St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 25TH APRIL 2018
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

PUBLIC BOARD AGENDA				Paper	Presenter
09:30	1.	Patient Feedback		Presentation	Kim Hughes
09:50	2.	Employee of the Month			Richard Fraser
		1.1	March		
		1.2	April		
10:10	3.	Apologies for Absence			
	4.	Declaration of Interests			
	5.	Minutes of the Previous Meeting held on 28th March 2018		Attached	
		4.1	Correct Record & Matters Arising		
		4.2	Action List	Attached	
Performance Reports					
10:20	6.	Integrated Performance Report		NHST(18) 32	Nik Khashu
		5.1	Quality Indicators		Sue Redfern
		5.2	Operational Indicators		Rob Cooper
		5.3	Financial Indicators		Nik Khashu
		5.4	Workforce Indicators		Anne-Marie Stretch
Committee Assurance Reports					
10.30	7.	Committee Report – Executive		NHST(18) 33	Ann Marr
10:40	8.	Committee Report – Audit		NHST(18) 34	Su Rai

10:50	9.	Committee Report – Quality	NHST(18) 35	David Graham
11:00	10.	Committee Report – Finance & Performance	NHST(18) 36	Jeff Kozer
BREAK				
Other Board Reports				
11:20	11.	Corporate Risk Register Report	NHST(18) 37	Nicola Bunce
11:30	12.	Board Assurance Framework Report	NHST(18) 38	Nicola Bunce
11:40	13.	Learning from Inpatient Deaths Quarterly Report *– to follow*	NHST(18) 39	Kevin Hardy
11:50	14.	Clinical & Quality Strategy Update	NHST(18) 40	Kevin Hardy
Closing Business				
12:00	15.	Effectiveness of meeting		Richard Fraser
	16.	Any other business		
	17.	Date of next Public Board meeting – Wednesday 30th May 2018		

NHS
St Helens and Knowsley Teaching Hospitals NHS Trust

Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Board meeting held on Wednesday 28th March 2018 in the Boardroom, Whiston Hospital

PUBLIC BOARD

Chair:	Mr R Fraser	(RF)	Chairman
Members:	Ms A Marr	(AM)	Chief Executive
	Mr D Mahony	(DF)	Non-Executive Director
	Ms S Rai	(SR)	Non-Executive Director
	Prof D Graham	(DG)	Non-Executive Director
	Mr J Kozer	(JK)	Non-Executive Director
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Mrs S Redfern	(SRe)	Director of Nursing, Midwifery & Governance
	Mr N Khashu	(NK)	Director of Finance
	Mrs C Walters	(CW)	Director of Informatics
	Mr R Cooper	(RC)	Director of Operations & Performance
	Ms N Bunce	(NB)	Director of Corporate Services
	Mr P Williams	(PW)	Director of Facilities Management/Estates
	Dr T Hemming	(TH)	Director of Transformation
In Attendance:	Ms J Byrne	(JBy)	Executive Assistant *(Minute Taker)*
	Ms K Hughes	(KH^2)	Head of Media, PR and Comms *(Observer)*
	Mr K Lomas	(KL)	Reporter, St Helens Star *(Observer)*
	Mr W Longshaw	(WL)	Director of Service Redesign *(Observer)*
	Dr S Pedder	(SP)	Div 'l Director, Surgical Care Group *(Observer)*
Apologies:	Mrs V Davies	(VD)	Non-Executive Director
	Prof K Hardy	(KH)	Medical Director
	Mr T Foy	(TF)	St Helens CCG *(co-opted member)*
	Cllr G Philbin	(GP)	Halton Council *(co-opted member)*

1. Patient Story

Clare Howarth (Patient Experience Manager) and Jan Lawton (Specialist Palliative Care Team Clinical Manager) presented the patient story on behalf of the patient.

The story was from a young mother with advanced bowel cancer and her experience of receiving palliative care at the Trust. The patient was very grateful for the kindness and care with which she had been treated, from the whole team of staff who were involved in supporting her. She also made some positive suggestions for how things could be improved for her and her family. The Board have agreed to implement these suggestions.

2. Employee of the Month

The Employee of the Month Award for March 2018 was awarded to Ms Emma Taylor, Sepsis Specialist Nurse who would be presented with her award at the April Board meeting.

3. Apologies for Absence

Apologies were noted as above.

4. Declaration of Interests

4.1 RF declared that he continued to be the interim Chair of Southport & Ormskirk Hospitals NHS Trust.

4.2 DG had been appointed to Provost (Vice Chancellor) at St Kitts Medical School. He declared his intention to resign from his Non-Executive position on the Board once a replacement had been appointed. RF congratulated DF on his appointment and thanked him for his contribution on the Board and to the Trust.

4.3 JK had been nominated as the Trust non-executive member of the HIS Board (Informatics).

5. Minutes of the previous meeting held on 28th February 2018

5.1. Correct Record

The minutes were accepted as a correct record.

5.2. Matters Arising

5.2.1 Learning from Inpatient Deaths Policy - the revised policy had been circulated to members following the last Board meeting and extensively reviewed at Quality Committee and the committee had recommended the policy for approval by Board members. The revised policy was approved.

5.3. Action List

Action 3 - Minute 5.1.2 (28.02.18): *Nasogastric Tubing Never Event* – a formal Investigation report had now been discussed at the Executive Committee and recommendations and an action plan would be taken to Quality Committee in May.

Action 5 - Minute 5.5 (28.02.18): *Staff Survey* – on agenda. Action closed.

Action 7 - Minute 8.7 (28.02.18): *Learning from Inpatient Deaths Policy* – approved. Action closed.

RF asked CW to provide an update to the Board on the Trust's response to a potential cyber security attack, following recent press articles. CW detailed the actions that the HIS had taken to protect the Trust and other HIS partners, which was in line with the guidance issued by NHS Digital. CW also detailed how the Trust's systems had been strengthened following the Wanacry cyber-attack on the NHS in 2017, however as the nature of attacks was constantly evolving a risk based approach had to be adopted and the risks were continually reviewed.

6. Integrated Performance Report (IPR) – NHST(18)20

The key performance indicators (KPIs) were reported to the board, following in-depth scrutiny of the whole IPR at the Quality and Finance and Performance Committees.

6.1. Quality Indicators

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

6.1.2. It was confirmed that the CQC planned to undertake Well Led Inspections on all Trusts by April 2019.

6.1.3. There were no never events in February, with 2-year to date. The investigations into both events had now been completed and a number of actions put in place to prevent a recurrence.

6.1.4. There were no MRSA bacteraemia cases in February, with 2 cases year to date. Of the 2 cases, 1 is awaiting the outcome of the appeals process and the Trust believes was not caused by our care, the other case was a contaminated specimen.

6.1.5. There were 2 C.Diff positive cases in February, with 21 cases year to date, against the NHSI threshold of 41, with 3 of the cases still subject to appeal.

6.1.6. In response to a query from SR, SRe confirmed the Trust had been notified the 2018/19 threshold would decrease by 1 from 41 to 40.

6.1.7. There were no grade 3 or 4 avoidable pressure ulcers in the year to date.

6.1.8. The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for February was 93.9%, year to date performance 93.9%.

6.1.9. During the month of January there was 1 inpatient fall resulting in severe harm. Year to date total for all falls resulting in harm is 16.

6.1.10. Venous thromboembolism (VTE) performance for January was 95.03%. Year to date performance is 93.52% against a target of 95%.

6.1.11. Latest reported annual Hospital Standardised Mortality Ratio (HSMR) for 2016/17 is 102.4.

6.2. Operational Indicators

6.2.1. RC presented the update on the operational performance.

6.2.2. Performance against the 62-day cancer standard was 85.1% in month.

6.2.3. A small number of patients did not meet the 31-day standard resulting in failure against the 96.0% target at 94.6% in month, but the standard was still being achieved year to date. Actions were in place at speciality

level to address this, including ongoing improvements in booking all patient appointments by day 7 to allow for patient-related delays.

6.2.4. A&E performance in month was 73.6% (type 1) and 87.2% (mapped STHK footprint – all types) against a target of 95%, attributable to continued high volumes of non-elective activity and the acuity of patients presenting, alongside Trust bed occupancy levels of over 98%. The A&E performance and the improvement plans had been examined in detail at the Finance and Performance Committee.

