St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 31ST MAY 2017
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

A G E N D A				Paper	Presenter
09:30	1	Employee of the Month			Richard Fraser
		1.2	April		
		1.2	May		
09:40	2	Patient Story			Sue Redfern
10:00	3	Apologies for Absence			Richard Fraser
	4	Declaration of Interests			
	5	Minutes of the previous Meeting held on 26th April 2017		Attached	
		5.1	Correct record & Matters Arising		
		5.2	Action list	Attached	
Performance Reports					
10:10	6	Integrated Performance Report		NHST(17)045	Peter Williams
		6.1	Quality Indicators		Sue Redfern
		6.2	Operational indicators		Kevin Hardy
		6.3	Financial indicators		Peter Williams
		6.4	Workforce indicators		Anne-Marie Stretch
10:30	7	Complaints, Claims and Incidents		NHST(17)046	Sue Redfern
BREAK					
Committee Assurance Reports					
10:50	8	Committee report – Executive		NHST(17)047	Ann Marr

10:55	9	Committee Report – Quality		NHST(17)048	George Marcall
11:00	10	Committee Report – Finance & Performance		NHST(17)049	Denis Mahony
11:05	11	Committee Report – Audit		NHST(17)050	Su Rai
		11.1	Adoption of annual accounts	NHST(17)051	
		11.2	Audit plan approval	NHST(17)052	
Other Board Reports					
11:15	12	Strategic update report		NHST(17)053	Peter Williams
11:25	13	Approval of Quality Account *[received electronically]*		NHST(17)054	Sue Redfern
11:35	14	Information Governance report		NHST(17)055	Christine Walters/ Francis Andrews
		14.1	FOI Annual Report	NHST(17)056	
11:45	15	Review of Trust Objectives 2016/17		NHST(17)057	Ann Marr
11:55	16	Mortality: Learning from deaths in the NHS		NHST(17)058	Kevin Hardy
12:15	17	Meeting Effectiveness Review – revised set of Terms of Reference		NHST(17)059	Peter Williams
Closing Business					
12:20	18	Effectiveness of meeting			Richard Fraser
	19	Any other business			
	20	Date of next Public Board meeting – Wednesday 28th June 2017			

Minutes of the St Helens and Knowsley Hospitals NHS Trust Board meeting held on Wednesday, 26th April 2017 in the Boardroom, Whiston Hospital

PUBLIC BOARD

Chair:	Mr R Fraser (RF)	Chairman
Members:	Ms A Marr (AM)	Chief Executive
	Mrs A-M Stretch (AMS)	Deputy Chief Executive/Director of HR
	Mrs C Walters (CW)	Director of Informatics
	Mr D Mahony (DM)	Non-Executive Director
	Mr G Marcall (GM)	Non-Executive Director
	Prof K Hardy (KH)	Medical Director
	Mr N Khashu (NK)	Director of Finance
	Mr P Williams (PW)	Director of Corporate Services
	Mr R Cooper (RC)	Director of Operations & Performance
	Ms S Rai (SR)	Non-Executive Director
	Mrs S Redfern (SRe)	Director of Nursing, Midwifery & Governance
Apologies:	Prof D Graham	Non-Executive Director
In Attendance:	Mr T Foy (TF)	St Helens CCG
	Mrs K Pryde	Executive Assistant (Minutes)

1. Apologies for Absence

1.1. Apologies noted.

2. Declaration of Interests

2.1. There were no declarations of interest relating to the business to be discussed at the meeting.

3. Minutes of the previous meeting held on 29th March 2017

3.1. Correct Record and Matters Arising

3.1.1. The minutes were approved as a correct record.

3.2. Matters Arising

3.2.1. None noted.

3.3. Action List

3.3.1. Minute 6.4.2 (30.11.16): Appraisals. AM asked for an audit to be carried out to ensure that information regarding complaints is captured in medical staff appraisals. Guidance for doctors during appraisal is that reflections against complaints must be included. Dr

Terry Hankin is carrying out the audit. AMS will provide further feedback at the meeting in May.

3.3.2. Minute 11.5 (25.01.17): HR indicators. AMS will provide a trend line for bank, agency and overtime usage at the meeting in July.

4. IPR – NHST(17)035

4.1. Quality Indicators

4.1.1. SRe provided a brief update on Quality Indicators.

4.1.2. There were no never events in March. The year to date total is 2.

4.1.3. There were no cases of MRSA bacteraemia in March. Year to date there have been a total of 3 MRSA incidents and 1 contaminant.

4.1.4. There were 4 C.Diff cases in March, taking the year to date total to 23 confirmed positive cases; 2 cases are to be appealed in May.

4.1.5. There were no grade 3 pressure ulcers in March, leaving the year to date total at 3 (2 of which were unavoidable).

4.1.6. There were 3 falls that resulted in severe harm during February. Year to date there have been a total of 20.

4.1.7. VTE performance for February was slightly below the required 95% target at 94.28%.

4.1.8. The year to December 2016 HSMR is 102.0%.

4.2. Operational Indicators

4.2.1. RC provided an update on the Operational Performance. A&E performance was 80.1% (type 1) and 87.4% (types 1 and 3). RC has met with 60 A&E staff to go through actions and what improvements have been made.

4.2.2. RTT incomplete performance was achieved in month (93.49%). Additional activity funded by NHSE to reduce RTT backlog resulted in an additional 18 T&O patients and 1208 dermatology patients being cleared.

4.2.3. RMS was discussed at the Finance & Performance meeting and reported back to Board.

4.2.4. GM acknowledged that there had been a noticeable improvement in A&E figures.

4.3. Financial Indicators

4.3.1. NK provided an update of the Trust's financial position. Provisional results for the financial year 2016/17 are expected to show a surplus of £3.3m after technical adjustments which is in line with agreed plans and control totals.

4.3.2. NK informed the Board that a letter had been received on Monday, 24th April, from NHSI, regarding bonuses for organisations achieving their control total. It was agreed that this will need to be sensitively reported given the financial outcome of our lead CCG and the good partnership working between our organisations. TF thanked the Board and said that the situation was appreciated by the CCG. A bonus of £1.5m was given to the Trust, which will have to be declared in the 2016/17 figures.

4.3.3. NK advised that the Trust had not been informed when the money would come into the organisation, and this was likely to be when 2016/17 accounts have been signed-off.

4.3.4. The Trust has provisionally delivered £15.2m of CIPs which is in line with the annual plan.

4.3.5. The Trust's cash balance at the end of March was £1.8m, in line with the Trust's external finance limit and represents 2 days of operating expenses.

4.3.6. The Trust fully utilised its capital resources in the year of £3.5m.

4.4. Workforce Indicators

4.4.1. AMS provided an overview of the Workforce Indicators.

4.4.2. Mandatory training compliance exceeded the target by 6.6%. Appraisal compliance has continued to improve and has ended the year 2.39% above target following significant effort from managers and L&OD team to meet the 85% target.

4.4.3. Absence has decreased in March to 4.2% which is a 0.48% improvement on the Q4 target. At year end, sickness absence is a 0.1% improvement on last year's outturn at month 12.

4.4.4. GM expressed his thanks to the HR team for all their hard work.

5. Corporate Risk Register – NHST(17)037

5.1. SRe provided an overview of the Risk Register.

5.2. There are 686 risks on the register, which includes 15 high risks; 6 in Corporate Services, and 3 in each of the Clinical Support, Medical and Surgical Care groups. The risk categories are:

5.2.1. 10 regarding patient care.
5.2.2. 2 regarding money and governance
5.2.3. 1 regarding staffing.

5.3. The proportion of risks with an overdue review date has deteriorated from 13% to 44%. This is due to year-end review dates which should be better phased. CIP sign off compliance has significantly improved to 96.9%.

5.4. The Executive Committee has agreed that 3 risks should be removed from the Corporate Risk Register:

5.4.1. Risk 1152 regarding 16/17 agency expenditure.
5.4.2. Risk 1555 regarding the apprenticeship levy.
5.4.3. Risk 1797 regarding air blenders for resuscitaires.

6. Board Assurance Framework – NHST(17)038

6.1. SRe provided an update for the Board.

6.2. The Executive Committee had reviewed the BAF in advance of its presentation to Board. This has ensured that the BAF remains current; that the appropriate strategic risks are captured; and that the proposed actions and controls are sufficient to mitigate the risks. Changes/additions to the BAF are:

6.2.1. Risk 1 – implementation of Stroke Service integration with WHH – phase 2 planned completion in 2017/18.

6.2.2. Risk 2 – Develop a detailed STP implementation plan with Alliance LDS and C&M partners in line with the priorities outlined in the next steps FYFV plan.

6.2.3. Risk 3 – Review of bed usage and allocations to achieve maximum throughput to safeguard both RTT and emergency access.

6.2.4. Risk 7 – Membership of the St Helens Strategic Estates Group and membership of the Alliance LDS Estates Enabling Group and Corporate Services programme board.

6.3. All changes/additions to the BAF were approved by the Board.

7. Committee Report - Executive – NHST(17)039

7.1. AM provided an update to the Board.

7.2. Decisions taken by the Committee included managing the IR35 tax rule implementation, and benchmarking of A&E services.

7.3. CW informed the Board that the pathology infrastructure noted in the report has subsequently been allocated capital funding.

7.4. Assurances regarding safer staffing, cardiovascular treatment, CQUIN performance, management of agency expenditure and risk management were obtained.

7.5. The business case to replace the EPR, and renewal of the soft FM service contract were agreed for recommendation to the Board. Proposals for radiology equipment refresh and skin preparation products (c£100K) were approved.

7.6. The Board were informed that successful negotiations with GE Medical have resulted in additional MRI and CT equipment within the current PFI financial contract.

7.7. Innovative work at Lancashire Teaching Hospital was discussed, as well as the school of nursing. The Board also discussed attrition rates and nursing applications.

7.8. AMS outlined plans for a regional bank of staff in Cheshire and Merseyside. This will provide the free movement of staff within these areas. Negotiations are also taking place with IndexR regarding the use of a mobile phone app for booking agency staff.

7.9. SR enquired as to whether there are financial implications if a member of staff wishes to leave an agency and move to the bank. AMS replied that this can happen but the Trust try to negotiate the fees; in some cases introductory fees could be 10% of salary.

7.10. Board members discussed the Exec to Exec meeting with St Helens CCG. TF commented that the degree of collaboration was impressive and gives a sense of optimism for working together.

7.11. CW informed the Board of two major milestones that had occurred for the Trust:

7.11.1. Theatres new IT system configuration was being tested – go live date in May

7.11.2. eMEWS has now gone live with significant clinical support received.

8. Committee Report – Quality Committee – NHST(17)040

8.1. KH summarised the report for the Board.

8.2. Complaints: timeliness remains an issue. Although the revised timescales for responses have been applied, it is too early yet for the changes to have filtered though. The number of second stage complaints has dropped significantly and the nature of complaints is largely unchanged. PALS enquiries have increased, which may be a positive step and reduce the number of complaints that become formal. AM said that far too much time is spent on re-writing drafts and this needs to be addressed.

8.3. Mortality: A review of the existing process is taking place and KH will present a paper at the May Board regarding national guidance. Discussion took place regarding the structured judgement reviews 30 days post hospital discharge and the need to access primary care records. It was confirmed that this is not routinely in place at present but could be arranged if required.

8.4. E.Coli: This was discussed in great detail at Quality Committee and the reasons for high instances of the infection in St Helens and Knowsley, which include high antibiotic usage in primary care and very high levels of resistance to Trimethoprim. TF said that this is being addressed by the CCG Medicines Management team but work would be required with the Trust regarding Trimethoprim. KH advised the Board that the hospital acquired cases of E.Coli are no higher than other Trusts in the area.

8.5. CAS alert (nasogastric tube misplacement): The report provided assurance to the Quality Committee on the progress made so far by the Trust and detailed further actions required.

8.6. The Hospital Pharmacy Transformation Programme (HPTP) has been produced following incorporation of best practice feedback from NHSI events and LDS and NW chief pharmacist network collaboration.

8.7. Other items discussed were the Quality Account, CQC action plan and updates from the Councils.

9. Committee report – Finance & Performance – NHST(17)041

9.1. DM presented the Finance & Performance Committee Report, which took place on 20th April.

9.2. Items discussed and actions agreed included:

9.2.1. Proposal and costing for co-location in ED.
9.2.2. DoH temporary loan facility.
9.2.3. Sickness review.
9.2.4. A&E
9.2.5. Ward dashboard.
9.2.6. CIPs.

9.3. NK had discussed risks regarding CQUIN and CIPs and the processes that are in place. GM commented that the Programme Management team had had a positive impact this financial year.

10. Committee report - Audit – NHST(17)042

10.1. SR provided a summary of the meeting held on 19th April.

10.2. Key items discussed were:

10.2.1. Updates from the external auditors.
10.2.2. Progress report from MIAA on the internal audit programme.
10.2.3. Director of Internal Audit report.

10.2.4. Draft internal audit plan
10.2.5. Internal audit charter.

10.3. There were no issues for escalating to the Board.

11. Revalidation update – NHST(17)043

11.1. SRe provided an update for the Board.

11.2. The NMC revalidation requirement of all nursing and midwifery registrants commenced in April 2016. The NMC introduced revalidation to assure the public, post Francis Report, of each registrant's on-going competence to practice and remain on the professional register. A total of 499 staff were revalidated in 2016.

11.3. AM asked if revalidation is part of the appraisal process and SRe confirmed that this was the case and will ensure that this is stated in the policy.

11.4. AMS enquired as to whether the NMC have a national revalidation template; if not, AMS would share the template from the GMC.

12. Purdah during 2017 government general election – NHST(17)044

12.1. PW summarised the paper for the Board.

12.2. For six weeks before the election, there are restrictions in place on the activity of civil servants and local government officials to minimise influencing the processes or their outcomes.

12.2.1. There are practical steps that the Trust must take to comply with this requirement from 22nd April and these were noted

13. Effectiveness of meeting

13.1. RC said that as always, there was good balanced discussion with succinct highlights taken from the committee reports. Having TF at the meeting provides a good link to primary care.

14. AOB

14.1. None noted.

15. Date of next meeting

15.1. The next meeting is scheduled for Wednesday, 31st May 2017 in the Boardroom, Whiston Hospital, commencing at 9.30 am.

Chairman: .....

Date: 6/6/17

Paper No: NHST(17)045
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) awarded the Trust an overall rating of **Outstanding** for the level of care it provides across ALL services. St Helens Hospital was rated as **Outstanding.** Whiston Hospital has been rated as **Good with Outstanding Features** placing it amongst the best hospitals in the NHS. **Outpatient and Diagnostic Imaging Services** at **BOTH** hospitals have been given the highest possible rating **Outstanding** – The first Outpatient and Diagnostic service in the country to ever be awarded this rating.

April 2017

There were no never events in April 2017.

There were no cases of MRSA bacteraemia in April 2017.

There was 1 C.Difficile (CDI) positive cases in April 2017. The annual tolerance for 2017-18 is 41 cases.

There were no grade 3 or 4 pressure ulcers in April 2017.

The overall registered nurse/midwife Safer Staffing fill rate for April 2017 was 93.6%

2016-17 performance

There were 2 falls that resulted in severe harm during March. Year to date there have been a total of 22.

Performance for VTE assessment for March was slightly above the required 95% target at 95.11%.

YTD HSMR was 102.1 up to February 2017.

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 17/18 financial outturn will have implications for the finances of the Trust
Stakeholders: Trust Board, Finance Committee , Commissioners, CQC, TDA, patients.
Recommendation: To note performance for assurance
Presenting Officer: N Khashu
Date of Meeting: OMǍǔ a l·è НЛМТ

Operational Performance

A&E performance was 82.0% (type 1) and 88.9% (type 1 & 3) in month. Whilst not yet at the required performance, the month on month improvement is recognised. The key actions identified for continued recovery of this position are being driven forward by the senior leaders across the organisation, focusing on both the Emergency Department and the Inpatient wards

Emergency Department key actions:
1. Immediate improvement to ED processes through the Urgent and Emergency Care Transformation Plan following a 30-60-90 Improvement Programme
2. Appropriate deployment of clinical resources to meet demand.
3. Improved use of IT to enable real time tracking of patients within 4 hours.

Inpatient areas:
1. Clinically led board rounds on inpatient wards
2. KPI of expected number of discharges per ward of which 33% to be achieved by midday
3. Senior daily review and escalation for patients who no longer need care in an acute bed, supported by weekly system wide Executive led Multi Agency Discharge Events (MADE)

The additional actions identified within the Trusts recovery plan will continue with support and focus being provided by ECIP in order to sustainably deliver the 95% target.

RTT incomplete performance was achieved in month (92.9%). Specialty level actions to address this continue, including targeted backlog clearance and collaborative working with the CCG to improve the quality and effectiveness of patient referral pathways.

Financial Performance

Surplus/Deficit - For the month of April 2017 (Month 1) the Trust is reporting an overall Income & Expenditure surplus of £0.319m against the YTD profiled plan of £0.459m. This is an adverse variance of £0.150m. Clinical Income was £2.1m behind plan, which mainly relates to the impact of reduced activity from the additional bank holidays and weekend in April 2017. This has been offset by reduced expenditure within variable costs, such as agency and other premium costs and released slippage in reserves. This will be recovered from productivity opportunities agreed with divisions around theatre utilisation and productivity. The Trust is planning to deliver its FOT surplus of £8.536m, which equates to (£0.581)m deficit excluding STF.

The Trust has delivered £0.84m of CIPs which behind Annual plan by £0.15m.

The Trust's cash balance at the end of April was £7.8m, in line with the Trust's External Finance Limit and represents 8 days of operating expenses.

The Trust has incurred £38k of capital expenditure in April.

Human Resources

The 2016 staff satisfaction score has again increased and the Trust remains in the top 20% of acute Trusts nationally. A full report was presented at the Trust Board in March 2017 and a summary presentation to staff took place on the 3rd May 2017.

Mandatory Training compliance exceeds the target by 6.1%. Appraisal compliance has reduced in April to 80.6% which is 4.4% behind a target of 85%. This is following the Trust having achieved 87.4% compliance in 2016/17.

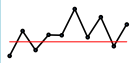
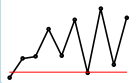
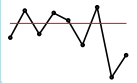
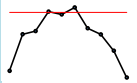
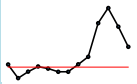
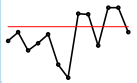
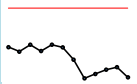
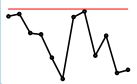
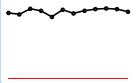
Absence has decreased in April to 3.5% which is a 0.75% improvement on the Q1 target.

The following key applies to the Integrated Performance Report:

▲ = 2017-18 Contract Indicator
▲£ = 2017-18 Contract Indicator with financial penalty
● = 2017-18 CQUIN indicator
T = Trust internal target

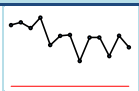
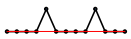
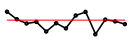
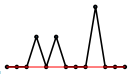
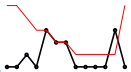
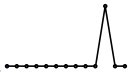
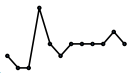
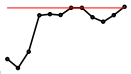
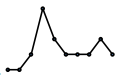
Apr-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 30-34)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Apr-17	2.2%	2.2%	No Target	2.5%		Overall SHMI and HSMR within control limits. Mortality fluctuates month-to-month, but is stable medium-term. Weekend mortality - has fallen again after 'Winter' increase (noisy metric).	Patient Safety and Clinical Effectiveness	Trust is exploring an electronic solution to improve capture of comorbidities and their coding. Focus on addressing R codes use by examining and improving the coding pathway. Palliative care lead aiming to deliver ED and Assessment Unit in-reach to allow input earlier in the patient pathway to improve care and HSMR. Major initiatives to improve management of AKI and Sepsis are well underway to improve care and reduce mortality.	KH
Mortality: SHMI (Information Centre)	Q	▲	Sep-16	1.05		1.00						
Mortality: HSMR (HED)	Q	▲	Feb-17	80.2		100.0	102.1					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Feb-17	95.8		100.0	115.1					
Readmissions: 30 day Relative Risk Score (HED)	Q	T	Dec-16	95.2		100.0	98.5		Continues to improve.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	Action underway to address babies returning electively but documented as emergency admissions.	KH
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Jan-17	94.9		100.0	93.5		Sustained reductions in NEL LOS are assurance that medical redesign practices continue to successfully embed.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Jan-17	73.2		100.0	91.0					
% Medical Outliers	F&P	T	Apr-17	2.4%	2.4%	1.0%	1.7%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in LoS, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Apr-17	50.0%	50.0%	52.5%	48.3%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. Critical care rep now attending all bed meetings to agree plan and to highlight patients who will require transfer over the coming 24 hours. Just below target in month.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients)	Q	▲	Mar-17	71.1%		90.0%	75.7%		eDischarge performance poor - there is insufficient trainee doctor resource to hit this target with existing paper-based systems.		Pending ePR, ongoing drive to improve realtime completion on ward rounds which will be helped by ePrescribing. Medium-term plan to supplement trainee doctor numbers with advanced nurses.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients)	Q	▲	Mar-17	85.7%		95.0%	90.0%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E)	Q	▲	Mar-17	99.0%		95.0%	99.0%					

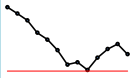
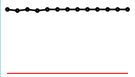
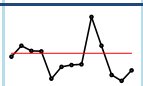
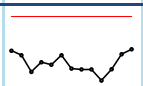
Apr-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

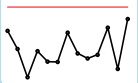
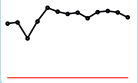
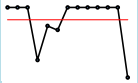
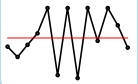
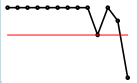
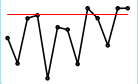
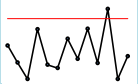
	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Apr-17	91.5%	91.5%	83.0%	94.0%		Target is being achieved	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Continued focus on delivery of this KPI to ensure our patients continue to receive the best possible care	RC
PATIENT SAFETY (appendices pages 37-39)												
Number of never events	Q	▲£	Apr-17	0	0	0	2		The National safety standards for invasive procedures will provide further mitigation against future never events.	Quality and patient safety	The RCA for the first never event has been submitted and lessons learnt cascaded. Actions implemented include central line insertion check list . The January 2017 never event is being made subject of a Serious Incident Investigation.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Apr-17	98.6%	98.6%	98.9%	98.8%		Figures quoted relate to all harms excluding those documented on admission. StHK performs well against its neighbours.	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	Apr-17	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. ePrescribing will be introduced, starting Spring 2017.	KH
Number of hospital acquired MRSA	Q F&P	▲£	Apr-17	0	0	0	4		There were no cases of MRSA bacteraemia and 1 C.Difficile (CDI) case in April 2017.	Quality and patient safety	Both January cases of hospital acquired MRSA bacteraemia have been investigated and Trust-wide action plans are in place to reduce the risk of any further cases. The Infection Control Team continue to support staff to maintain high standards and practices. They also monitor and undertake RCA for any hospital acquired BSI and CDI. CDI and Antibiotic wards rounds continue to be undertaken on appropriate wards.	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲£	Apr-17	1	1	41	23					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Apr-17	1	1	No Target	17					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Apr-17	0	0	No Contract target	1		No grade 3 or 4 pressure ulcers in month	Quality and patient safety	The Trust remains compliant with tissue viability training for all nursing staff including bank staff	SR
Number of falls resulting in severe harm or death	Q	▲	Mar-17	2		No Contract target	22		STHK moderate, severe and death harm from falls YTD is 0.156 per thousand bed days(YTD) against a 0.19 national benchmark.	Quality and patient safety	The RCAs have been completed and lessons learnt cascaded.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲£	Mar-17	95.11%		95.0%	93.36%		VTE performance like eDischarge is compromised by trainee doctor numbers pending e-solutions.	Quality and patient safety	E -Prescribing solution will resolve achieving target in 2017. E-prescribing roll out now underway.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Jan-17	2		No Target	23					
To achieve and maintain CQC registration	Q		Apr-17	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	Apr-17	93.6%	93.6%	No Target	94.9%		Shelford Patient Acuity has been completed and will be reported to Trust Board in May 2017.	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	Apr-17	0	0	No Target	2					

Apr-17

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 41-48)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Mar-17	95.9%		93.0%	95.1%		Key access targets achieved	Quality and patient experience	A Programme approach is being utilised to monitor and improve the timeliness of the patients journey along the Cancer pathways.	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Mar-17	98.6%		96.0%	97.9%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Mar-17	89.3%		85.0%	88.4%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Apr-17	92.9%	92.9%	92.0%	93.5%		At specialty level T&O, Plastic Surgery, ENT, General Surgery and Urology are failing the incomplete target. The Dermatology backlog clearance plan has significantly improved its and the Trust RTT position. The impact of the RMS scheme introduced in July by St Helens CCG, Knowsley CCG in November and Halton CCG commenced roll out in April is also impacting on RTT performance due to new referral drop.	There is a risk due to the current medical bed pressures, the increase in 2ww referrals and activity, impact of RMS in unbalancing the numerator / denominator that the elective programme will be compromised risking increases in backlogs and worsening RTT performance.	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. A backlog management plan is in place and alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand. NHSE backlog clearance commenced beginning of February and completed by end of March clearing 18 T&O and 1208 dermatology patients. actions to maintain and improve RTT performance reliant on theatre and bed capacity along with staff availability in collaboration with CCG's in ensuring RMS delivers in a sustainable and manageable way	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Apr-17	100.0%	100.0%	99.0%	100.00%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Apr-17	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Apr-17	0.5%	0.5%	0.8%	0.7%		The target was achieved in April 2017. This metric continues to be directly impacted by increases in NEL demand (both surgical and medical patients).	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. Continued analysis of the referral drop and impact on RTT underway to include forecast year end position	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Mar-17	100.0%		100.0%	100.0%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Apr-17	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Apr-17	82.0%	82.0%	95.0%	76.1%		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	The urgent and emergency care transformation plan has several interconnected workstreams designed to improve overall 4 hour access performance. **Emergency Department/Front Door** The Department commenced a 90 day Improvement Programme at the end of March. During April staff engagement events and focus groups were set up. In May PDSA cycles will occur testing various processes including 'walk in' streaming, Stretcher Triage streaming and departmental efficiencies to be gained from environmental changes and a number of key roles changes in Medical, Nursing and support function roles. **Flow through the Hospital** 1. Continuation of use of the SAFER Care Bundle to increase hospital discharges before midday to 30% of all discharges and ensure that all patients receive a review of their care by a senior clinical decision maker daily. 2. Standardising ward level Board Rounds so that these are consistently delivered across the Care group, they will incorporate full attendance by all members of the MDT including doctors, to establish a clear plan for the day against the priorities of value added care and safe and effective admissions and discharges (flow). Specific attention will be focused on achieving a safe and effective discharge of at least one (golden) patient by 10.00 every morning. 3. Multi-Agency Discharge Events (MADE) are now taking place weekly within the Trust with system wide representation from Executives monthly. These involve a structured board round on each ward in the presence of cross economy representatives, clinical leads and managers. The main aim is to remove barriers and blocks that prevent patients with complex needs being discharged safely from hospital.	RC
A&E: Total time in A&E: % < 4 hours (All Types)	F&P	▲	Apr-17	88.9%	88.9%	95.0%	85.1%					
A&E: 12 hour trolley waits	F&P	▲	Apr-17	0	0	0	0					

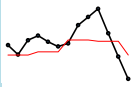
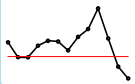
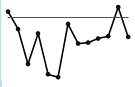
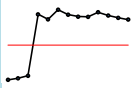
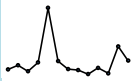
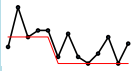
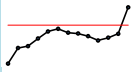
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Apr-17	0	0	0	0		Increased demand for IP capacity has a direct bearing on the ability to maintain this quality indicator.	Patient Experience	Maintained focus and awareness of this issue across 24/7.	RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Apr-17	22	22	No Target	338		A delay in responding to patient complaints leads to a poor patient experience.	Patient experience	The Complaints Team are continuing to work on reducing the small backlog of overdue complaints and to improve the timeliness of responses. Complaints training will be provided in the next two months for staff involved in both investigating complaints and drafting responses.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Apr-17	34	34	No Target	293					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Apr-17	47.1%	47.1%	No Target	58.0%					
Friends and Family Test: % recommended - A&E	Q	▲	Apr-17	89.1%	89.1%	90.0%	86.6%		The YTD recommendation rates remain slightly below target for A&E, maternity (antenatal, birth and post-natal ward) and outpatients, but are above target for in-patients and post natal community maternity services.	Patient experience & reputation	Feedback from the FFT responses is fed back to individual areas to enable actions to be taken to address negative feedback, as well as using positive feedback. The Patient Experience Manager is working with individual services, including the Emergency Department, to look at key areas of concern and the actions that need to be taken to address these. This is monitored via the Patient Experience Council monthly. Training sessions have been provided to ward staff to raise awareness of the importance of responding to feedback to patients and to share the actions taken as a result of this feedback on the patient experience notice boards in public areas and a centralised system for monitoring this was introduced in April 2017.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Apr-17	95.4%	95.4%	90.0%	95.5%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Apr-17	88.9%	88.9%	98.1%	98.5%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Apr-17	97.4%	97.4%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Apr-17	87.5%	87.5%	95.1%	98.7%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Apr-17	100.0%	100.0%	98.6%	93.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Apr-17	94.3%	94.3%	95.0%	94.4%					

Apr-17

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 51-55)												
Sickness: All Staff Sickness Rate	Q F&P	▲	Apr-17	3.5%	3.5%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.8%		Absence has decreased in April to 3.5%, which is 0.75% ahead of the Q1 target. Nursing sickness including HCAs was 0.8% which is better YTD target and 1.4% better than last years outturn.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	Targeted HCA action plan in place continues to be accelerated during May 2017 along with audit on timely Return to Work interviews/stages/levels & recording onto ESR in timely way. There are departments where managers are not strictly complying with the Attendance Management policy, this is being addressed.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P	T	Apr-17	4.5%	4.5%	5.3%	5.9%					
Staffing: % Staff received appraisals	Q F&P	T	Apr-17	80.6%	80.6%	85.0%	87.4%		Mandatory Training compliance exceeds the target by 6.1%. Appraisal compliance has reduced in month and is 4.4% behind target at 80.6%.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The L&OD team continue to work with managers of non compliant staff to ensure continued improvement.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Apr-17	91.1%	91.1%	85.0%	91.6%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q4	91.9%		No Contract Target			Whilst response rates fluctuate we remain in the top 3 acute Trusts in our region for both response and recommendation rates.	Staff engagement, recruitment and retention.	Continue to expand the number of local FFT trainers to scrutinise comments; ensure FFT posters are widely disseminated; and expand the use of "You said, we did" posters.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q4	82.2%		No Contract Target						
Staffing: Turnover rate	Q F&P	T	Apr-17	0.9%	0.9%	No Target	9.8%		Staff turnover remains stable and well below the national average of 14%.		Turnover is monitored across all departments as part of the Trusts Recruitment & Retention Strategy with action plans to address areas where turnover is higher than the trust average. Further action is required by Ward Managers to provide more support to newly qualified nurses.	AMS
FINANCE & EFFICIENCY (appendices pages 58-62)												
UoRR - Overall Rating	F&P	T	Apr-17	3.0	3.0	3.0	3.0		The Trust's forecast for year end performance is 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. Reducing agency expenditure in line with NHSI annual cap.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Apr-17	844	844	15,315	15,248					
Reported surplus/(deficit) to plan (000's)	F&P	T	Apr-17	319	319	8,536	4,861					
Cash balances - Number of days to cover operating expenses	F&P	T	Apr-17	8	8	2	2					
Capital spend £ YTD (000's)	F&P	T	Apr-17	38	38	8,015	3,519					
Financial forecast outturn & performance against plan	F&P	T	Apr-17	8,536	8,536	8,536	4,861					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Apr-17	96.6%	96.6%	95.0%	94.3%					

