. Details of the work undertaken this year are contained in section 2.3.2 above.

3.5.1. Accreditation of Department of Anaesthesia

The Department of Anaesthesia at St Helens and Knowsley Teaching Hospitals NHS Trust is the first in the North West region and only the 8th department in the country to be awarded accreditation status by the Royal College of Anaesthetists. The accreditation process included an in-depth review of both Whiston and St Helens sites by the anaesthesia clinical services accreditation (ACSA) panel. The panel consisted of five people who benchmarked the service against an extensive list of standards by means of interview, paperwork examination and 2 separate site review walk-abouts. They looked at four domains; the care pathway, equipment facilities and staffing, patient experience and clinical governance. All of the standards are mapped to the five key lines of enquiry used by the CQC.

3.5.2. Promoting health

The Trust actively promotes the health and well-being of patients by undertaking a holistic assessment on admission that looks at physical, social, emotional and spiritual needs. Patients are referred or signposted to relevant services, for example, dieticians, smoking cessation and substance misuse. The initial review of patients includes a number of risk assessments that are used to highlight specific concerns that are acted upon, including nutrition and hydration and falls. The Trust has a Smoke Free Policy in place that ensures a healthy environment for staff,

patients and visitors, with measures in place to support staff and patients to give up smoking. In addition, the Maternity Service was awarded the Baby Friendly Initiative, which actively promotes breast feeding.

The Trust works in partnership with other agencies to provide holistic services throughout the patient's journey to ensure a seamless service, supported by integrated pathways across the hospital and community settings. Examples of this include the work of our Community Falls Team, who work collaboratively with primary and community care and our Infection Prevention and Control Team who liaise closely with community teams and GP services.

3.6. Patient experience

Whiston and St Helens hospitals were named as the best hospitals in the UK for patient experience in 2015. The award from CHKS Top Hospitals recognised the consistently high standards of care provided to patients at St Helens and Knowsley Teaching Hospitals NHS Trust. The Trust was chosen following an analysis of external performance data in five areas:

- CQC inpatient survey
- CQC Emergency Department, outpatients and maternity surveys
- National Friends and Family Test (FFT) scores
- Patient-Led Assessment of the Care Environment (PLACE) in which the Trust has also been named the best acute provider in the NHS
- Patient Reported Outcome Measures (PROMS)

This award underlines the hard work of all staff who continue to strive for excellence and reflects the Trust's vision to provide 5-star patient care. The Trust has been shortlisted again in this category for the forthcoming awards.

The Trust actively engages with patients through a number of initiatives:

- Introduction of Patient Participation Group looking at services across the Trust and ways to further improve care and the environment on a monthly basis.
- Patient stories at the Trust Board and the Patient Experience Council to discuss both experiences that were positive and those we can learn from to make services better, no matter how small the change
- Learning from patient stories and providing 'lessons learnt' to staff across the Trust
- Support from the specialist cancer nurses for Gutsy Guys, a group of patients who have in some way either directly or via a loved one been affected by an upper gastro-intestinal (GI) cancer, such as stomach or oesophageal cancer. This year the patients ran an event to promote early symptoms of upper GI cancers for both the public and professionals.

The Trust is committed to listening to our patients and engaging with them to improve the services we deliver. The Patient Advice and Liaison Service (PALS) is the Trust's eyes and ears and the team interacts on a daily basis with our patients, relatives and carers to provide help, advice and support. Two main areas for improvement were identified from feedback from patients; the availability of the team

and higher visibility, particularly with the office environment. This has led to extending the opening hours, with greater access for our patients, and a refurbished office to provide greater presence in the main reception area, with a more comfortable environment for our patients to share their experiences.

DN: Display in call out box
A further area for improvement identified through patient comments was the booking and rearrangement of appointments. A new 'queue buster' system has been commissioned by the Trust, that calls patients back should they choose not to wait in a queue at busy times. If they opt for the call back option, they can hang up and, without losing their space in the queue, an appointments clerk calls them back when it is their turn. The new service has been working well, with patients commenting on how useful the service is.

DN: Display in call out box
The Trauma and Orthopaedic Directorate also created an admission lounge in March 2015. It was developed as part of the Directorate's strategy to improve patients' experience pre-operatively.