6.2.5. SR asked for an update on the A&E extension scheme. PW confirmed the additional funding for the A&E extension had been received and the scheme would be completed in the next financial year.

6.2.6. AM confirmed that the new extension would provide a logical flow of patients through A&E and more effective triage at the front door, which would support performance improvements, by directing patients in to the right pathways and reducing admissions.

6.2.7. DM commented that attendances seemed to have increased this month but admissions had remained relatively stable. The reasons for this were discussed and SRe noted that the Trust was still experiencing a high level of flu (10 -12 patients a day).

6.2.8. JK had participated in a quality walk round in A&E earlier in the week and noted the positivity of the staff and their engagement with the improvement plans.

6.2.9. Despite a continued reduction in the elective programme in month to support accommodation of non-elective activity RTT incomplete performance was maintained at 93.5% in month against a target of 92.0%.

6.3. **Financial Indicators**

6.3.1. NK presented the update on the financial performance.

6.3.2. The Trust had reported an overall income and expenditure surplus of £3.5m, inclusive of all allowable Sustainability and Transformation Fund (STF) worth £5.1m.

6.3.3. The planned surplus was £7.5m, giving an adverse variance of £4m year to date. This adverse variance of £4m recognised £3m of STF that would no longer be allocated (for not achieving A&E and financial performance) and exceptional net operational cost pressures as a result of the winter escalation of an additional £1m.

6.3.4. The Trust had delivered £11.4m of the Cost Improvement Programme (CIP) and was £(2.4)m behind the year to date plan which was reflected in the Trust's current financial performance. It was expected that the CIP plan would be in the region of £12.5m by year end, short of the target by £3m.

6.3.5. Based on these operational pressures, NK reported that the Trust had now formally reduced its forecast outturn to c£2.4m from the control total of £8.5m, £4m of which was the assumed non-allocation of STF and the remaining £2m related to the unprecedented net impact of winter, mainly through high pay costs for the rest of the year. This meant, excluding STF, the Trust was now forecasting an adverse variance of £2m from its original control total of £0.6m. The year to date and forecast financial position had been supported by the full utilisation of relevant reserves and balance sheet provisions. The revised forecast outturn had been notified to NHS Improvement, with the monthly finance report; however the formal procedure required Board approval of this change. NK proposed to discuss the specific declarations as an item of any other business. This was agreed.

6.3.6. RF stated the deterioration in the financial position was disappointing, but felt the whole board was fully aware of the pressures that the Trust had been facing and supported the decisions to protect the experience and safety of patients.

6.3.7. The Trust's cash balance at the end of February was £12.531m, representing 13 days of operating expenses. The Trust has incurred £7.8m of capital expenditure in the 11 months to February.

In response to a query from DM, NK confirmed the cash position was secure at £2m, which was in line with expectations and would be discussed further at Audit and Finance & Performance Committees.

6.4. **Workforce Indicators**

6.4.1. AMS presented the update on the workforce indicators.

6.4.2. Sickness absence in February was 5.3% against the Q4 target of 4.68%. Year to date sickness absence was 4.7% compared to 4.8% in 2016/17.

6.4.3. Mandatory training compliance was 86% against the target of 85%. Appraisal compliance was 85% which was on target. AMS thanked all the Directors and staff for their support in achieving these improvements.

7. Committee Report – Executive – NHST(18)21

7.1. AM presented the report to the Board, which summarised Executive Committee meetings held during February 2018.

7.2. The Executive Committee had agreed the final St Helens Shared Care Record Business Case to present to Board for approval.

7.3. The Committee had agreed the actions to be taken in response to the initial never event investigation report regarding nasogastric tubing.

7.4. In relation to the Maternity Patient Survey results, some of the improvements that had been introduced were disappointingly not reflected in the survey's

results therefore it had been agreed to repeat the survey locally, for mothers experiencing the service now, to assess if the recent developments had addressed some of the poor scores.

7.5. The Executive Committee received assurance reports covering Marshalls Cross Medical Centre, safer staffing, agency and locum usage, appraisal and mandatory training compliance, the Integrated Performance Report (IPR), from the Risk Management Council, the Corporate Risk Register and the Medway Implementation Programme.

7.6. RF sought assurance that Medway was on track to 'Go Live' as planned. CW confirmed that the Medway Programme Board provided regular status reports to the Executive Committee and that the project remained on target, although there was still a lot of work to be done. A quality assurance framework will be in place to ensure effective reporting and all identified risks had comprehensive mitigation plans. AMS reported that there was a great sense of anticipation about the new system due to its comprehensive functionality. There were targets for the staff that needed to have completed training before the system could go live and a number of ways that this could be completed. The training rates were now being monitored on a weekly basis by the Executive Committee.

7.7. In response to a query from SR regarding safer staffing, AM confirmed the escalation processes in place to monitor and review staffing levels every day and ensure that every ward had sufficient staff, including the use of overtime, the staff bank and agency staff if necessary. There were also plans in place via the recruitment and retention strategy to recruit more qualified nursing staff, including overseas recruitment. The challenges of oversees recruitment including the long lead in time and visa application restrictions were discussed. AMS confirmed that NHS Employers were in the process of lobbying Government about the difficulties being experienced by Trusts nationally and the urgent need to support the NHS to secure more staff.

8. Committee Report – Quality – NHST(18)22

8.1. DG presented the Chair's report to the Board, which summarised the issues discussed at the Quality Committee meeting held on 20th March 2018.

8.2. Issues that the Quality Committee wished to escalate to the Board were:

8.3. Further action was needed to ensure all patients were assessed for delirium, standing and lying blood pressure and vision as part of the falls risk assessment, as audit had shown these tests were not always recorded in the patient notes. An action plan had been developed and progress would be monitored to ensure that performance approved as this was a key strand of the falls prevention strategy.

8.4. Further work had been requested, for the May meeting, to ensure that the CIP Quality Impact Assessment reviews were sufficiently robust to provide ongoing assurance that there had been no negative quality impacts, once schemes had been embedded.

8.5. In future national patient surveys results would be reported directly to the Quality Committee and the action plans agreed by the Executive, before delegation to the Patient Experience Council to provide assurance of delivery.

9. Committee Report – Finance and Performance – NHST(18)23

9.1. JK presented the Chair's report to the Board, which summarised key issues discussed at the Finance and Performance Committee meeting held on 22nd March 2018.

9.2. Matters escalated to the Board were:

9.3. The committee had reviewed the financial positon and noted the adverse variance to plan year to date and outturn forecast.

9.4. The committee had reviewed the NHSI offer and were recommending that the Trust accept the proposed control total for 2018/19 with the understanding this would require a CIP in the region of £19m (5.2% of operating expenditure) and would be extremely challenging to deliver, without more transformation schemes across the health system to make a contribution. The assumptions made in developing the financial plan had also been noted.

9.5. RF was encouraged by the current CIP performance but agreed that CIP 5.2% would prove to be challenging, when reliance on partners to deliver a material contribution was taken into consideration. Further work on the detail of the CIP schemes had been requested by the Committee.

9.6. The proposed financial plan for 2018/19 had been reviewed by the Committee, and was being recommended to the Board, with the risks acknowledged.

9.7. NK provided an update on the 2018/19 contract negotiations. Reporting that contracts had been agreed with all commissioners by the planning deadline of 23rd March. The negotiations had been challenging but constructive and a number of joint CIP opportunities had been identified that would be progressed.

10. Statutory and Regulatory Report – NHST(18)24

10.1. NB presented the report which provided an update on key regulatory and strategic developments since the last Trust Board meeting.

10.2. The draft Operational Plan for 2018/19 had been submitted in line with the timetable. The final plan would be presented to Board members in April for approval, before submission to NHSI.

10.3. NB had recently attended an event to discuss the Use of Resources (UoR) inspection process, initially being rolled out for non-specialist acute Trusts. The paper detailed how the UoR rating would impact on the overall CQC rating of Trusts. It is anticipated that NHSI would carry out the UoR reviews prior to a Trust having its Well Led CQC inspection.

10.4. Board members noted NHSI's new guidance detailing the process for Trusts being put into special measures for reasons of quality and finance, and how it would work with the CQC.

10.5. Board members noted that NHS Providers had recently published a briefing note setting out the reasons why Wholly Owned Subsidiaries were used by

some NHS organisations.