APPENDIX A

			Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	2016-17 YTD	2016-17 Target	FOT	2015-16	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	100.0%	100.0%	87.5%	93.1%	89.3%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	96.2%	94.4%	95.2%	85.0%		99.2%		
	Total > 62 days		0.0	0.0	1.5	1.0	1.5	0.0	0.0	0.0	0.0	1.0	0.0	0.5	0.5	6.0			1.0		
Lower GI	% Within 62 days	▲ £	100.0%	100.0%	83.3%	100.0%	100.0%	93.3%	81.8%	71.4%	58.3%	100.0%	91.7%	93.3%	100.0%	89.3%	85.0%		94.5%		
	Total > 62 days		0.0	0.0	2.0	0.0	0.0	0.5	1.0	1.0	2.5	0.0	0.5	0.5	0.0	8.0			3.0		
Upper GI	% Within 62 days	▲ £	81.8%	75.0%	90.9%	0.0%	100.0%	100.0%	0.0%	85.7%	88.9%	100.0%	81.8%	0.0%	87.5%	78.7%	85.0%		88.9%		
	Total > 62 days		1.0	0.5	0.5	0.5	0.0	0.0	1.5	1.0	0.5	0.0	1.0	4.0	0.5	10.0			5.0		
Urological	% Within 62 days	▲ £	84.0%	85.7%	84.6%	81.3%	75.0%	79.3%	76.9%	96.2%	82.6%	70.0%	95.7%	100.0%	67.6%	81.4%	85.0%		80.8%		
	Total > 62 days		2.0	2.0	3.0	3.0	4.0	3.0	4.5	0.5	4.0	6.0	0.5	0.0	6.0	36.5			28.0		
Head & Neck	% Within 62 days	▲ £	50.0%	50.0%	100.0%	37.5%	71.4%	66.7%	100.0%	80.0%	33.3%	33.3%	100.0%	80.0%	80.0%	67.3%	85.0%		71.1%		
	Total > 62 days		0.5	0.5	0.0	2.5	1.0	0.5	0.0	0.5	1.0	1.0	0.0	0.5	0.5	8.0			6.5		
Sarcoma	% Within 62 days	▲ £	100.0%		85.7%			100.0%			100.0%	100.0%			100.0%	93.3%	85.0%		87.5%		
	Total > 62 days		0.0		0.5			0.0			0.0	0.0			0.0	0.5			0.5		
Gynaecological	% Within 62 days	▲ £	71.4%	66.7%	81.8%	100.0%	85.7%	92.3%	33.3%	100.0%	90.9%	92.3%	100.0%	85.7%	100.0%	90.1%	85.0%		76.4%		
	Total > 62 days		1.0	0.5	1.0	0.0	0.5	0.5	1.0	0.0	0.5	0.5	0.0	0.5	0.0	5.0			8.5		
Lung	% Within 62 days	▲ £	88.2%	66.7%	81.5%	90.0%	91.7%	82.6%	100.0%	80.0%	87.5%	91.7%	68.2%	77.8%	100.0%	82.7%	85.0%		86.5%		
	Total > 62 days		1.0	1.0	2.5	0.5	0.5	2.0	0.0	1.0	0.5	0.5	3.5	1.0	0.0	13.0			10.5		RC
Haematological	% Within 62 days	▲ £	86.7%	100.0%	100.0%	0.0%	50.0%	50.0%	100.0%	100.0%		66.7%	66.7%	100.0%	100.0%	77.6%	85.0%		70.5%		
	Total > 62 days		1.0	0.0	0.0	2.5	3.0	1.0	0.0	0.0		1.0	1.0	0.0	0.0	8.5			13.0		
Skin	% Within 62 days	▲ £	96.7%	97.5%	96.0%	100.0%	97.3%	93.7%	95.7%	92.6%	97.4%	95.7%	95.7%	100.0%	100.0%	96.5%	85.0%		94.5%		
	Total > 62 days		0.5	0.5	1.0	0.0	0.5	2.0	1.0	2.0	0.5	1.0	1.0	0.0	0.0	9.5			13.0		
Unknown	% Within 62 days	▲ £	50.0%		100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	66.7%	0.0%	50.0%	82.6%	85.0%		83.3%		
	Total > 62 days		0.5		0.0	0.0	0.0	0.0	0.0			0.0	0.5	0.5	1.0	2.0			1.5		
All Tumour Sites	% Within 62 days	▲ £	89.5%	91.8%	88.0%	87.5%	85.8%	89.4%	87.9%	92.0%	86.6%	85.8%	89.1%	87.6%	89.3%	88.4%	85.0%		88.6%		
	Total > 62 days		7.5	5.0	12.0	10.0	11.0	9.5	9.0	6.0	9.5	11.0	8.0	7.5	8.5	107.0			90.5		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £	100.0%	100.0%					100.0%		50.0%				100.0%	83.3%	85.0%		100.0%		
	Total > 31 days		0.0	0.0					0.0		1.0				0.0	1.0			0.0		
Acute Leukaemia	% Within 31 days	▲ £				100.0%										100.0%	85.0%		100.0%		
	Total > 31 days					0.0										0.0			0.0		
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)046
Title of paper: Aggregated incidents, complaints & claims report quarters 3 & 4 2016-17
Purpose: This paper provides the Trust Board with a summary of quantitative and qualitative analysis of incidents, complaints, claims and inquests in the final two quarters of 2016-17 (using information obtained from the Datix system). The report includes a summary of key issues identified and actions taken.
Summary for 1st October 2016 to 31st March 2017: **Incidents:** • Number of incidents affecting patients per 1,000 bed days: 47.61 • Number of incidents resulting in moderate harm or above per 1,000 bed days: 0.93 **Complaints:** • 178 1st stage complaints received, a slight increase of 5% above quarters 1 & 2 • Clinical treatment and admissions & discharges were the main reason for complaints **PALS:** • 1006 PALS concerns raised, representing a 3% decrease from quarters 1 & 2 • Communication was the main cause of PALS concerns **Clinical Negligence Claims:** • 55 new clinical negligence claims received
Corporate objectives met or risks addressed: Safety – We will embed a learning culture that reduces harm, achieves good outcomes and enhances the patient experience.
Financial implications: There are no direct financial implications arising from this report
Stakeholders: Patients, carers, commissioners, CQC and Trust staff.
Recommendation(s): Members are asked to consider and note the report.
Presenting officer: Sue Redfern, Director of Nursing
Date of meeting: 31st May 2017

1. Introduction

The Datix electronic reporting system allows incidents, complaints, claims and PALS information to be collated and cross-referenced. This report attempts to draw out the trends and learning derived from the aggregation and analysis of internal incident reporting and of the complaints, claims and PALS enquiries received by the organisation. The emphasis is on patient experience and safety. The information includes, reported incidents, serious incidents (SIs) reported on the Strategic Executive Information System (StEIS), complaints, PALS and litigation (claims and inquests).

The data included in this report covers 1st October 2016 to 31st March 2017 (Q3 & Q4).

2. Quantitative analysis

There were 5621 patient incidents during this period with 42 incidents reported to StEIS and 110 incidents categorised as moderate harm or above. The Trust received 178 1st stage complaints, a 5% increase compared to quarters 1 & 2, and 1006 PALS concerns, a 3% decrease from quarters 1 & 2. There were 55 new clinical negligence claims received, a 10% increase from quarters 1 & 2.

3. Top five themes

Table 1: Top five themes from incidents, complaints, PALS and claims

Incidents		Complaints		PALS		New clinical negligence claims	
Accident that may result in personal injury	1691	Clinical Treatment	70	Communications	224	Failure to diagnose/ treat	33
Implementation of care or on-going monitoring/ review	1129	Admissions and Discharges (excl. delayed discharge re care package)	24	Admissions and Discharges (excl. delayed discharge re care package)	195	Failure to recognise complications of treatment	3
Medication	683	Patient Care/ Nursing Care	20	Clinical Treatment	110	Failure to warn (informed consent)	2
Access, Appointment, Admission, Transfer, Discharge	558	Values and Behaviours (Staff)	14	Patient Care/ Nursing Care	92	Inappropriate treatment	2
Clinical assessment (investigations, images and lab tests)	506	Waiting Times	12	Appointments	89	6 claims related to a separate theme	

Note: The chart above should be used as guidance only as the claims received often fall into more than one category, for example there may have been negligent performance of a surgical procedure followed by a fall on the ward, or failure to diagnose a condition with general unhappiness regarding the care received.

Colour key for top ten themes

Clinical care
Communication and records
Access/admission/discharge issues
Attitude/behaviour/competence

4. Incident data

The charts below shows the organisation's activity for reporting against harms (moderate and above) for 2015-16 to 2016-17, showing a slight decrease overall. There has been an increase in reporting as shown in chart two, which indicates the open and learning culture across the Trust, in which staff are actively encouraged to report all incidents.

Chart 1: Moderate Harm and above

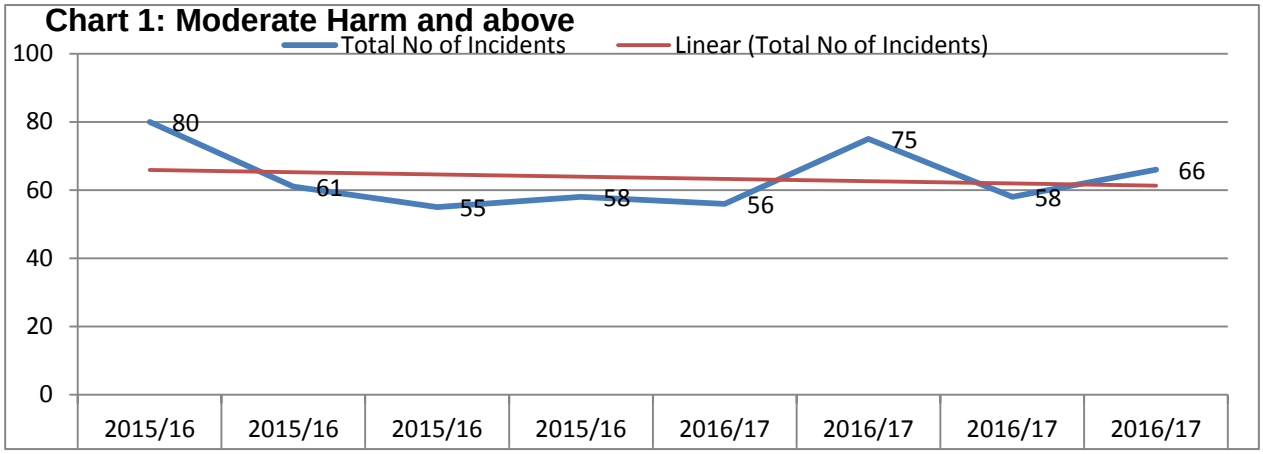
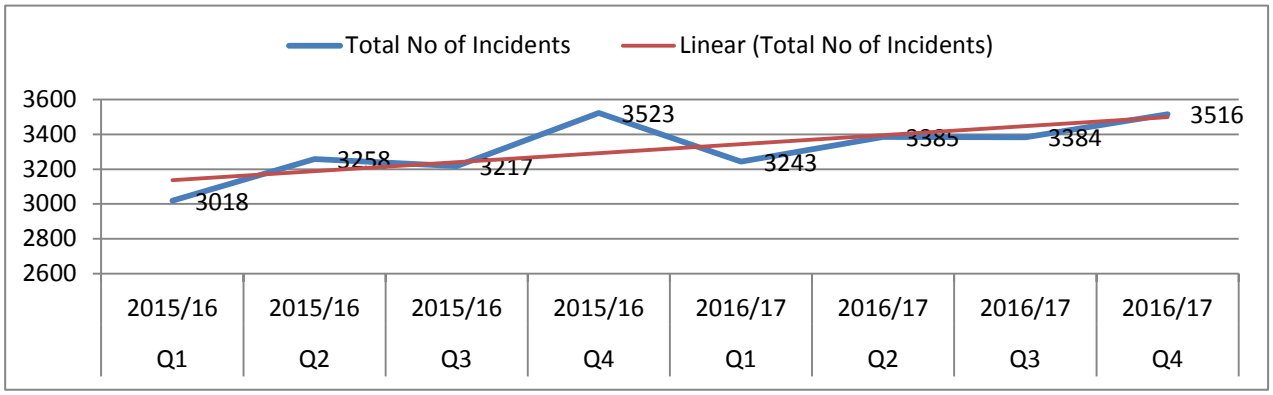


Chart 2: Total Incidents reported



4.1. Thematic analysis of incidents reported to StEIS in quarters 3 & 4

Table 3: Incidents reported to StEIS in quarters 3 & 4 by top three categories:

	Q3	Q4	Total
Falls	6	9	15
Delayed diagnosis of cancer	3	5	8
Sub Optimal Care	6	5	11

4.2. Actions taken as a result of serious incidents

A root cause analysis investigation is undertaken of each serious incident, with recommendations and an action plan produced to reduce the risk of a reoccurrence. Examples of the actions taken include:

- Improving documentation
- Reiterating guidelines, policies and ACE behavioural standards
- Improvements to pathways

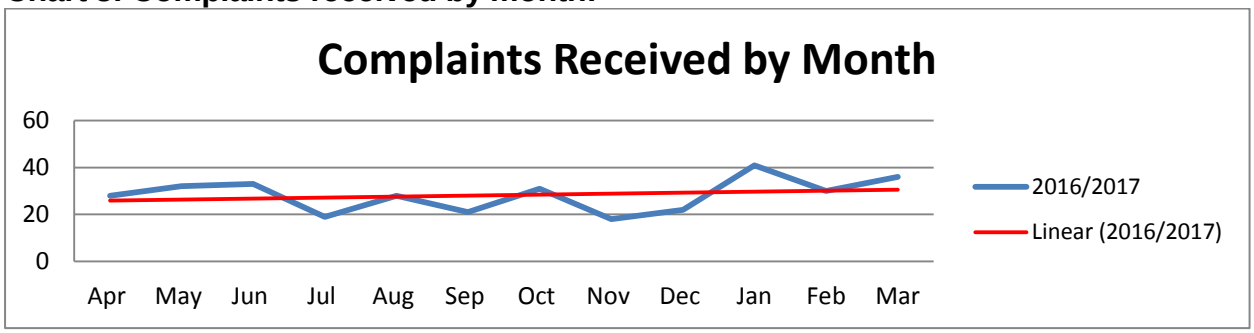
- Improved communications with patients and carers, with improved use of documentation, including discharge information
- Increased use of seat/bed pads falls alarms rather than clip alarms to prevent them being removed and to promote patient safety
- Introduction of core care plan for patients with epilepsy

5. Complaints and PALS

The following data is based on figures that are generated via DatixWeb and are correct at the time of reporting.

The chart below highlights the months the Trust received complaints in 2016-17, showing a slight increase over the time period shown, which can be partially explained by increased awareness of the Trust's complaints procedures.

Chart 3: Complaints received by month:



5.1. Actions taken as a result of complaints

Each complaint response includes any learning that has been identified and the necessary actions in each area. This has included:

- Staff training and awareness raising
- Individual reflections by staff
- Dissemination of required changes at team meetings
- Increasing ward clerk cover from 8am-8pm daily in specific area, with escalation plan in place when the ward clerk is absent
- Improved communication by keeping nursing documentation in new files at the end of beds
- Ensuring medical staff are aware of the need to confer with Radiology when imaging is subtle
- Raised awareness of importance of peak flow as important indicator of asthma
- Medical staff reminded that wedge compression fractures are very common in elderly patients.
- Presentation given to all medical staff within ED to remind them of the importance of lowering their threshold for performing x-rays amongst older patients

6. PALS data

There were 1006 PALS contacts/enquiries during Q3 &Q4 2016-17. This represents a 3% decrease compared to Q1 & Q2. The main themes for PALS contacts are shown in table 2 above.

7. Legal Services Department Activity

7.1. Clinical Negligence Claims

The trust received 55 new clinical negligence claims in Q3 and Q4 2016-17, with 32 received by the Surgical Care Group and 23 by the Medical Care Group.

7.2. Actions taken as a result of claims

Learning is identified following each claim and improvements are undertaken to prevent a repeat of the incident. The following are examples of changes made as a result of claims:

- Specific additions to the information provided when consenting patients on potential risks and side effects when undertaking urological surgical procedures.
- Creation of new Specialist Medical review guideline standard operating procedure.
- Introduction of a Community Nursing Team Operational Policy
- Changes to the pathway of care for patient that develop pancreatitis after an endoscopic retrograde cholangio-pancreatography (ERCP)

7.3. Inquests

The Trust, via the Legal Services Department, proactively manages non-routine inquests. These inquests are when members of Trust staff are called to give evidence and/or there are novel or contentious issues. In many cases there are lessons to be learned and require a corporate witness to inform the Coroner of these lessons and what action has been subsequently taken to prevent recurrence.

One inquest was conducted in quarter 3 and the Coroner delivered a narrative verdict (a factual statement of the circumstances surrounding someone's death, without attributing the cause to an individual) with no criticism of the Trust.

Four inquests were conducted in quarter 4, three found to be accidental deaths and one due to natural causes. Two were narrative verdicts, one with no criticism of the Trust and the other had slight criticism.

Conclusion

The primary causes for incidents, complaints and clinical negligence claims throughout quarters 3 and 4, 2016-17 have been of a clinical nature. In comparison, the primary reason for PALS concerns has been communication. However, complaints often include multiple reasons for a complaint and communication is cited as the main secondary cause of complaint in the same time period.

The second leading cause of both complaints and PALS concerns are, however, similar and related to admissions and discharges.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)047

Title of paper: Executive Committee Assurance Report.

Purpose: To feedback to members key quality issues arising from the Executive Committee meetings.

Summary:

1. Between the 14th April and 18th May five 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 changes to the SIRI process, pursuing Creative Commons Licences, managing the IR 35 Task rule implementation, use of AQuA Infection Control data, measures to safeguard cancer performance, a review of duplicate GP letters, and promotion of Reservist Day.
3. Assurances regarding safer staffing, the impact of referral management systems, mandatory training, appraisals, risk management, management of agency expenditure, response to cyber-attack, were obtained.
4. With regards to financial commitments, the proposal to create additional mortuary capacity at Whiston (c. £120k) was approved. The scheme to replace the paediatric A&E reception desk was deferred for a more cost-effective solution.
5. There are no other 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: 31st May 2017.

EXECUTIVE COMMITTEE REPORT (14th April to 18th May 2017)

The following report highlights key issues considered by the Committee.

20th April

1. Safer Staffing /Vacancy Dashboard

    1.1. The latest data was scrutinised. Staffing pressures on Ward 1A following the increase from 27 to 32 beds were noted and further work is ongoing to review the establishment. AMS confirmed that the vacancy dashboard correlated with safer staffing.

2. Referral Management System (RMS)

    2.1. Phil Nee, Dave Miles, and Darran Hague provided an update on the impact of St Helens CCG RMS since its introduction in July 2016, and more recently Knowsley and Halton systems (November & January respectively). It was noted that outpatient referrals are down; however, admissions remain broadly the same. In addition DNAs have reduced, and first to follow ups are unchanged.

    2.2. The need for a forecast by specialty was noted in order to plan for activity going forward. In addition, dialogue with CCG's needs to be maintained in order that the impacts can be fully understood.

27th April

3. SIRI process

    3.1. An improvement event in late 2016/17 resulted in a comprehensive action plan to improve the entire process and Martin Hepke attended to provide an update. The comparative over reporting in the Trust was discussed and a more consistent approach going forward proposed. The current SIRI template and process was discussed and initiatives to increase the pool of managers available for RCAs discussed, to be taken forward by SR.

4. Sherdley GP Tender

    4.1. Mark Hogg and Nicola Bunce provided an update on the Trust proposal. Risk, the utilisation of Trust space and opportunities were discussed in detail.

5. RMS

    5.1. The need to share the Trust data set with CCGs was acknowledged and actions to ensure data accuracy in advance were agreed.

6. Clinical Quality Performance Group (CQPG)

    6.1. SR provided feedback from the latest meeting which included CAMHS involvement and eReferral which is a key CCG action given the large number of paper referrals still being generated by GPs.

7. Mandatory Training and Appraisal data

    7.1. AMS presented the regular data for discussion.

8. STP feedback

    8.1. General progress was discussed. One key issue is the allocation of IT funding where Trusts with mature systems have received the majority.

9. ePrescribing

    9.1. CW provided an update on the latest pilot. Francis Andrews is assisting junior doctors to ensure a faster and smoother implementation process.

4th May

10. Primary Care Overview

    10.1. As a development session, Dave Miles provided a presentation covering the history, the 3 main contracts, commissioning for services and funding.

11. Creative Commons Licence

    11.1. Jeanette Anders and Charlotte Ward described an initiative for sharing publications etc. with other organisations that provides some intellectual property protection without the need for copyright. Following discussion on the system for recording and policing the licences it was approved.

12. IR35 impact

    12.1. Malise Szpakowska attended to provide an update in respect of engagements under Personal Services Contracts (PSCs). Currently it is estimated that 19 are outside the scope of IR35 following their own assessment however ongoing re-evaluation is anticipated especially as this figure is higher than anticipated. In addition further clarity is required regarding the 'substitution' clause.

13. Clinical Governance & Clinical Audit

    13.1. KH presented a proposal for arranging future Audit meetings addressing the frequency, timing and agendas. In addition, the proposal for a 'senior medical reading room' on the Whiston site was proposed. The Committee was generally supportive, acknowledging that further discussion would be necessary.

14. AQuA Quarterly Safety Report

    14.1. KH took members through the latest report which focussed on infection, and in particular Trust performance against 22 local Trusts. It was agreed that SR should review the information and consider incorporating some key messages in the report to Quality Committee.

    14.2. Infection control on our wards was discussed and it was agreed that a further concerted effort on dress codes, use of hand gels, and the importance of insuring that gel dispensers are functioning and filled, is required.

15. **11th May**

16. Corporate Risk Register report

    16.1. PW reported on Datix information as at 2nd May, noting the total number of risks were 674 with 13 high/extreme risks that have been escalated to the CRR (7 x Patient Care, 2 x Money, 3 x Governance and 1 x Staffing).

17. New high risk – cancer performance targets

    17.1. Pat Gillis and RC reported on the change in breach allocation regarding 62 day cancer performance involving multiple-trust pathways. Whilst mitigations have been put in place, maintaining standards will be challenging. It was noted that the additional resource of MDT co-ordinators had improved daily tracking. It was agreed that measures to streamline pathways and to remove all non-value added steps must be made, and to this end PMO support was approved.

18. STP feedback

    18.1. AM reported on her meeting as LDS lead where capital was discussed with £325m national funding being made available. The Southport & Ormskirk proposal to improve A&E and frailty facilities was agreed as the priority.

18th May

19. Agency usage

    19.1. NK presented the April data with £760k spend. Whilst expenditure is reducing it still translates into year-end costs in excess of the £7.3m cap being applied.

20. Safer Staffing / Vacancy Dashboard

    20.1. The report for April was discussed. It was agreed that KH and SR would review and benchmark the report format, to design a more informative report which provides improved assurance on the management of safe staffing levels.

21. Cyber security incident

    21.1. CW provided a briefing on the 12th May incident. Whilst IT services were disrupted none of the Trust's equipment was infected and the Trust complied fully with instructions from NHS Digital and other government agencies. Good communications ensured that staff were briefed throughout and as a follow-up action the Trust's Business Continuity Plans in this respect are being reviewed.

22. HIS Strategy

    22.1. CW provided a brief overview of the IT plans 2017 – 2020 and members were asked to provide feedback on the draft.

23. Extension of technical support to Hearts

    23.1. PAS replacement is ongoing in line with the programme for completion by March 2018. However, the support for the outgoing Hearts system expires at the same time therefore providing no fall-back for slippage. It was agreed that a small buffer should be negotiated for exceptional circumstances.

24. St Helens mortuary building

    24.1. PW presented a proposal to increase the body-storage capacity at Whiston in order to negate the need for the St Helens facility as a fall-back each winter. The proposal was agreed (c. £120k) which would also enable ideas for alternative use of the building to be progressed.

25. Integrated Performance Report

    25.1. The April draft report was reviewed and amendments agreed.

26. Duplicate letters

    26.1. The issue of duplicate patient letters to GP Practices was discussed. RC and CW agreed to develop proposals to reduce paper correspondence and postage.

27. A&E Paediatric Reception

    27.1. The proposal for capital works in A&E to create a replacement patient reception desk was discussed, following which it was agreed that RC would review the needs and develop a more cost-effective solution.

28. Non-medical reservists

    28.1. TH advised of Armed Forces Reservist Day scheduled for 21st June. It was agreed that promotion at the Trust should be considered.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)048

Title of paper: Committee Report – Quality Committee

Purpose: To summarise the Quality Committee meeting held on 23 May 2017 and escalate issues of concern.

Summary:

Key items discussed were:

1. Complaints – slight decrease in complaints received in month compared to March
2. Safer Staffing – Executive Committee are undertaking a deep dive into the staffing levels in wards with the 4 worst fill rates
3. IPR – A&E performance was discussed, it was agreed to discuss in detail at the Finance and Performance Committee later in the week.
4. CAS Alert Action Plan (Nasogastric rube misplacement)
5. Safeguarding training update
6. Approval of Quality Account subject to:
   i. amendment relating to reduction of 3 grade 3 ulcers being downgraded to 1.
   ii. Agreement sought regarding request from Knowsley LA request to have mortality data for weekend admissions included in Quality Account – Quality Committee agreed to think about it in the future but not to include in 2017 report.
7. Fasting Policy update – quality indicator work ongoing, a further audit will be undertaken
8. Supervisor of Midwives update
9. Falls Update – check correlation between safer staffing and falls
10. Feedback from Councils
    i. Patient Safety Council
    ii. Patient Experience Council – significant improvements to discharge rates in relation to TTOs.
    iii. Clinical Effectiveness Council
    iv. CQPG – changes to the Police and Crime Act in relation to the Mental Health Act wef 1 April 2017. CCGs will need to agree systems in place to address the changes.
    v. Executive Committee
11. Policies – it was agreed to review all overdue policies at a future Quality Committee meeting.

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: George Marcall, Non Executive Director
Date of meeting: 31 May 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)049

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance and Performance Committee, 25th May 2017

Summary:

Agenda Items

For Information

- Bed occupancy figures
- HIS Strategy
- Cheshire & Merseyside 5 Year Forward View update

For Assurance

- A & E update
  - the Committee were further assured by the update on the action plan to improve performance and the proposal for co-locating a Primary care streaming service
- Integrated Performance Report Month 1 2017/18
- Draft 2016/17 Finance Report
  - £4.861m surplus, including £1.51m bonus STF
- Finance Report Month 1 2017/18
  - Clinical income behind plan by £2.1m mainly relating to the reduced activity from the extra Bank Holidays and weekend in April; there is a plan in place to recover the lost activity
- Governance Committee Briefing Papers:
  - CIP Council

Actions Agreed

- MUST Nutrition Tool
  - The paper to be presented to the Quality Committee
- Bed Occupancy figures
  - Bed modelling to be reviewed by the Committee in July
- IPR
  - Backlog review to be presented to the Committee in July
- Month 1 Finance Report
  - Review of Cashflow forecast
- CIP Council
  - 1718 CIP programme to be presented to the Committee

Corporate objectives met or risks addressed: Finance and Performance duties

Financial implications: None as a direct consequence of this paper

Stakeholders: Trust Board Members, NHSI

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

Presenting officer: Denis Mahony Non-Executive Director

Date of meeting: 31st May 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17) 050 (including NHST(17) 051 and 052)

Title of paper: Committee Report - Audit

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

Summary:

NHST (17) 051 – Adoption of Annual Accounts

A meeting of the Audit Committee was held on 23rd May 2017. The following matters were discussed and reviewed:

- **The Trust's Annual Governance Statement** – This was presented for information by Nik Khashu, Director of Finance.

- **Presentation of the audited annual accounts for 2016/17 –** The accounts were presented by Dave Brimage, Assistant Director of Finance, to the Audit Committee with a view to approval of the accounts by the Audit Committee on behalf of the Trust Board after consideration of the external auditor's Audit Findings Report (see below).

- **The Audit Findings Report (ISA260) –** This was presented by Karen Murray of Grant Thornton, the Trust's external auditors. The report was a positive report and included an unqualified opinion on the Trust's financial accounts.

- **Approval of the Trust's accounts** – The Audit Committee approved the Trust's audited financial accounts for 2016/17 on behalf of the Trust Board following consideration of the presentations above.

- **Letter of Representation from Trust Management to the External Auditor** – This was presented by Nik Khashu and approved by the Audit Committee.

- **Presentation of the Trust's Quality Account for 2016/17** – The Quality Account was presented by Anne Rosbotham-Williams on behalf of Sue Redfern, the Director of Nursing.

- **Auditor's Report on the Trust's Quality Account** – This was presented by Karen Murray of Grant Thornton and gave a positive conclusion to the Quality Account review.

- **The Annual Report** – This was presented by Peter Williams, Director of Corporate Services and was endorsed by the Trust's External Auditor insofar as:

    - It contained at least all the mandatory disclosures required;
    - It reflected what was in the annual accounts where figures were quoted and;
    - those figures audited in the annual report by the External Auditor (ie. Remuneration, Pension and Pay Multiplier numbers) were verified to Trust records and calculations.

NHST(17) 052 – Audit Plan Approval

- The 2017/18 internal audit plan, which is risk-based, was agreed by the Audit Committee at its April 2017 meeting following consultation with the Trust's Board directors. It is recommended therefore that the Trust Board formally approves the plan.

Corporate objectives met or risks addressed: Contributes to the Trust's Governance arrangements

Financial implications: None as a direct consequence of this paper

Stakeholders: The Trust, its staff and all stakeholders

Recommendation(s): For The Board to note and ratify the approval by the Audit Committee of the Trust's financial accounts for 2016/17 and to approve the 2017/18 Internal Audit Plan.