Patients are informed at their pre-operative assessment that they will attend the lounge on the day of surgery. The admissions nurse explains to the group what will happen on the day and they are given an information leaflet about the reasons for their stay in the lounge. Patients attend on the day of their operation and are assessed by the medical teams. Patients are given an estimated time of surgery and they are free to come and go as they please, being called to theatre from the lounge area at the appropriate time.

The unit has seen approximately 1700 patients in the last ten months. The number of patients who have had their surgery cancelled due to lack of available beds has reduced as a result of this initiative. Patients are pleased with the unit as they feel they are well informed and do not have to worry about not getting a bed. A dedicated nursing team is available to assist patients and keep them regularly informed about what is going on, thus improving the patient experience.

3.6.1. Friends and Family Test

The national Friends and Family Test (FFT) evaluates patient experience as soon after treatment as possible, highlighting when there are high levels of patient satisfaction and where improvements could be made.

Indicator	Source	Reporting Period	STHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Friends & Family Test - A&E -	NHS England	Mar-16	15.1%	12.0%	0.8%	47.2%	M

Indicator	Source	Reporting	STHK	National Performance			
Response Rate							
Friends & Family Test - A&E - Response Rate	NHS England	Feb-16	16.9%	13.3%	0.2%	46.4%	
Friends & Family Test - A&E - Response Rate	NHS England	Jan-16	13.3%	12.9%	0.4%	39.9%	
Friends & Family Test - A&E - Response Rate	NHS England	Dec-15	11.2%	12.7%	0.0%	44.3%	
Friends & Family Test - A&E - % recommended	NHS England	Mar-16	84.8%	83.5%	49.3%	98.9%	
Friends & Family Test - A&E - % recommended	NHS England	Feb-16	84.6%	84.9%	46.3%	100%	
Friends & Family Test - A&E - % recommended	NHS England	Jan-16	85.0%	86.3%	52.5%	100%	
Friends & Family Test - A&E - % recommended	NHS England	Dec-15	93.5%	87.4%	57.6%	100%	
Friends & Family Test - Inpatients - Response Rate	NHS England	Mar-16	24.4%	24.1%	5.5%	100%	
Friends & Family Test - Inpatients - Response Rate	NHS England	Feb-16	26.2%	24.9%	6.1%	100%	National average includes Independent Sector Providers
Friends & Family Test - Inpatients - Response Rate	NHS England	Jan-16	24.5%	24.3%	4.6%	100%	
Friends & Family Test - Inpatients -	NHS England	Dec-15	23.3%	23.4%	4.7%	100%	

Indicator	Source	Reporting	STHK	National Performance			
Response Rate							
Friends & Family Test - Inpatients - % recommended	NHS England	Mar-16	95.6%	95.7%	74.2%	100%	
Friends & Family Test - Inpatients - % recommended	NHS England	Feb-16	96.1%	95.7%	74.2%	100%	
Friends & Family Test - Inpatients - % recommended	NHS England	Jan-16	95.5 %	95.7%	72.7%	100%	
Friends & Family Test - Inpatients - % recommended	NHS England	Dec-15	96.5%	95.6%	73.4%	100%	

At the beginning of January 2016 we changed service providers to roll out Friends and Family Test to all areas and to increase the numbers being surveyed from 3500 to 35000 each month. The new provider has a fully automated reporting system providing informative reports with comments collated into themes and with trends incorporating demographic data.

This will enable areas to obtain and review all responses and to continue to monitor and maintain a high quality and standard of service. This new system also enables areas to produce action plans as a direct result of the feedback received that will enable best practice to be shared to other areas throughout the trust.

DN: present in call out box

The list below provides examples of some of the comments received and the responses provided to this feedback from the FFT during 2015-16:

- **You said, "The staff did not give us proper information."**
- We are working on our discharge checklist to provide accurate and updated information on discharge from hospital.

- **You said**, "**Short staffed, need more nursing assistants."**
- We are currently recruiting into our vacancies and review this regularly. Staffing is reviewed on a daily basis and any identified shortfalls are managed appropriately.

- **You said "The staff are very helpful and are there when you need them, they are all a lovely bunch."**
- We replied, "We are here to help you and your family at this time. We endeavour to make ourselves available to you in a friendly and approachable manner."

- **You said, "99/100; the only slight fault, it appeared not enough nurses on duty Saturday PM. They were overrun with issues more important than mine."**
- Ward staff were reminded to consider the feelings of all patients as the smallest things often makes the biggest impact.