11. Infection Control Report – NHST(18)25

11.1. SRe presented the annual infection control report (IPC) for financial year 2016/17, which outlined activity in accordance with the Health & Safety at Works Act 2008.

11.2. During 2016/17, the IPC performance improved in comparison to the previous year and the report acknowledged the hard work of both clinical and non-clinical staff who all contributed to safe care within the Trust.

11.3. Further improvement in performance had been achieved in 2017/18 which would be reported in the Quality Account and the next IPC annual report.

11.4. Responding to a query from AM, SRe confirmed future IPC reports would be presented to Board members in June each year, to bring it in line with financial rather than calendar year reporting.

11.5. Board members approved the report.

12. Approval of Budget Plans – NHST(18)26

12.1. NK presented the report and asked Board members to approve the opening budget for 2018/19:

- Income and expenditure plans, noting the CIP required to achieve the control total deficit of £1.8m;
- Recurrent CIP plans of £19m including significant contribution from system transformation opportunities;
- A capital programme that is achievable within resource limits;
- Risks and assumptions to achievement of the plan included:
    - Full achievement of CQUINS;
    - Full achievement of CIPS;
    - Achievement of access target trajectories;
    - No material contract fines or penalties;
    - Cash payments are prompt and full;
    - The Trust manages within its capital resources;
    - No winter funding formally given;
    - Impact of CCG QIPS which have not been provided and detailed to date.

12.2. The paper also summarised key financial risks.

12.3. The plan had been reviewed by the Finance and Performance committee who had recommended approval. The Board discussed the risks in depth and also the ramifications for the Trust of not setting a budget to achieve the control total.

12.4. The Board approved the 2018/19 budget. It was noted NK would write to NHSI around the risk of PFI indexation. This was a local issue and growing adverse impact to the Trust.

13. Annual Board Effectiveness Review – NHST(18)27

13.1. NB presented the paper.

13.2. The paper set out the process and timescales for the 2017/18 annual effectiveness review of the Board and its Committees.

13.3. NB requested all members returned the questionnaires that had recently been circulated.

13.4. RF welcomed any comments or suggestions on how the Board and Committee structure could be improved.

13.5. The review report will inform the Board development programme for 2018/19, identify any skills gaps and make recommendations to strengthen the governance structure of the Trust.

13.6. Reports will be presented at Committee meetings in April and the overarching findings to the Audit Committee and Trust Board in May.

14. Annual CQC Registration – NHST(18)28

14.1. SRe presented the report to the Board.

14.2. The Trust is required to register with the CQC and has a legal duty to be compliant with the fundamental standards set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

14.3. The report provided assurance of how the Trust complied with each of the requirements. SRe noted that the Trust continued to comply with all the regulations.

14.4. On the basis of the evidence presented, the Board confirmed that it continued to be compliant with all the CQC regulations.

15. Annual Mixed Sex Declaration – NHST(18)29

15.1. SRe reported that the Trust was compliant with the standard and there had been no mixed sex breaches during the year. This was a significant achievement considering the Trust had been operating at maximum capacity and the Board thanked staff for their support.

15.2. In response to a query from DM, SRe confirmed there was a policy in place and transgender patients were accommodated in single rooms.

The Board approved the annual declaration.

16. Review of Staff Survey – NHST(18)30

16.1. AMS presented the paper, which highlighted the outcome from the 2017 staff survey, which was overwhelmingly positive.

16.2. The Trust scored above average in 27 of the 32 national indicators, which was significantly better than other acute trusts.

16.3. 22 key finding scores are in the best 20% of Acute Trusts.

16.4. Action plans for 2018-19 are being produced, bespoke to different Care Groups/departments where the results can be analysed to show the differences at this level.

16.5. There are some areas where further improvement is still needed most notably the level of violence and aggression to staff from patients, staff understanding how their role makes a difference to patients, the quantity of appraisals and communication from senior managers.

16.6. DM noted the 5% reduction in staff agreeing that their role makes a difference to patients/service users. AMS confirmed this related mainly to admin and clerical staff based off site that sometimes served many organisations as part of the shared service arrangements and possibly felt disconnected from front line services. Further communications were being planned to stress the critical importance of their contribution.

16.7. RF agreed it was incredibly important to stress how important that first point of contact was. He believed the Trust's success could be attributed to its willingness to listen to every voice no matter what job it was.

16.8. The Board noted the report.

17. Trust Objectives 2018/19 for approval – NHST(18)31

17.1. The Chief Executive presented the proposed objectives for 2018/19.

17.2. The objectives were aligned to support the achievement of the Trust's operational plan and the furtherance of its strategic direction and vision to deliver Five Star Patient Care.

17.3. A member of the Executive Team would take lead responsibility for each of the objectives which would be built into the individual's personal objectives for the year.

17.4. As far as possible progress against each of the objectives would be translated into key performance indicators or measurable targets that would be reported via the Integrated Performance Report (IPR) or through the governance structure, to provide regular assurance of delivery to the Board.

17.5. With reference to objective '*8.1 we will use benchmarking and reference costs to achieve best practice*', JK suggested a line should be included to make CIP more explicit.

17.6. RF agreed with JK's suggestion as he believed it was important the objectives were relevant.

17.7. SR queried whether there was enough balance between internal and collaborative objectives with the move towards more collaborative working and

whether the objectives would be perceived as 'too internal' by the Trust's partners.

17.8. AM stressed the importance of collaborative working whilst also not losing sight of the 'day job'. Although the document was a public document it was not sent to partners.

17.9. The Board approved the objectives with the CIP addition.

18. Any Other Business

18.1. As agreed, NK presented the Forecast Outturn Change Assurance Statement required by NHS Improvement.

18.2. The Board reviewed and confirmed each statement. The statements were therefore agreed and the submission was signed on behalf of the Board.

19. Effectiveness of Meeting

19.1. SP was a member of both the Quality Committee and Clinical Effectiveness Committee and said it was good to see how the discussions fed into the Board.

19.2. SP commented on the patient story and asked if it was a regular item. RF confirmed both positive and negative stories came to Board meetings.

19.3. SP was disappointed there was no representation from St Helens CCG, however RF assured SP it was unusual that no-one was in attendance.

19.4. WL congratulated the Chair on his excellent timing and believed there had been good challenge from the non-executive directors. He added that as part of his Nye Bevan Programme he needed to understand what made an effective Board. He believed there was a positive culture in the Trust and Board was instrumental in creating this.

19.5. KL added the meeting was well structured with a wide range of items discussed and good comments from Board members.

19.6. RF thanked everyone for their feedback.

20. Date of Next Meeting

20.1. The next meeting is scheduled for Wednesday 25th April 2018 in the Boardroom, Level 5, Whiston Hospital, commencing at 09:00 hrs.

Chairman: .....

Date: 25.04.18 .....

NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 25TH APRIL 2018

No	Minute	Action	Lead	Date Due
~~1.~~	~~31.01.18 (13.3)~~ 28.02.18 (4.3)	~~AMS to contact the local Trusts with lower staff turnover to ensure all good practice is being following in relation to retention of staff.~~ Action closed. Follow up action: AMS to undertake further analysis of leavers and pipeline for recruitment initiatives, for review by the Executive Committee and to include a waterfall analysis in the next HR Indicators Board report.	~~AMS~~ AMS	~~28.02.18~~ 30.05.18
2.	28.02.18 (5.1.2)	Nasogastric Tubing Never Events – ~~SRe to provide feedback on results of RCAs at next Quality Committee~~. Action Closed. Update: 28.03.18: recommendations and action plan to be taken to Quality Committee in May.	SRe	30.05.18
3.	28.02.18 (5.3.6)	SRe to present paper regarding the Maternity Reduction for Clinical Negligence Scheme for Trusts (CNST)	SRe	30.05.18
4.	28.02.18 (8.3)	Quality Committee to develop proposals for a severity rating of complaints and bring recommendations to the Board.	DG	30.05.18
5.	28.02.18 (13.2)	AMS to undertake further investigation of the issues raised by the WRES survey action plan in relation to disciplinary action.	AMS	30.05.18

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: NHST(18)32
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

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

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

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

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.

There were no never events in March 2018 but 2 reported year to date (target = 0).

There were no MRSA bacteraemia cases in March 2018 but 2 cases year to date (target = 0). Of the 2 cases, 1 case is under appeal and 1 was a contaminated specimen.