Presenting officer: Su Rai, NED and Chair of Audit Committee

Date of meeting: 31st May 2017

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)053
Title of paper: Strategic and Regulatory Update Report
Purpose: To provide the Board with assurance that the Trust continues to take account of external strategic developments that could impact the future direction of the organisation and all regulatory requirements to comply with governance good practice.
Summary: There have been no national policy or strategy announcements during the election purdah period. This report includes briefing on; 1. Single Oversight Framework – Board Declarations 2. Board declaration – Condition G6 3. Board declaration – Condition FT4
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, C&M FYFV, Commissioners, NHSI
Recommendation(s): 1. The Board approves the annual declaration of compliance with the Provider Licence condition G6 2. The Board approves the annual declaration of compliance with the Provider Licence condition FT4
Presenting officer: Peter Williams, Director of Corporate Services
Date of meeting: 31st May 2017

Strategic and Regulatory Update Report

1. Single oversight framework – Board declarations

Board members will recall that the NHS Trust Development Authority (NHSTDA) Accountability Framework required NHS Trust Boards to make monthly declarations. A number of these were in relation to compliance with the NHS Provider Licence; (www.gov.uk/government/Annex_NHS_provider_licence_conditions.pdf)

A licence was issued to Foundation Trusts (FT) when they were authorised. "Shadow" reporting against the Monitor Provider Licence standards was required as part of the FT development pipeline.

In December 2015 the requirement for these monthly declarations and statements by Boards (of both NHS Trusts and NHS Foundation Trusts) was suspended, while the NHSTDA and Monitor came together to form NHS Improvement (NHSI), and develop a single regulatory framework for all NHS Provider organisations. This resulted in the development of the Single Oversight Framework which came into effect in September 2016.

In April NHSI issued guidance that for the financial year 2017/18 onwards a more streamlined version of these declarations was required from all Trust Boards.

The requirement for NHS Trusts is fore Boards to make annual declarations against conditions G6 and FT4 of the Provider Licence conditions (Appendix A). The declaration for condition G6 has to be made by 31st May each year and the declaration for condition FT4 made annually by 30th June.

These declarations must be made by the Board, but do not have to be formally submitted to NHSI. Instead NHSI will undertake audits of Board papers to verify that the declarations have been made.

2. Board declaration – Licence Condition G6

As a NHST Trust this organisation does not have a Provider Licence or conditions against the licence. The requirement for this organisation is therefore for the Board to satisfy itself and make a declaration that it has been compliant with all duties and responsibilities assigned to it under the NHS Acts, and that it is operating in a way that meets the 7 principles of the NHS as set out in the Constitution (Appendix B).

The Board must also be satisfied that it has had in place a robust risk management system that would enable it to identify and manage any potential risks to compliance.

The suggested form of declaration is;

"Following a review for the purposes of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the financial year most recently ended, the licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution."

Sources of assurance for the Board that it can make this declaration are;

- Continued CQC registration
- CQC Inspection ratings
- MIAA audit of the Trust Risk Management and Board Assurance Frameworks – with Significant Assurance

Recommendation

The Board approves the annual declaration of compliance with the Provider Licence condition G6

3. Board declaration – Licence condition FT4

Licence condition FT4 relates to the standards of corporate governance in the preceding year.

The requirement to conform to best practice standards for corporate governance is a condition that has always applied to public bodies.

The Board makes a formal Corporate Governance Statement each year as part of the annual report and accounts which describes the governance structure and processes of the organisation, and this statement is reviewed by the external auditors.

The suggested form of declaration is;

The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.

The Board is satisfied that the Licensee has established and implements:

(a) Effective board and committee structures;
(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
(c) Clear reporting lines and accountabilities throughout its organisation.

The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:

(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) To ensure compliance with all applicable legal requirements.

The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

Sources of assurance that the Board can rely on to make this declaration are;

- CQC Inspection Report (Well led standard)
- Corporate Governance Statement made as part of the annual report and accounts and reviewed by the Trusts auditors
- Annual Board effectiveness review of 2016/17
- Trust accountability framework and annual business cycle
- NHS Improvement segmentation rating – March 2017
- Well led framework self-assessment and action plan

Recommendation

The Board approves the annual declaration of compliance with the Provider Licence condition FT4

ENDS

Condition G6 – Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

(a) The Conditions of this Licence,

(b) Any requirements imposed on it under the NHS Acts, and

(c) The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

(a) The establishment and implementation of processes and systems to identify risks and guard against their occurrence; and

(b) Regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

Condition FT4 – NHS foundation trust governance arrangements

1. This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:

(a) Have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; and

(b) Comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:

(a) Effective board and committee structures;

(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and

(c) Clear reporting lines and accountabilities throughout its organisation.

5. The Licensee shall establish and effectively implement systems and/or processes:

(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;

(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; Section 6 – NHS Foundation Trust Conditions

(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);

(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;

(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and

(h) To ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;

(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

(e) That the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

(f) That there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

8. The Licensee shall submit to Monitor within three months of the end of each financial year:

(a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and

(b) If required in writing by Monitor, a statement from its auditors either:

(i) Confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or

(ii) Setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year

Appendix B

NHS Constitution - Principles that guide the NHS

Seven key principles guide the NHS in all it does. They are underpinned by core NHS values which have been derived from extensive discussions with staff, patients and the public. These values are set out in the next section of this document.

1. The NHS provides a comprehensive service, available to all

It is available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

2. Access to NHS services is based on clinical need, not an individual's ability to pay

NHS services are free of charge, except in limited circumstances sanctioned by Parliament.

3. The NHS aspires to the highest standards of excellence and professionalism

It provides high quality care that is safe, effective and focused on patient experience; in the people it employs, and in the support, education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population. Respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.

4. The patient will be at the heart of everything the NHS does

It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. As part of this, the NHS will ensure that in line with the Armed Forces Covenant, those in the armed forces, reservists, their families and veterans are not disadvantaged in accessing health services in the area they reside. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services.

5. The NHS works across organisational boundaries

It works in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS is an integrated system of organisations and services bound together by the principles and values reflected in the Constitution. The NHS is committed to working jointly with other local authority services, other public sector organisations and a wide range of private and voluntary sector organisations to provide and deliver improvements in health and wellbeing.

6. The NHS is committed to providing best value for taxpayers' money

It is committed to providing the most effective, fair and sustainable use of finite resources. Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.

7. The NHS is accountable to the public, communities and patients that it serves

The NHS is a national service funded through national taxation, and it is the government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)054

Title of paper: Draft Quality Account 2016-17

Purpose: To present the final draft of the Quality Account for review and approval by the Board, following its review by the Quality Committee, external partners and External Auditors.

Summary:

The final draft of this year's Quality Account has been completed subject to the outstanding information being inserted, that is, finalisation of the Clostridium difficile figures following the outcome of appeal meeting on 26th May and written comments from the St Helens and Knowsley Clinical Commissioning Groups (CCGs).

The Director of Nursing and Assistant Director of Governance presented the draft Account to a number of external partners:

- Halton CCG and Halton Borough Council (26th April)
- St Helens and Knowsley CCGs, Knowsley Local Authority and Healthwatch Knowsley (8th May)
- Knowsley Council Health Scrutiny Sub-Committee and Healthwatch Knowsley (9th May)

Grant Thornton have reviewed the draft version and undertaken testing of the VTE and Clostridium difficile indicators. They presented their limited assurance report to the Audit Committee on 23rd May and have provided a provisional unqualified conclusion, subject to a review of the outstanding joint feedback awaited from St Helens and Knowsley Clinical Commissioning Groups.

The feedback from these presentations has led to some minor amendments and additional information on the work undertaken by the Trust which are listed in section 4.3 of the Quality Account. Knowsley Council Health Scrutiny Sub-Committee and Healthwatch Knowsley asked that mortality of weekend admissions is included in the quality priorities for 2017-18.

It was reviewed by the Quality Committee at its meeting on 23rd May, 2017 and discussed the request made by Knowsley Council Health Scrutiny Sub-Committee and Healthwatch Knowsley, recommending that this is not included as a quality priority, but continues to be proactively monitored via the Quality Committee and the Board.

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 and approve 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.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 31st May, 2017

Appendix 1

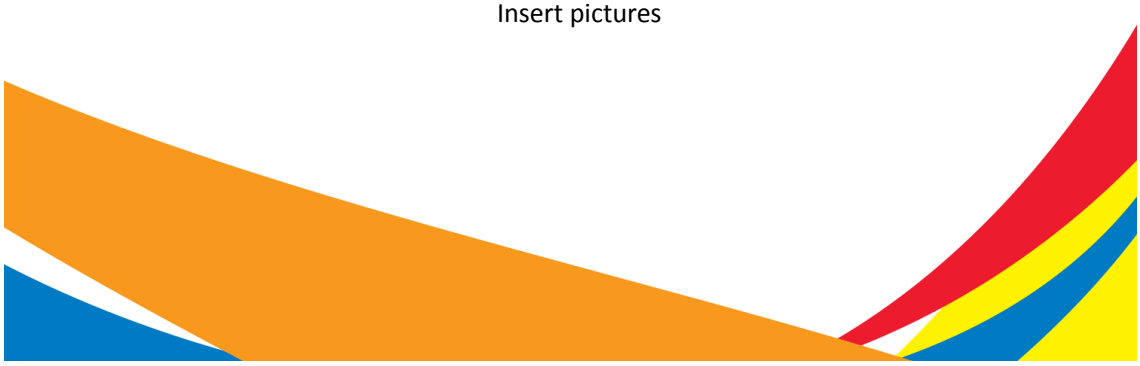
Draft Quality Account 2016 – 2017

Front cover

St Helens and Knowsley Teaching Hospitals NHS Trust

Quality Account 2016-17

Insert pictures



What our patients say about us

At first I was worried about coming in for my operation however, everyone I spoke to was lovely and friendly and put my mind at ease.
The nurses were especially fantastic and looked after me until I left.
Nothing was too much trouble.
I'd definitely recommend St. Helens.

Very welcoming staff, made me feel at ease when I was very anxious. Whole system seemed very efficient.

Sanderson Suite

The Dietitian had wonderful social skills and made me feel totally at ease - very knowledgeable and gave me useful information. Lovely lady whom I would recommend to all

Diabetes outpatients

The whole end-to-end service was exemplary. Staff at all levels were attentive & efficient. The day bed that I was allocated was superb - couldn't have been bettered if I'd have gone private. I can't thank the hospital & its employees enough.

General surgery day case

The doctor was very thorough with his examinations on me and allowed me the time to understand what was wrong with me.

Treated with care and courtesy. Professional staff; a credit to the NHS

Emergency Department

General care very good. I felt safe at all times.

Ward 4A – Surgical Care Group

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1. Section 1

1.1. Summary of quality achievements in 2016-17

Quality of services overall

- Care Quality Commission (CQC) ratings from their latest report in 2016 remain in place, with St Helens Hospital, Outpatients and Diagnostic Imaging Services and the caring domain rated as **outstanding** across the Trust, **the best rating possible** and the Trust rated as good overall.
- Quality care accreditation tool (QCAT) rolled out across all general inpatient areas, with gold standards awarded to six wards.

Patient safety

- Patients received 98.8% new harm-free care during 2016-17. This is harm that has occurred whilst an inpatient in the Trust in 2016-17 reported via the NHS Safety Thermometer.
- No patients experienced a hospital acquired grade 4 pressure ulcer.
- Continued to reduce the number of Clostridium Difficile infections, performing significantly better than the target.
- Reductions in incidents resulting in harm from 2013-14 benchmarks (Sign up to Safety)
    - 69% reduction in theatre-related episodes of moderate/severe harms
    - 54% decrease in prescribing incidents resulting in harm
    - 17% decrease in falls incidents resulting in harm
- 94.9% fill rate for registered nurses/midwives.
- 82% of frontline staff received the flu vaccination.

Patient experience

- Top five for patient experience (CHKS Top Hospitals Best in the UK awards).
- 2nd nationally in the Patient Led Assessments of the Care Environment (PLACE).
- 95.5% of inpatients would recommend our services, as recorded by the Friends and Family Test.
- Patients rated the Trust 8.9 out of 10 for overall care in cancer, above the national average.

Clinical effectiveness

- 99% of electronic E-attendance summaries sent for patients attending the Emergency Department (ED) within 24 hours.
- A-rated with sustained excellent performance in the Sentinel Stroke National Audit Programme.
- 94% of stroke patients spent at least 90% of their hospital stay on a stroke unit
- Sustained achievement of the cancer performance targets against the national cancer waiting times standards.
- Introduced a pathway to provide rapid access to expert oncology advice for patients referred to the Primary Care Musculoskeletal Clinical Assessment Service (MCAS) who have suspected serious pathology following imaging. This supports earlier diagnosis of cancer and appropriate management with timely key worker support. This was a joint project with the MCAS Team from North West Boroughs Healthcare NHS Foundation Trust.

Well-led

- Extremely positive national staff survey results with the Trust being placed **6th nationally and best in the North West for overall staff engagement.** The Trust achieved the highest score for 8 of the 32 indicators and was in the top 20% of Trusts in the following areas:
    - Care of patients is the organisation's top priority
    - Organisation acts on patient concerns
    - Staff would recommend organisation as a place to work
    - Staff satisfaction with the quality of work and patient care they are able to deliver
    - Staff ability to contribute towards improvements at work
    - Quality of appraisals
- The Trust was highly commended in the HSJ Patient Safety Awards for Best Organisation.
- The Trust was awarded the Navajo Charter Mark. This is an equality mark signifying good practice, commitment and knowledge of the specific needs, issues and barriers facing lesbian, gay, bisexual and transgender (LGBT)
- Awarded the contract to deliver adult community services in St Helens, in partnership with North West Boroughs Healthcare NHS Foundation Trust and St Helens Rota.
- The Trust's Payroll Service provides payroll, pensions and HR administration services to 23 NHS organisations across Cheshire and Merseyside (about 65% of trusts, including Clinical Commissioning Groups (CCG) and hospices).
- During 2016-17, the Trust was awarded contracts to provide Human Resources Lead Employer services on behalf of Health Education England to General Practitioners (GPs) in Training based in West Midlands, East of England and more recently East Midlands. This is in addition to the Lead Employer service for trainees in Cheshire and Merseyside.

1.2. Summary of 2016-17 external awards, nominations and high profile visits

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

Patient Safety

- Debbie Gleeson, Lead Tissue Viability Nurse, won a **European Pressure Ulcer Advisory Panel travel award** to present her pioneering work on reducing the incidence of heel pressure ulcers in the hospital using the Parafricta – a low friction technology invented in the UK. Her work has confirmed the importance that rubbing friction and shear plays in the formation of such wounds, as well as pressure, and the improvement that taking simple measures such as using the Parafricta bootees in patients at risk could make. Over a 5 year period the initiative resulted in 84% reduction in heel pressure ulcers in the hospital. The initiative means the hospital is well below the national average for such injuries.
- Debbie has been shortlisted for the British Journal of Nursing's Pressure Care Nurse of the Year 2017.
- Valya Weston, Lead Infection Prevention and Control Nurse, won one of the '**Rising Stars of IV Therapy**' at the British Journal of Nursing awards in March 2017.

- Rachel Duncan, Macmillan Skin Cancer Clinical Nurse Specialist, and the Skin Team won first prize at the UKONS conference in Brighton for their poster, **Education Clinic in Skin Cancer Patients**.
- The Communications Team was shortlisted for the Best Digital and Social Media Campaign at the **NHS Flu Fighter Awards 2017** for the Trust's innovative #ProtectYourself campaign which encouraged staff to protect themselves against flu.
- Informatics Skills Development Awards:
- The electronic modified early warning score (eMEWS) project was shortlisted for "Best Improvement in Patient Safety" in 2016.
- Debbie Warburton, Business Change Lead Nurse, was shortlisted in the "Clinician in Informatics" category for her work on the eMEWS project.
- E-Handover solution, a joint project between Dr Chakri Molugu, Consultant Acute Medical Unit, and Informatics was shortlisted in the "Innovation" category

Patient Experience

- The Cancer Clinical Trials team were the first nationally to be **adopted by Macmillan Cancer Support**. This is a kite mark for the high standard of care that the team support.
- Julie Sanderson, Bereavement Midwife, was named **Bereavement Worker of the Year** in the prestigious National Butterfly Awards 2016 and named North West Nurse of the Year at this year's North West Pride Awards for her outstanding commitment to bereaved parents.
- Natalie Hayes, Diabetic Clinical Nurse Specialist, received a **Beacon of Hope Award** at the Lymphoma Association's annual awards ceremony for her amazing work in providing a "buddying service" to young lymphoma patients at St Helens Hospital.
- Julie Parr, Macmillan Cancer Information and Support Manager, was awarded the Lymphoma Association **Beacon of Hope Award**, following her nomination by a young Lymphoma patient and her family for support given to them during her lymphoma treatment and recovery period.
- Amanda Lomax, Cancer Support Worker won second prize in the Macmillan poster completion for **Holistic Needs Assessment – Our Experience**
- The Acute Oncology Macmillan Clinical Nurse Specialists, Christine Rhall, Maureen Scotton and Jeannette Ribton and physiotherapist Ruth Sephton were **finalists in the Nursing Times Cancer Nursing category**.
- Lilac Centre achieved the **Macmillan Quality Environment Mark award** (MQEM)

Clinical Effectiveness

- Helen Thornton, Clinical Nurse Specialist for Children & Young People with Diabetes, has been **shortlisted for the RCN 'Child Health Award'** 2017
- Acute Kidney Injury Team were awarded the **best overall abstract** at a joint Greater Manchester & Eastern Cheshire Strategic Clinical Network and National Institute for Health Research conference
- The Trust's Urology Cancer Team was part of an award winning pilot for an IT system, **My Medical Record**, developed by University Hospital Southampton NHS Foundation Trust. The system, which allows patients to access their test results from home, won the Health Service Journal's Using Technology to Improve Efficiency award.
- Baroness Cumberlege attended to launch the Trust's **Midwifery Strategy**, which actively promotes midwifery led care.

- David Mowat, MP (Warrington South) visited the Trust to see how we are **reducing delayed discharges** and working collaboratively with partners across St Helens to glean any practical lessons which could be applied elsewhere.

The Trust continues to celebrate success internally and hosted its 12th Annual Staff Awards presentation evening in May 2016 to celebrate the hard work and achievements of staff in providing excellent patient care. The annual awards and the Employee of the Month Award are important ways of recognising and rewarding the on-going dedication and commitment of staff throughout the year.

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

We are pleased to present the Trust's eighth 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, aiming for positive outcomes every time. This continues to be embedded in the everyday working practices of staff throughout the Trust.

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 (StHK) Vision

St Helens and Knowsley Teaching Hospitals NHS Trust's Values

The Trust's vision is the driving force for our focus on continuous improvement, supported by the Clinical and Quality Strategy. The Strategy was refreshed in 2016 and covers the next 4 years. It outlines the specific areas for quality improvement that will deliver our aspiration to provide the highest standards of care. The Strategy focusses on a small number of clinical and quality improvements that are key local health economy priorities. Delivery of the Strategy will ensure we maintain our CQC rating of outstanding for caring and move from good to outstanding for the other domains.

The Strategy's key performance indicators are monitored monthly by the Board via the Integrated Performance Report, which is also reviewed in detail by the Quality Committee.

The Trust has delivered a comprehensive programme of clinical audits throughout the year, with a number of quality improvements delivered as a result of the audit findings. The audit programme is reported to the Quality Committee via the Clinical Effectiveness Council.

In addition, the Trust has rolled out a quality care accreditation programme which measures leadership, patient care, safety and experience on all wards. The quality care accreditation tool (QCAT) programme ensures that individual ward areas are clear on the quality standards required and any shortfalls requiring an improvement plan. The QCAT incorporates many quality indicators into the final score including CQC fundamental standards, nursing care indicators and harm-free care scores. It also incorporates the Friends and Family Test results, staff training and appraisal rates and patient care and safety standards, including nutrition and hydration, falls, pressure ulcers and infections. Both the nursing care indicators and the QCAT use peer review to provide assurance on the quality of care being provided to patients. The outcomes of the QCAT programme are reported to the Quality Committee.

Members of the Board and Executive Team continue to regularly visit the wards and departments across the Trust, completing formal annual quality ward rounds to review quality and performance, noting areas of good practice and any actions being taken at a local level to address areas of concern. This provides the opportunity for the Board to see first-hand the care being provided to patients and for the clinical areas to provide both quantitative and qualitative information to demonstrate that the services are safe, effective, responsive, caring and well-led in line with the CQC's domains. Representatives from our local Clinical Commissioning Groups (CCGs) are invited to attend the quality ward rounds.

We have continued to work more widely with patients and carers during the year to ensure that they are able to influence changes made to our services. The Trust has a Patient Participation Group and has patient representatives on several Trust groups. 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.

We continue to work with our local Healthwatch partners to improve our services, particularly in respect of seldom heard groups within the community. This is shown in the progress achieved in meeting the agreed targets for the Equality Delivery System (EDS2) outcomes. 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.

This Quality Account details the progress we have made with delivering our agreed priorities 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 2017-18, which were subject to consultation with staff, patient representatives and our commissioners.

I am pleased to confirm that the Board of Directors has reviewed the Quality Account for 2016-17 and confirm that it is a true and fair reflection of our performance and that, to the best of our 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 of our staff who have contributed, during another very challenging year, to our very many exceptional achievements.

Ann Marr
Chief Executive
St Helens and Knowsley Teaching Hospitals NHS Trust
May 2017

2. Section 2

2.1. About us

2.1.1. Our services

St Helens and Knowsley Teaching Hospitals NHS Trust 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 a dedicated cancer unit. The Trust also 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 a challenging year, set within the financial challenges facing the NHS. There has been a continued increase in demand for 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, but was disappointed to have two never events and to fail to achieve the target of zero methicillin resistant staphylococcus aureus (MRSA) bacteraemia, outlined in more detail below. The Trust uses incidents as opportunities for learning and, therefore, has detailed action plans in place to address any issues arising from the investigations of these cases.

There has been a significant annual increase in most areas, other than the Emergency Department which showed a similar number of attendances to the previous year. The biggest increase was in unplanned admissions, as shown by the activity figures below:

- 51,565 non-elective admissions - 8.1% increase
- 48,790 elective episodes - 7.2% increase
- 455,433 total outpatient attendances - 5.3% increase
- 4,061 births - 4.1% increase
- 103,323 ED attendances - 0.6% decrease

2.1.2. Our staff and resources

Our staff and resources

The Trust's annual total planned income for 2016-17 was £335 million. We employ more than 5,000 members of staff and we are a lead employer for the Mersey Deanery & West Midland Deanery responsible for nearly 4,000 trainee specialty doctors, based in hospitals and general practice (GP) placements throughout Merseyside, Cheshire and West Midlands.

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.

The average staff turnover rate in the Trust for 2016-17 was 9.8%, which is lower than the national rate of 15.7%. However, this overall rate masks variations between disciplines and the significant recruitment challenges which remain 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 acknowledges the challenges that it faces in maintaining high quality care when delivering the increased activity levels highlighted above and in working to ensure appropriate staffing levels across all areas. The Trust is required to externally report nurse and midwifery staffing levels, with details of the total planned number of hours worked by registered and care staff measured against the total number of actual hours worked to produce a monthly fill rate as a % for nights and days on each ward. Agency, bank, overtime, extra time hours, discharge coordinators and ward managers' supernumerary management days are included in the actual hours worked totals in accordance with guidance. A monthly ward fill rate of 90% and over is considered acceptable nationally and the Trust consistently exceeds this standard. The safer staffing figure, however, does not analyse skill mix or the impact of temporary staff on a shift by shift basis, which can impact on the quality of care provided. There is an embedded process for reviewing nurse staffing levels across the Trust on a daily basis to support the delivery of high quality care and to maximise patient safety.

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

The Trust continues to actively work with its health and social care partners across Cheshire and Mersey to improve the way services are delivered, to implement the NHS Five Year Forward View for the local population and to secure a sustainable health system.

This is being driven by the Alliance Local Delivery System that brings together four CCGs, five NHS service providers and the Local Authorities covering St Helens,

Knowsley, Warrington and Halton to work collectively to develop the services of the future.

The three acute hospital care providers in this locality are also working collaboratively to ensure that patients can access high quality clinical services when they need them. An example of this is the recent stroke services collaboration with Warrington and Halton Hospitals NHS Foundation Trust, whereby all stroke patients are now treated at a Hyper Acute Stroke Unit at Whiston Hospital, receiving the specialist expert care they need in the immediate aftermath of their stroke.

There are several specialist service work streams that form part of the Cheshire and Mersey future planning process including cancer services, cardio-vascular disease, neurology and neurosciences, women's and children's services. The Trust is a full participant in all of the groups related to acute care provision, as they develop guidance on how best to achieve high quality care and eliminate unwarranted variation in outcomes for patients.

The Trust is part of a range of other whole health economy partnerships, including the Accident and Emergency Delivery Board which coordinates a whole system response to the demand for urgent care services, provided by hospitals, community providers, social care and primary care.

The Trust is a member or associate member of the Health and Well-Being Boards (or equivalent) in the three Boroughs where it principally delivers services, St Helens, Knowsley and Halton. Participation in the Health and Well-Being Boards helps to determine the health improvement priorities and development strategies for these populations.

In 2016-17 the Trust formed a partnership with North West Boroughs Healthcare NHS Foundation Trust and St Helens Rota GP out-of-hours services. Together we have been awarded the contract to provide Adult Community Nursing services for St Helens residents. These new services are an exciting opportunity to further integrate services and could be the foundations of an accountable care system for the borough of St Helens. This approach is designed to enable more patients to be treated in community settings, with access to a range of services and health care staff that can help to keep people well, rather than reacting when they become seriously ill and need to be admitted to hospital.

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. Staff also attend the North West intravenous/aseptic non-touch technique (ANTT) forum meetings.

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.

Informatics continues to strengthen the infrastructure and platforms on which all the Trust's critical systems are based. The team has demonstrated the Trust's commitment to the security of systems and information by gaining accreditation to the Cyber Essentials Security Standards, a set of technical controls to achieve basic protection from Internet-borne commodity threats. This provides assurance that the Trust has met a national standard of cyber security recognised by the UK Government.

Key achievements in 2016-17 have been:

- Embedding the electronic modified early warning score system, (eMEWS), across all inpatient wards and in the Emergency Department, working closely with nurses and doctors. Clinicians now use mobile devices to record and review patient observations, replacing the paper process that existed previously. Some of the benefits are already being realised, with a reduction in the number of high risk admissions from patient wards to the Critical Care Unit, nursing time being released to spend on caring for patients and financial savings through reduced paper usage.
- A number of clinical forms and information can also be accessed to inform clinical decision-making including apps on burns care, antibiotic advice and general prescribing advice and recommendations.
- Continued enhancements of the eMEWS technology, maximising this technology to prepare for future digitisation of patient processes and elimination of paper forms.
- Upgrade to the Electronic Document Management System (EDMS) across the hospital. This is a system where all documents related to patient attendances in the hospital are stored. The upgrade makes doctors' access to the system much faster and has provided some additional functionality such as 'timelines' which are helpful to clinicians as they can instantly see when the patient attended the hospital and go straight to the documents that are related to that particular visit.

Reflecting on the upgraded EDMS, Rowan Pritchard-Jones (Consultant Burns and Plastic Surgeon & Chief Clinical Information Officer) said:-
'Version 4 brings a contemporary look with improved features to support our clinical care. The thumbnails make for slick navigation. The upgrade also opens the door for other critical projects that integrate with the EDMS system to move forward.'

- Upgraded systems in cancer services and in the Critical Care Unit.
- Upgrades to the system used to order and receive pathology and radiology results to provide more functionality as requested by the clinicians.
- Implementation of an extension of the current 'my prostate health' system which now incorporates a breast care module, providing patients with up-to-date, approved documentation and results.
- Commencement of a project to replace paper, hand-written prescriptions by clinicians electronically prescribing and administering drugs at the patient bedside. Over the forthcoming year, this will a significant system deployment in the hospital and will achieve many benefits including reduction in missed doses and prescribing errors, reduction in drug spend and releasing clinical time for patient care.
- Deployment of a new printing and scanning solution across the Trust, SMART PRINT which has increased the security of patient information. Documents do not now automatically print, and users have a unique PIN number to be input to allow printing of their documents from a work queue. Financial benefits will be realised from this

project based on saving money on printing, consumables and paper and reducing the Trust's carbon footprint.

- The New Trust SharePoint website which was built, developed and launched by the Informatics Web Team, providing easier navigation for users, a fund raising page, social media updates and the "Ask Ann" section, where members of the public can contact our Chief Executive directly.
- Development of eHandover clinical app, in collaboration with one of our Acute Medicine consultants. The app facilitates safer and more efficient handover of patient care from the Emergency Department to the inpatient ward.
- Implementation of an electronic pathway with the Cancer Services Team, across all tumour sites which facilities patients who present as an emergency with a suspected cancer diagnosis being seen in a specialist clinic within seven days. The aim is to facilitate an early diagnosis and avoid unnecessary admissions.
- Improvements in discharge planning for patients requiring Social Services intervention prior to discharge, by digitising the manual, paper process, improving information flow between the Trust and Social Services and significantly reducing medically fit patient's length of stay.

It has been a busy year for the Informatics Team and next year will be even busier with continuous improvements and innovations to Trust systems and infrastructure as we embrace the challenges and opportunities this will bring.

2.2. Summary of how we did against our 2016-17 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.

2016-17 Progress in achieving 2016-17 quality goals

Quality Improvement Goal	Outcome delivered	Progress
Reduce avoidable harm by 50% in the next 3 years (falls, pressure ulcers, medication incidents) using 2013-14 as the benchmark	Partially achieved	• 17% reduction in falls resulting in harm • 23% reduction in all pressure ulcers since 2013-14, with no hospital acquired grade 4 pressure ulcers • Action plans in place to reduce pressure ulcers, never events and MRSA bacteraemia
To further embed the process for learning from incidents and complaints	Partially achieved	• Evidence of learning from complaints reported 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 and incidents investigations. • Further work is required to ensure there is a systematic process for identifying and sharing lessons learnt across the Trust, with increased medical leadership and input in place in 2017-18.
Further reduce mortality of weekend admissions.	Not achieving	• Latest figures (February 2017) show a slight increase in the hospital standardised mortality ratio (HSMR) from 112.9 to 115.1. • The Executive Team has increased investment in weekend working, but national shortages have left some consultant posts unfilled. • The Trust is constantly striving for new ways to improve the quality of care in the face of staff shortages, including challenging historic professional boundaries and exploring innovative new ways of working. • The Trust Board and Quality Committee will continue to monitor mortality figures, however it is unclear why nationally there is higher mortality in weekend admissions and, therefore, this will not be included as a quality priority in 2017-

Quality Improvement Goal	Outcome delivered	Progress
		18.
Earlier identification and initiation of appropriate treatment thus reducing mortality due to sepsis for patients attending the Trust	Achieved	• Delivery of CQuIN target • Reduced length of stay (currently 10.5 days versus 13.8 days in 2014) and reduced readmissions • Work will continue to reduce mortality from sepsis, which has seen a reduction from 17% to 14% since the introduction of the Sepsis Team.
To deliver 5-star care to patients admitted to hospital with an Acute Kidney Injury (AKI), demonstrated by reduced lengths of stay and achievement of the local Commissioning for Quality and Innovation (CQuIN) target for effective discharge communication for patients with AKI	Achieved	In the short time that the AKI team has been established a number of successful achievements have been demonstrated: • StHK was the only participating Trust to achieve the appropriate care score target for AKI set by Advancing Quality Alliance in 2015-16. • The AKI team enabled achievement of the National CQuIN for 2015-16 and local CQuIN for 2016-17 that focussed on enhancing communication regarding AKI and further plans between secondary and primary care. • An average of a 2 day reduction in length of stay for all patients with AKI and a 2.6 day reduction in AKI survivors with hospital-acquired AKI. • A reduction in readmissions after a diagnosis of AKI on the previous admission • A reduction in utilisation of critical care for AKI
Increase the percentage of e-discharge summaries sent within 24 hours to 90%	Not achieving	• Annual figure (75.7%) is lower than last year (79.9%), due in part to increased activity and fewer trainee doctors. • Medium-term plan is to supplement trainee doctor numbers with advanced nurses.