- **You said, "The treatment given was first class, the staff, especially the nurses and catering staff were friendly and efficient. The food was good. "** We said, "Thank you to the caterers who provide a good choice of food."

- **You said, "I was immediately put at ease. The friendliness and professionalism of all staff was amazing, despite being in a single ward the 3 weeks just flew by".**
- We said, "Positive feedback disseminated to all disciplines at daily Multi-Disciplinary Team."

3.6.2. Complaints

The Trust takes patients' complaints extremely seriously and has put measures in place during the year to improve the timeliness of responses to those who made the effort to highlight concerns about their care. The average time to respond to new complaints improved from 35.5% in 2014-15 to 61.4% of new complaints responded to within the agreed timescale during 2015-16. In 2015-16, the Trust received a total of 292 complaints overall, of which 276 were written complaints. One written complaint was withdrawn, resulting in a total of 275 written complaints for the year. This compares to 281 new complaints received in 2014-15.

The Trust has made a number of changes to services following complaints, including:

- Introduced open visiting on a number of wards to improve communication with patients, carers and families
- Increased the presence of pharmacy technicians on the wards to reduce the need for medication charts to be removed from the clinical areas, thus reducing the number of missed doses
- Provided customer care and conflict resolution training for staff
- Additional training on electronic system to ensure discharge letters are sent
- Outpatient referral forms amended to ensure patients' additional needs are identified prior to attending the department so that these can be more readily met
- Amendments made to information leaflets to raise awareness that patients may be seen by different medical staff
- Posters displaying the uniforms different staff members wear installed on each ward
- Reinforcement of the Trust's ACE behavioural standards

The Trust introduced a complaints satisfaction survey in 2015, in order to identify key areas for improvement in the management of the complaints process. Overall the majority of respondents to the survey were satisfied with how easy it was to make a

complaint, had their complaint acknowledged within three working days and were provided with a contact number for the complaints team. However, the area of most dissatisfaction was in the length of time taken to respond, so in order to improve the timeliness of responding to complainants going forward, the Trust has taken the following actions:

- Implemented weekly compliance monitoring
- Continued to invest in complaints writers to support the clinical teams in the complaints investigation process
- Provided additional training for statement writers

This remains a key area for improvement and, therefore, the Trust is in the process of implementing a revised complaints team structure, which will include clinical staff. This will be supported by key performance indicators and clear targets for improvement, as well as learning from organisations that perform well in this area.

3.7. Summary of national patient surveys

3.7.1. National cancer patient experience survey (NCPES)

The Trust participated in the NCPES survey, however the results have not yet been published. The findings of the survey will be published in next year's Quality Account.

NHS England, in response to the 2014 National Cancer Patient Experience Survey, set up a buddying scheme to enable those trusts rated in the top five to provide mentorship and support to those in the bottom five.

St Helens and Knowsley Teaching Hospitals NHS Trust was 4th nationally and was buddied with Ashford and St Peter's Hospitals NHS Foundation Trust. This led to the sharing of best practice to raise performance. The programme ran from May to December 2015. The two trusts had multiple teleconferences, during that time, to discuss challenges in delivery of cancer care and a team from Ashford and St Peter's had the opportunity to visit St Helens and Knowsley Teaching Hospitals NHS Trust for a day to look at our cancer services, meet the team and visit diagnostic services. Ashford and St Peter's Hospitals NHS Foundation Trust have introduced some new working structures and improved their engagement with their executive team to move the cancer agenda forward, as a result of the scheme.

3.7.2. National inpatient survey

The Trust participated in the annual National Inpatient Survey coordinated by the CQC.

The results were published in June 2015 and were broadly consistent with the previous year's survey for our Trust. The feedback from patients continues to indicate that the care provided at Whiston and St Helens hospitals is amongst the best in the country.

The Trust was included in the 'best performing' trusts nationally across five indicators and was not included in the 'worst performing' trusts for a single indicator. The standards of hygiene continue to be amongst the best in the country and the Trust achieved one of the highest national scores for ensuring that patients were given enough privacy when being examined or treated. The areas where we were rated in the best performing Trusts are:

- Were you given enough privacy when being examined or treated?
- In your opinion, how clean was the hospital room or ward that you were in?
- How clean were the toilets and bathrooms that you used in the hospital?
- Were you ever bothered by noise at night from other patients?
- Were you ever bothered by noise at night from hospital staff?