There were 2 C.Difficile (CDI) positive cases in March 2018. The total number of confirmed CDI positive cases year to date is 23 (threshold = 41).

There have been no grade 3 or 4 avoidable pressure ulcers year to date.

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for February 2018 was 93.9%. YTD performance is 93.9%.

During the month of February 2018 there was 3 inpatient fall resulting in severe harm . YTD total is 20.

Performance for VTE assessment for February 2018 was 95.24%. YTD performance is 93.67% against a target of 95%.

Final HSMR for 2016-17 is 102.4

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: 25th April 2018

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (February 2018) at 88.3%. The 31 day target was also achieved with 96.6% performance against a target of 96%. 2 week rule compliance was also achieved with 94.9% performance. One of the cancer 62 day indicators (62 day wait for first treatment from urgent screening referral) failed to achieve in February 2018 (88.9% v target of 90.0%). This was due to 2 late referrals from another Trust which are counted as a 0.5 breach each. Actions are underway at specialty level to address this.

Type 1 A&E performance for March was 67.7% and Mapped STHK Footprint - All Types was 84.0%. March 2018 activity was 12% higher than March 2017 (1056 more patients). This coupled with medical staffing shortages and continued bed pressures has led to a deterioration in performance.
All efforts are continuing to be made to bridge the current rotational gaps in medical staffing. In addition plans are being worked up to recurrently address the medical staffing shortfalls to have less dependency on the rotation, plus increase physical ED space and bed capacity to keep pace with demand ahead of next winter. The Emergency Care Improvement Programme team continues to support the trust, with further improvement work related to key actions focusing on both the Emergency Department and the Inpatient wards.

RTT incomplete performance was delivered at 94% v target of 92.0%. Specialty level actions to maintain this achievement continue.

Financial Performance

As advised at month 11 the reportable surplus for 2017/18 will be behind plan by c.£6.3m. The provisional surplus is £2.2m including the achieved STF allocation of £5.1m and the utilisation of reserves.
The Trust finished the year with a closing cash balance of £11.7m and Capital expenditure of £9.18m both of which were in line with the plans for the year.

Finance indicators within the IPR are greyed out subject to final accounts being submitted.

Human Resources

Absence in March reduced from February by 0.56% but is above the Q4 target of 4.68% by 0.02%. YTD absence is 4.7% against last year outturn of 4.8%.

Mandatory training compliance is 92.5% and exceeds the target by 7.5%. Appraisal compliance is 88.4% which exceeds the target by 3.4%.

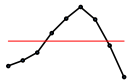
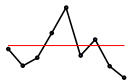
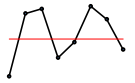
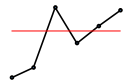
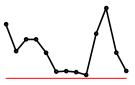
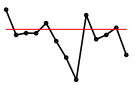
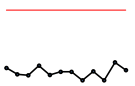
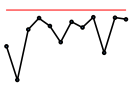
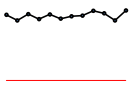
The following key applies to the Integrated Performance Report:

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

Mar-18

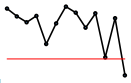
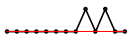
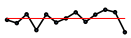
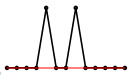
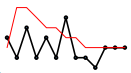
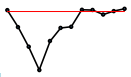
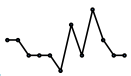
St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

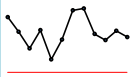
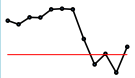
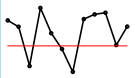
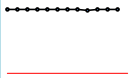
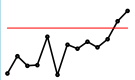
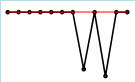
	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 31-37)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Mar-18	2.4%	2.4%	No Target	2.5%		Overall SHMI and HSMR within control limits. Mortality fluctuates month-to-month, but is stable medium-term. Crude mortality typically increases (nationally) in Winter. Latest NHS evidence supports previous work that patients admitted at weekends and out of hours are sicker. Specific diagnostic groups with raised mortality (e.g. COPD and stroke) are subject to intensive investigation.	Patient Safety and Clinical Effectiveness	Trust is implementing an electronic solution to improve capture of comorbidities and to prompt palliative care review in those known to that service. 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-17	1.03		1.00						
Mortality: HSMR (HED)	Q	▲	Nov-17	89.1	100.4	100.0	102.4					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Nov-17	80.5	96.7	100.0	115.0					
Readmissions: 30 day Relative Risk Score (HED)	Q	T	Oct-17	98.4	101.6	100.0	97.8		The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms. Readmissions have risen in recent months which is being dominated by ambulatory care. It was suggested that ambulatory readmissions might have been a result of inappropriate coding of elective returns - audit has shown that this is not the case	Patient experience, operational effectiveness and financial penalty for deterioration in performance	There were a small number of misattributed elective returns and this process has been corrected.	KH
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Aug-17	97.9	91.7	100.0	93.8		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	Aug-17	109.7	99.6	100.0	92.1					
% Medical Outliers	F&P	T	Mar-18	1.4%	2.3%	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. Continued focused management of all patients requiring discharge support. A review of the Trust bed model has resulted in plans to reconfigure some surgical beds to medical thus reducing outliers.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Mar-18	41.2%	49.2%	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.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Feb-18	70.3%	69.5%	90.0%	75.7%		eDischarge performance poor - there is insufficient trainee doctor resource to hit this target with existing paper-based systems.		Pending ePR, we have devised an automated eDischarge notification which will be computer generated and send within 24 hours. Thereafter a full discharge summary will be sent within 14 days. We're seeking CCG approval at CQPG before implementation.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Feb-18	92.6%	89.6%	95.0%	90.0%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Feb-18	99.3%	99.0%	95.0%	99.0%					

Mar-18

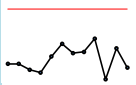
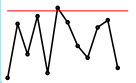
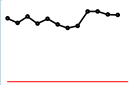
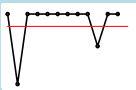
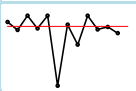
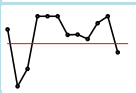
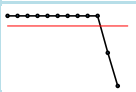
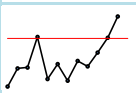
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	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	▲	Mar-18	79.4%	90.3%	83.0%	94.0%		Target is being achieved YTD. With effect from April 2017, STHK is also treating patients from the Warrington Area.	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Performance has deteriorated in month with plans in place to recover to previous high performance	RC
PATIENT SAFETY (appendices pages 39-42)												
Number of never events	Q	▲£	Mar-18	0	2	0	2		The National safety standards for invasive procedures will provide further mitigation against future never events.	Quality and patient safety	The RCA and action plans for never events reported has being developed. Immediate actions have already been implemented including communication to staff, development of training (medical and non-medical) and policy revision. Mitigations and Trust wide actions being undertaken.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Mar-18	98.0%	98.9%	98.9%	98.8%		Achieving standard YTD	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	Mar-18	0	0	0	0		The trust continues to have no inpatient prescribing errors which cause serious harm. Trust has moved from being a historic low reporter of prescribing errors to a higher reporter - which is good.	Quality and patient safety	Intensive work on-going to reduce medication errors and maintain no serious harm.	KH
Number of hospital acquired MRSA	Q F&P	▲£	Mar-18	0	2	0	4		Two MRSA cases YTD (1 case under appeal and 1 contaminated specimen). Internal RCAs on-going with more recent cases.	Quality and patient safety	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	▲£	Mar-18	2	23	41	21					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Mar-18	2	22	No Target	17					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Feb-18	0	0	No Contract target	1		No grade 3 or 4 avoidable pressure ulcers YTD	Quality and patient safety	The Trust provides ongoing tissue viability training for all nursing staff including bank staff . New pressure ulcer reduction actions being implemented.	SR
Number of falls resulting in severe harm or death	Q	▲	Feb-18	3	20	No Contract target	22		3 severe harm fall reported in February.	Quality and patient safety	Immediate review undertaken to implement immediate actions. Root cause Analysis being carried out. Strategic falls actions being implemented as plan .	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲£	Feb-18	95.24%	93.67%	95.0%	93.36%		VTE performance remains inconsistent. A recent survey of successful units showed that they all have electronic solutions. The ePrescribing solution implementation has been delayed because of problems with this version of the software.	Quality and patient safety	Every effort is being made to supplement routine reviews with additional activity to improve performance pending an electronic solution.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Mar-18	3	31	No Target	28					
To achieve and maintain CQC registration	Q		Mar-18	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	Feb-18	93.9%	93.9%	No Target	94.9%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	Two Shelford audits were reported together in January 2018.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Feb-18	0	1	No Target	2					