2.3. Quality priorities for improvement for 2017-18

The Trust's quality priorities for 2017-18 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.

The consultation was undertaken using SurveyMonkey and received 102 replies, a 44% increase (31 replies) from the previous year. There was positive support for the proposed priorities, all receiving more that 90% agreement. The priority to improve the effectiveness of discharge received the most support (99%) and provision of respiratory ward based non-invasive ventilation (NIV) supported by appropriate equipment and staffing levels received the lowest (92%).

	Safety		
Priority title	**1. Maintain the safety of patients in the Emergency Department**	**2. Reduce avoidable harm from falls, pressure ulcers and medication incidents by 50% in the next 3 years**	**3. Refresh and redesign the process for learning from incidents and complaints**
Rationale:	The Trust is aware that some patients may have to wait longer in the Emergency Department at certain times than at other times. The Trust remains committed to ensuring that patient safety is paramount at all times.	Patient safety remains our top priority. 2017-18 will be the third 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'.	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.
Measurement	• Meeting the ambulance handover time of less than 30 minutes • All patients to have a two hourly check (intentional rounding),	• Reducing the rate 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	• Demonstrate a learning safety culture through increased reporting of incidents • Improve on the timeliness of investigating and reporting serious

	which will assess the safety of the environment, the need for pain relief, levels of nutrition, the need to have their position changed, the requirement for bedrails and toileting requirements • All patients to have their vital signs monitored and their modified early warning system (MEWS) score recorded in line with the frequency stipulated by the Trust's MEWS Policy This will be measured by a quarterly audit of 25 casenotes of patients waiting more than 6 hours in the Emergency Department. This will include a review of any new harms that have occurred in relation to falls and pressure ulcers.	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 3 and 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	incidents • 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
Monitoring	This will be monitored by the Quality Committee	This will be monitored by the Patient Safety Council and reported to the Quality Committee.	This will be monitored by both the Patient Safety and Patient Experience Councils and reported to the Quality Committee.

	Clinical effectiveness	**Patient experience**	
Priority title	**4. Provide respiratory ward based non-invasive ventilation (NIV) supported by appropriate equipment and staffing levels in the next 12 months**	**5. Increase the percentage of e-discharge summaries sent within 24 hours to 90%**	**6. Improve the effectiveness of discharge planning**
Rationale:	The benefits of ward-based NIV, provided outside the Critical Care Unit (CCU), include:	In order to communicate the on-going treatment plan when patients are discharged it is essential to share the	A key theme of patient feedback during the year has been the need to continue to improve the Trust's discharge planning

	• Early intervention to prevent further respiratory deterioration
	• Improved patient experience by the provision of support in a less intimidating setting
	• Reduced need to use critical care beds for patients who would otherwise not require admission to the CCU
	• Improved patient outcomes, particularly for those patients with Chronic Obstructive Pulmonary Disease (COPD) associated with hypercapnoeic ventilatory failure (abnormally elevated carbon dioxide levels in the blood), demonstrated by:
	  ○ Decreased mortality
	  ○ Decreased length of hospital stay
	  ○ Rapid clinical improvement within the first hour
	  ○ Decreased need for intubation
	  ○ Reduction in treatment failure
	  ○ Reduced complications associated with treatment
		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.	processes for patients and carers. Commencing discharge planning as soon as patients are admitted, actively involving patients and their carers in the process and reducing delays in discharge will improve the patient and carers' overall experience of care.

Measurement	• Increase in registered nursing by 5.6 whole time equivalents to ensure one registered nurse with relevant competencies to deliver ward-based NIV per shift. • Purchase, installation and	Numerator - % of summaries issued Denominator - % of discharges	• Quarterly audits to confirm that: ○ Daily multidisciplinary board rounds are taking place, with input from senior clinicians, with escalation of internal and external delays

	training in the use of 3 remotely monitored beds with 3 NIV machines on ward 2C • Introduction of appropriate use of NIV in COPD patients with hypercapnoeic respiratory failure outside the ITU • Improve overall survival at discharge for COPD patients based on standard mortality ratios for the appropriate disease grouping		○ Patient Journey leaflets and discharge information are given out on admission with the first home of choice letter ○ All patients with delays of 6 days or more are reviewed at the weekly length of stay meetings • Roll out of daily board rounds to include weekends
Monitoring	This will be monitored by the Clinical Effectiveness Council and reported to the Quality Committee.	This will be monitored by the Clinical Effectiveness Council and reported to the Quality Committee.	This will be monitored by the Patient Experience Council and reported to the Quality Committee.

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 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 2016-17, the Trust provided and/or sub-contracted £280m 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 2016-17 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 2016-17.

The other income generated by the Trust relates to education and training, research and development, services to other NHS bodies and private finance initiative (PFI) related income.

2.4.2. Participation in clinical audit

Annually NHS England publishes a list of National Clinical Audits and Clinical Outcome Review programmes that it advises Trusts to prioritise for participation and inclusion in their Quality Accounts (QA) for that year. This will include projects that are on-going and new items.

During 2016-17, 35 national clinical audits and 2 national confidential enquiries covered NHS services that St Helens and Knowsley Teaching Hospitals NHS Trust provides.

During that period, the Trust participated in 97% (n34) individual 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 the Trust participated in, and for which data collection was completed during 2016-17, 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.

It should be noted that some audits are listed as one entity; however several individual audit projects can have been undertaken under the single heading, such as NCEPOD, and in some instances may include a programme of work, such as chronic obstructive pulmonary disease (COPD); as detailed below:

- **National Confidential Enquiry into Patient Outcome and Death (NCEPOD)** - 6 individual audits, including the Child Health Review programme

- **COPD Audit Programme -** 2 audits

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data was collected during 2016-17, 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. Participation in Quality Account audits 2016-17

National Clinical Audits and Clinical Outcome Review Programmes	Status	Rate of Case Ascertainment
Diabetes (Paediatric): Paediatric National Diabetes Audit (PNDA)	Completed	100%
Asthma (Paeds & Adult) (Care In Emergency Department (ED)) (Royal College of Emergency Medicine: RCEM)	Completed	100%
Severe Sepsis & Septic Shock (Care in ED) (RCEM)	Completed	100%
Inflammatory Bowel Disease (IBD) UK - 4th Round	Completed	100% - main audit 100% - biologics
British Society for Rheumatology (BSR) Rheumatoid and Early Inflammatory Arthritis	Completed	100%
Adult Asthma (British Thoracic Society (BTS)	Completed	100%
National Audit of Dementia (NAD)	Completed	100%
Diabetes (Adult)* National Diabetes Audit (Adult) (NDA (A)	Completed	2015-16 data 50%
Paediatric Pneumonia (BTS)	Completed	100%
Chronic Obstructive Pulmonary Disease (COPD) secondary care dataset pilot	Completed	100%
Stress Urinary Incontinence Audit	Active	-
Nephrectomy Audit	Active	-
Learning Disability Mortality review (LeDeR)	Active	-
National Emergency Laparotomy Audit (NELA)	Active	-
National Prostate Cancer Audit (NPCA)	Active	-
National Ophthalmology Audit	Active	-
National COPD Programme: (BTS) National COPD Secondary Care Audit: Start: Feb-17	Continuous monitoring	-
Percutaneous Nephrolithotomy (PCNL)	Continuous monitoring	100%
Adult Critical Care: Case Mix Programme - Intensive Care National Audit & Research Centre	Continuous Monitoring	100%

National Clinical Audits and Clinical Outcome Review Programmes	Status	Rate of Case Ascertainment
(ICNARC)		
Severe Trauma: Trauma Audit & Research Network (TARN)	Continuous Monitoring	100%
Acute Coronary Syndrome or Acute Myocardial Infarction: Myocardial Ischaemia National Audit Project (MINAP)	Continuous Monitoring	100%
National Cardiac Arrest Audit (NCAA)	Continuous Monitoring	100%
Sentinel Stroke National Audit Programme (SSNAP)	Continuous Monitoring	100%
Neonatal Intensive and Special Care (National Neonatal Audit Programme (NNAP))	Continuous Monitoring	Jan-Dec 2016 100%
Cystic Fibrosis Registry	Continuous Monitoring	100%
Bowel Cancer: National Bowel Cancer Audit Programme (NBOCAP)	Continuous Monitoring	97% - Based on latest published figures available - 2015/16
Oesophago-Gastric Cancer: National Audit Oesophago-Gastric Cancer (NAOGC)	Continuous Monitoring	89-90% - Ascertainment rate group – based on latest published figures available - 2015/16
Lung Cancer: National Lung Cancer Audit (NLCA)	Continuous Monitoring	304 cases – ascertainment level not set - figure based on latest published figures available – 2016 report (cases diagnosed 2015)
National Heart Failure (HF)	Continuous Monitoring	75% - based on latest published figures available – 2014-15
Falls And Fragility Fractures Programme (FFFAP) -Includes National Hip Fracture Database (NHFD)	Continuous Monitoring	91.8% (NHFD) based on latest published figures available – cases reported in 2015
National Joint Registry (NJR)	Continuous Monitoring	108.6% - based on latest published figures available – 2014-15
Elective Surgery: National patient-reported outcomes measures	Continuous Monitoring	85.5% Participation rate –

National Clinical Audits and Clinical Outcome Review Programmes	Status	Rate of Case Ascertainment
(PROMS)		based on latest published figures available – 2015-16

*Please note: The National Diabetes Audit relies on direct data capture from electronic systems but currently the Trust's systems are paper-based; therefore we have to submit a labour-intensive sample audit.

National Confidential Enquiries (3)			
2016-17	**Participation**	**Status**	**Rate Of Case Ascertainment**
NCEPOD – (Medical & Surgical Clinical Review Outcome Programme)			
Non-invasive ventilation (NIV)	Yes	Completed	100%
Acute Pancreatitis	Yes	Completed	100%
Mental Care Health in Acute Hospitals	Yes	Completed	100%
Cancer in Children, Teens and Young Adult (0-25yrs)	Yes	Active	100% to date Participating in 18-25 years age group only
Child Health Clinical Outcome Review Programme (NCEPOD)			
Mental Health Conditions in Young People	Yes	Completed	100%
Chronic Neuro-disability	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%

In addition to the audit activity undertaken through participation in the National Clinical Audits and Clinical Outcome Review Programmes, the Trust also participated in 17 other National Audits.

2.4.2.2. Trust participation in other National Audits (not included on the Quality Accounts List)

National Audits 2016/17	Participation	Status
British Orthopaedic Trainees Association (BOTA)/ British Orthopaedic Network Environment (BONE) - paediatric orthopaedic trauma snapshot (POTS)	Yes	Completed

National Audits 2016/17	Participation	Status
National BTS smoking cessation audit	Yes	Completed
Consultant sign-off in ED CEM	Yes	Completed
Society for Acute Medicine (SAM) Benchmarking Audit (SAMBA) 2016	Yes	Completed
Rapid Access Chest Pain Clinic (RACPC) audit programme	Yes	Continuous monitoring
Rotational delivery at full dilatation (ReDEFINe)	Yes	Completed
National pregnancy in diabetes audit (NPID) 2016-17	Yes	Completed
Implant breast reconstruction audit (iBRA)	Yes	Completed
iBRA2 Study for plastic surgery	Yes	Completed
Audit of impact of immediate breast reconstruction on the delivery of adjuvant therapy (iBRA)	Yes	Completed
iBRA3 TeaM Study - therapeutic mammoplasty (Plastics)	Yes	Active
iBRA3 TeaM Study - therapeutic mammoplasty (Gen Surgery)	Yes	Active
National 3rd Corrective Jaw Treatment Audit	Yes	Active
National Nutritional Care Audit - BAPEN	Yes	Active
Identification of patients with a learning disability using International Classification of Diseases (ICD) codes	Yes	Active
National audit of breast cancer in older patients (NABCOP)	Yes	Active
Breast and Cosmetic Implant Registry	Yes	Continuous monitoring

The reports of 38 national clinical audits were reviewed by the provider in 2016-17 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:

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)/Child Heath Programme
The Trust has participated in all eligible studies during 2016-17. Completed study reports have been disseminated and reviewed with report recommendations implemented or planned.

Reports published in 2016-17 or due 2017-18:
- Care of Patients with Mental Health Problems in Acute General Hospitals (January 2017)
- Chronic Neurodisability – Cerebral Palsy (due December 2017)
- Mental Health Conditions in young people (due December 2017)
- Non-Invasive ventilation (due June 2017)

Current In-Progress NCEPOD studies

- Cancer in Children, Teens and Young Adult Study
- Acute Heart Failure

NCEPOD Sub-arachnoid Haemorrhage (SAH) Study:

- A headache pathway is in use that now covers the management of SAH.

NCEPOD Sepsis study:

Actions implemented or on-going are listed below:

- Trust team leading on sepsis includes a Consultant, Sepsis Nurse Lead and sepsis team with 5 specialist nurses at present.
- Plans to expand the team by 2 more nurses (at least one with paediatric training/experience).
- Approval sought for all sepsis specialist nurses to work towards clinical skills accreditation.
- Updated sepsis screening tool in place in the Emergency Department and a management pathway consistent with NICE guidance (July 2016) is in place.
- Aim for members of the sepsis specialist nurse team to be included in medical emergency team (MET) bleep by May 2017 to alert them to potential in-patient sepsis - currently awaiting approval.
- Development of online sepsis course to enable further staff training and education, as well as free up specialist nurses to provide clinical care
- Sepsis study days on-going with dates for course every month until December in place. So far excellent attendance on the course.
- Sepsis policies and standard operating procedures to be updated for both adults and paediatrics by end April
- A paediatric sepsis screening tool was introduced in the Emergency Department in November 2016, as well as a sepsis screening section in the paediatric admission pro forma. Staff education from paediatric leads has been delivered, with future plans for a paediatric sepsis study day.
- Sepsis team now following up patients reviewed in ED, to ensure those admitted have antibiotic review within 72 hours by specialist nurse or competent clinician as per CQuIN guidance for 2016-17.
- Plan for sepsis team to extend services to assist GP Admissions Unit at weekends, to ensure patients are screened and treated for sepsis captured within the hour.
- GP Admissions Unit and Acute Medical Unit admissions areas now using new Trust pathway in accordance with NICE guidelines to screen all emergency patients for sepsis.
- New intranet page will provide updated link to sepsis information for staff to access updated resources and training materials.

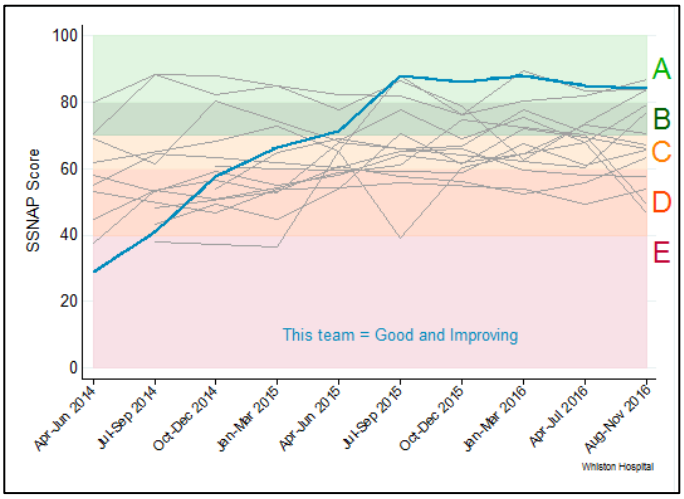
National Paediatrics Diabetes Audit (NPDA) 2015-16

All children admitted with Type 1 diabetes are checked to see if annual review bloods are required.

A link between the pathology Order Comms System (OCS) and the Twinkle Database (Paediatric patient management system) is currently being planned which will assist with automated data collection; reducing the risk of errors via manual entry, and result in freeing up clerical and nurse specialist time.

Sentinel Stroke National Audit programme (SSNAP)
The Sentinel Stroke National Audit Programme (SSNAP) is the National Clinical Audit for Stroke and the main source of stroke data in the NHS. Data is collected on every stroke patient admitted to hospital in England, Wales and Northern Ireland.

The report summary received for the Overall SSNAP score performance over two and half years (April 2014 to November 2016) of the stroke care provided by our hospital stated that performance recently was **'Good'** and the performance over the last 2 years was **'Improving'** as shown by the chart below:



We have remained one of the highest performing trusts in the UK in this audit, remaining one of the approximately 20 stroke units rated as 'outstanding' ('A') based on performance benchmarking in the national audit.

One of the key improvement changes we have made this year has been to increase access to our stroke unit for residents living in Warrington and Halton. Evidence shows that larger and better-performing Hyperacute Stroke Units deliver better outcomes for patients in terms of mortality and disability. All patients with a suspected stroke within four hours of onset across St Helens, Knowsley, Halton and Warrington area are now admitted to Whiston's Hyperacute Stroke Unit for the acute portion of their care.

Vital signs in children (care in ED) – College of Emergency Medicine (CEM)
A separate paediatric triage sheet included on ED casualty card is now in place.

Vital signs in children (care in ED) – College of Emergency Medicine (CEM)
Clexane prophylaxis for patients with immobilised lower limbs is in place.

Procedural Sedation in Adults (care in ED) – College of Emergency Medicine (CEM)
A safe sedation pro forma has been developed by CEM and this has been implemented.

BTS Smoking Cessation audit
The audit found that this Trust was better than the national average for documentation as a whole and offering smoking interventions to our patients. Smoking cessation is being monitored by the smoking key performance indicators

(KPI) and the national COPD continuous audit currently underway. This Trust became a smoke free hospital on 1st April 2017.

BTS Paediatric Asthma National Audit 2015
Provision of a clear asthma plan and discharge planning information for families is given.

NNAP National Neonatal Audit Programme 2014
Babies who are delivered at or below 30 weeks will have follow up in the Neonatal Leads baby clinic so early developmental problems are picked up and babies are referred accordingly.
Breastfeeding rates are below the national average and the Breastfeeding team will be leading actions to address this.

ICNARC
The ICNARC- Case Mix Programme produces quality indicators and comparable data with similar units & all other units participating. The Trust performs well for all indicators, other than delayed discharges from the Critical Care Unit, for which a robust discharge dashboard has been produced and implemented.
ICNARC data is also used to ensure systems are in place for reviewing any unplanned readmissions, risk adjusted acute hospital mortality, out-of-hours discharges & Unit acquired infections.

2.4.2.3. Local clinical audit information

The reports (results) of 163 local clinical audit projects were reviewed by the provider in 2016-17 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:

Quality Improvement Project: Inpatient Post Fall Review
A new falls review pro forma has been designed, piloted and implemented.

Management of Headaches
A pro forma and pathway have been implemented.

Ward Round Efficiency Audit – General Medicine
Role cards are now used for every consultant-led ward round.

Audit of Performance & Consent gained for Lumbar Punctures
Lumbar puncture (LP) procedure documentation aid and patient information leaflet created.

Plan to create an LP consent form and an LP pack, which includes apparatus/ documents needed to efficiently and safely perform an LP. This is to be included in the Acute Medical Unit induction for junior doctors.

Omitted Doses Audit
Omission of medications seemed to be reducing since 2013.
A “safety huddle tool” to improve hand-over by nursing staff has been implemented, which now features a specific medication issues section.

Management of Acute Gallstone Disease
A new position of an Emergency Surgery Co-ordinator for Cholecystectomy is now in post to review all 'hot' gallbladders. Increased theatre sessions for 'hot' gallbladders are in place.

Management of moderate/severe acute pancreatitis
Patients should be investigated appropriately for cause of acute pancreatitis and a flowchart has been created for use on the Surgical Assessment Unit to aid this. Education provided to junior doctors regarding this matter.

Palliative Care: Enhanced Rapid Discharge Audit (ERD)
Documentation and systems have been amended to aid ERD discharges.

Opioid Prescribing in Palliative Patients
Patients provided with information relating to opioids by Pharmacy with 'to take out' (TTO) medicines.

Management of Henoch-Schonlein Purpura (HSP) Patients
HSP proforma designed, based on tertiary guidelines, and the HSP leaflet has been updated.

Critical Care Audit of the use of Albumin in Burns Patients
Update to burns fluid guidance and minor changes made on Critical Care Unit protocol file (electronic).

Review of Time of Injury to Surgery for Hand Trauma Patients (Burns & Plastics)
A new triage process has been introduced.

Audit of Antibiotic Prescribing in Hand Trauma (Burns & Plastics)
A new hand trauma pro forma has been designed and implemented.

Audit of Perineal Trauma
National (UK) incidence has risen to 2.9%. The Trust guideline has been updated to reflect current data and to clarify the incidence of third and fourth degree tears. Audit data collection tool has been updated accordingly, to reflect the changes in preparation for re-audit.

Stillbirth Audit
The audit tool has been redesigned following the introduction of Growth Assessment Protocol. A request for more post mortem training from Alder Hey Children's NHS Foundation Trust was implemented.

Heath, Work and Well-Being - Screening Nurse Records Maintenance 2015
A standardised pro forma for MRSA and dermatology conditions has been created and is in use.

Trust wide - 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 will be reviewed again and the data collection tool re-designed to reflect changes in the hospital information systems and rolled out during 2017.

Trust-wide 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. This approach has continued this year with results shared/discussed following each round of audit and improvements have been demonstrated.

Endoscopy Global Rating Scale (GRS) audit programme
The Endoscopy Department participates in approximately 15 audits undertaken annually/bi-annually as part of the GRS audit programme. All results are discussed and circulated with examples of actions implemented, including the introduction of new consent forms, reviewing of guidelines, possible expanding clinics and implementing system updates to improve services and care.

Care of the Deceased Patient Audit
The new communication checklist is currently being piloted and early indications are that it is going well; provided no changes are required the new checklist will be rolled out in the summer of 2017.

Once the new checklist is finalised the procedure will be updated accordingly. Presentations for nursing staff will be developed on the care of the deceased to inform them of changes and updates.

SILVER TRAUMA: Audit on Management of Patient aged > 75yrs (TARN)
A prospective injury severity score (ISS) chart is to be developed and validated.
A Silver Trauma Fast-Track form is under development and the feasibility of a new pathfinder option for local ambulance services is being reviewed. The trauma team activation system has been adapted.

Efficiency of Naso-Gastric Feeding On Critical Care Unit
Enteral feeding guidance has been amended.
Development of a chart for nursing staff to follow if altering patient's feeding rates.
Change of feed to be planned in conjunction with the Pharmacy Department.
Education to nursing staff to be undertaken to reinforce these changes/provide information.

Re-Audit of Non- Hip Fragility Fractures
Aim to admit the majority of patients with non-hip fragility fractures under the care of Geriatricians.
All patients who present with fragility fractures need to be assessed for bone protection and protection commenced if felt to be appropriate.
Consider development of multidisciplinary team meetings to include non-hip fragility fracture patients.

Continue to assess pain and ensure that adequate analgesia is provided to all patients who present with fragility fractures.

Audit of Dermatology HIV Clinic Service: St Helens & Broadgreen Hospitals
Plan to open up HIV Dermatology clinic service to a wider geographical area in the region and consider doing more joint sessions between BGH and St Helens Hospitals (at present once a year).

Palliative Care: End of Life (EoL) Complaints Audit
Review the best way to identify themes of complaints received.
A gap analysis is to be undertaken as per recommendations in the EoL Strategy
An integrated education development programme to be rolled for all staff, to include advanced communication, and continued on-going education for all health professionals on EoL care.

Compliance with National Patient Safety Agency Guidance for patients with Nasogastric (NG) Feeding Tubes

- The audit tool has been updated to include more sensitive data.
- Re-auditing every 6 months and presenting at relevant audit meetings.
- The NG tube chart has now been implemented and, from our most recent audit, been shown to improve compliance with national guidance.
- Emails sent to nursing staff regarding NG insertion training available at Nightingale House.
- Discussions held at Nutrition Link Nurse meetings regarding importance of insertion checks and subsequent position checks.
- Doctors are to complete training on NG insertion and position checks.
- Senior Nurse drafting article for Speak Out Safely magazine.
- POWTOON been developed for training purposes.
- All documentation for NG tubes been reviewed and put into one document for trial on 3D, 4C and Stroke unit, awaiting trial and outcome.
- Competencies are being developed for insertion and initial position checks and subsequent position checks.

Delays in Transferring Women to Delivery Suite after Induction
Continue with cycle of induction of labour audits, including rapid re audits and review management. A specific audit of feto-maternal outcomes in relation to induction of labour is planned.

Re-Audit of Outpatient Hysteroscopy Services
2-year robust plan of audits has been devised for the coming audit years (2017-18 and 2018-19) with the focus on those areas highlighted in the audit as in need of improvement.

12 audits reviewed in this year indicated that no changes were necessary as standards had been met.

2.4.3. Participation in clinical research

Clinical research is about improving the clinical treatments available to patients and discovering new ways of managing conditions. St Helens and Knowsley Teaching Hospitals NHS Trust is passionate about the contribution that clinical research can make to patient care. Our engagement with clinical research demonstrates that our patients are able to gain access to the best available treatments and services, which have been rigorously tested, as well as innovative and leading edge treatments that can significantly improve health outcomes.

The Trust is a partner organisation in the North West Coast Clinical Research Network (NWC CRN) and works collaboratively with them to increase the opportunities for patients to take part in clinical research. We ensure that studies are carried out efficiently and meet the National Institute for Health Research (NIHR) high level objectives, which include increasing the number of patients recruited to NIHR portfolio studies.

In April 2016 a new national research approval system was implemented, the Health Research Authority (HRA). The Trust has worked hard to put in place mechanisms to ensure a smooth transition.

During 2016-17 the Trust was involved in 168 studies and the NIHR supported 150 of these.

The number of participants, including patients and staff, receiving NHS services provided or sub-contracted by St Helens and Knowsley Teaching Hospitals NHS Trust between April 2016 and March 2017 was 913. The total recruitment was made up of:

- 868 recruited to NIHR adopted studies.
- 45 recruited to non-NIHR adopted studies, that is local and student.

We were pleased that NIHR recruitment figures have exceeded those forecasted during 2016-17, and that the Trust successfully recruited 868 participants against the proposed target of 500.

In 2016-17 the RDI department produced RDI Permission (Confirmation of Capacity & Capability) for 26 new studies and the Trust rigorously adhered to the national benchmark for approving studies within the NIHR timeframe of 70 days.

The Trust has impressive research activity across a wide range of clinical specialities. Since 1st April 2016 we have approved 26 NIHR studies in the following areas:

Speciality	Number of Studies
Anaesthetics	2
Cancer	5
Cardiology	2
Critical Care	3
Diabetes	1
Gastroenterology	5

Paediatrics	1
Renal	1
Rheumatology	1
Stroke	1
Surgical	1
Trust Wide	2
Woman & Child Health	1

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

St Helens and Knowsley Teaching Hospitals NHS Trust met the 70-day benchmark in two of the non-commercial study trials submitted in the data collection period for 2016-17. The 70-day benchmark was not achieved in seven studies, due to patients being approached but declining to take part. The Trust, however, did meet the recruiting to time and target for all four commercial studies that closed in 2016-17.

2.4.3.2. Commercially sponsored studies

We have continued to increase our participation in commercially sponsored studies, with 30 commercial studies active within the Trust in cancer, diabetes, dermatology, gastroenterology, rheumatology and emergency medicine.

2.4.3.3. Key achievements

- In line with NWC CRN objectives to increase the number of Chief Investigators (CI) in the region & increase the commercial contract studies we are extremely pleased that Dr Himanshu Kataria (Consultant in Emergency Medicine) and local Specialty Research Group (SRG) lead for Injuries and Emergencies was appointed CI for two commercial studies:
    - Post Authorisation Safety Study (PASS) to Evaluate the Risk of Hepatotoxicity and Nephrotoxicity from Administration of Methoxyflurane (Penthrox®) for Pain Relief in Hospital Accident & Emergency Departments in the United Kingdom
    - Penthrox™ Survey to evaluate the educational materials of Penthrox.
- The Trust is pleased to have been the first site in UK for both of the above studies and we continue to recruit to these two studies ahead of time and target.
- The Trust has appointed a Research Nurse in ED as a part-time secondment opportunity for two ED nurses, which will help to improve the ED nursing staff morale, recruitment and retention.
- Cancer research at the Trust has continued to make excellent progress in 2016-17. At present there are 17 open studies actively recruiting across all tumour

groups. This year 119 patients diagnosed with cancer have participated in a cancer research study. The Cancer Research Team at the Trust is the first research team in the country to be adopted by Macmillan (August 2016), which is a truly great and praiseworthy achievement. The team have also been recognised for recruiting the 3000 patient to the Mammo-50 breast cancer study.

- The Trust was the first site in the North West Coast to recruit to the ARCHIE study, a paediatric study looking at the early use of antibiotics in at risk children with influenza.
- The Gastroenterology team at St Helens and Knowsley Teaching Hospitals NHS Trust are extremely pleased with the expansion of their research portfolio. In the last 12 months they have been involved in three major commercial studies. They have recruited to two studies looking at new treatments for Ulcerative Colitis and Crohns Disease and one observational study for patients on biologic therapies for Ulcerative Colitis. A major achievement for the team has been recruiting the 1st patient in Europe to one of the studies. This has been a very busy year for the team, with a number of new studies in the pipeline and they are fast becoming recognised as a site that exceeds in this speciality.
- In June and October 2016, the Trust was also the top recruiter to the MAMMO 50 study, Mammographic surveillance in breast cancer patients aged 50 years or over.
- In July 2016, the Trust was again the top recruiter to the Outcome of Treatment in Psoriatic Arthritis study (OUTPASS).

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.

In order to promote research in January 2017 the Trust launched its own Research Twitter account to keep the public and staff up to date with latest research developments and events at the Trust.

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

2.4.3.4. Research aims for 2017-18

Our aims for 2016-17 are to continue to:

- Ensure that we build on existing strengths and key areas of current research, as well as supporting developments in other health priority areas.
- Continue to work in partnership with the CRN NWC to meet the NIHR high level objectives.
- Continue in the direction of travel in line with the Trust Strategy for RDI and the Department of Health objectives to increase recruitment into NIHR portfolio adopted studies.
- Support and encourage the growth of commercial studies.

- Provide first rate support for applications and administration through the Research Office and ensure that effective information and advice is given to all researchers.
- Maintain the quality of research undertaken at the Trust by introducing and adapting to new systems and processes.
- Promote research to patients and public by increasing the use of social media, as well as liaising with the Trust's Patient Experience Manager and Communication Team.