The full benchmarked results can be found on the Care Quality Commission's website at http://www.cqc.org.uk/

3.7.3. National survey of women's experiences of maternity services 2015

The results of the survey were published in December 2015 and show that the Trust received the highest score nationally for six of the questions, including being:

- Given the help needed when contacting a midwife during pregnancy
- Involved enough in decisions about antenatal care
- Spoken to in an understandable way during labour and birth
- Told who to contact if needing advice about emotional changes after birth

The Trust did not score in the worse ratings for any of the questions asked and the answers given demonstrated that the care was above the national average in a number of questions, especially in relation to:

- Information received
- Being given enough time to ask questions
- Involvement of partner or someone close during labour
- Cleanliness of the facilities.

We are taking a number of actions to further improve the service, including developing our normality strategy to increase the range of choices for women for both the lead professional and the place of birth.

4. Annex

4.1. Statement of directors' responsibilities in respect of the Quality Account

The Board of Directors is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2012) to prepare a Quality Account for each financial year.

The Department of Health issues guidance on the form and content of the annual Quality Account, which has been included in this Quality Account.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered 2015-16
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with Department of Health guidance.

The Board of Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Richard Fraser
Chairman
Date: XX 2016

Ann Marr
Chief Executive
Date: XX 2016

4.2. Written statements by other bodies

4.2.1. Local Healthwatch – Halton

Commentary on
St Helens & Knowsley Teaching Hospitals NHS Trust
Quality Account 2015-16

Healthwatch Halton welcomes the opportunity to provide this commentary on St Helens & Knowsley Teaching Hospitals NHS Trust Quality Account for 2015/16.
The report is very detailed and well written.
The Trust is to be congratulated on the excellent service given in:

- The Overall Quality Service provided
- Patient Safety
- Patient Experience
- Clinical Effectiveness
- Leadership

Healthwatch Halton is pleased to see the recognition of staff by both internal and external awards.
The Trust's participation in so many clinical audits is noted and we are encouraged to see the list of actions being taken to improve the quality of healthcare provided.
We would like to congratulate the Trust on achieving all its targets bar one, i.e. Emergency Department waiting time within 4 hours - 85% against target of 95%.
The Trust is also to be commended on achieving amongst the best North West Crude in-hospital Mortality Rates.
The priorities for improvement are clearly defined. We are encouraged to see the improvements this year in complaint response times from 35.5% to 61.3%, though we feel there is still plenty of room for improvement on this and we are pleased to note the target of 90% for next year.
We note that some other areas chosen have been priorities for a few years and we would hope to see similar improvements during the next 12 months in:

- Weekend mortality rates
- Patient discharge

We are pleased to note the Trust's inclusion of early identification and treatment of sepsis as a priority for the next 12 months.
The inclusion of patient comments in the report are welcome, as are the responses provided to the feedback from the Friends & Family Test.
The rating, for the second year running, of the best acute NHS Trust in England following the Patient Led Assessments of the Care Environment (PLACE) inspections is to be applauded.
Healthwatch Halton looks forward to being involved more closely with the Trust's work over the coming 12 months.

Doreen Shotton & Brian Miller
Healthwatch Halton Quality Account Leads

4.2.2. Halton Borough Council, Health Policy and Performance Board

Further to receiving a copy of your draft Quality Accounts and the Joint Quality Accounts event held on 19th April that your colleagues Sue Redfern and Anne Rosbotham-Williams attended to present a summary of your Quality Accounts, I am writing with the Health Policy and Performance Board comments. The Health Policy and Performance Board particularly noted the following key areas:

During the year 2015/16 the Board were pleased to note that the Trust achieved all three of their priorities. The Board noted in particular, the following:
Under the Quality of Services overall, the Board were very pleased to note that the Trust were rated as outstanding by CQC for Caring and that the following actions were being put in place in response to CQCs comments:

- Continue to work with your health economy partners to improve access to urgent and emergency care
- Continue to strengthen the processes to further reduce risks within maternity services
- Maintain robust systems for the storage of medications
- Continue to ensure the appropriate skill mix of staff and that the privacy and dignity of patients in coronary care unit is maintained at all times.