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 43-51)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Feb-18	94.9%	95.1%	93.0%	95.1%		Two week, 31 and 62 day targets achieved YTD.	Quality and patient experience	A Cheshire and Mersey Cancer Alliance PTL has been established as part of the wider strategy to support system wide issues across patient Cancer pathways. Locally the focus is on accelerating pathway redesign and reducing variation in pathway performance by improved clinical engagement . Tumour specific dashboards are being redesigned to assist with visibility of clinical pathway performance. Increased scrutiny at patient level of open pathways and action planning at the weekly Cancer PTL review meeting. Actions arising from the reviews include working to establish improvements in booking by day 7, inter service transfers ,review of complex pathways requiring multiple MDT access and improved clinical and managerial accountability.	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Feb-18	96.6%	97.6%	96.0%	97.9%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Feb-18	88.3%	87.1%	85.0%	88.4%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Mar-18	94.0%	94.0%	92.0%	93.5%		In March 3 specialties are failing the 92% incomplete target; ENT, Plastics and T&O. On going backlog clearance plans continue with good effect but similar issues regarding theatre and bed capacity remain. RMS and more recent MCAS primary care services also have compounded the position. However, RMS and MCAS remains unpredictable with short / no notice diverts back to secondary care	Surgical Beds are still planned to be handed to the Medical Care Group. Bed availability to manage the Surgical demand will potentially risk the backlog increasing, causing more incomplete performance failures. Additional risk also caused by impact of RMS and MCAS	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. A backlog management plan is in place and alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand. Actions to maintain and improve RTT performance reliant on theatre and bed capacity along with staff availability in collaboration with CCG's in ensuring RMS delivers in a sustainable and manageable way	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Feb-18	100.0%	100.0%	99.0%	100.00%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Mar-18	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Mar-18	1.0%	0.6%	0.8%	0.7%		The cancelled ops target continues to be achieved YTD. February and March underperformed due to NEL activity in both medicine and surgery. Underperformance against the 28 day metric relates to two patients, one in October and one patient in December. One patient required a bespoke ophthalmic lens and one patient was cancelled due to orthopaedic trauma and was unable to be accommodated in time.	Patient experience and operational effectiveness Poor patient experience	The planned increase in elective surgical activity in St Helens has commenced including increasing GA capacity on Saturdays. 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	▲ £	Feb-18	100.0%	99.3%	100.0%	100.0%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Mar-18	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Mar-18	67.7%	78.2%	95.0%	76.1%		March 2018 Type 1 performance was 67.7% which was a deterioration on February position. ED and GPAU activity in March was 12% higher than March 2017 (1056 additional patients) and 17% busier than February 2018 (1458 additional patients attended). It has been another challenging month due to continuation of flu, high volume of admissions and acuity and staffing shortages. Additional bed capacity has remained opened to support flow. Work has continued to maintain low numbers of 'good to go' patients.	Patient experience, quality and patient safety	The urgent and emergency care transformation plan has several interconnected work streams designed to improve overall 4 hour access performance. Emergency Department/Front Door processes in place including 'walk in' streaming, Stretcher Triage streaming and internal departmental efficiencies and exit from ED. GP streaming in place as per NHSE recommendations. Flow through the Hospital Continuation of use of the SAFER Care Bundle to increase hospital discharges before midday to 33% and standardisation of daily Red to Green board rounds and afternoon huddles. Twice weekly discharge tracking meetings to manage medically optimised and DTOC escalation. Monthly Executive Multi-Agency Discharge Events (MADE) continue across the whole system to remove barriers and blocks that prevent patients with complex needs being discharged safely from hospital. Following 6a ECIP event and system resilience planning, commenced daily AMU/ED huddles and Community Matron in reach which is proving beneficial. Frailty in-reach to ED commenced. 1pm Frailty/ED/SpR safety huddle in place.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Mar-18	84.0%		95.0%						
A&E: 12 hour trolley waits	F&P	▲	Mar-18	0	0	0	0					

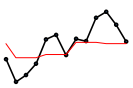
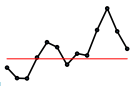
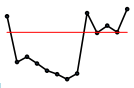
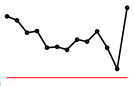
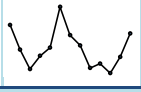
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	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	▲ £	Mar-18	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	Mar-18	18	224	No Target	338		% new (Stage 1) complaints resolved in month within agreed timescales continues to improve overall. The decrease in the number of new complaints received in the last few months has continued for March with 18 received.	Patient experience	The Complaints Team have cleared the small backlog of overdue complaints and continue to improve the timeliness of responses. There is now a stable central Complaints Team in place, with additional input from a senior clinician that is supporting this improvement.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Mar-18	19	270	No Target	293					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Mar-18	78.9%	67.0%	No Target	58.0%					
DTOC: Average number of DTOCs per day (acute and non-acute)			Feb-18	17	21	No Target	17		In February 2018 the average number of DTOCS (patients delayed over 72 hours) was 17. This is lower than the number in February 2017.		Tracking meetings happen with LA/CCG and wards twice weekly to ensure the numbers of DTOCs are maintained below 20.	RC
Friends and Family Test: % recommended - A&E	Q	▲	Feb-18	86.0%	88.1%	90.0%	86.6%		The YTD recommendation rates remain below target for A&E, maternity (birth, postnatal community) and outpatients, but are above target for in-patients, antenatal, and postnatal ward maternity services. Outpatients saw an increase in recommendation rates in February 2018.	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 to improve morale. The Patient Experience Manager continues to work with leads in each area where performance is below target, to identify specific themes for improvement, which are then displayed as 'you said, we did' posters.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Feb-18	96.2%	95.8%	90.0%	95.5%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Feb-18	100.0%	98.4%	98.1%	98.5%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Feb-18	96.9%	97.6%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Feb-18	93.5%	96.3%	95.1%	98.7%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Feb-18	90.0%	98.5%	98.6%	93.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Feb-18	95.5%	94.6%	95.0%	94.4%					

Mar-18

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 53-60)												
Sickness: All Staff Sickness Rate	Q F&P	▲	Mar-18	4.7%	4.7%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.8%		Overall absence in March reduced but is still slightly above the Q4 target of 4.68% by 0.02%. Qualified & HCA sickness also reduced in month to 5.8% against a target of 5.3%.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	During March, the Absence Support team have supported the HR Advisors with welfare visits and stages to ensure timely action is taken and staff and managers are supported during this very busy period. The Absence Support Team have also been undertaking spot checks of staff absences to ascertain whether triggers have been hit and action subsequently taken by managers in line with the policy.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P	T	Mar-18	5.8%	5.7%	5.3%	5.9%					
Staffing: % Staff received appraisals	Q F&P	T	Mar-18	88.4%	88.4%	85.0%	87.4%		Mandatory Training compliance exceeds the target by 7.5%. Appraisal compliance exceeds the target by 3.4%.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The Education, Training & Development and Workforce Planning teams continue to work with managers to ensure on-going maintenance of compliance for both Mandatory Training & Appraisals.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Mar-18	92.5%	92.5%	85.0%	91.6%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2	85.0%		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.	The Q4 survey has been completed in Clinical Support Services and Corporate areas and results are expected in late April.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2	76.1%		No Contract Target						
Staffing: Turnover rate	Q F&P	T	Mar-18	1.0%		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 61-66)												
UORR - Overall Rating	F&P	T							As advised at month 11 the reportable surplus for 2017/18 will be behind plan by c.£6.3m. The provisional surplus is £2.2m including the achieved STF allocation of £5.1m and the utilisation of reserves. The Trust finished the year with a closing cash balance of £11.7m and Capital expenditure of £9.18m both of which were in line with the plans for the year. Finance indicators within the IPR are greyed out subject to final accounts being submitted.	Financial		NK
Progress on delivery of CIP savings (000's)	F&P	T										
Reported surplus/(deficit) to plan (000's)	F&P	T										
Cash balances - Number of days to cover operating expenses	F&P	T										
Capital spend £ YTD (000's)	F&P	T										
Financial forecast outturn & performance against plan	F&P	T										
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T										