2.4.4. Clinical Goals agreed with commissioners

A proportion of the Trust's income in 2016-17 was conditional on achieving quality improvement and innovation goals agreed between the 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 2016-17 and for the following 12 month period are shown in the tables below:

CQuIN targets 2016-17

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 waiters 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.

Proposed CQuIN targets 2017-18

Commissioner	CQuIN Ref	Scheme Title	Indicator Title
CCG	1a	NHS Staff Health & Well-being	NHS Staff survey results for the provider.
CCG	1b	NHS Staff Health & Well-being	Healthy food for NHS staff, visitors & patients (maintaining the four changes that were required in the 2016-17 CQuIN & introducing three new changes to food and drink provisions).
CCG	1c	NHS Staff Health & Well-being	Improving the uptake of flu vaccinations for front line clinical staff.
CCG	2a	Reducing the Impact of Serious Infections	Timely identification & treatment for sepsis in ED & acute inpatient settings.
CCG	2b	Reducing the Impact of Serious Infections	Empiric review of antibiotic prescriptions.

CCG	2c	Reducing the Impact of Serious Infections	1] Appropriate use of antibiotics 2] Usage duration review
CCG	4	Improving services for people with mental health needs who present to ED	Improving services for people with mental health needs who present to ED.
CCG	6	Advice & guidance	Advice & guidance
CCG	7	E-referrals	E-referrals
CCG	8	Proactive & safe discharge	Proactive & safe discharge
Specialised Commissioning	5b	Right setting: to ensure patients are cared for in the most clinically appreciate setting	WC5: Neonatal community outreach
Public Health England	1a	NHS staff health & well-being	Specific CQuIN for cytology programme
Public Health England		Dental e-referrals & managed clinical network involvement	Dental e-referrals & managed clinical network involvement

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 and assesses services against five key questions to determine the quality of care a Trust provides, asking if services are:

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

If it has cause for concern, it may undertake special reviews/investigations and impose certain conditions.

The last Chief Inspector of Hospitals CQC comprehensive planned inspection 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 provided. 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 2016-17.

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 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

The Trust intends to take the following action to address the points made in the CQC's assessment:

- The key actions identified for improving access to urgent and emergency care are being driven forward by the senior leaders across the organisation. There is focus on both the Emergency Department and the inpatient wards and improvements to the processes are identified in the Urgent and Emergency Care Transformation Plan. Actions include the appropriate deployment of clinical resources to meet demand and improved use of information technology to enable real time tracking of patients within 4 hours. In addition, a number of actions are being taken to improve patient flow in inpatient areas including clinically-led board rounds on inpatient wards, identifying early morning discharges to support flow; senior daily review and escalation for patients who no longer need care in an acute bed, supported by weekly system wide Multi Agency Discharge Events (MADE) and an agreed expected number of discharges by ward. The additional actions identified within the Trust's recovery plan will continue with support and focus being provided by the Emergency Care Improvement Programme in order to sustainably deliver the 95% target.

- Continue to focus on ensuring staff appraisals and mandatory training are up-to-date.
- Complete the assessment of the impact of the amber care bundle in light of the development of the national initiative, recommended summary plan for emergency care and treatment (ReSPECT).

St Helens and Knowsley Teaching Hospitals NHS Trust has made the following progress by 31st March 2017 in taking such action:

- Maintain robust systems for the storage of medications, with regular audits to demonstrate compliance.
- Actions 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.
- Strengthened the processes and timeliness of risk management within maternity services.
- Development of a specific Maternity strategy, with a focus on midwifery-led care.
- Adaptations to the Maternity Unit bereavement rooms to enhance patient experience.
- 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

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 in place to ensure that information, including patient information, is handled in a confidential and secure manner.

The Trust continues to benchmark itself against the Information Governance Toolkit. The toolkit is an online system which allows NHS organisations and partners to assess themselves against NHS Digital 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 2016-17

was 80% and was graded 'green'. This means that the Trust is compliant in all sections of the Information Governance Toolkit.

The Trust are continuing to monitor patterns and trends of Information Governance incidents and implementing measures to reduce these to the lowest level practicable.

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 the management of information risk to the Board. This role is held by the Director of Informatics, who is SIRO trained, registered and accredited.

2.4.7. Clinical coding error rate

The Trust was subject to an audit of clinical coding, based on national standards undertaken by Clinical Classifications Service (CCS) approved clinical coding auditors in line with the Information Governance Toolkit requirement 505 in March 2017.
The error rates reported for diagnoses and procedure coding (clinical coding) were:-

2016 data reported in March 2017				
Measure	Primary diagnosis incorrect	Secondary diagnosis incorrect	Primary procedure incorrect	Secondary procedure incorrect
IG Toolkit audit	4%	2.7%	2.9%	1.8%

2.4.8. Data quality

The Trust continues to be committed to ensuring 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

The 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 2016-17 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:

Care Setting	StHK result	National Average
Admitted patient care	99.4%	99.3%
Outpatient care	99.5%	99.5%
Accident and Emergency care	98.7%	96.7%

- Included the patient's valid General Medical Practice Code was:

Care Setting	StHK result	National Average
Admitted patient care	100%	99.9%
Outpatient care	100%	99.8%
Accident and Emergency care	100%	99.0%

(Source: SUS Data Quality Dashboard latest published report: April 2016 – January 2017)

In all cases, the Trust performed as well as or better than the national average, 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	Source	Reporting Period	StHK	National Performance			Comment
				Average	Lowest Trust	Highest Trust	
SHMI	NHS IC	Oct-15 to Sep-16	1.048	1.000	0.690	1.164	Next SHMI data (for Jan-16 to Dec-16) due to be published in June 2017
SHMI	NHS IC	Jul-15 to Jun-16	1.020	1.000	0.694	1.171	
SHMI	NHS IC	Apr-15 to Mar-16	1.034	1.000	0.678	1.178	
SHMI Banding	NHS IC	Oct-15 to Sep-16	2	2	3	1	
SHMI Banding	NHS IC	Jul-15 to Jun-16	2	2	3	1	
SHMI Banding	NHS IC	Apr-15 to Mar-16	2	2	3	1	
% of patient deaths having palliative care coded	NHS IC	Oct-15 to Sep-16	33.1%	29.7%	0.4%	56.3%	
% of patient deaths having palliative care coded	NHS IC	Jul-15 to Jun-16	30.6%	29.2%	0.6%	54.8%	
% of patient deaths having palliative care coded	NHS IC	Apr-15 to Mar-16	29.3%	28.5%	0.6%	54.6%	

The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:
Information relating to mortality is monitored monthly and used to drive improvements.
The mortality data is provided by an external source (Dr 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 and lessons learnt are disseminated to further improve the care provided.

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
EQ-5D adjusted health gain: Groin Hernia	NHS IC	Apr-16 to Dec-16 (provisional)	0.067	0.087	0.032	0.142	Next PROMs data due to be published early Aug-17 * data suppressed due to small numbers
EQ-5D adjusted health gain: Groin Hernia	NHS IC	Apr-15 to Mar-16 (provisional)	0.051	0.088	0.021	0.157	
EQ-5D adjusted health gain: Hip Replacement Primary	NHS IC	Apr-16 to Dec-16 (provisional)	0.449	0.449	0.334	0.551	
EQ-5D adjusted health gain: Hip Replacement Primary	NHS IC	Apr-15 to Mar-16 (provisional)	0.413	0.438	0.320	0.512	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS IC	Apr-16 to Dec-16 (provisional)	0.325	0.330	0.252	0.414	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS IC	Apr-15 to Mar-16 (provisional)	0.288	0.320	0.198	0.398	
EQ-5D adjusted health gain: Varicose Vein	NHS IC	Apr-16 to Dec-16 (provisional)	*	0.093	0.011	0.169	

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
EQ-5D adjusted health gain: Varicose Vein	NHS IC	Apr-15 to Mar-16 (provisional)	0.067	0.096	0.018	0.150	
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, and so the quality of its services, by: Delivering a number of actions to improve patient experiences following surgery. Monitoring the PROMs data at the Clinical Effectiveness Council.							

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 16+ readmitted to the Trust within 28 days of discharge	NHS IC	Apr-11 to Mar-12	12.73	11.45	0.00	17.15	2011-12 is the latest data available. Date to be confirmed when the next version is due. Lowest and best national performance based on acute providers
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 16+ readmitted to the Trust within 28 days of discharge	NHS IC	Apr-10 to Mar-11	12.60	11.43	0.00	17.10	

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 0-15 readmitted to the Trust within 28 days of discharge	NHS IC	Apr-11 to Mar-12	11.39	10.01	0.00	14.94	
(Indirectly age, sex, method of admission, diagnosis, procedure standardised, procedure standardised) % of patients aged 0-15 readmitted to the Trust within 28 days of discharge	NHS IC	Apr-10 to Mar-11	10.66	10.01	0.00	14.11	

The St Helens and Knowsley Teaching Hospitals NHS Trust considers that these 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 priority.

Reviewing and improving discharge planning.

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Patient experience measured by scoring the results of a selection of questions from the national inpatient survey focussing on the responsiveness to personal needs.	NHS IC	2015-16	70.9	69.6	58.9	86.2	Next version due Aug-17
Patient experience measured by scoring the results of a selection of questions from the national inpatient survey focussing on the responsiveness to personal needs.	NHS IC	2014-15	71.3	68.9	59.1	86.1	

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 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 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.

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Q21d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2016	80.8%	69.8%	48.9%	84.8%	All data is for Acute Providers only
Q12d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2015	81.7%	69.2%	46.0%	85.4%	
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2016	17%	25%	16%	36%	
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2015	21%	26%	16%		
% believing the organisation provides equal opportunities for career progression/promotion	NHS staff surveys	2016	91%	86%	69%	95%	
% believing the organisation provides equal opportunities for career progression/promotion	NHS staff surveys	2015	92%	87%		96%	

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-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 development of the vision and values of the Trust
Honest and open culture, with staff supported to raise concerns via Speak Out Safely champions and Speak in Confidence website

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Friends & Family Test - A&E - Response Rate	NHS England	Mar-17	18.5%	12.9%	0.3%	44.0%	FFT national data for Mar-17 to be published early May-17
Friends & Family Test - A&E - Response Rate	NHS England	Feb-17	19.0%	12.7%	0.7%	45.5%	
Friends & Family Test - A&E - Response Rate	NHS England	Jan-17	19.9%	12.3%	0.5%	44.4%	
Friends & Family Test - A&E - Response Rate	NHS England	Dec-16	16.9%	11.0%	0.3%	43.3%	
Friends & Family Test - A&E - % recommended	NHS England	Mar-17	85.3%	87.1%	45.9%	100.0%	
Friends & Family Test - A&E - % recommended	NHS England	Feb-17	88.4%	87.4%	47.8%	100.0%	
Friends & Family Test - A&E - % recommended	NHS England	Jan-17	86.4%	86.7%	45.5%	100.0%	
Friends & Family Test - A&E - % recommended	NHS England	Dec-16	86.1%	86.0%	58.1%	100.0%	
Friends & Family Test - Inpatients - Response Rate	NHS England	Mar-17	28.6%	26.1%	2.4%	79.4%	National average includes Independent Sector Providers
Friends & Family Test - Inpatients - Response Rate	NHS England	Feb-17	29.5%	25.1%	4.0%	100.0%	

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Friends & Family Test - Inpatients - Response Rate	NHS England	Jan-17	30.0%	23.6%	3.8%	95.5%	
Friends & Family Test - Inpatients - Response Rate	NHS England	Dec-16	25.0%	22.6%	4.9%	96.7%	
Friends & Family Test - Inpatients - % recommended	NHS England	Mar-17	95.9%	95.9%	82.2%	100.0%	
Friends & Family Test - Inpatients - % recommended	NHS England	Feb-17	96.0%	95.8%	75.6%	100.0%	
Friends & Family Test - Inpatients - % recommended	NHS England	Jan-17	95.9%	95.7%	79.5%	100.0%	
Friends & Family Test - Inpatients - % recommended	NHS England	Dec-16	95.4%	95.4%	76.3%	100.0%	

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 the Friends and Family Test across all areas.

The data is submitted monthly to NHS England.

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:

Continuing to promote Friends and Family Test (FFT) using a variety of methods, including face-to-face and technology.

Actively working with ward staff to improve levels of engagement with the system, to ensure the latest results are shared at local level.

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
% of patients admitted to hospital who were risk assessed for VTE	Internal	Quarter 4 2016-17	94.4%	*	*	*	*National VTE data for Q4 2016-17 will be published early June 2017 All data is for Acute Providers only
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 3 2016-17	94.7%	95.6%	76.5%	100.0%	
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 2 2016-17	94.3%	95.5%	72.1%	100.0%	
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 1 2016-17	89.9%	95.6%	80.6%	100.0%	

The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this percentage is as described for the following reasons:
Continued focus on achieving the target of 95% of patients having a VTE risk assessment within 24 hours of admission to ensure that they receive the most appropriate treatment, having achieved 93.36% for 2016-17.
Root cause analysis (RCA) undertaken on VTEs recorded on Datix to ensure best practice is followed.
Data on VTE risk assessments are submitted to NHS England each month.
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:
Maintaining focus on, and closely monitoring, the rate of risk assessments undertaken each month by the Quality Committee.
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.
Providing on-going training for clinical staff.

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	Internal	April-16 to Mar-17	10.21	/	/	/	Apr-15 to Mar-16 data was published in July 2016
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	GOV.UK	Apr-15 to Mar-16	16.5	14.9	0	66.0	
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	GOV.UK	Apr-14 to Mar-15	18.6	15.0	0	62.6	

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 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, 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:
Proactive awareness raising campaign 'Let's C off C-Difficile' to support the on-going reduction of cases.
Ensuring that all staff are compliant with mandatory training for infection 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.

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Incidents per 1,000 bed days	Internal Datix system	Oct-16 to Mar-17	38.26	*	*	*	Based on acute (non-specialist) trusts with complete data (6 months data) *National data not yet available
Incidents per 1,000 bed days	nrls.npsa.co.uk	Apr-16 to Sep-16	38.81	39.64	21.15	71.81	
Incidents per 1,000 bed days	nrls.npsa.co.uk	Oct-15 to Mar-16	39.27	38.60	14.77	75.91	
Number of incidents	Internal Datix system	Oct-16 to Mar-17	4517	*	*	*	
Number of incidents	nrls.npsa.co.uk	Apr-16 to Sep-16	4504	4985	1485	13485	
Number of incidents	nrls.npsa.co.uk	Oct-15 to Mar-16	4761	4835	1499	11910	
Incidents resulting in severe harm or death per 1,000 bed days	Internal Datix system	Oct-16 to Mar-17	0.25	*	*	*	
Incidents resulting in severe harm or death per 1,000 bed days	nrls.npsa.co.uk	Apr-16 to Sep-16	0.12	0.16	0.01	0.60	
Incidents resulting in severe harm or death per 1,000 bed days	nrls.npsa.co.uk	Oct-15 to Mar-16	0.14	0.16	0.00	0.97	
Number of incidents resulting in severe harm or death	Internal Datix system	Oct-16 to Mar-17	29	*	*	*	
Number of incidents resulting in severe harm or death	nrls.npsa.co.uk	Apr-16 to Sep-16	14	19	1	98	

Number of incidents resulting in severe harm or death	nrls.npsa.co.uk	Oct-15 to Mar-16	17	20	0	94	
Percentage of patient safety incidents that resulted in severe harm or death	Internal Datix system	Oct-16 to Mar-17	0.6%	*	*	*	
Percentage of patient safety incidents that resulted in severe harm or death	nrls.npsa.co.uk	Apr-16 to Sep-16	0.3%	0.4%	0.0%	1.7%	
Percentage of patient safety incidents that resulted in severe harm or death	nrls.npsa.co.uk	Oct-15 to Mar-16	0.4%	0.4%	0.0%	2.0%	

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 be published is up to September 2016. The Trust's overall percentage for 2016-17 of incidents that resulted in severe harm or death was 0.48%.

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 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.

Due to reasons of confidentiality, NHS digital has supressed figures for those areas highlighted with an '*' (an asterisk). This is because the underlying data has small numbers (between 1 and 5)

2.4.11. Performance against national targets and regulatory requirements

The Trust aims to meet all national targets. Performance against the key indicators for 2016-17 is shown in the table below:

Performance Indicator	2015-16 Performance	2016-17 Target	2016-17 Performance	Latest data
Cancelled operations (% of patients treated within 28 days following cancellation)	Not achieved	100.0%	100.0%	Apr-16 to Mar-17
Referral to treatment targets (% within 18 weeks and 95th percentile targets) - Admitted	No target set	N/A	76.6%	Apr-16 to Mar-17
Referral to treatment targets (% within 18 weeks and 95th percentile targets) - Non-admitted	No target set	N/A	95.5%	Apr-16 to Mar-17
Referral to treatment targets (% within 18 weeks and 95th percentile targets) – Incomplete pathways	Achieved	92%	93.5%	Apr-16 to Mar-17
Cancer: 31-day wait from diagnosis to first treatment	Achieved	96%	97.9%	Apr-16 to Mar-17
Cancer: 31-day wait for second or subsequent treatment:				
- surgery	Achieved	94%	98.2%	Apr-16 to Mar-17
- anti-cancer drug treatments	Achieved	98%	100.0%	Apr-16 to Mar-17
Cancer: 62-day wait for first treatment:				
- from urgent GP referral	Achieved	85%	88.4%	Apr-16 to Mar-17
- from consultant upgrade	Achieved	85%	95.3%	Apr-16 to Mar-17
- from urgent screening referral	Achieved	90%	93.7%	Apr-16 to Mar-17
Cancer: 2 week wait from referral to date first seen:				
- urgent GP suspected cancer referrals	Achieved	93%	95.1%	Apr-16 to Mar-17
- symptomatic breast patients	Achieved	93%	95.5%	Apr-16 to Mar-17
Emergency Department waiting times within 4 hours - Type 1 only	Not achieved	95%	76.1%	Apr-16 to Mar-17
Percentage of patients admitted with stroke spending at least 90% of their stay on a stroke unit	Achieved	83%	94%	Apr-16 to Mar-17
Clostridium Difficile	Achieved	41	23	Apr-16 to Mar-17
MRSA bacteraemia	Achieved	0	3	Apr-16 to Mar-17

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.

3.1. Summary of how we did in achieving our strategies

3.1.1. Clinical and Quality Strategy 2016-20

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 and Quality Strategy was refreshed in 2016 and the Board chose to narrow its focus to ten difficult and challenging goals that will support the achievement of the vision.

These are to achieve:

- 4 hour access target for 95% of patients in the Emergency Department to be seen, treated and admitted or discharged in under four hours
- English average standard mortality ratio (SMR) for weekend versus weekday mortality
- 62-day cancer target for all tumour groups
- National target for 95% of patients admitted to have their risk of a VTE assessed
- Improved number of eDischarges sent within 24 hours of discharge
- Reduced number of moderate and severe harms as a result of inpatient falls
- Improved timeliness of complaint responses
- Improved timeliness of first dose antibiotics in sepsis
- Improved timeliness of surgery for fractured neck of femur
- English average standard mortality ratio (SMR) for Critical Care mortality

A review of progress against the strategy was undertaken in January 2017 and reported to the Quality Committee. The update noted the actions being taken by the Trust to meet the targets outlined above. These included:

- Working with the Emergency Care Improvement Programme (ECIP) staff and others and significant investment in additional task-specific management capacity, better ways of working and whole-system reform to improve performance in meeting the 4 hour access target.
- Reviewing how best to deploy consultant resource across the hospital to ensure review of emergency admissions, whilst maintaining other aspects of performance
- Establishing realistic deadlines for responding to complaints and continuing with the new systems and processes, as well as overseeing a review of complaints and incidents to make them medically-led and streamlined to ensure effective lessons learnt framework in place.
- Investment in the Sepsis Team resulting in significantly improved performance and better patient outcomes
- Work to improve out of hours anaesthetic and consultant support for trauma to improve the timeliness of surgery for fractured neck of femur

3.1.2. Nursing and Midwifery Strategy 2014-18

The Strategy's aim is to embed the Chief Nursing Officer's '6Cs' through strong clinical leadership.

The outstanding work of some of our nurse leaders to improve patient care has resulted in national recognition during 2016-17 as highlighted in section 1.2 above.

Care
The focus on effective management of medication errors, falls, pressure ulcers and infection control prevention remains a high priority. The Trust ran a successful 'Let's C off C-Difficile' campaign, launched early in the year to ensure the number of cases of this unpleasant infection acquired within the hospital continue to reduce.

The lessons learnt from the cases of MRSA bacteraemia were shared with all clinical frontline staff in a Trust newsletter, through the provision of direct clinical supervision and the usual communication channels.

The number of patients experiencing moderate or severe harm as a result of an inpatient fall remains below the national benchmark. A new additional initiative includes the recent introduction of hip protectors to prevent the harm occurring in very high risk patients.

The e-prescribing system roll out is to commence shortly Trust-wide optimising medication prescribing and administration.

Compassion
Feedback from patients surveyed across the Trust using the national Friends and Family Test informs us that we are continuing to deliver compassionate care.

Working towards 'Excellence in Dementia Care' continues, with the successful pilot of John's Campaign on the Care of the Elderly wards. Carers of patients with cognitive impairment are welcomed to stay with their loved ones throughout their hospital stay if they wish to. John's campaign is now being cascaded out to all inpatient wards.

The End of Life Care Strategy was ratified earlier in the year and is being progressed through a steering group to ensure the end goal of 'Excellence in End of Life Care' is achieved.

The Trust launched its Maternity Strategy which incorporates all the learning from recent national reports. The increasing activity within the Maternity Department, with the birth rate achieving over 4,000 births for the first time in over 10 years, has resulted in an increase in the number of midwives and the successful implementation of a new role of maternity support workers within the service. In addition, the service launched a very successful Facebook page, to provide information to women about maternity services. To date the maternity launch film has been viewed more than 26,000 times, which is the most viewed film to date on the Trust's social media. The 'Facebook the Midwife' video content surrounding the live chat gained more than 8,400 views, providing the opportunity for women to interact with our staff and get instant feedback.

Nursing documentation has been redesigned to ensure holistic assessments of patients and effective care planning, including discharge planning is optimised.

The electronic observations system, which calculates each patient's modified early warning score (e-MEWS), is now operational in all adult and paediatric inpatient areas. Scoring pain is part of this assessment ensuring all patients routinely have their pain and discomfort assessed.

Courage
All 25 adult inpatient wards have been audited using the ward Quality Care Accreditation Tool (QCAT) and awarded a bronze, silver or gold based on the results of this comprehensive assessment of the quality of care and leadership provided.

Six wards have achieved a gold award to date:
- Ward 4D, Burns Unit
- Ward 5B, Care of the Elderly
- Ward 4A, General Surgery
- Ward 3 Alpha, Elective Joint Surgery
- Ward 3A, Plastic Surgery
- Ward 1B, Acute Medical Unit and GP Admissions Unit

Two wards have achieved bronze and 17 silver. Action plans are produced for each element that requires improvement.

Staff are encouraged at all times to speak out safely if they have concerns regarding patient care. The Trust has appointed four designated safety guardians and a Freedom to Speak Up Guardian. In addition, an on-line anonymous system to encourage staff to report any concerns was launched in the summer of 2016. This enables staff to report issues in confidence and to receive personal feedback within 72 hours on any actions taken as a result of their concern.

Commitment
The Trust is committed to ensuring that the right staff, with the right skills are caring for patients.

The recruitment of registered nurses remains an on-going challenge nationally. The Trust was delighted to welcome the first cohort of registered nurses from India in 2016. Recruitment days are held regularly throughout the year to attract newly qualified staff to the Trust where they will receive a very well-evaluated 12 month preceptorship programme to support them to be effective, caring and competent registered nurses.

Monthly safer staffing reports are submitted to the NHS Choices website and evidence that the average fill rate of registered and care staff on all inpatient wards is approximately 95% throughout the year. The fill rate is the number of actual staff working each shift against the planned number for the shift. The matrons meet daily to review staffing to ensure safety and patient care is prioritised on each ward. The Board reviews the funded ward establishments of registered nurses and care staff twice a year, looking at the levels of patient need and complexity to observe if the staffing levels remain at the correct level across inpatient areas.

The Trust is committed to becoming a smoke-free site and offers support to patients and staff to stop smoking, including onward referral to community specialist services.

Competence
On-going continuous professional development (CPD) is in place for qualified nurses and midwives to complete post-registration education modules at degree and masters level. This year focussed on mentorship, non-medical prescribing and clinical examination modules to ensure students and newly qualified staff are appropriately mentored and to enhance timely, effective patient care.

The go-live of the Nursing and Midwifery Council (NMC) revalidation process for registrants every 3 years commenced in April 2016. All registrants who were required to were able to revalidate successfully, with support given where necessary.

A Trust-wide review of almost 200 nurses employed in specialist roles was undertaken and a roles, responsibilities and key performance indicators framework was devised to enable effective career progression and succession planning. The review highlighted the invaluable contribution nurse specialists and advanced nurse practitioners make to the patient journey.

Communication
The Trust implemented a documented adult transfer of care form for patients transferring internally, to ensure improved and consistent information about the patient is shared.

A revised format for the ward patient experience communication boards was introduced with input from patient representatives to ensure that meaningful information about the care provided for patients is presented on each ward.

A network of Patient Experience Champions was established across different wards and departments to act as a point of contact for patients and to focus on improving FFT response rates. The network looked at innovative ways of supporting staff to

reduce noise at night, by developing visual reminders for roll out to inpatient areas in 2017-18.

Bedside information was collated for patients and carers, including a guide to staff uniforms, mealtimes and discharge information for roll out in 2017-18.

Case study examples to illustrate the need for effective communications were shared across the Trust.

3.1.3. Equality, Diversity and Inclusion Strategy

The Trust is committed to ensuring that its staff and service users enjoy the benefits of a healthcare organisation that respects and upholds individuals' rights and freedom. Equality and human rights are at the core of the organisation's beliefs and the Trust strives to ensure that people with protected characteristics under the Equality Act 2010 are afforded the same quality services as everyone else.

During 2016-17, the Trust developed an Equality, Diversity and Inclusion Strategy which provided additional support in delivering the vision of 5-star patient care. The Trust's corporate objectives also reflect the rights and values detailed in the NHS Constitution and the strategy promotes the Trust's commitment to equality, diversity and human rights in all its activities, whether as a service provider or an employer. Patients remain the Trust's number one priority and involving them in decisions about their care and treating them with dignity and respect at all times is paramount.

The Trust has an Equality and Diversity Steering Group which meets quarterly to ensure all external standards are fully complied with. The steering group is composed of a range of staff from all disciplines: clinical, non-clinical, staff-side unions, Healthwatch representatives and independent service users.

All Trust policies are reviewed in line with the Equality Act 2010 and are subject to an equality analysis before they can be formally ratified. In addition, all staff have equality and diversity training as part of their induction programme and mandatory training.

The refreshed Equality Delivery System (EDS2) has continued to be developed. This is a toolkit designed to support NHS organisations to deliver better outcomes for patients and better working environments for staff. The Trust has worked closely with local Healthwatch organisations to develop those EDS outcomes which are important to the local population. Ways of engaging with stakeholders from all equality groups will remain a priority.

The Trust, as a public body, is subject to the Public Sector Equality Duty (PSED). The PSED is comprised of two elements, the general duties and the specific duties. One of the specific duties is the requirement to publish Equality Objectives.

During 2016 The Trust's equality objectives were revised based on evidence derived from the National Inpatient Survey, the National Staff Survey and feedback from local Healthwatch organisations, patient representatives, complaints and FFT results.

The agreed equality objectives are as follows:-

1. The Trust's services are fully accessible to all patients and are responsive to their individual needs, including those patients from protected groups.
2. Patients report positive experiences of their care and are fully involved and supported in making decisions about their treatment.
3. The Trust's workforce is appropriately skilled to provide compassionate, personalised care to meet the needs of all its patients, including those from protected groups.
4. The Trust's senior leaders demonstrate their commitment to equality.

Progress against the objectives is embedded into the Trust's governance structures and is monitored by both the Patient Experience and Workforce Councils who report to the Quality Committee and Trust Board.

The Trust is required to provide communication support in the form of Interpreter Services for patients who do not use English as a first language (Foreign Language Interpretation) and for those who communicate using British Sign Language (BSL).

The Trust has an Interpreter and Translation Policy which governs the use of interpreters informing all staff of the duties, accountabilities and responsibilities in respect of patients who require interpreter and/or translation facilities. In addition, it provides guidance and support for staff and details all actions which must be carried out.

The Trust's use of interpreters has increased significantly over the last twelve Months, for both foreign languages and for British Sign Language. This is principally due to both the greater usage of Trust services by an increasingly diverse local population and a greater awareness on the part of Trust staff of their responsibilities. For the first time Polish has taken over from Chinese Cantonese as the most called for language requiring interpretation.

The Trust was awarded the Navajo Charter Mark. This is an equality mark supported by lesbian, gay, bisexual and transgender (LGBT) community networks across Merseyside. It is a signifier of good practice, commitment and knowledge of the specific needs, issues and barriers facing LGBT people in Merseyside.

The application process was designed to assess the Trust in terms of LGBT friendliness and the application included five distinct elements:-

- Practices and Policies
- Training
- Staff Recruitment & Engagement
- Monitoring
- Service Users and LGBT Engagement

Achieving the Charter Mark means that the Trust can demonstrate that it:

- Is in line with statutory requirements and promotes best practice in engaging with the LGBT community.
- Recognises and is addressing the difficulties in ensuring that its services are accessible to the LGBT community.
- Has raised awareness amongst staff with regard to particular issues that affect LGBT people accessing services.

The Accessible Information Standard (AIS) was rolled out across the Trust during the year. The standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

The Standard pays particular reference to patients who are blind, deaf, deaf/blind or who have a learning disability. The Standard specifically aims to improve the quality and safety of care received by individuals with information and communication needs, and their ability to be involved in autonomous decision-making about their health, care and well-being.

There are five basic steps which make up the Accessible Information Standard:-

1. Ask: Identify/find out if an individual has any communication/ information needs relating to a disability or sensory loss and if so what they are.
2. Record: Record those needs in a clear, unambiguous and standardised way
3. Alert/Flag: Ensure that recorded needs are highly visible whenever the individual's record is accessed and prompt for action
4. Share Include information about individuals' information or communication needs as part of existing data sharing processes (and following existing information governance frameworks)
5. Act: Take steps to ensure that individuals receive information which they can access and understand, and receive communication support if they need it.

An AIS standard operating procedure was developed which formed the basis for each area to roll out the standard in a manner which took account of the particular needs of each individual area but which followed a basic agreed Trust approach.

A range of publicity material was developed in the form of posters, information leaflets and communication cards to be issued to patients on request.