In terms of Patient Safety, the Board were pleased to note the following:

- No Never Events since 2013;
- 48% reduction in falls following the introduction of the Falls Strategy in October 2015; and
- 50% reduction in the number of Grade 3 pressure ulcers and no Grade 4 pressure ulcers.

The Board are pleased to note the following Improvement Priorities for 2016 – 2017:

- Reduce avoidable harm from falls, pressure ulcers and medication incidents by 50% in the next 3 years – this is an area that the Board are particularly interested to see a reduction;
- Further reduce mortality of weekend admissions;
- Earlier identification and initiation of appropriate treatment thus reducing mortality due to sepsis for patients attending the Trust.

The Board would like to thank St Helens and Knowsley Teaching Hospitals NHS Trust for the opportunity to comment on these Quality Accounts.

Yours sincerely,

Councillor Joan Lowe
Chair, Health Policy and Performance Board

4.2.3. Halton Clinical Commissioning Group

Re: Quality Report 2015-2016

Many thanks for submission of the Quality Report for 2015-2015 and for the presentation to local stakeholders on 19th April 2016. This letter provides the response from NHS Halton CCG to the Quality Report.

The CCG has now been in place for three years and we have I believe maintained excellent working relationships with yourself and the hospital team. NHS Halton CCG staff attend the Clinical Quality and Performance Group, which scrutinises the key quality indictors in the Quality Schedule and CQUINs in partnership with St Helens CCG who are the co-ordinating commissioner; these meetings are proving to be both effective and useful. NHS Halton CCG would like to congratulate the whole team for the on-going commitment to quality care for service users and their families. The CCG would like to note in particular the work of Mrs Sue Redfern Director of Nursing Midwifery and Governance and her team on the continued progress in relation to quality in this year. NHS Halton CCG values the constructive relationships we have formed and the ability to develop and maintain links to your clinicians and the commitment they have shown to improving the quality of services and working in partnership with the CCG as part of the One Halton Programme.

NHS Halton CCG welcomes the work delivered by the Trust in relation to improving care for patients and congratulates you on your successes in the area. The trust is to be congratulated on the positive performance in the recent Care Quality Commission inspection. The CCG notes the development and implementation of the Nursing and Quality Strategies and the delivery of your planned improvements targets NHS Halton CCG is also pleased to note the delivery against the commissioner quality priorities in particular improvements in stroke services and the 50% reduction in pressure ulcers. We would like to commend the Trust on its on-going commitment and progress in relation to visible clinical leadership.

NHS Halton CCG are pleased to see the planned Quality Priorities for 2015/2016 and the focus on continuous improvement in all areas.

We look forward to working with the Trust through 2016/17, helping to improve the quality of services for our patients through the NHS contractual mechanisms and the review and management of Serious Incidents, applying good governance and ensuring lessons are learnt throughout the Trust.

Yours sincerely

Jan Snoddon
Chief Nurse/Quality Lead
NHS Halton CCG
Email: jan.snoddon@haltonccg.nhs.uk

4.2.4. St Helens Clinical Commissioning Groups

Quality Accounts 2015-2016

On behalf of St Helens CCG I am writing to thank you for sharing St Helens & Knowsley Teaching Hospital NHS Trust draft Quality Account for comment. This letter of support for the Trust Quality account also summarises the key points discussed at the presentation meeting.

We would like to thank Sue Redfern and Anne Rosbotham-Williams for attending the event on the 6th May 2016 and presenting an overview of the work undertaken in the Trust during 2015-2016. The presentation was informative and there were many examples of excellent practice and evidence of a strong commitment across the Trust to effective, safe and compassionate care, and this was also evident throughout the Quality Account. The CCG recognises the hard work undertaken to improve quality across the Trust and the commitment from the Trust Board to maintain high standards, which was endorsed by CQC in your report.

The summary of quality achievements was excellent but it would have been useful to see last year's priorities at the beginning of the report as a comparison against the priorities for this year.

The CCG would like to see included within the account more focus on challenges within the Trust for example: falls and staffing, you presented that you have recruited from India to ensure safer staffing levels are achieved, however it is not detailed within the report. There was also a lack of information around the challenges in AED and VTE which we feel should have been incorporated into the quality account.

The Trust priorities for improvement to reduce avoidable harm from falls, pressure ulcers and medication incidents by 50% in the next 3 years are encouraging, and we agree that further embedding of processes from lessons learned would be a positive outcome.