APPENDIX A

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

			Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	2017-18 YTD	2017-18 Target	FOT	2016-17	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	96.2%	94.4%	100.0%	84.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	96.7%	85.0%		95.2%		
	Total > 62 days		0.5	0.5	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.5	3.5			6.0		
Lower GI	% Within 62 days	▲ £	93.3%	100.0%	76.9%	100.0%	100.0%	92.3%	84.6%	69.2%	88.9%	82.4%	78.6%	80.0%	91.7%	84.7%	85.0%		89.3%		
	Total > 62 days		0.5	0.0	1.5	0.0	0.0	0.5	1.0	2.0	0.5	1.5	1.5	2.0	0.5	11.0			8.0		
Upper GI	% Within 62 days	▲ £	0.0%	87.5%	100.0%	100.0%	100.0%	33.3%	88.9%	80.0%	100.0%	86.7%	100.0%	100.0%	63.6%	85.9%	85.0%		78.7%		
	Total > 62 days		4.0	0.5	0.0	0.0	0.0	1.0	0.5	0.5	0.0	1.0	0.0	0.0	2.0	5.0			10.0		
Urological	% Within 62 days	▲ £	100.0%	67.6%	92.7%	59.3%	82.1%	83.3%	81.3%	87.5%	77.4%	90.2%	96.6%	60.9%	93.5%	81.9%	85.0%		81.4%		
	Total > 62 days		0.0	6.0	1.5	5.5	3.5	3.0	4.5	1.5	3.5	2.0	0.5	9.0	1.0	35.5			36.5		
Head & Neck	% Within 62 days	▲ £	80.0%	80.0%	66.7%	66.7%	75.0%	75.0%	42.9%	20.0%	100.0%	83.3%	80.0%	33.3%	66.7%	61.4%	85.0%		67.3%		
	Total > 62 days		0.5	0.5	0.5	0.5	0.5	0.5	2.0	2.0	0.0	0.5	0.5	1.0	0.5	8.5			8.0		
Sarcoma	% Within 62 days	▲ £		100.0%	66.7%		100.0%		0.0%	100.0%			50.0%	33.3%	100.0%	58.3%	85.0%		93.3%		
	Total > 62 days			0.0	0.5		0.0		0.5	0.0			0.5	1.0	0.0	2.5			0.5		
Gynaecological	% Within 62 days	▲ £	85.7%	100.0%	70.0%	83.3%	100.0%	68.8%	55.6%	83.3%	100.0%	94.1%	55.6%	100.0%	66.7%	79.0%	85.0%		90.1%		
	Total > 62 days		0.5	0.0	1.5	1.0	0.0	2.5	2.0	0.5	0.0	0.5	2.0	0.0	0.5	10.5			5.0		
Lung	% Within 62 days	▲ £	77.8%	100.0%	100.0%	73.7%	85.0%	100.0%	72.7%	71.4%	87.5%	66.7%	100.0%	80.0%	100.0%	83.7%	85.0%		82.7%		
	Total > 62 days		1.0	0.0	0.0	2.5	1.5	0.0	1.5	1.0	0.5	3.0	0.0	1.5	0.0	11.5			13.0		RC
Haematological	% Within 62 days	▲ £	100.0%	100.0%	100.0%	66.7%	50.0%	71.4%	100.0%	50.0%	100.0%	85.7%	76.9%	100.0%	88.9%	80.2%	85.0%		77.6%		
	Total > 62 days		0.0	0.0	0.0	1.0	1.0	1.0	0.0	3.0	0.0	0.5	1.5	0.0	0.5	8.5			8.5		
Skin	% Within 62 days	▲ £	100.0%	100.0%	92.5%	93.9%	98.1%	93.9%	93.0%	88.9%	95.2%	98.2%	97.7%	98.2%	95.2%	95.3%	85.0%		96.5%		
	Total > 62 days		0.0	0.0	1.5	1.0	0.5	1.5	1.5	2.0	1.0	0.5	0.5	0.5	1.0	11.5			9.5		
Unknown	% Within 62 days	▲ £	0.0%	50.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%		79.3%	85.0%		82.6%		
	Total > 62 days		0.5	1.0	1.0	0.0	0.0	1.0	0.0	0.0	1.0	0.0	0.0	0.0		3.0			2.0		
All Tumour Sites	% Within 62 days	▲ £	87.6%	89.3%	88.2%	81.6%	91.4%	87.1%	84.5%	80.6%	89.5%	90.3%	90.6%	85.1%	88.3%	87.1%	85.0%		88.4%		
	Total > 62 days		7.5	8.5	8.0	12.5	7.0	11.0	13.5	12.5	6.5	9.5	7.0	15.0	8.5	111.0			107.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £		100.0%					100.0%		100.0%		100.0%	100.0%		100.0%	85.0%		83.3%		
	Total > 31 days			0.0					0.0		0.0		0.0	0.0		0.0			1.0		
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(18)33

Title of paper: Committee Report - Executive

Purpose: To provide assurance to the Trust Board on those matters delegated to the Executive Committee.

Summary:

The paper provides a summary of the issues considered by the Executive Committee at the meetings held during March 2018.

There were a total 5 Executive Committee meetings held during March.

The Executive Committee agreed:

- The ward swap of 3C to become a medical ward, following the Easter bank holiday weekend.
- To progress plans to create Nurse Associate roles in the Trust, and support other staff to train as registered nurses.
- The expansion of e-payslips to retention of employment (ROE) staff, with appropriate access to PCs.
- The recommendations from the never event investigation report.

The Executive Committee received the regular assurance reports covering Marshalls Cross Medical Centre, safer staffing, agency and locum usage, appraisal and mandatory training compliance, the Integrated Performance Report (IPR), and from the Risk Management Council, the Corporate Risk Register and the Medway Implementation Programme.

Corporate objectives met or risks addressed: All 2018/19 Trust objectives.

Financial implications:

None arising directly from this report, requiring Trust Board approval.

Stakeholders:

Patients, Patients Representatives, Staff, Non-Executive Directors, Commissioners, Regulators.

Recommendation(s): That the report be noted.

Presenting officer: Ann Marr, Chief Executive.

Date of meeting: 25th April 2018.

FEEDBACK FROM THE EXECUTIVE COMMITTEE
March 2018

1. Introduction

There were 5 Executive Committee meetings in March 2018.

Many of the items from the meetings early in the month have already been formally reported at the Quality Committee, Finance and Performance Committee or Trust Board meetings in March as part of the normal reporting cycle.

2. 1st March 2018

2.1 Shift Shortfall report for January

The Director of Nursing, Midwifery and Governance presented the report which showed that during January 92.34% of shifts were staffed as planned number of registered nursing staff. The shortfall position of shifts on the Medical Wards was more challenging, although it was noted that the Trust had a number of escalation beds open in January reflecting the operational challenges. There was assurance that the Trust escalation process had been followed in all instances and all attempts had been made to cover the shifts, using bank staff, overtime or agency staff. There was no correlation between staffing levels and patient harms, but this was constantly monitored. The Executive Committee agreed that further benchmarking information should be sought to compare StHK with other local Trusts.

2.2 Bed Configuration

The Director of Operations and Performance presented the assurance report on the planned ward swap between surgery and medicine on ward 3C. The Medical Director and Director of Nursing, Midwifery and Governance had reviewed and approved the plans.

This move was to reflect the increased demand for medical beds.

The move took place on 19th April and went well.

2.3 Pre-registration Nursing Workforce Plans

The Director of HR/Deputy CEO and Director of Nursing, Midwifery and Governance presented a report outlining proposals to support more staff to train to become qualified nurses, via the emerging alternative training routes and to introduce a new role of Nurse Associate, which is being piloted in a number of Trusts nationally. The Committee agreed the proposals in principle with further work being required to understand fully the financial implications and how the Nurse Associates would be supported in these new roles.

2.4 Capital Programme

The Director of Estates and Facilities presented a report detailing the planned capital schemes and variation requests submitted to New Hospitals to make changes to the hospital estate. It was agreed that due to the very limited capital resources available to the Trust, all proposed developments falling outside the PFI footprint of lifecycle replacement programmes needed to be prioritised to avoid aborted design and management fees, and to ensure maximum return on investment. In future regular reports will be made to the Executive Committee to provide assurance and strategic oversight of the proposed schemes.

2.5 Marshalls Cross Medical Centre

The Director of Transformation presented the monthly activity and assurance report in relation to the primary care practice. Actions were agreed to promote the practice to staff working for the Trust. Recruitment to the permanent GP and Advanced Nurse Practitioner (ANP) posts remained a challenge.