3.1.4. Human Resources and Workforce Strategy 2014-19

The provision of excellent services to patients, their loved ones and local communities is the Trust's top priority, as highlighted by the most recent 2016 NHS Staff Survey. Supporting this are a number of strategies including the five year HR and Workforce Strategy, which sets out the Trust's plans to develop a management culture and style that empowers, builds teams and recognises and nurtures talent through learning and development. The Trust encourages a culture of caring, kindness and mutual respect. The delivery of the strategy will enable staff to continue to provide 5-star patient care throughout the Trust. There are a number of other 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 and in September 2016, became the host for the Merseyside Career Engagement Hub. The Hub, working in collaboration with local schools, colleges and Job Centre Plus is improving access to structured work placements for a range of local people including, students, the long term unemployed and disadvantaged people from the local community in an effort to provide them with the skills and experience to gain employment in the NHS.

3.1.4.1. Staff survey key questions

The national staff survey provides a key measure of the experiences of the Trust's staff, with the findings used to reinforce good practice and to identify any areas for improvement. The Trust's response rate for the 2016 survey was 55%, which is equivalent to last year and is amongst the highest response rates for acute trusts nationally.

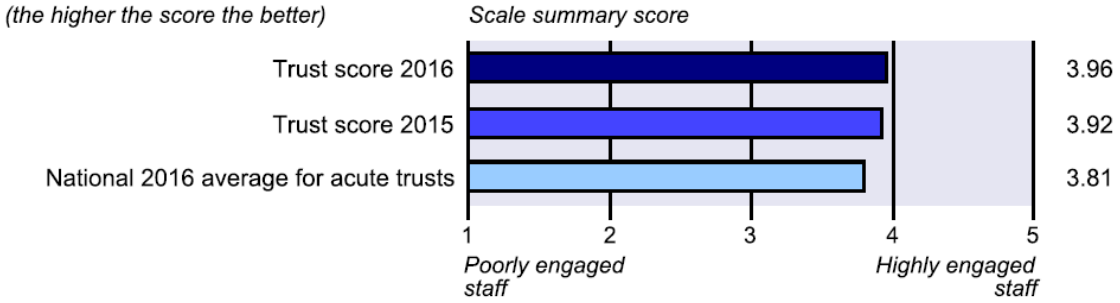
The Trust has once again improved its performance, being in the top 20% of all acute trusts nationally for 24 of the 32 indicators, including:

- Providing equal opportunities for career progression/promotion
- Staff recommending the organisation as a place to work and receive treatment
- Staff motivation at work
- Staff satisfaction with the quality of work and patient care they are able to deliver

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.

OVERALL STAFF ENGAGEMENT



Possible scores range from 1 to 5, with 1indicating poorly engaged staff (with their work, their team and their trust) and 5 indicating a highly engaged workforce. The Trust's score of 3.96 showed an increase since 2015 and was the **6th nationally when compared with trusts of a similar type and was the best in the North West.**

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

Key Finding	StHK % score 2016	StHK % score 2015	National acute average
Care of patients is the organisation's top priority	85	83	76
Organisation acts on patient concerns	82	80	74
Staff would recommend organisation as a place to work	75	71	62
Staff satisfaction with the quality of work and patient care they are able to deliver	86	84	79
Staff ability to contribute towards improvements at work	72	68	70
Staff feeling unwell due to work related stress	25	28	35
Quality of appraisals	67	63	62

Whilst the overwhelming majority of responses to the 2016 survey were positive, there were 2 areas where staff experience was not as positive as the Trust would want:

- Whilst the score 81% of staff would 'be happy with standard of care if a relative needed treatment' is significantly better than the national average, it has seen a 1% reduction from the 2015 survey score.
- The number of respondents stating they have experienced physical violence from patients, relatives, public and staff is very low, however this is a concern as it is greater than the national average for similar trusts

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 2017-18.

3.1.4.2. Health, Work and Well-being

The Health, Work and Well-being Strategy 2016-2021 was launched at the Health Work and Well-being Day in September 2016. It was developed to meet the requirements of current national guidance and recommendations, to ensure that the improvement of health and well-being of the Trust workforce remains a Trust priority.

The aim of the Strategy is to work with the staff to integrate health & well-being into the day-to-day activities so that the Trust creates a sustainable, positive and healthy working environment. A healthy motivated workforce is integral to achieving better care for patients. It is well researched that supporting the well-being of the workforce is paramount to achieving higher levels of performance (Boorman Review, 2009).

The Health, Work and Well-being Service continued to encourage staff well-being by promoting a number of initiatives for staff throughout the year. These included:

- Annual Open Day
- Know Your Numbers……Blood Pressure Monitoring
- Dry January
- Weight Management
- Sun Safety
- Staff Counselling Awareness
- NHS Games in July 2016, which is now an integral part of the well-being calendar. It is open to all staff and includes a 5k run, golf, badminton, football, netball and rounders

The Health, Work and Well-being Service continued to ensure that all frontline staff received a flu vaccine in order to protect themselves, their patients and their families. The overall percentage uptake for the Flu Campaign 2016-17 was 82% which was amongst the highest in Cheshire and Merseyside.

The Service is involved with numerous training initiatives, for example, “You and Your Well-being” which supports staff who need extra support to manage stress.

The Health, Work and Well-being Service continued to meet the standards and achieved accreditation for Safe Effective Quality Occupational Health Services (SEQOHS). This year there has been an increase in internal audits of both clinical and non-clinical activity, thus ensuring that improvements are continually being made.

3.1.4.3. Clinical education and training

Developments within the Clinical Education Team have continued over the past year. A key success was the implementation of a clinical skills teaching programme to support international recruitment. The programme is designed to prepare candidates to sit their final exams, with a 90% pass rate to date.

The simulation team have successfully procured a neonatology simulator, following on from last year’s work in the Emergency Department regarding paediatric in-situ

simulation. The Trust is in the process of implementing neonatology simulation training, initially in the special care baby unit. The team will then provide neonatology simulation in obstetric theatres. Future plans are to expand the provision of simulation training across multiple directorates, allowing teams to train together in the transfer of sick patients across the Trust.

In January 2017, the Medical Undergraduate Team provided evidence to Liverpool University and Health Education England North West as part of the Quality Review Process. The initial feedback was very positive; the quality of education and support provided to the Medical Undergraduates was described as an "exemplar for undergraduate medical education". The final report has not yet been issued.

3.2. Cancer Services

There have been a number of developments within our cancer services during 2016-17 and these are summarised below:

- Rolled out the Macmillan Recovery package, including a living with and beyond cancer event which includes a health and well-being clinic, facilitated by the Clinical Nurse Specialists. Patients have access to health trainers and information and support on work, finance, lifestyle and physically activity, as well as access to support groups and psychological support.
- The Trust's Chemotherapy Day Unit received additional investment in its 25th anniversary year to expand its treatment capacity and to equip the staff with specialist skills. Our Unit is now open between 8am and 8pm Monday to Friday, with plans to open on Saturdays in the coming year. This enables our patients to have more flexibility for scheduling of appointments and means we can offer treatment closer to home for more people.
- Our Macmillan Information Centre has been enhanced this year by the appointment of a welfare benefits advisor, ensuring that cancer patients have access to finance and benefits advice on site. There have been over 3,000 benefits contacts since April 2016.
- Charitable funding donations to our chemotherapy unit have enabled us to purchase additional cool cap facilities for patients who are undergoing chemotherapy that causes hair loss.
- In addition to the cool caps, we have also refurbished a room to create a hair dressing salon where patients can have consultations with our Trust employed hairdresser regarding choice of wigs, styling and wig care education. We plan to launch this in May 2017.
- Introduced a cancer breach review meeting to ensure every patient's pathway that goes beyond 62 days is individually reviewed and any lessons learned are shared and acted upon.
- Development of a pathway to provide rapid access to expert oncology advice for patients referred to the Primary Care Musculoskeletal Clinical Assessment Service (MCAS) who have suspected serious pathology following imaging. This supports earlier diagnosis of cancer and appropriate management with timely key worker support. This was a joint project with the MCAS Team from North West Boroughs Healthcare NHS Foundation Trust.

3.3. Patient safety

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

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

1. **Put Safety First -** Commit to reducing avoidable harm by 50% from 2015 to 2018 and make public our goals and plans developed locally. Avoidable harm is harm that can be prevented. The pledges and progress to end of 2016-17 are shown below:
   - Maintain a 50% reduction in **theatre-related episodes of avoidable harm**. The following figures are compared to the project benchmark data 2013-14:
     - 42% increase in incidents resulting in all harms, with a 115% increase in low harm incidents; this is likely to be due to an increase in incident reporting, highlighting a better reporting culture.
     - 69% decrease in incident resulting in moderate, severe harm or death.
   - Reduce the incidence of **Clostridium Difficile and avoidable MRSA infections**. There were 3 incidents of MRSA bacteraemia in 2016-17; which is a 50% increase on the 2013-14 baseline. There has been an 11% reduction of cases of Clostridium Difficile measured against 2013-14. The Trust has implemented an MRSA pathway and care bundle to enhance care. There is additional information below relating to further actions taken to eliminate MRSA infections.
   - Reduce **prescribing error rates** through the implementation of an error response and re-education system.
     - 54% decrease in incidents resulting in harm from 2013-14
     - 62% decrease in low harm incidents from the project benchmark data from 2013-14
     - 100% increase in incidents recorded as moderate (up from 2 in 2013-14 to 4 in 2016-17)
   - 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.
     - The roll out of the Electronic Modified Early Warning Score (eMEWS) System to all inpatient wards was completed in March 2016. Roll out in Emergency Department is due for completion in September 2017.
   - Reduce to 0 the number of **never events** reported in the organisation.
     - There have been 2 never events recorded in 2016-17. Actions from these events, included the following:

     Retained guide-wire:
     - Development, implementation and on-going monitoring of Local Safety Standards for Invasive Procedures (LocSSIP) checklist for line insertion in line with NHS England guidance (2015) including awareness of the possibility of a retained guide wire.
     - LocSSIP to be included in Trust policy with staff training and audit plan in line with NHS England guidance.

- Development, implementation and monitoring of training strategy including written competency assessment framework for medical staff who undertake central line insertion.
- Development and implementation of Human Factors training for Critical Care Unit multidisciplinary team.
- Review discharge follow up processes for patients discharged home directly from Critical Care Unit.
- Review medical staffing requirement on Critical Care Unit to ensure there is sufficient senior staff on site to support junior staff to maintain patient and staff safety.

Retained drain cap in surgical wound.

- Review of local safety standards and local theatre standard with the following changes made:
  - Clearly defined countable products.
  - Reiterated procedure for how sharps item are handled.
  - Standardised practice around management of waste items.
  - Added a process to record cut items on the surgical white board.
  - Clarified the process for recording items retained purposefully.
- These changes have been implemented within various theatre settings across the organisation.

- The Trust will have zero tolerance on **hospital acquired grade 4 pressure ulcers** and will continue to seek to reduce harm from pressure ulcers of all grades by 50% from the 2013-14 benchmark.
  - No grade 4 pressure ulcers for the last 4 years
  - 75% decrease in avoidable grade 3 pressure ulcers – one grade 3 in 2016-17
  - 32% decrease in avoidable grade 2 pressure ulcers
  - No change in avoidable grade 1 pressure ulcers
  - 23% decrease in all pressure ulcers since 13/14

The Trust proactively reviews all patients who are admitted with a pressure ulcer and liaises with the community tissue viability team to share findings and to ensure continuity of treatment for the patients.

- The Trust will continue to seek a reduction in harm from **inpatient falls**.
  - 17% decrease in incidents resulting in harm.
  - 19% decrease in low harm incidents from the project benchmark data from 2013-14.
  - 5% increase in incidents resulting in moderate, severe harm or death, up from 36 in 2013-14 to 39 in 2016-17.

  A thematic review of falls reported on Strategic Executive Information System (StEIS) has been conducted which has highlighted the need for re-launch of the falls strategy and reinvigoration of falls training. A falls training pilot is currently planned for the Medical Assessment Unit along with the establishment of a bedrails working group. The Trust plans to re-launch the falls strategy in Q1 of 2017-18.
- Introduce patient safety briefings to increase staff awareness of risk.
  - Patient safety briefings have been successfully implemented in maternity. A number of tools have been piloted in different areas in preparation for a Trust-wide roll out in 2017-18.

2. **Continually learn** - Make our organisation more resilient to risks by acting on the feedback from patients and staff, by constantly measuring and monitoring how safe our services are.
    - Undertake a programme of safety walks throughout the organisation which will involve patients, staff and key stakeholders, discussing, identifying and addressing issues/areas for improvement.
        - A programme of quality ward rounds is now in place with each clinical area being visited annually by a team which includes Executive and Non-Executive members of the Board who meet with staff to discuss any issues and areas for improvement.
    - Continue to develop information systems to support quality and safety dashboards, improving access to clinical outcome data and acting on these to improve.
        - Standardised quality and safety dashboards have been implemented across all wards in the form of electronic Qlikview dashboards which display patient safety data for all wards. Each ward has also implemented a public ward display board which utilises safety crosses to display patient safety data.
    - Publish a quarterly Human Factors in Healthcare Newsletter, accessible to all staff, detailing areas of risk reduction and sharing lessons learnt.
        - This newsletter is published quarterly and made available to all staff via the intranet. The effectiveness of the newsletter will be reviewed in 2017-18 and other methods of communication will be explored.
    - Make improvements to the monitoring and completion of action plans following patient safety incidents, clinical claims, complaints and clinical audit.
        - Action planning functionally in the Trust incident reporting system has been utilised to monitor progress against any actions from investigations of Strategic Executive Information System (StEIS) reported serious untoward incidents. Further roll out of this facility is planned for 2017-18 to include all incidents.
    - Seek opportunities to both share our successes and learn from others' success to increase the efficiency of regional, national and local safety improvement.
        - The Trust works closely with the NHS England and regional safety groups to ensure shared learning from patient safety incidents.
    - The Trust faces a number of challenges in terms of investigating serious incidents in a timely fashion. In order to address this, the Trust has reviewed the process for investigating and responding to serious incidents, with input from commissioning colleagues and is working to develop streamlined processes to improve the management of investigations, supported by redesigned standard operating procedures. The Trust is also piloting the use of formalised 72 hour reviews for all StEIS reportable incidents.

3. **Honesty -** Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
    - Always tell our patients and their families/carers if appropriate, if there has been an error or omission resulting in harm. 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 its statutory duty of candour is delivered under the Trust's 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 to 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 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.
    - In 2017-18 the Trust will carry out a comprehensive review of all cases of moderate harm or above to confirm that the Duty of Candour requirements have been met.
- Undertake an awareness raising campaign to support our staff in the being open process and incorporate this further into Patient Safety Training.
    - An awareness raising campaign is planned for 2017-18 following a Trust-wide review of duty of candour.
- Publish annual reviews and patient safety information, both internally and externally. Internal reporting structures are in place in regard to all aspects of patient safety and the Trust reports information via annual quality accounts. In addition, the Trust publishes monthly safety figures via participation in the Open and honest: driving improvement programme.

4. **Collaborate** - Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
    - Work with partners to share best practice and improve clinical pathways for patients.
        - 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. Staff also attend the North West intravenous/aseptic non-touch technique (ANTT) forum meetings.
    - Ensure good practice and lessons learnt are shared and embedded throughout both of our two hospitals.

    - Good practice and lessons are shared through the quarterly patient safety newsletter, root cause analysis reports and the Trust-wide governance structures.
- Roll out and share outcomes from our research and pilot programmes to ensure improvements are implemented across the organisation.
    - The Trust participates in a wide ranging clinical research programme, with details in the research section above.

5. **Support -** Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.
    - Continue the Trust programme of 6 audit half days per year. These days focus on learning from experience and audit and celebrating good practice.
        - The Trust continues with the programme of audit sessions which are highly valued by staff.
    - Continue the Trust Human Factors and Root Cause Analysis (RCA) training programmes to develop a reactive and adaptive workforce capable of recognising, deconstructing and effectively reducing avoidable harm.
        - The Trust continues with its programme of human factors and root cause analysis training which is well attended by all staff groups.

3.3.2. Infection prevention and control

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

- Promote and sustain infection prevention policy and practice in the pursuit of patient, service user and staff safety within the Trust.
- Adopt and promote evidence-based infection prevention and control practice across the Trust.
- Identify, monitor and prevent the spread of pathogenic organisms, including multi-resistant organisms throughout the Trust.
- Reduce the incidence of healthcare associated infections by working collaboratively across the whole health economy.

In February 2016, the hospital became concerned about the potential transmission of multi-drug resistant pseudomonas aeruginosa (MDR *P)* in the Burns Unit and Critical Care Unit (CCU). This is an opportunistic pathogen rarely affecting healthy individuals but it can cause a wide range of infections in patients with a compromised immune system. It is a well-recognised cause of infections acquired in hospital settings among burns and intensive care patients. An action plan was developed following a detailed investigation and a review by Public Health England (PHE) and this is being delivered in line with the deadlines stated.

Up until July 2016, the Trust had not reported a single case of MRSA bacteraemia since September 2014. However, since July 2016 the Trust has reported three cases of MRSA bacteraemia. Detailed post-infection reviews (PIRs) have been undertaken on all cases in conjunction with the CCG and Public Health England and the lessons learned from each case have formed the basis of a detailed Trust-wide action plan. A summary of the key lessons learned from the PIRs is listed below:

- Ensure that all staff are aware of the lessons learnt from PIRs of MRSA bacteraemia cases, via effective communication of information regarding infection alerts between different wards, clinical teams and members within a team.
- Ensure timeliness of MRSA screening and of the commencement of topical suppression for patients with a history of, or newly positive for, MRSA.
- Ensure that all new starters are aware of their responsibilities with regards to Aseptic Non-Touch Technique (ANTT), are competent and that the ANTT competency status of staff is easily identifiable.
- Ensure that all clinical staff with a responsibility for taking blood cultures are aware of and adhere at all times to the Trust Blood Culture Policy for Adult Patients and that there is an audit trail of who takes a blood culture sample.
- Devise and implement a standardised process within the Trust for taking paediatric blood cultures, ensuring staff are aware of the best practice as stated in the Paediatric Blood Culture Policy.
- Devise and implement a standardised process within the Trust for the insertion and care of urinary catheters ensuring staff are aware of the best practice as stated in the Urinary Catheter Policy.
- Ensure all patients are correctly assessed for the most appropriate vascular access device.
- Ensure that all clinical staff with prescriber responsibilities are aware of and adhere at all times to the Trust Antibiotic Policy.
- Ensure staff accountability with regards to appropriate care and provision for patients with MRSA.

A number of actions will be supported by the implementation of e-prescribing across the Trust in 2016-17.

The Trust continues to work closely with the infection prevention and control, patient safety and quality teams in the wider health economy, attending collaborative meetings across the region in order to improve infection prevention and control practices and monitoring.

3.3.3. 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.
- Convening a bedrails working group.
- 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.
- Providing non-slip anti-embolic stockings.
- 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.

3.3.4. Safeguarding

The Trust takes its statutory responsibilities to safeguard vulnerable patients of all ages very seriously and welcomes external scrutiny of its robust policies, procedures and processes.

The Trust has a dedicated Safeguarding Team comprising of:

- Named Professional Safeguarding Adults
- Named Nurse Safeguarding Children
- Doctor, Safeguarding Children
- Named Midwife

The team is supported by Specialist Safeguarding Nurses and administration staff.

The team provides support and delivers mandated safeguarding supervision, training and advice to all staff throughout the organisation and ensures that policies and procedures are reviewed regularly in line with current legislation. This includes all aspects of safeguarding such as Prevent, Child Sexual Exploitation, Trafficking and Modern Slavery. Standard operational procedures, underpinned with the appropriate staff training, have been introduced to ensure victims of forced genital mutilation are safeguarded effectively and patients are supported if at risk of or are a victim of domestic abuse, forced marriage, honour-based violence and child sexual exploitation.

The Trust's Safeguarding Assurance Framework has separate safeguarding children and adults steering groups which meet quarterly to discuss required actions, activity and updates on current practice.

3.3.4.1. Safeguarding Children

The Trust continues to work pro-actively with St Helens, Knowsley and Halton Local Safeguarding Children Boards (LSCB) as either a Board or Sub-Committee member. It is expected that there will be some changes to the LSCB structures and statutory function following the Wood Review (2016), however, the Trust will ensure that safeguarding continues to be a priority and will maintain partnership working across the footprint.

The Safeguarding Team contribute to any multi-agency reviews including Serious Case Reviews, Practice Learning or Management Reviews. Any identified learning points are shared across the Trust and any necessary actions implemented to improve practice.

The Trust has been inspected recently as part of a local CCG Safeguarding Children inspection carried out by the CQC and is participating in the subsequent actions to address the recommendations from the report.

The Trust continues to support and safeguard children at risk of all forms of abuse contributing to the 'early help' agenda and multi-agency safeguarding procedures. Safeguarding compliance is monitored by St Helens CCG through key performance indicators, which also provides assurance to Halton and Knowsley CCG.

3.3.4.2. Safeguarding Adults

The Trust continues to work pro-actively with St Helens, Knowsley, Halton and Liverpool Safeguarding Adult Boards as either a Board or Sub-Committee member. There are plans to create a Pan-Mersey Adult Board which the Trust will actively participate in.

The Trust, along with partner agencies, continues to work in line with current statutory guidance (The Care Act 2014) which is now fully embedded in practice. The Safeguarding Team contributes to any multi-agency reviews including safeguarding adult reviews, domestic homicide reviews and management reviews. Any identified learning points are shared across the Trust and any necessary actions implemented to improve practice.

The Trust continues to support the patient journey of adults who have additional needs or who are identified as potentially being adults at risk. This cohort of patients includes people with a learning disability, mental health issues, substance misuse or any other vulnerability factor. The Safeguarding Team works closely with staff to identify and safeguard these individuals.

Safeguarding compliance is monitored by St Helens CCG through key performance indicators, which also provides assurance to Halton and Knowsley CCG.

3.3.4.3. Mental Capacity Act and Deprivation of Liberty Safeguards

The Trust complies with the Mental Capacity Act Guidance, supported by up-to-date policy and process. Applications for Deprivation of Liberty Safeguards have increased in line with local and national trends. The Trust meets regularly with relevant agencies to share best practice and ensure practice follows current legislation.

3.3.4.4. Domestic Abuse

The Trust actively contributes to the local domestic abuse agenda with active participation at both St Helens and Knowsley multi-agency risk assessment conferences (MARAC) along with reports by exception to Halton and Warrington. The Trust policy is due to be reviewed to ensure compliance with the NICE Quality Standard published in 2016. Training is embedded in all levels of both safeguarding children and adults sessions to ensure that the workforce is competent in the identification and support of domestic abuse victims and children. Contribution to Domestic Homicide Reviews assists the Safeguarding Team in identifying areas of good practice as well as areas for improvement.

3.3.4.5. Learning Disability

Guidance has been implemented for patients with a learning disability attending any department within the Trust on how to meet their individual needs. This is supported by a toolkit to ensure that staff are able to provide the highest standards of care.

3.4. 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, clinical audit and application of NICE guidance.

3.4.1. National Institute for Health and Care Excellence (NICE)

178 pieces of new or updated NICE guidance were released during 2016-17. There is a system in place to ensure all relevant guidance is distributed to the appropriate clinical lead to assess its relevance and the Trust's compliance with the requirements. Action plans are produced for any shortfalls to ensure compliance is achieved. The Trust is fully compliant with 54 of those issued in 2016-17 and working towards achieving the remainder.

3.4.2. Mortality

The Trust monitors its mortality statistics monthly and undertakes in-depth reviews for Clinical Diagnostic Groups that flag higher than the national average. The Trust is currently reviewing its mortality review processes in line with the recommendations put forward by the National Quality Board to ensure we are fully compliant and learn lessons accordingly.

3.4.3. Clinical audit

The Trust has an active clinical audit programme and is an active participant in required national audits where performance is strong. Details of the work undertaken this year are contained in section 2.4.2 above.

3.4.4. Intensive Care National Audit & Research Centre (ICNARC)

The Trust performs well against the national quality indicators, except for delayed discharges from Critical Care, therefore work is on-going to ensure the timely step down of patients to wards and substantial progress is being made to ensure patients are discharged from intensive care into a ward bed within 4 hours of being identified as suitable.

3.4.5. Copeland risk adjustment barometer (CRAB)

The outcomes of patients who have had inpatient surgery in the Trust are reviewed with trends in morality and complications for the Trust as a whole and within surgical specialities identified using the CRAB methodology. As a whole the Trust performs well and reviews all deaths that occur in low risk groups, as well as those scoring high risk.

3.4.6. 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.

The Trust's Volunteer Department has continued to build community partnerships by forging new links with the Department for Working & Pensions who are promoting volunteering as a platform to build confidence, learn new skills and improve both mental and physical well-being but ultimately help people back into employment. In addition, Activate, a charity that delivers personalised education programmes for young adults with disabilities, is keen to form a working partnership to provide volunteer opportunities for their students.

3.5. Patient experience

The Trust implemented its Patient Experience Strategy in 2016-17, which focuses on ensuring that the Trust effectively engages with patients, their families and carers so that care is of the highest quality from the start of the patient's journey from admission through to discharge.

St Helens and Knowsley Teaching Hospitals NHS Trust was in the top five for the CHKS Top Hospitals award for patient experience in 2016, recognising the consistently high standards of care provided to patients at the Trust.

The Trust is committed to listening to its patients and engaging with them to improve the services delivered. The Patient Advice and Liaison Service (PALS) provides an invaluable service, working with patients, relatives and carers to provide help, advice and support.

In addition, the Trust actively engages with patients through a number of initiatives:

- Patient Participation Group looking at services across the Trust and ways to further improve care and the environment on a quarterly basis. Topics have included hospital food, falls prevention and the Emergency Department.
- Resolution of issues at a local level, via the five-a-day initiative, when the Patient Experience Manager visits five patients each day to ask about their care, their level of involvement and any issues they may have.
- Patient stories at the Trust Board and the Patient Experience Council to discuss both experiences that were positive and where improvements can be made, no matter how small the change. This has included working with catering to provide finger food, supporting stroke patients to eat their meals at a shared dining table, raising awareness of the need for clear communications and the provision of a separate entrance and exit to the Delivery Suite to allow bereaved parents to enter and leave through a designated area. In addition, communication flows were improved between the pre-operative team and ward staff to ensure key information about individual patient needs and treatment plans was shared in a timely manner.

Further improvements to patient care made as a result of feedback include:

- The introduction on Ward 3 Alpha of a joint replacement dressing clinic for patients who have undergone hip and knee replacements for them to return for removal of clips/sutures or for a postoperative wound review. Patients were concerned that they were unable to get appointments in the community. The

feedback has been very positive from both patients and staff. The initiative has allowed patients to go home sooner in the knowledge that any issues can be picked up at their clinic appointment.
- Revision of the fractured neck of femur pathway.
- Introduction of question and answer sessions for families and carers of patients on 5D Stroke Unit, to provide general information about strokes, how they are caused, the different impact and effects of strokes on individual patients and possible future outcomes. The sessions were attended by a consultant, speech therapist, physiotherapist and a nurse and were well received by those that attended.
- Provision of infection control compliant bladeless fans to ensure end-of-life patients are made as comfortable as possible

3.5.1. 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.

The Trust has embedded the use of the new system for Friends and Family Test that was introduced in January 2016. The system enables local areas to obtain and review their responses and to use the comments to drive improvements and reinforce good practice.

The list below provides examples of some of the comments received and the responses provided to this feedback during 2016-17:

- **You said, "Friendly, efficient staff, clean hospital, very conscious of patient safety, understanding and issues of consent. Felt very confident to be a patient there."**
- The Trust shared this with the staff involved and thanked them for maintaining high standards of care.

- **You said**, **Staff are very nice and I have been well looked after.**
- The Trust staff always strive to provide 5-star patient care.

- **You said**, **I don't like the isolation of the private rooms.**
- The Trust replied, We understand that side rooms can be lonely at times. We maintain regular checks to ensure that patients' needs are being met.

- **You said, Mum feels nursing/staff and medical staff have been wonderful! Frustrating at times due to obvious staff shortage but no reflection of the care given. Thank you.**
- The Trust responded, We are pleased that you felt that we provided wonderful care. We aim to provide safe care, ensuring all shifts are staffed to carry on providing 5-star patient care.

3.5.2. Complaints

The Trust takes patients' complaints extremely seriously and has put measures in place during the year to ensure that they are appropriately investigated and that patients are provided with a comprehensive response.

Work remains on-going 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 within the agreed timescale improved from 35.5% in 2014-15 to 61.4% in 2015-16, but dipped to 58% in 2016-17 due to an increase in complaints and operational pressures throughout the Trust. However, there was a big improvement in the responses in the complainant satisfaction survey of those who thought their complaint was responded to in a reasonable timeframe; an increase to 86% from 39% in the previous year.

In 2016-17, the Trust received a total of 338 new complaints that were opened for investigation. This compares to 293 new complaints received in 2015-16. In addition, the Trust saw a significant reduction in the number of complainants that were dissatisfied with the initial response, decreasing by 43%, from 74 in 2015-16 to 42 in 2016-17.

The Trust has made a number of changes to services following complaints, including:

- Introduction of a pain management tool based around the College of Emergency Medicine best practice guidelines in all areas within the Emergency Department, including all triage areas.
- Amending care plans to give clear instructions for how often anti-embolitic stockings should be changed and how long they need to be worn for.
- Promotion of the structured shift handover for nursing care, based on situation, background, assessment and recommendation (SBAR).
- Reinforcing the need for improved communications within teams, including the Emergency Department.
- On-going reinforcement of the Trust's ACE behavioural standards, at ward meetings and via the Trust's governance structure.

The Trust has continued to conduct the Complaints Satisfaction Surveys throughout 2016-17, with a copy of the survey sent out with all response letters. There were 28 responses in total. Overall the majority of respondents to the survey were satisfied with how easy it was to make a complaint (86%) and were provided with a contact number for the complaints team (79%). The majority of respondents (70%) reported that they were either fairly satisfied or very satisfied with the way in which their complaint was handled, an increase from 62% the previous year.

3.6. Summary of national patient surveys

3.6.1. National inpatient survey

The Trust participated in the annual National Inpatient Survey coordinated by the CQC.

The results were published in June 2016 and were broadly consistent with the previous year's survey for the Trust. Overall the feedback from patients continues to indicate that patients have a positive experience of their care.

The Trust was included in the 'best performing' trusts nationally across two indicators and was not included in the 'worst performing' trusts for any indicators. The areas where the Trust rated in the best performing trusts are:

- 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?

The Trust's Patient Experience Council oversees the delivery of the action plan that is in place following the survey. The plan includes a range of actions being taken to further improve standards across a number of areas.

The full benchmarked results can be found on the Care Quality Commission's website at http://www.cqc.org.uk/

3.6.2. National cancer patient experience survey (NCPES)

The Trust participated in the latest NCPES survey. The results were published in July 2016 and show that the Trust continues to provide a high standard of cancer care. The scores were within the expected range for all the questions, apart from two in which the Trust performed better than the expected range and one was lower, as shown in the tables below:

Scores that exceeded the expected range

	StHK	Expected range	National average
Felt they were given enough support from health or social services on discharge	59%	32-57%	45%
Received a care plan	44%	24-42%	33%

Scores within the upper limits of the expected score range

	StHK	Expected range	National average
Always treated with respect and dignity	92%	82-92%	87%
Knew who to contact if worried post discharge	96%	90-98%	94%
Had confidence and trust in the doctors treating them	89%	78-90%	84%
Families had opportunity to talk to a doctor	79%	64-80%	72%

Score achieving less than expected

	StHK	Expected range	National average
Received easy to understand information about the type of cancer they had	64%	65-79%	72%

The Trust is working hard to improve the written information provided to patients about the type of cancer they had, as the Trust scored slightly below (64%) the lower expected range (65%). This includes improving the discharge information provided for some specialties.