From reviewing the draft quality accounts we noticed that there was no mention of the CQUIN and feel this should be incorporated into the report.

Lastly, I look forward to continuing to work with yourself and the Trust to ensure we provide effective high quality care for local people.

Yours sincerely

S O'Brien

Prof Sarah O Brien
Chief Nurse

4.2.5. Independent Auditor

4.2.6. Amendments made to the Quality Account following receipt of the written statements from other bodies

A number of changes were made following the presentation of the draft Quality Account to other bodies during April and May. This included enhancing the information provided on the work undertaken by the Trust in the following areas:

- Actions taken to meet the challenges within nursing recruitment (section 2.2)
- Delivering actions following the recommendations in the CQC report for meeting access targets in the Emergency Department and improvements in Maternity Services (section 2.4.5.1)
- Actions being taken to improve VTE risk assessment (section 2.4.10)
- Complaints management (section 3.6.2)
- Dementia care (section 3.1.2)
- Promoting health (section 3.5.2)
- Local employment opportunities (section 3.3)
- Safeguarding (section 3.4.5)

In addition, the summary of performance against last year's quality priorities was moved to earlier in the document, to section 2.2.

4.3. Abbreviations

AMU	Acute Medical Unit
AKI	Acute kidney injury
ANTT	Aseptic Non-Touch Technique
AQ	Advancing Quality
AQuA	Advancing Quality Alliance
BTS	British Thoracic Society
CEM	College of Emergency Medicine
CAMHS	Child and adolescent mental health services
CCGs	Clinical Commissioning Groups
COPD	Chronic Obstructive Airways Disease
CQC	Care Quality Commission
CQuIN	Commissioning for Quality and Innovation
CRN	Clinical Research Network
DATIX	Integrated Risk Management, Incident Reporting, Complaints Management System
ED	Emergency Department
EDMS	Electronic Document Management System
EDS or EDS2	Equality Delivery System
eMEWS	Electronic Modified Early Warning Score
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends & Family Test
GP	General Practitioner
GI	Gastro-intestinal
HCAI	Healthcare Acquired Infections
HES	Hospital Episode Statistics
HF	Heart Failure
HSCIC	Health and Social Care Information Centre
HSMR	Hospital standardised mortality ratio
HWWB	Health, Work and Well-being
IBRA	Implant Breast Reconstruction Audit
ICD	International Classification of Diseases
ICNARC	Intensive Care National Audit & Research Centre
ICO	Information Commissioner's Office
IGT	Information Governance Toolkit
LGBT	Lesbian, gay, bisexual, transgender
LTC	Long-term condition
MARAC	Multi-Agency Risk Assessment Conferences
MBRRACE-UK	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK
MDS	Myelodysplastic Syndromes
MET	Medical Emergency Team
MINAP	Myocardial Ischaemia National Audit Project
MODSS	Multidisciplinary Obstetric Drills, Skills, and Simulation
MRSA	Methicillin-resistant staphylococcus aureus
NAOGC	National Audit Oesophago-Gastric Cancer
NBOCAP	National Bowel Cancer Audit Programme
NCAA	National Cardiac Arrest Audit
NCEPOD	National Confidential Enquiry into Patient Outcome and Death

NDA(A)	National Diabetes Audit Adult
NDFA	National Diabetes Foot Care Audit
NELA	National Emergency Laparotomy Audit
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NNAP	National Neonatal Audit Programme
NPCA	National Prostate Cancer Audit
NPSA	National Patient Safety Agency
NRLS	National Reporting Learning System
PALS	Patient Advice and Liaison Service
PbR	Payment by Results
PEG	Percutaneous Endoscopic Gastrostomy
PLACE	Patient-Led Assessments of the Care Environment
PNDA	Paediatric National Diabetes Audit
PPE	Personal protective equipment
PROMs	Patient Reported Outcome Measures
PU	Pressure ulcer
RCA	Root Cause Analysis
RDI	Research Development and Innovation
SHMI	Summary Hospital-level Mortality Indicator
SIRO	Senior Information Risk Owner
SSNAP	Sentinel Stroke National Audit Programme
STP	Sustainability and Transformation Plan
SAH	Subarachnoid Haemorrhage
SUS	Secondary Uses Service
TARN	Trauma Audit & Research Network
TDA	Trust Development Authority
TIA	Transient Ischaemic Attack
VTE	Venous Thromboembolism