3. 8th March 2018

3.1. Emergency Planning – Lock Down Exercise

The Director of Estates and Facilities reported on the exercise to test the ability to "lock down" the Whiston site. A formal report with recommendations to improve the procedures will be prepared.

3.2 Staff Friends and Family Test (FFT) Reporting

The Director of HR/Deputy CEO provided an update on the new arrangements to report on the results on the staff FFT results, and the impact of actions taken for specific groups of staff/services.

3.3 Agency Usage

The Director of HR/Deputy CEO presented the monthly report on the use of agency and locum staff in January. There was a significant increase in expenditure since month 9, reflecting the operational pressures in Medical Care and increased staff sickness. There had been an increase in off framework and above agency cap spend on mainly nursing and medical staff. The positive impact of the Staff Bank recruitment campaign was acknowledged.

There was assurance that the Premium Payments Scrutiny Council was providing the required scrutiny and challenge, and that the agreed escalation and approvals processes were being adhered to.

3.4 International Recruitment

The Director of HR/Deputy CEO presented an update on international recruitment for registered nurses. The combined impact of the different

international schemes was planned to be in the region of 5 new nurses per month. However, the lead in time was still very long, complex and costly for the individuals. The difficulty in obtaining visas was also a limiting factor.

3.5 PCs to Access Electronic Payslips

The Director of HR/Deputy CEO presented a business case to install a number of PCs to ensure ancillary and domestic staff could access electronic payslips, to bring these staff in line with the rest of the Trust. This was to ensure that staff who did not otherwise have access to a computer or other electronic devices could obtain this information before the switch from paper payslips was made. The proposals to install a number of dedicated PCs at secure locations at both hospitals were agreed to enable the staff to move to electronic payslips. Training would also be put in place to ensure that all staff could access the information.

4. 15th March 2018

4.1 Risk Management Council and Corporate Risk Register (CRR) Report

The Director of Estates and Facilities presented the Chair's report from the Risk Management Council and the 13 risks that had been escalated to the CRR during February for further scrutiny were issues associated with transfusion competency training and ICU staffing.

4.2 Appraisal and Mandatory Training Report

The Director of HR/Deputy CEO presented the monthly report for February split by reporting Director. Actions were agreed for those Directors who were not currently meeting the targets, for all their staff.

4.3 Marshalls Cross – Staffing

The Director of Transformation presented an update on the action plan to recruit to the practice and offer sufficient appointments for patients. GP interviews had now taken place and offers had been made. The Director of Transformation was also exploring best practice service models from across the country.

4.4 Integrated Performance Report (IPR)

The committee reviewed the IPR report for February and agreed changes to the commentary.

4.5 Place based Care

The Director of HR/Deputy CEO provided feedback on the recent St Helens Cares People's Board.

5. 22nd March 2018

5.1 Stroke Service Update

Members of the Stroke team attended the Executive Committee to present an update on the hyper acute stroke service that had been in operation for

12 months. The service had performed very well in the recent Sentinel Stroke National Audit Programme (SNNAP), which provided assurance that the service model was delivering improvements across a number of the domains. There was discussion on the next planned phase to create a single stroke unit for mid-Mersey at the Trust, and the bed/staffing capacity that would be required. The team were thanked for their significant achievements over the last 12 months.

5.2 St Helens Community Nursing Contract

The St Helens Locality Operations Director from North West Boroughs Healthcare NHSFT had been invited to the Executive Committee to give an update on the work that had been undertaken with the District and Community Nursing Teams, since April 2017. The progress made to date in implementing the service specification was noted and the next steps outlined. There was also discussion of how different parts of the system, community and mental health teams, could work more closely together, as well as with the acute sector. The need for further transformation and the opportunities of delivering these services in partnership was recognised.

5.3 Never Event – Lessons Learned

The Director of Nursing, Midwifery and Governance and the Assistant Medical Director for Unscheduled Care presented the root cause analysis investigation report of the recent never event that had occurred in January relating to the misplacement of a nasogastric tube. A number of immediate actions had been put in place, including additional training and changes to Trust policies. The recommendations of the investigation report were accepted and will be actioned. Further assurance that the Trust's processes for reporting and responding to never events were sufficiently timely was requested. The report and lessons learned would be reported to the Quality Committee.

5.4 Medway Implementation Programme Report

The Director of Informatics presented the assurance report from the Medway Programme Board. Staff training had now commenced and the critical importance of ensuring sufficient staff were trained on the new system was stressed. The programme remained rated as amber, with risks being managed and continued confidence that the implementation date of 30th April remained achievable**.**

5.5 Safer Staffing/Vacancy Dashboard

The Director of Nursing, Midwifery and Governance presented the February safer staffing report and vacancy dashboard. It was noted that the medical wards remain a recruitment challenge.

5.6 Lead Employer Tender Options Appraisal

The Director of HR/Deputy CEO presented a paper detailing the potential options in relation to the tender opportunity for the Lead Employer contract, for Doctors in Speciality Training on behalf of Health Education England North West (HEENW).

The Trust currently holds the contract to provide this service for Cheshire and Merseyside.

6. 29th March 2018

6.1 Easter Weekend Staffing Plans

The Director of Nursing, Midwifery and Governance and Director of Operations and Performance reported on the staffing plans for the Easter bank holiday weekend, and the approvals needed for off framework shifts that may be required in some areas. The plans to maintain patient safety were reviewed and agreed.

6.2 Consultant Staff – Local Clinical Excellence Awards

The Director of HR/Deputy CEO gave an update on the national consultant contract negotiations and the implications for local clinical excellence awards. Specific guidance is awaited and there will then be discussions with the Local Negotiating Committee.

6.3 Shift Shortfall Report

The Director of Nursing, Midwifery and Governance presented the report on nurse shift shortfalls during February. 92.72% of shifts were staffed as planned which was a slight improvement on January. It was reported that there were 15 new registered nurse starters in March which would help improve the situation.

6.4 Weekly Medway Programme Update

The Director of Informatics presented the Medway programme report. In this last phase of preparation for go live there would be weekly reports. The key priority was staff training and Directors were asked to ensure that their staff booked and attended training.

6.5 CQC Routine Provider Information Request

The Director of Corporate Services reported that the Trust had received a request from the CQC to provide its annual Provider Information Request (PIR) return. The annual PIR submission is part of the new CQC inspection regime and is not necessarily an indication of an imminent Well Led Inspection. The PIR timescale of 17th April was extremely short, especially with the Easter bank holiday.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)34

Title of paper: Committee Report – Audit

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

Summary: The Audit Committee met on 18th April 2018.

The following matters were discussed and reviewed:

External Audit :

- External audit progress report (GT)

Internal Audit:

- Progress/update report on Internal Audit (MIAA)
- Director of Internal Audit Report 2017/18 (MIAA)
- Internal Audit Draft Plan 2018/19 (MIAA)
- Internal Audit Charter (MIAA)

Anti-Fraud Services:

- Anti-Fraud Work Plan 2018/19 (MIAA)
- Annual Report 2017/18 (MIAA)

Trust Governance and Assurance:

- The Director of Nursing update (DoN representative).

Standing Items:

- The audit log (report on current status of audit recommendations) (ADoF)
- The losses, compensation and write-offs report for the period 1st April 2017 to 31st March 2018 (ADoF).
- Aged debt analysis as at end of March 2018 (ADoF).
- Tender and quotation waivers report (ADoF).

Any Other Business:

- Trust response re questions from External Auditor to Management (DoF)
- Chair's response re questions from External Auditor to Those Charged with Governance (DoF)
- Draft Accounting Policies 2018/19 (ADoF) (NB. No significant changes from last year)
- Going Concern (DoF)

Key:

GT= Grant Thornton (external auditor)
MIAA = Mersey Internal Audit Agency (internal audit and anti-fraud services)
DoF = Director of Finance
DoN = Director of Nursing, Midwifery & Governance
ADoF = Assistant Director of Finance (Financial Services)
NB. There was no meeting required of the Auditor Panel required on this occasion.

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, in respect of the draft accounting policies, to agree.

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

Date of meeting: 25th April 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)35

Title of paper: Committee Report – Quality Committee

Purpose: To summarise the Quality Committee meeting held on 17 April 2018 and escalate issues of concern.