The full results can be found at http://www.ncpes.co.uk

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 2016-17
- 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: May 2017

Ann Marr
Chief Executive
Date: May 2017

4.2. Written statements by other bodies

4.2.1. Knowsley Council Health Scrutiny Sub-Committee and Healthwatch Knowsley

Joint commentary on the Quality Account of St Helens and Knowsley Teaching Hospitals NHS Trust by Knowsley Council Health Scrutiny Sub-Committee and Healthwatch Knowsley.

The Quality Account for St Helens and Knowsley Teaching Hospitals NHS Trust was considered at a meeting of the Health Scrutiny Sub-Committee on Tuesday 9 May 2017. Representatives from Healthwatch Knowsley were invited to attend the meeting and contribute to the discussions and commentary.

It was acknowledged that the Trust had reported on two "never" events occurring during 2016/ 2017. Representatives reiterated how important it was to avoid such occurrences and were reassured that the appropriate learning had been taken on board.

Concern was expressed regarding the 2016/2017 priority to further reduce the mortality of weekend admissions not being achieved or included as a priority moving forward. Whilst it was explained that the reasons for such patterns were yet to be fully understood, representatives emphasised that it should be highlighted as a priority for 2017/ 2018 whilst national research was ongoing. It was important that the Trust gave the right impression to the public about how seriously it continues to take this issue.

Reference was made to staffing levels as the Trust's activity was increasing. It was acknowledged that this was a key challenge in terms of ensuring there are no staffing shortfalls in specific areas. It was recognised that options such as international recruitment were being pursued but this was an area that required an ongoing focus.

Concern was expressed around the response levels to customer satisfaction questionnaires. Representatives acknowledged that efforts were ongoing to improve the response rate and highlighted how important it was for these efforts to be successful.

Representatives from the Sub-Committee and Healthwatch referred to the size of the Quality Account document and expressed concern about accessibility to the public. Whilst they received assurances that an executive summary of the document would be produced that would be more user-friendly, they asked for their comments to be taken on board.

Members welcomed the Trust's open approach to highlighting areas of improvement and its honesty in suggesting that the picture was not as positive as the previous year. There was an acknowledgement that the Trust continues to face financial challenges. The Sub-Committee and Healthwatch representatives were grateful for the Trust's detailed presentation and Quality Account and thanked the representative for taking time to attend the meeting and provide information.

4.2.3. Halton Borough Council

HALTON
BOROUGH COUNCIL

Ann Marr
Chief Executive
St Helens and Knowsley Teaching
Hospitals NHS Trust
Whiston Hospital
Warrington Road
Prescot, Merseyside
L35 5DR

Our Ref	EST
If you telephone please ask for	Emma Sutton-Thompson
Your ref	
Date	12th May 2017
E-mail address	Emma.Sutton-Thompson @halton.gov.uk

Dear Ann,

Quality Accounts 2016 - 2017

Further to receiving a copy of your draft Quality Accounts and the Joint Quality Accounts event held on 26th April that your colleague Sue Redfern 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 2016/17 the Board were pleased to note that the Trust made progress against the following priorities;

- A 17% reduction in falls resulting in harm.
- The recruitment of a permanent team to address complaints response times.
- Delivering 5-star care to patients admitted to hospital with acute kidney injury.

In terms of Patient Safety, the Board were pleased to note the following:

- There were no hospital acquired grade four pressure ulcers.
- The Trust achieved a 69% reduction in theatre related episodes of moderate/severe harm.
- Clostridium Difficile infections were reduced by 23%.
- Changes were made to the design of a plastic cover on wound drain equipment following two never events and amendments made to procedure.

Under the Quality of Services overall, the Board were very pleased to note;

- The Trust was rated as good overall by CQC and outstanding for Caring.
- The Ward quality care accreditation tool (QCAT) was rolled out across all general inpatient areas and gold standards awarded to six wards.

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HALTON
BOROUGH COUNCIL

The Board are pleased to note the following Improvement Priorities for 2017 – 2018:

- Continue to reduce avoidable harm from falls, pressure ulcers and MRSA infections by 50% in the next 3 years.
- Improve the effectiveness of discharge planning and increase the percentage of e-discharge summaries sent within 24 hours to 85%.
- Refresh and redesign the process for learning from incidents and complaints.

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

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4.2.4. St Helens and Knowsley CCGs, Knowsley Local Authority and Healthwatch Knowsley

4.2.5. Independent Auditor

4.3. Amendments made to the Quality Account following receipt of the written statements from other bodies

Section	Amendment
2.1.2	Additional narrative included to make explicit the challenges in continuing to provide high quality care when delivering increased levels of activity and facing recruitment difficulties in some areas, with additional information relating to safer staffing.
2.2	Additional information and data included to expand on the outcomes achieved from last year's quality priorities. Explanation included confirming that the Board will continue to monitor mortality of weekend admissions and rationale for not including it as one of the six priorities for 2017-18.
2.3	Additional outcome measures to be reviewed to confirm
2.4.1	Additional information provided to clarify different types of income.
2.4.10	Clarity provided that the Quality Committee will closely monitor the delivery of the VTE risk assessment rate.

4.4. Abbreviations

AMU	Acute Medical Unit
AKI	Acute kidney injury
ANTT	Aseptic Non-Touch Technique
AQ	Advancing Quality
AQuA	Advancing Quality Alliance
BAPEN	British Association of Parenteral and Enteral Nutrition
BONE	British Orthopaedic Network Environment
BOTA	British Orthopaedic Trainees Association
BSR	British Society for Rheumatology
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
DMOP	Department of Medicine for Older People
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
IBD	Inflammatory Bowel Disease
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
ISS	Injury severity score
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
NIV	Non-invasive ventilation
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
OCS	Order Comms 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
RACPC	Rapid Access Chest Pain Clinic
RCA	Root Cause Analysis
RCEM	Royal College of Emergency Medicine
RDI	Research Development and Innovation
ReDEFINe	Rotational Delivery at Full Dilatation
SAMBA	Society for Acute Medicine (SAM) Benchmarking Audit
SAH	Subarachnoid haemorrhage
SHMI	Summary Hospital-level Mortality Indicator
SIRO	Senior Information Risk Owner
SSNAP	Sentinel Stroke National Audit Programme
STP	Sustainability and Transformation Plan
SUS	Secondary Uses Service
TARN	Trauma Audit & Research Network
TDA	Trust Development Authority
TIA	Transient Ischaemic Attack
VTE	Venous Thromboembolism

NHS
St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)055
Title of paper: Information Governance Annual Report
Purpose: To provide the Board with assurance that St Helens and Knowsley Teaching Hospitals Trust operates within the parameters defined in the Information Governance Toolkit and have completed the annual submission to demonstrate such compliance.
Summary: Every year the Trust must demonstrate compliance with Information Governance requirements by completing the NHS Digital 'Information Governance Toolkit'. There is a requirement for all NHS organisations to meet the minimum of Level 2 across all requirements within the Toolkit. This report summarises the Trust's IG Toolkit submission for 2016-2017 and includes an update from both the Caldicott Guardian and Senior Information Risk Owner (SIRO). This report ensures that the Trust Board are adequately briefed on the Information Governance Agenda.
Corporate objectives met or risks addressed: Communications, Systems and Safety, Risk Management, Efficiency and Performance
Financial implications: *None directly from this report.*
Stakeholders: *Staff, Patients, Executive Committee, Trust Board, Commissioners.*
Recommendation(s): The Board are asked to note and approve the content of this paper and to continue to support the evolving Information Governance Agenda going forward.
Presenting officers: Christine Walters, Director of Informatics (SIRO)
Date of meeting: 31st May 2017

1. 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 NHS Digital 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 NHS Digital. Version 14 of the Information Governance Toolkit was released in June 2016. The Trust assesses itself against 45 criteria and evidence expectations have again risen considerably making it more difficult to achieve compliance.

Completion of the IG Toolkit is a mandatory requirement for NHS organisations and is strongly recommended for private companies which process NHS patient data. Larger organisations, such as Acute Trust's, are also required to have their IG Toolkit submission externally audited.

Failure to complete the IG Toolkit can have serious implications for organisations. For most NHS organisations, completion of the IG Toolkit is a contractual obligation with Commissioners, therefore; non-compliance could incur financial penalties or impact the Trust's ability to bid for new services in the future. The Information Commissioner has also shown that satisfactory completion of the IG Toolkit can act as a strong mitigation against regulatory fines imposed should an incident be reported to them.

2. IG Aims

St Helens & Knowsley Teaching Hospitals NHS 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.

3. Executive summary

An initial baseline assessment against all 45 requirements was submitted as required at the end of July 2016, with an action plan developed through to March 2017.

Mersey Internal Audit Agency (MIAA) has completed an audit of the Trust's Toolkit submission (as required of larger NHS organisations) during October 2016 and January 2017 to assess the Trusts compliance against these requirements. MIAA audited 15 of the 45 requirements. The audited requirements covered elements of; IG Management, Training, Information Sharing, Subject Access Requests, Information Flow Mapping, Information Risk Management, Information Security, Data Quality and Corporate Records management.

The Trust has subsequently received the audit report from MIAA – the Trust has been able to maintain their rating of 'Significant Assurance', from the previous 4 year's submissions.

Significant Assurance

A final submission of the IG Toolkit was made in March 2017. Our submission shows the Trust score has remained the same this year as for 2015-2016. However; this is not a case of the Trust 'standing still'; the rise in evidence expectations for this version of the IG Toolkit has meant that significant work has been completed in order to maintain the Trust's score.

Version 13 2015 -2016	Version 14 2016 – 2017
80%	80%

4. Senior Information Risk Owner Update (SIRO)

This section of the paper is designed to inform and give assurance to the Board of progress made against the Information Governance work programme for 2016-2017 and to outline the key priorities and associated work programmes for 2017-2018.

This section will provide assurance, from the SIRO, that the Trust:

- Have an active and effective Information Governance Steering Group forum, meeting monthly
- Manage and investigate any Information Governance / Confidentiality incidents and issues
- Regularly review and update Trust Information Governance Policies

4.1 Role of the SIRO

The role of SIRO at all NHS Trust's has been mandated since 2007, following significant data losses in the public sector. The SIRO is required to be an Executive Director, Chief Information Officer or a Senior Manager with access to the Trust Board. Broadly; the SIRO's duties include; being accountable for information at the Trust, fostering a culture for protecting and using data, providing a focal point for managing information incidents, and being concerned with the management of all information assets.

The SIRO also takes overall ownership of the Trust's Information Risk Policy (incorporated within the Network & Information Security Risk Policy); act as a champion for information risk on the Board and provide written advice to the Accounting Officer on the content of the Trust's Statement of Internal Control in regard to information risk.

The SIRO will implement and lead the NHS Information Governance (IG) risk assessment and management processes within the Trust and advise the Board on the effectiveness of information risk management across the Trust.

4.2 SIRO Training

The SIRO is required to receive appropriate training as necessary to ensure they remain effective in their role as Senior Information Risk Officer for the Trust. The Trust SIRO completed appropriate training on 25th April 2017, provided by an accredited, external training provider.

4.3 Information Governance Steering Group

The Information Governance Steering Group (IGSG) is a standing committee accountable to the Trust Risk Management Council and, ultimately, the Trust Board. Its purpose is to support and drive the broader Information Governance agenda and provide the Trust Board with the assurance that effective Information Governance best practice mechanisms are in place within the Trust. The IGSG is chaired by the Trust Caldicott Guardian, with the Trust SIRO as Deputy. Core membership includes; Trust Directors and Assistant Directors, Heads of Quality, Heads of Service and Senior Managers.

Agenda items for the IGSG, during 2016-2017, have included:

- Cyber-attack aimed at the Trust (January 2017)
- Risk Register updates (standing Agenda item)
- Caldicott Issues Log Report (standing Agenda item)
- Information Flow Mapping reports
- Privacy Impact Assessments for new projects
- GFi (USB port lock-down) implementation
- Complex Password proposal
- Spam email filtering
- IG incidents reportable to the ICO

The IGSG have approved the following new/reviewed Policies during 2016-2017:

- Remote Access Policy
- Network & Information Security Risk Policy
- Backup Policy
- Disaster Recovery Policy
- Corporate Records Management Policy
- Management of Health Records Policy

5. IG Incidents

5.1 Reportable Incidents

The investigation and management of IG incidents at the Trust is monitored by the IGSG, via the monthly Caldicott Issues Log Report.

The Trust has a duty to internally report any incident regarding personal data, however minor. For the financial year 2016/2017 we reported one incident to the Information Commissioner's Office (ICO). The Information Commissioner's Office outcome is as follows:-

Incident 1 - **No Further Action Taken**

This incident related to a patient radiology report containing personal and sensitive information being sent, in error, to the incorrect patient. The Radiology report was accidentally put in an envelope containing another patient's appointment letter.

When the patient received their appointment letter they also received the erroneous Radiology report. The patient proceeded to locate the address of the patient who as the subject of the Radiology report and hand delivered it to the correct address. The patient's daughter received the report. The report contained a diagnosis that the daughter, and other members of the patient's family, was not aware of. A complaint was then made to the Trust PALS team concerning a breach of confidentiality.

Upon being made aware of the complaint – the Information Governance department immediately informed the Trust Caldicott Guardian & Senior Information Risk Owner (SIRO). Using the NHS Digital 'Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation', the decision was made that this was indeed a reportable incident and the Information Commissioner's Office were duly noted.

A full investigation was launched, by Radiology, with actions taken to minimise the likelihood of any recurrence. The patient was contacted by the Trust Caldicott Guardian and an apology, on behalf of the Trust, was made. This was then followed by a further, written apology and an update on what the Trust was doing to ensure this did not happen again in the future.

The ICO returned to the Trust with the decision that the incident warranted no further action from them in their role as the regulatory body for data protection. This was due to the Trust's quick response to the incident, and the fact that "while the sending of the report to the wrong address caused distress to the data subject, the data does not appear to have been more widely disclosed".

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.

5.2 Cyber-attack Incident

During January 2017, the Trust found itself under a sustained and co-ordinated cyber-attack. The attack consisted of an exceptionally high number of hoax phone calls being received at the Trust. These callers attempted to trick staff into believing the calls were originating from "Microsoft" or "the IT department". The aim of these hoax calls was to harvest user credentials in order to allow the attackers to gain access to the Trust network. The attack lasted for 6 days with the Trust continuing to receive a small amount of similar calls up to, and including April 2017.

Once it was discovered that the Trust were under attack in this way; the Informatics Cyber Security Response Plan was initiated. Immediate preventative steps were taken and appropriate law enforcement agencies were informed. The Trust gained expert advice from CareCERT (NHS Digital's Computer Emergency Response Team). Regular communications were sent to all staff, which proved to be vital in our defence.

Once the bulk of the attack had abated; the HIS began a process of reviewing all internal controls in place. This review encompassed our technology, policies and security safeguards.

The HIS have increased staffing on the security rota, which is designed to alert the HIS to potential threats to the IT network. Staff on this rota are proactively monitoring; internet activity (suspicious or unusual traffic), email activity (quarantine suspicious emails or attachments) and patch management (to ensure devices have the latest security updates).

A specific risk has also been placed on the Corporate Risk register and is currently rated at 16. This risk has a dedicated action plan and is monitored through the Risk Management Council and HIS Operations Board.

The Board are asked to note that this threat will not diminish. Most likely is that the attackers will simply change the vehicle of attack, i.e. from phone to email. The HIS are well on the way to improving existing cyber defences and its user education programme in order to mitigate the effect of future cyber-attacks against the Trust.

5.3 March 31st 2017 IG Toolkit Submission

Version 14 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 1st April 2016 and 31st March 2017.

5.4 Overall Position

The Trust maintained its IG Toolkit score of 80% from 2015-2016. Within the IG Toolkit, there are only 3 possible ratings; Satisfactory, Satisfactory with Improvement Plan, or Unsatisfactory. As with 2015-2016; 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.

	31st March 2015 Annual Submission V.12	31st March 2016 Annual Submission V.13	31st March 2017 Annual Submission V.14
Overall Results	**82% (Green)**	**80% (Green)**	**80% (Green)**
	(45 out of 45 answered)	(45 out of 45 answered)	(45 out of 45 answered)

5.5 Submission

The Information Governance Steering Group was asked to approve and sign off the 31st March 2017 attainment levels in version 14 of the IG Toolkit prior to formal submission.

5.6 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.

Where standards were not being met action plans were prepared and were monitored to ensure improvement and compliance.

5.7 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').

6. Caldicott Guardian Review

Dr Francis Andrews is the Trusts registered Caldicott Guardian; the role of the guardian is to safeguard and govern uses made of patient information within the Trust, as well as data flows to other NHS and non-NHS organisations. Caldicott Guardianship is a key component of the broader information governance agenda.

NHS organisations have been required to appoint a Caldicott Guardian since 1999, when it was mandated by NHS England. The Caldicott Guardian has a key role in ensuring that the Trust achieves the highest practical standards for handling patient information. This includes representing and championing confidentiality requirements and appropriate information sharing at the highest level of the Trust.

The purpose of this section is to provide assurance, to the Trust Board, that the Caldicott Guardian function within the Trust is operating at a satisfactory level and that it is appropriately supported within the existing Information Governance structure.

The Trust Caldicott Guardian is supported by the Director of Informatics in her role as Senior Information Risk Owner (SIRO) and the Information Governance Manager and his team, comprising of a Senior Information Governance Officer, two Information Governance Officers and an Information Security Officer. As Chair of the Trust's Information Governance Steering Group, the Caldicott Guardian is also assisted by a number of senior members of staff who are members of this Group. These include: Trust Directors, Heads of Quality, Heads of Service and senior Managers.

The Caldicott Guardian believes that he has enough support to carry out his duties appropriately.

The Caldicott Guardian is a vital source of guidance and expertise for the Information Governance Manager and Team, please see below for a selection of topics which the Caldicott Guardian has provided expert guidance on within the financial year 2016-2017.

6.1 Information Sharing

The Trust has a suite of Information Sharing Agreements which document the 'how's, whys and where's' of information sharing at the Trust which are subject to an annual review by the Information Governance team. New sharing agreements produced this year, and signed by the Caldicott Guardian, have included (but are not limited to):

- Agreements with Stop Smoking Services for pregnant women in Liverpool, St Helens, Knowsley and Halton
- 2016 National Cancer Patient Experience Survey
- EPaCCs End of Life Care project
- Public Health England – National Congenital Anomaly and Rare Disease Registration Service
- National Healthy Child Programme with local Community provider

Existing information sharing agreements, which were in place prior to 2016-2017, are maintained by the Information Governance Team and are subject to an annual review; this

was carried out by the IG team during the year and was completed in February 2017. A further review exercise will commence July 2017.

The Caldicott Guardian provides expert advice and guidance on the investigation and management of information governance incidents, specifically; any potential patient harm may occur due to a reported incident, in consultation with the Trust IG Manager and SIRO; decide whether incidents are required to be report to the Data Protection regulator for England (Information Commissioner), and whether a patient should be informed of an incident which concerns their confidential information.

6.2 Information Governance Steering Group

As Chair of the Trust's Information Governance Steering Group, the Caldicott Guardian has the correct forum in which to advise on; information governance, information security or information sharing issues which come before the Group.

Specific issues that the Caldicott Guardian has advised upon during 2016-2017, include (but are not limited to):

- Produced a paper on when it would be appropriate to inform a patient/data subject of a breach of their confidentiality
- Advising on the new CQC and National Data Guardian regulations within the NHS
- Radiology emailing appointment reminders pilot
- Changes to EU Data Protection legislation (EU General Data Protection Regulation aka EU GDPR)
- Children's Community Nursing Team requesting authorisation to take photographs on Trust iPhones
- Review and approval of Information Governance Policies.

For 2017-2018 the Trust Caldicott Guardian will continue to be a source of expert guidance and assistance to the SIRO, IG Manager and IG team. All existing duties of the Caldicott Guardian (as outlined above) will continue to be met during 2017-2018.

6.3 Issues for the coming year

However; there will be two main priorities for the Caldicott Guardian and the Information Governance Steering Group, going forward into 2017-2018:

EU GDPR

1. The new European General Data Protection Regulation (EU GDPR) represents a substantial development in data protection law.The primary objectives of the GDPR are to give individuals back the control of their personal data and to simplify the regulatory environment for international business by unifying the regulation within the EU.

   GDPR strengthens the principles of data protection by putting more focus on accountability and security. Organisations processing personal data will now be obliged not only to comply with the new law, but also to demonstrate they have complied.

Many of the GDPR's main concepts and principles are parallel with those of the existing Data Protection Act 1998; therefore organisations complying with the Act can be confident of effectively applying the same approach to the Regulations. As with any major change, buy in from senior management along with amending existing implementing new policies or procedures will be essential.

We need to get it right. As from May 2018 the maximum fine for non-compliance has risen from £500,000 to €20,000,000 – about £17 million at today's exchange rates.

The Information Governance Team will work toward the implementation of GDPR on behalf of the Trust this programme of work will be monitored via the IGSG. The Information Governance Team requests support from the Board on this legislative change.

2. Advising on the information governance and information security considerations in the deployment of any new systems/software at the Trust; especially the new Trust EPR.

Requirement Status

Version 14 (2016-2017) Assessment			
	Description	**Version 13 March 2016**	**Version 14 March 2017**
Information Governance Management			
14-101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	3	3
14-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	3	3
14-110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	2	2
14-111	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
14-112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	2	2
Confidentiality and Data Protection Assurance			
14-200	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
14-201	The organisation ensures that arrangements are in place to support and promote information sharing for coordinated and integrated care, and staff are provided with clear guidance on sharing information for care in an effective, secure and safe manner	3	3
14-202	Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use of this information are appropriately respected	2	2

Version 14 (2016-2017) Assessment			
	Description	**Version 13 March 2016**	**Version 14 March 2017**
14-203	Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use	3	3
14-205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	2	2
14-206	Staff access to confidential personal information is monitored and audited. Where care records are held electronically, audit trail details about access to a record can be made available to the individual concerned on request	2	2
14-207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	2	2
14-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	2	2
14-210	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			
14-300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	3	3
14-301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	2	2
14-302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	3	3

Version 14 (2016-2017) Assessment			
	Description	**Version 13 March 2016**	**Version 14 March 2017**
14-303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	3	3
14-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	3	3
14-305	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
14-307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	3	3
14-308	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
14-309	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
14-310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	3	3
14-311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	3	3
14-313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	3	3
14-314	Policy and procedures ensure that mobile computing and teleworking are secure	2	2

Version 14 (2016-2017) Assessment			
	Description	**Version 13 March 2016**	**Version 14 March 2017**
14-323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	2	2
14-324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	2	2
Clinical Information Assurance			
14-400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	2	2
14-401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	2	2
14-402	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
14-404	A multi-professional audit of clinical records across all specialties has been undertaken	3	3
14-406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	3	3
Secondary Use Assurance			
14-501	National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop	3	3
14-502	External data quality reports are used for monitoring and improving data quality	2	2
14-504	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

Version 14 (2016-2017) Assessment			
	Description	**Version 13 March 2016**	**Version 14 March 2017**
14-505	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
14-506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	3	3
14-507	The secondary uses data quality assurance checks have been completed	2	2
14-508	Clinical/care staff are involved in validating information derived from the recording of clinical/care activity	2	2
14-510	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards	3	3
Corporate Information Assurance			
14-601	Documented and implemented procedures are in place for the effective management of corporate records	2	2
14-603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	3	3
14-604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	2	2

Freedom of Information Annual Report 2016-2017
(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 2016 to 31st March 2017
b) source of request
c) type of request
d) monthly breakdown
e) year on year comparison

The Trust continues to working towards compliance 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 Trust

TRUST BOARD

Paper No: NHST(17)056
Title of paper: Freedom of Information Act (FOIA) Annual Report
Purpose: To provide assurance that St Helens and Knowsley Teaching Hospitals NHS 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 (2016-2017) to previous years, where relevant.
Corporate objectives met or risks addressed: Systems, Communications
Financial implications: None directly from this report.
Stakeholders: *Staff, Patients, Executive Committee, Trust Board, Commissioners.*
Recommendation(s): The Board are asked to note and approve the content of this report and to support the compliance with the Freedom of Information Act
Presenting officer: *Christine Walters, Director of Informatics*
Date of meeting: 31st May 2017

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 (2016-2017) 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
Annual Total 14-15	552	146	84	0	188	36	18	28	24
Annual Total 15-16	479	77	86	1	212	34	11	7	21
Annual Total 16-17	663	122	94	1	354	48	12	2	30

Table 1 shows number of FOI requests for 2016-2017, showing that the number of requests received has increased significantly from the 2015-2016 figures (38% increase).

Chart 1 - Categories of Request for 16/17

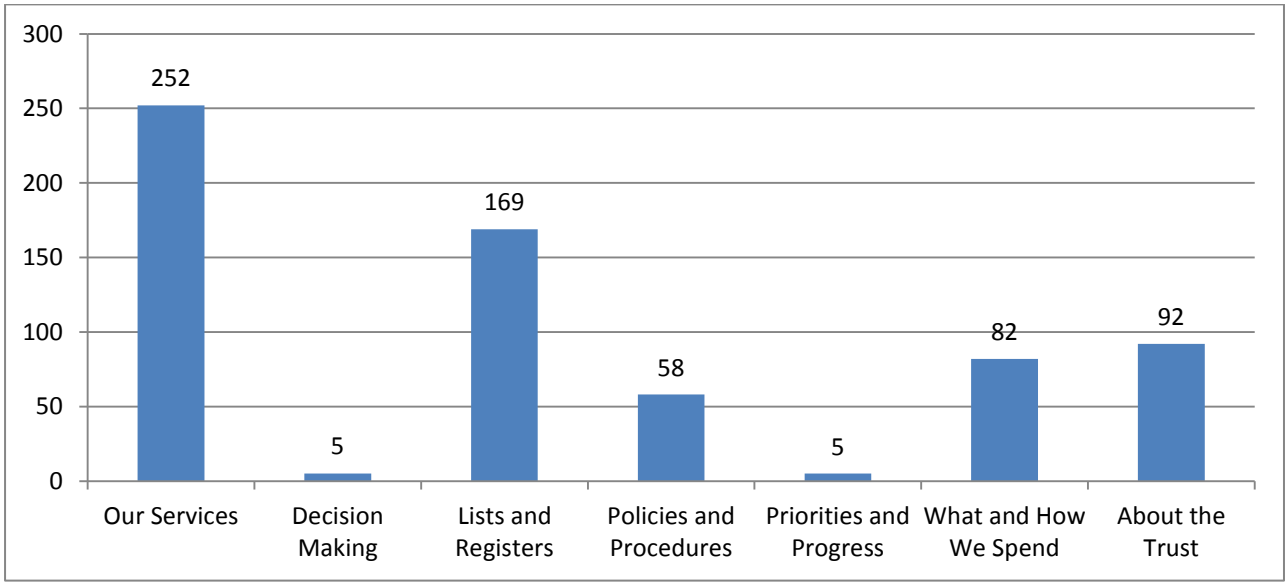


Table 2 - Examples of Category Request

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

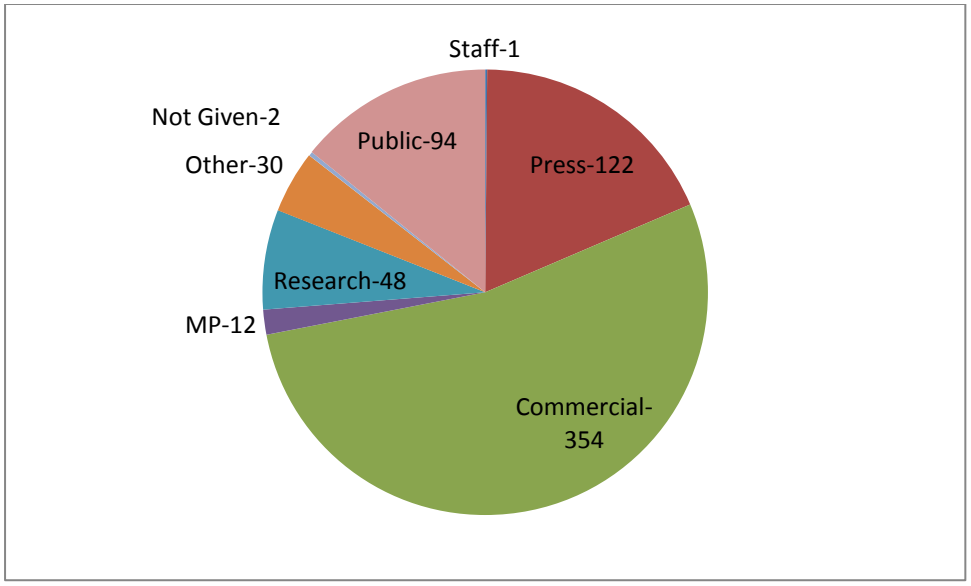
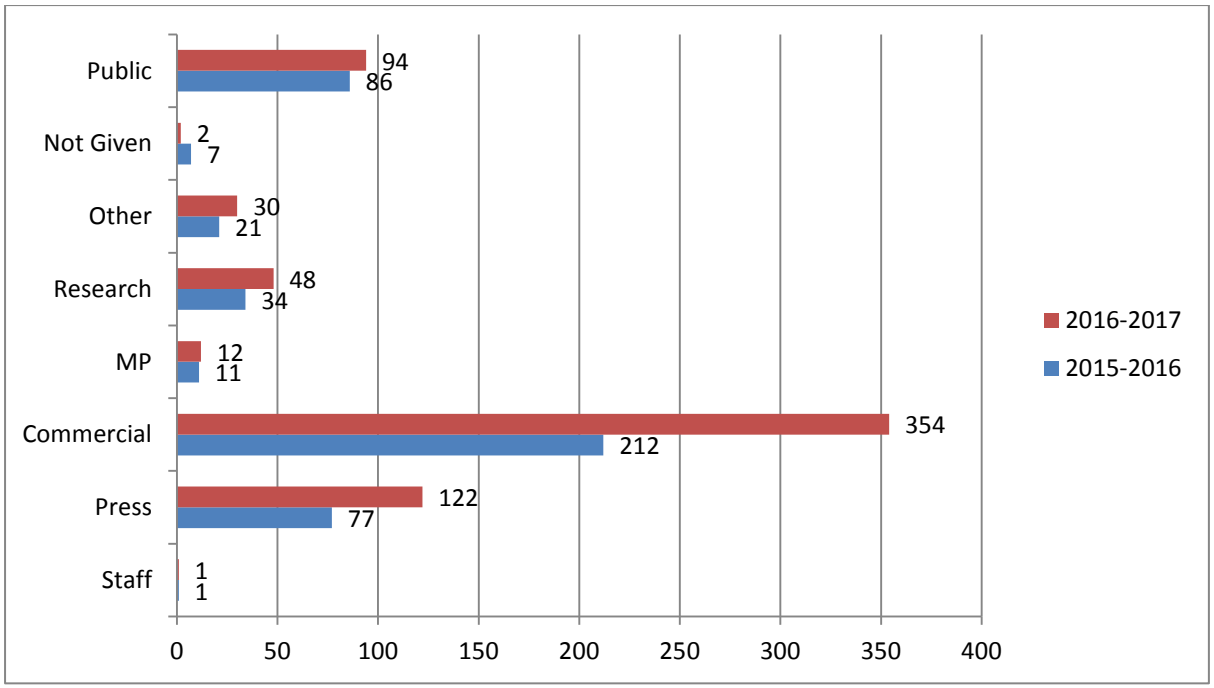


Chart 3 – Comparison of 2015-2016 and 2016-2017 Applicant Type



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. These types of requests have increased by 66% from 2015-2016. Press requests have also increased over the 12 month period by 58% compared to the same period for 2016-17.

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 MPs have increased slightly in 2016-17; from 11 to 12. Requests where the applicant did not disclose an affiliation (i.e. MP, Research, etc.) – Not Given[1] - are the only category to have seen a decrease in 2016-2017 (requests from staff have remained the same as 2015-2016, with only 1 request received).

Performance

The Trust received 663 FOIA requests for 2016-2017; compared to 479 requests for 2015-2016. The Trust strives to respond to all requests in accordance with the 20 working days timeframe that the legislation dictates. Out of the 663 requests received the Trust responded to 43% within 20 working days, with 42% of responses released after the deadline. At the time of writing; the remaining 15% of requests were still open. This compliance figure can be attributed to the significant increase in

[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.

requests the Trust has had to manage during 2016-2017 (up 38% from 2015-2016), and also the increasingly complex nature of requests the Trust has received.

The Executive lead for Freedom of Information, Anne Marie Stretch has written to all Executives and Senior Managers responsible for FOIA requests to remind them of their responsibilities in ensuring FOIA requests are responded to in a timely manner.

The FOIA team will continue to monitor compliance levels and highlight specific concerns back upto to Anne Marie Stretch for further action if necessary.

The IG Team are currently working with the relevant staff within Informatics to create a new system for managing FOIA requests when they are received into the Trust. This system will utilise SharePoint and will aim to automate as much of the administration of request as possible so as to reduce the effect that these requests have on resource within the IG team.

Appeals

Applicants have a right to appeal if the information they have requested has been subject to an exemption.

The Trust has received two requests for appeals this financial year. On both occasions the Trust maintained its original decision and explained to the respective applicants how it had arrived at those decisions.

The applicants were satisfied with the Trusts responses.

Conclusion

The number of Freedom of Information requests received by the Trust in 2016-2017 increased from the previous year from 479 to 663. This is a significant increase in the number of requests the Trust has received this financial year. This has undoubtedly affected the Trust's compliance with the statutory timescales contained within the FOIA.

This increase however, still 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.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)057
Title of paper: Trust Objectives Review
Purpose: To advise Trust Board members of the year-end progress against 2016/17 Trust objectives.
Summary: 1. The Trust has agreed twenty-seven objectives for 2016/17. 2. The following paper reports on progress throughout the year against each one. In addition, progress has been RAG rated where green equates to criteria being fully met; amber being good progress being made; and red indicating non-achievement or insufficient progress. 3. Whilst the rating is subjective the results show: a. 22 objectives (81%) graded green b. 4 objectives (15%) graded amber primarily due to timeliness of discharges and transfers; performance against a small number of standards; timeliness of complaint responses; and agency expenditure c. 1 objective (4%) graded red regarding emergency access performance.
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 progress being made and the actions proposed to achieve the optimum year-end outturn.
Presenting officer: Ann Marr, Chief Executive.
Date of meeting: 31st May 2017.

PROGRESS AGAINST 2016/17 TRUST OBJECTIVES

The following table summarises progress to date against the Trust's five key objectives linked directly to patient care, and four associated and supporting objectives.

5 STAR PATIENT CARE – Care We will deliver care that is consistently high quality, well organised, reflects best practice, and provides the best possible experience of healthcare for our patients and their families	
1	Improve the patient experience by continued advancements in clinical care and timeliness of discharges and transfers • *Clinical care continues to be evidence-based and of a high quality as verified by Performance Standards, the Integrated Performance Report and the 'Outstanding' care rating from CQC's Chief Inspector of Hospitals report* • *Timeliness of discharges and transfers has improved but medically optimised patients still occupy a significant number of acute beds, resulting in internal bed pressures* • *Initiatives to improve patient flow have included clinically-led board rounds; identifying early morning discharges; senior daily review; and escalation for patients who no longer need care in an acute bed supported by system wide Multi Agency Discharge Events (MADE)* • *A reduction in LoS has released beds and helped reduce the adverse impact of further increased non-elective admissions* • *A new Maternity Strategy, drafted with significant input from patients and staff and capturing new ways of working, has been launched*
2	Continue to make progress towards the four key 7-day service standards • *Initial consultant review within 14 hours is achieved the vast majority of times, but for admissions at certain times, particularly at weekends, this has not always proved possible* • *Access to diagnostics remains excellent* • *Consultant directed interventions 24/7 is inconsistent and subject to an improvement plan* • *Ongoing consultant review (daily for emergency admissions & twice daily for high-dependency patients) has improved but is constrained by consultant resource (a combination of lack of posts and lack of appropriate people to fill posts)*
3	Deliver performance indicators as outlined in the nursing strategy, ensuring adequate numbers of nurses are always available and staffing is routinely reviewed using recognised acuity tools • *The Trust continues to monitor safer staffing data where fill rate percentages consistently exceed the target of 90%. Care hours per patient per day is a further metric being scrutinized* • *Shelford acuity and dependency audits were carried out in June and October to support safer staffing data* • *Optimum employment of substantive staff is pursued* • *The Quality Care Assessment Tool (QCAT) was rolled out to all appropriate wards with 5 now achieving gold standard. This tool has recently been introduced in outpatient departments* • *Ward managers, matrons, and Maternity band 7's are participating in development programmes* • *The Trust is awaiting receipt of the Nurse Staffing tools being developed by NHSI and reflecting Carter recommendations, which will make reporting more transparent and open to benchmarking*
5 STAR PATIENT CARE - Safety We will embed a learning culture that reduces harm, achieves good outcomes and enhances the patient experience	
4	Further utilise the "sign-up for safety" indicators to improve safety and clinical outcomes and improve processes to raise the Trust's standing in the "learning from mistakes" league table • *The Trust continues to achieve above 98% new harm-free care, outperforming local Trusts* • *Trusts with high incident reporting usually have a better and more effective safety culture and the NHS National Reporting and Learning Service league table shows us above the median, and other benchmarks confirm we continue to improve*

5	Make further improvements regarding effective venous thromboembolism screening, administration of medicines, avoidable hospital acquired infections, pressure ulcers, acute kidney injury and sepsis, and other improvements specified in the Clinical Quality Strategy • *VTE assessment is close to target. The full implementation of ePrescribing in 2017 should enable consistent achievement of this target* • *Available benchmarks suggest excellent progress improving the management of AKI and Sepsis* • *There were two never event in 2016/17 which were very regrettable but did provide lessons* • *MRSAb performance was poor last year and the subject of an intensive improvement programme* • *C.difficile performance was well within target. Community antibiotic prescribing must be improved and we are working with the CCGs to drive better performance in primary & secondary care* • *Falls resulting in moderate or severe harm are within national norms, but still result in unnecessary morbidity and mortality and are the subject of an internal improvement plan for the year ahead* • *There were no grade 4 pressure ulcers and work is focussing on eliminating the causes of the one avoidable grade 3 case* • *The eMews electronic observation and escalation system has been fully implemented. Work is now focussing on fully realising the clinical benefits* • *Medicines Management, medicines storage and Aseptic Unit performance have all improved significantly in 2016/17*
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 mortality indicators are both largely stable and within national control limits; crude mortality remains consistently better than the NW average* • *Weekend admission mortality is volatile; recent evidence (Lancet) suggests it relates largely to acuity and complexity of weekend admissions*
5 STAR PATIENT CARE – Pathways As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient	
7	Work closely with CCG colleagues to improve emergency access performance, and explore opportunities for joint working that will simplify the patient journey for example frailty pathways and discharge to assess • *A&E attendances are largely stable however the conversion rate to admission has increased by circa 8% suggesting higher acuity and complexity of those attending* • *Whole system collaboration with ECIP is focused on improving performance by admission avoidance, better streaming, greater use of ambulatory care and more timely discharge* • *The Trust took over Community services on April 1st which offers a further opportunity to strengthen alternatives to hospital inpatient care*
8	Continue to develop and embed alternative pathways to benefit patient care such as those related to ambulatory emergency care to reduce non-elective admissions, and midwifery-led care for women having low risk births • *Alliance with Warrington Trust regarding the management of their acute stroke cases have been implemented* • *A growing number of conditions are being managed through ambulatory care pathways to reduce non-elective admissions and length of stay* • *The plans for a midwifery-led facility have been approved and will be implemented in 2 phases starting in June*

9	Use benchmarking data intelligence to reduce variation and improve outcomes • *The Project Management Office actively reviews benchmarking data with care groups to drive improvements, reduce variation and deliver better outcomes by learning from the best* • *Benchmarking data and associated intelligence is used extensively to drive improvement and gain assurance* • *Get It Right First Time (GIRFT) benchmarking is being used to drive improvements in many surgical specialties and in the case of Orthopaedic surgery have transformed clinical and financial performance* • *Work on STP and LDS proposals has required extensive use of comparative data to identify improvements, especially with respect to radiology, pathology and pharmacy 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 improve response rates and outcomes from the Friends & Family Test. Continue to use patient stories to learn lessons and share best practice • 95.5% of inpatients would recommend our services, as recorded by the Friends and Family Test • Centralised monitoring and support is now in place to ensure each area publically displays their results and the actions being taken to continuously improve services • Patient stories are reported to the Board, including the actions taken as a result • We continue to receive excellent feedback from patient groups
11	Improve compliance with the timeliness of responses to complaints and continue to reduce complaints related to staff attitude and behaviour • Timeliness of complaint responses continues to be a challenge, and at the year-end was 58% and remains a focus of management attention • The structure and arrangements for handling complaints saw a complete review and work is now being undertaken to examine each step in the process to identify specific areas for improvement • There was a 22% reduction in the number of complaints relating to values and behavior in 2016/17 and ACE behavioral standards continue to be reiterated as part of the appraisal process
12	Improve patient information and communications via the website and other social media channels, as well as more traditional routes. Embrace opportunities for communications with patients and relatives to help the Trust plan future service developments • *The noticeboard displays at the entrance to all wards and departments introduced in 2015/16 are now firmly embedded and leaflets continue to be regularly reviewed and revised* • *The revised Trust website continues to receive positive feedback* • *The Trust's social media sites continue to be very popular for staff, patients, and stakeholders with new content added twice daily. In the last 12 months Facebook has reached 1,816,296 people and Twitter has reached 474,600 people* • *In September 2016 a Facebook page dedicated to our Maternity Unit was launched and has reached 522,252 people to date* • *Improved verbal and written communication is being addressed through a range of staff training modules and monitored through appraisal systems*

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	Continue to implement the next phase of IT systems including: a clinical portal, e-prescribing, electronic medical early warning system, theatre system and next generation Electronic Document Management System • *eMEWS implementation was completed successfully and fluid balance has now gone live* • *The pilot for ePrescribing is ongoing and rollout is imminent* • *The EDMS has gone live and the Clinical Portal project will commence soon* • *The Maternity System offline community module was successfully implemented* • *The Critical Care information system was upgraded* • *There has been a slight delay in the new Trust Intranet whilst branding is reconsidered* • *Opera Theatre system roll-out is ongoing*
14	Continue to maintain the national data quality standards encompassed in the IG toolkit • *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 Trust retained its 'green rated' overall 80% score in 2016/17 despite an increase in the required standards* • *In 2016/17 additional focus was placed on cyber-security and Trust plans held up well in the recent international ransomware incident. The Trust achieved the required standard for care essentials in IT security*
15	Develop a 3-year IM&T Strategy which builds the foundations to support clinical transformation • *The HIS Strategy for 2017/20 incorporating local and wider informatics plans was approved* • *The associated Trust IT Strategy is in advanced draft form and due to be submitted for Board approval in June* • *The programme to replace the core Patient Administration System is ongoing and due for completion by March 2018*
DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce that feel valued and supported to care for our patients	
16	Identify creative approaches to recruitment and retention to ensure the Trust remains an employer of choice, ensuring support and training for recruits from overseas. Explore opportunities for increasing our volunteer workforce • *The 5-year Recruitment & Retention Strategy is in place and meeting the planned trajectory* • *There is an ongoing schedule of recruitment campaigns and open days linked to Universities and Colleges to attract clinical staff* • *The international recruitment campaign to employ overseas nurses has proved extremely challenging, however, most recently 12 RGNs have joined the organisation* • *Collaboration with junior doctor training in the Czech Republic has continued to provide high-quality doctors to the Trust* • *Plans to increase the pool of volunteers are ongoing. A new 5-year Volunteer Strategy has been developed extending the range of roles* • *Plans in support of the 5-year Talent Management Strategy continue to be delivered and coaching and bespoke leadership support interventions are aligned to OD plans* • *Delivery of apprenticeships in a range of subject areas are ongoing with circa 120 completed in 2016/17*

17	Achieve the planned benefits from the implementation of eRostering, eJob-planning, eTimesheets & eExpenses. Ensure safe staffing levels are maintained, whilst adhering to guidance for agency usage caps & frameworks • *Achievement of the Lord Carter action plan remains on target with the development of SOPs and checklists to monitor the adherence to NHSI guidance on back office functions and agency spend* • *A benefits realisation programme for eRostering is ongoing designed to address unwarranted variation and reduce bank and agency spend* • *E-rota for Junior Doctors in Training was implemented in November 2016* • *The phased implementation of E-Job Planning for Consultants and SAS Doctors with the refreshing of job plans in line with a revised job planning policy is ongoing* • *e-expenses were implemented as part of a national rollout programme*
18	Develop new approaches to celebrate innovation from front line staff to further enhance public, patient and staff engagement, and also empower staff to easily raise concerns • *The Trust's SFFT outcomes remain within the top quartile of responses nationally* • *Excellent results were achieved in the National Staff Survey with the Trust being best in the North West for overall staff engagement, and having the best score nationally for 8 of the 32 key findings* • *Cultural surveys are ongoing as part of the development of OD plans* • *OD interventions and professional coaches for leaders graded Band 7 and upwards are in place* • *Achievement of the 2016/17 Francis action plan was achieved including successful launch of the online "Speaking out in Confidence" portal*
OPERATIONAL PERFORMANCE We will meet and sustain national and local performance standards	
19	We will pursue all clinically based performance indicators related to the quantity of activity undertaken; the quality of services provided; and the timeliness of diagnosis and treatment • *The Trust continues to monitor performance across many hundred quality parameters which are captured in the monthly Integrated Performance Report* • *Trust performance remains very strong. Actions are in place to improve some cancer 62-day pathways and clinical care in ED remains high quality despite suboptimal flows* • *Stroke care is amongst the best in England and work to understand stroke mortality is on-going*
20	We will seek to achieve all relevant standards required of the Trust and our staff, and look to deliver the activity levels required to meet Trust operational plans • *Non-elective activity levels continue to exceed contract levels and impact on our ability to efficiently manage elective referrals, however, the vast majority of activity performance standards are being met* • *Progress against emergency access targets is currently a regular item for discussion at Committees and the Board* • *Pressures on physical accommodation (beds, theatres, outpatients and scanning) are challenging*
21	We will monitor all trends in performance, and take remedial action to improve outcomes and results • *The Integrated Performance Report is monitored at specialty, Care Group and Trust level* • *Areas of concern are thoroughly investigated and reported through Executive, Quality and Finance & Performance Committees prior to review by the Board. In addition, a Board Development session was devoted to exploring the IPR metrics to ensure a consistent understanding by Directors*
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 and continue to review the financial systems, processes, and controls, to enhance effective financial governance • *The Trust achieved its statutory financial duties with respect to capital cost absorption; external finance limit and capital resource limit, and delivered its predicted financial control total*

23	Continue to refine service and patient level information reporting and develop capacity, and demand modelling capability at divisional and departmental levels, to support decision making at organisational and service level • *Areas for improvement in 2016/17 included bar-coding of equipment and Medical Job plans. Whilst some progress was made these are ongoing and will be carried over* • *The internally developed tool to model patient flows on bed availability underpinned the plans to increase the bed base by creating escalation facilities* • *The KPMG STP commissioned capacity model has been shared with stakeholders and work is ongoing to review bed, theatre and workforce capacity in light of demand*
24	Use available benchmarking data to assess performance and underpin service transformation initiatives • *The advancement of strategic plans on a wider STP footprint has involved robust benchmarking of back-office services to explore where working differently could be beneficial* • *The recent Lord Carter report and development of the 'model hospital' offers greater opportunity to explore relative efficiencies of services and seek to emulate the best* • *The PMO continues to assist operational managers with in-depth system and process reviews and achievement of CIP initiatives*
SUSTAINABILITY AND TRANSFORMATION PLANS We will work closely with NHS Improvement, and commissioning, local authority and provider partners in Cheshire and Merseyside to develop plans to deliver sustainable services	
25	Meet all the compliance requirements set by NHS Improvement for long-term sustainability of clinical services • *Collaborative working initiatives with local providers are ongoing on both the Alliance Local Delivery System (Southport and Ormskirk, and Warrington and Halton) and Cheshire and Merseyside (C&M) Five Year Forward View (FYFV) footprints* • *The Trust has developed 5-year strategic plans and 2-year operational plans required by commissioners and regulators and met all the required deadlines* • *The Trust is a member of the St Helens Peoples Board and is supporting the local health system to achieve its goal of becoming an Accountable Care System in 2018*
26	Foster positive working relationships with health economy partners and help create the joint strategic vision for health services, incorporating patient pathway improvements from sharing patient information • *The Trust continues to contribute in wider strategic planning discussions with commissioners, providers and other relevant stakeholders and has put forward representatives to participate in the cross-cutting theme groups (e.g. cancer)* • *Joint working on non-elective workstreams have been strengthened with the creation of the Urgent Care Board and joint improvement reviews* • *The productivity of meetings with our main commissioner has improved significantly with agreement of 2017/18 contracts without the need for mediation* • *Executive Team to Team meetings have been held with commissioners and providers during the year, and the regular monthly meeting with NHS Improvement has been maintained*
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 to reflect the outcome of the C&M FYFV plans in due course* • *Briefing around strategic plans has not commenced in earnest, following advice from the centre, but is hoped that both staff and public briefings and discussions will soon progress* • *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*

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)058
Title of paper: Learning from deaths in the NHS
Purpose: For decision to adopt the recommendations of this paper
Summary: There is to be a new compulsory national system for learning from deaths in the NHS, new national reporting requirements and a new focus during CQC inspections. This paper describes the national proposal and the local context and recommends establishing a group to develop and implement an STHK plan to meet national guidance.
Corporate objectives met or risks addressed: Care, safety, systems, pathways
Financial implications: No new expenditure recommended at this juncture
Stakeholders: All staff
Recommendation(s): Members are asked to approve
Presenting officer: Kevin Hardy
Date of meeting: 31st May 2017

“Patients Sometimes Die – where’s the harm in that”

Learning from Deaths in the NHS @ St Helens & Knowsley Teaching Hospitals NHS Trust

Professor Kevin Hardy
Medical Director
April 2017

Background

The government has set a mandate for the NHS to offer "the safest, most compassionate, highest quality healthcare in the world" by becoming "the world's largest learning organisation" ('The government's mandate to NHS England for 2017-18', Department of Health, March 2017).
This resonates well with St Helens & Knowsley Teaching Hospitals' (STHK) long-held aspiration to deliver '5-star care'.

(from C-Ci Summit 2017 *'Never Say… Never-Events Again'* - *exploring how we can materially and sustainably shift the dial on avoidable harm and mortality, The Kings Fund, March 2017)*

The STHK board has for many years placed great emphasis on understanding mortality data and on deriving learning from deaths, most recently in its April 2016 paper, 'Mortality Review – a new System for England' which described a major overhaul of STHK mortality review processes (both mortality benchmarking and retrospective case record review) to align our practice with recommendations from the NHS Medical Director, Sir Bruce Keogh. Following the establishment of a Mortality Surveillance Group (MSG), as recommended by Sir Bruce, and implementation of that new system in Spring 2016, Dr Francis Andrews, Assistant Medical Director and medical vice-chair of the MSG led an extensive internal consultation and review of our systems and processes, and of learning from mortality review elsewhere in the NHS, in the Winter of 2016/17. It is the learning from Dr Andrews' review, complemented by the CQC report 'Learning, Candour and Accountability - a review of the way NHS trusts review and investigate deaths of patients in England (December 2016), and the National Quality Board's 'National Guidance on Learning from Deaths – a framework for NHS Trusts and Foundation Trusts on identifying, reporting, investigating and learning from deaths in care' (March 2017) that underpins this Board update.

The purpose of the paper is to use our learning from Dr Andrews' review, the CQC review and the new national guidance to describe the evolving process of learning from deaths and to seek approval for a further re-boot of STHK Mortality Surveillance, Investigation & Learning.

Recommendations

Details of the reports, their findings and their recommendations, including executive summaries can be found in the appendices embedded at the end of this paper.

1. I propose that STHK establish a working group, chaired by Dr Terry Hankin, Deputy Medical Director to develop a policy on learning from deaths and I would suggest that we consult with patients & public, local CCGs, relevant mental health trusts and relevant others, perhaps through St Helens Peoples Board & CQPG in developing this policy.

2. Working in collaboration with NW Boroughs Partnership and MerseyCare, STHK must establish a near real-time system for identifying and flagging in the PAS all patients with 'Learning Difficulties' (LD) and 'Severe Mental Illness' (SMI), as well as those STHK inpatients detained under the Mental Health Act (MHA)or Deprivation of Liberty Safeguards (DOLS).

3. From April 2017, STHK must take steps to report all IP deaths (total) and deaths within 30 days of IP discharge (total); all deaths in those with LD, SMI, MHA, DOLS; all deaths in those aged < 18 years, all maternal deaths, all deaths following 'relevant' procedures, all deaths as a result of suicide, all deaths associated with a NEVER event, MRSA bacteraemia or Clostridium difficile infection and all deaths in diagnostic or treatment groups where our most recent national SHMI data shows statistically significantly increased mortality. From 1st October 2017 STHK must *publish* its mortality report, including the proportion deemed 'avoidable'. Quality Account regulations will be changed to require this data to be published in the annual Quality Account from June 2018. CQC inspections will also strengthen its assessment of learning from deaths.

4. In addition to those subgroups detailed in (3), we must be able to identify (I would suggest through DATIX) all deaths in which staff, patients, relatives or carers have raised concerns. Ideally, relatives or carers of every inpatient death should be contacted within 24-48 hr of the death and 'interviewed' by an independent senior clinician to proactively establish whether the family had any comments (positive or negative) or concerns. The death certificate should also be reviewed by that clinician (see Medical Examiner role – mandatory introduction of which appears to have been delayed until 2019).

5. I propose that the policy will include a process whereby we screen all deaths (total IPs + total deaths within 30-days of discharge) for the sub-groups described in (3) and (4) above. These, together with a 5% sample of mostly low risk deaths from the remainder will be investigated.

Those groups in whom STEIS reporting and SIRI Level 2 RCA is mandated will be referred to the Director of Nursing and investigated in that way; the remainder will have a retrospective case record review (RCRR), using the LeDeR programme methodology for LD (see Annex E of NQB National Guidance on Learning from Deaths), the National Child Mortality Review Programme methodology for people aged < 18 years without LD (see Annex F of NQB National Guidance on Learning from Deaths), the Mothers and Babies: reducing risk through audits and confidential enquiries across the UK (MBRRACE-UK) (see Annex G of NQB National Guidance on Learning from Deaths) for maternity related deaths, the Structured Judgement Review in Mental Health Trusts (see Annex J of NQB National Guidance on Learning from Deaths) for SMI and the RCP Structured Judgement Review (SJR) for all other adult deaths subject to RCRR.

LD, Suicide, MHA, DOLS and SMI RCRRs must be multiagency reviews in collaboration with MH Trusts; Paediatrics and Maternity have existing multiprofessional systems for mortality review, but these must be strengthened to ensure that they comply with NQB guidance. RCP SJR RCRRs must comply with NQB guidance. RCP will provide training in SJR.

6. MSG must report regularly to Board. There might be a cumulative report of the status of SMART actions/Themes arising from RCRR as a standing item at Quality Committee, with a 6-monthly formal report to Board (Assurance) – it is a national requirement that there is a board-level Patient Safety Director (not a new post) and a NED lead.

   Delivery of the actions will be the responsibility of the Care Groups, with accountability resting with the Divisional Clinical Leadership (Divisional Director & Divisional Nurse/Governance Lead). Learning needs to be shared across the health economy – consideration needs to be given to how to achieve this – possibly CQPG?

7. Learning and understanding from RCRR must be integrated with findings from other data, including complaints, clinical audit information, mortality data, patient safety incident reports…… The working group will need to consider how this is to be achieved and what will be the relationship between the MSG, CEC, QC, Board, Care Group Governance meetings and the wider health economy. I wonder whether incorporation into IPR will be the most effective means of integration. Any qualifying safety incidents identified through RCRR must be reported through NRLS.

8. The Trust must have a policy on dealing with bereaved families and carers (see NQB guidance).

Appendix 1. Francis Andrews Review of STHK Mortality Review, Winter 2016/17.

Mortality review update Francis Andev

Appendix 2. Care Quality Commission. Learning, candour and accountability – a review of the way NHS Trusts review and investigate the deaths of patients in England.

CQC -learning-candour-acc

Appendix 3. Letter from NHSI & CQC on Learning from Deaths

17022204 - Learning from deaths letter217

Appendix 4. National Quality Board. National Guidance on Learning from Deaths. A framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from Deaths in Care.

nqb-national-guidanc e-learning-from-deatl

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(17)059

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 2016/17 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. The final part of this review is the issuing of revised ToR for each forum incorporating agreed changes.
4. Given that a detailed review was completed as part of the 2015/16 exercise the remit of this latest review was more basic to ensure they continue to align with latest guidance.
5. Whilst the memberships in the ToR have not been altered, recent changes in the Trust Board members will need to be addressed in the actual attendees at meetings going forward.
6. A change to the Remuneration Committee ToR regarding approval of minutes is being considered and this will be taken to the Audit Committee for consideration in due course.

Corporate objective met or risk addressed: Contributes to the Trust's Governance arrangements.

Financial implications: None directly from this report.

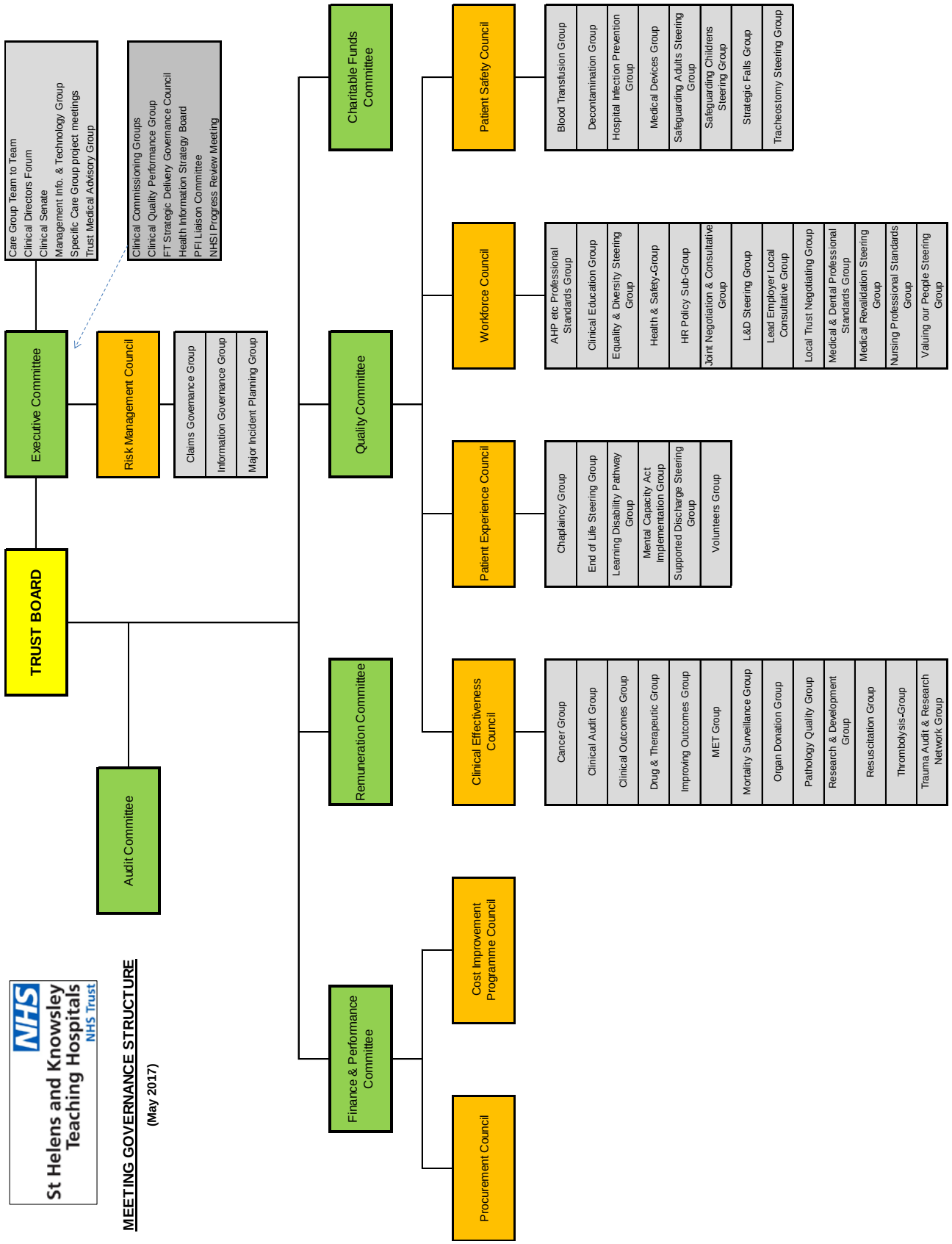
Stakeholders: The Trust, its staff and all stakeholders.

Recommendation(s): The Board are asked to approve the attached ToR which reflect the outcomes from the meeting effectiveness reviews.

Presenting officer: Peter Williams, Director of Corporate Services.

Date of meeting: 31st May 2017.

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.

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	Core Members Membership will comprise the Chairman and all Non-Executive Directors. In attendance 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.

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.

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.

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.

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).

	In attendance 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.

ENDS