Summary: Key items discussed were:

1. Complaints

- 18 1st stage complaints were received and opened in March 2018; a decrease of 1 from February 2018
- At the end of March 2018, there were 35 open 1st stage complaints (a decrease of 1), including 1 overdue (an increase of 1) from the previous month
- The Trust responded to 78.9% 1st stage complaints within agreed timeframes during March 2018, a decrease compared to February 2018, but an improvement against the overall yearly average.

Annual Report Summary:

- The Trust received 224 1st stage complaints in 2017-18, a reduction of 44% (114 less than the previous year)
- The Trust responded to 67% of those complaints within agreed timescale, an improvement in the previous two years' performance (58% in 2016-17 and 61.4% in 2015-16)
- The number of PALS enquiries has increased by 15% compared to the previous year, rising to 2333 in 2017-18
- 3.8% of PALS enquiries became a formal complaint
- 2 formal investigations were opened by PHSO in 2017-18, a reduction of 8 from 2016-17.

2. IPR

A&E performance, infection control, finance & HR targets were discussed.

- The reportable surplus for 2017/18 will be behind plan by c.£6.3m. The provisional surplus is £2.2m including the achieved STF allocation of £5.1m and the utilisation of reserves.
- The Trust finished the year with a closing cash balance of £11.7m and Capital expenditure of £9.18m both of which were in line with the plans for the year.

3. Safer Staffing – Data received too late to submit formal report.

4. CQC Action Plan Update
   Of the original 57 actions, the 2 remaining actions have now been completed.

5. HPTP

Overall performance on the benchmarks is good:

- Clinical pharmacy plan with funded proposals approved by Executive Committee on 25 January 2018. Recruitment is under way. The key aim is to improve the review of new patients on admission and improve the rate of medicines reconciliation within 24 hours for both medical and non-elective surgical patients.
- A paper providing options for outsourcing of outpatients dispensing is to be presented to the Executive Team by the end of May 18.
- Aseptic services. Return of NHSI review data to Deloitte completed. Initial results

expected in April 2018. MHRA inspection of Aseptic Unit scheduled in May. Following approval from MHRA, the Unit will move from a dispensing to a manufacturing model.

- Omnicell cabinets delivered and are being configured for wards 1b/1c and also for Pharmacy controlled drugs management.
- Roll-out of ePMA is delayed pending resolution of issues by JAC and roll-out of Medway System-C EPR.
- NHSI Emergency Care Improvement Programme (ECIP) Team visited the Trust to review pharmacy and medicines flows on 11 April 2018. General feedback was positive and some opportunities for improvement were identified.

6. Mortality Surveillance Update

The first meeting under the new structure is due to take place on 15 May 2018. This will report directly into the Clinical Effectiveness Committee.

7. Francis Action Plan Update

The Francis Action Plan update has been incorporated into the Well Led Framework and will be presented to Workforce Council going forward.

8. National Inpatient Survey & Action Plan

- The response rate for the Trust was 36% which equates to 430 usable responses from 1179. The target response rate was 60% nationally.
- A follow up CQC report will be published in May/June 2018 (TBC) which compares this Trust to all Trusts, not just those using Quality Health to carry out their survey.
- QH results and our FFT data together with local surveys undertaken do not triangulate.
- An action plan has been developed to address the key areas of improvement.

9. ICCR Report

- The Trust ceased using the LCP in January 2015 following the review and recommendations set out by the Leadership Alliance, and in conjunction with local community clinical staff created a care plan called the Individual Care and Communication Record (ICCR). This care plan is based on the 5 key recommendations stated in the One Chance to Get it Right report (Improving people's experience of care in the last few days and hours of life).
- Presently on version 4 of the ICCR, it has been updated and improved to include a daily medical review assessment page. Codes have been added to support the audit process and the form meets NICE guidance.

10 Feedback from Councils:

Patient Safety Council: Summary page noted. The following was escalated:

- VTE risk assessment update for February 2018 - 95.24% risk assessment completed, which is above the target of 95%. Monthly audit of 50 VTE risk assessment to measure appropriate prophylaxis in line with NICE Guidance shows 100% compliance with prescription of Clexane, and 85% compliance with application of stockings. RCA review being undertaken on 3 suspected hospital acquired DVT identified in February 2018.
- Inpatient falls - In February 2018 there were 153 inpatient falls in the Trust, which is lesser than previous month reported of 190 falls. Of these 110 resulted in no harm, 45 in low harm, 1 in moderate harm and 2 in severe harm. YTD Moderate, Severe and Death falls per 1000 bed days was 0.08 for both over 65s (target less than 0.12 - RCP) and total patient falls per 1000 bed days was 8.51 to the internal target of 6.0.

Patient Experience Council: Summary page noted. The following was escalated:

- The Care Provision for the Dying Patient Individual Care & Communication Record

(ICCR) was being used with up to 70% of appropriate patients.

Clinical Effectiveness Council – No update given as the meeting scheduled for March did not take place.

CQPG – Nothing to escalate.

Executive Committee – Summary page noted, nothing to escalate.

11. Policies/Documents Approved:
    - Annual meeting effectiveness review

12. AOB
    None noted.

Items to be escalated to the Board:

- Complaints update and annual report - greater engagement with families prior to the end stage of the complaints which has also made a big difference.
- IPR - HR compliance
- CQC action plan all items resolved
- In-patient Survey – disappointing results, we need scrutinise the comments to ensure the correct solutions are put in place to address the issues.

Corporate objectives met or risks addressed: Five star patient care and operational performance.

Financial implications: None directly from this report.

Stakeholders: Patients, the public, staff and commissioners

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

Presenting officer: Chair of Committee

Date of meeting: 25 April 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)36

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance and Performance Committee, 19th April 2018

Summary:

Agenda Items

For Information

- A&E Update
  - The Committee reviewed current performance within A&E compared to our peers within Cheshire & Mersey as well as nationally. Performance significantly dropped for March which was in line with national performance. Discussion centred on how we can use predictable patterns in attendances to improve resilience next winter. Plans are underway to strengthen the substantive workforce within senior medical and nursing to avoid the reliance on training grade doctors and agency staff.
  - A review of the 90 day improvement programme was presented with an update on the implementation status of the individual schemes. Additional work needs to be done to confirm whether the intended benefits from these schemes have been realised.
- Review of 2017/18 and Agenda for 2018/19
  - Changes were proposed to update the annual work plan for 2018/19 to include A&E performance as a standing item, replace commercial strategy with 'PLACE' development and include SLR to SLM within Trustwide SLR.
  - Chair requested CIP to be a monthly rather than quarterly update.
  - Workplace to be fully approved at the next meeting.
- Annual Meeting Effectiveness Review
  - The structure of the committee was reviewed by its members and was found to be fit for purpose. All meetings were quorate and attendance had improved on 2016/17.
  - Recommendations were made relating to:
    - Correct and consistent use of the Trust's standard cover sheet
    - key points of papers to be drawn out for member with detailed supporting or technical information be added as appendices
  - Changes to ToR to include benefit realisation from approved business cases were approved

For Assurance

- CIP Programme update
  - CIP plans continue to develop within the Care Groups and a number of schemes have been identified with CIP lead officers and indicatives values. Master document was shared with the committee to give assurance of the progress that has been made.
  - Formal QIA process is still in place and continues to be monitored. Any schemes identified for 2018/19 will follow this process once they have a completed CIF form and CIP lead.
  - Discussion on how to present the CIP target we anticipate being achieved through STP working to ensure accountability within the organisation. It was

recommended this was assigned to Execs at this stage with a view to apportioning out across the Care Groups later in the year as opportunities are identified.

- Integrated Performance Report Month 12 was reported
  - Discussion took place around operational performance with specific reference to the cancer and RTT performance. The RTT graphs within the IPR relating to number of patients on incomplete pathways were also discussed.
  - Mandatory Training and Appraisal figures have exceeded targets for 2017/18 and the committee recognised the work put into this by the Care Groups. Sickness absence has also reduced on the previous year despite the difficulties of the winter period.
- Provisional Finance Report Month 12 2017/18
  - The final accounts for 2017/18 are still being calculated and will be subject to Audit approval.
  - Indicative figures show a surplus of £2.2m (including STF) which translates to a £2.9m deficit excluding STF.
  - The Cash and Capital positions were also presented and accepted.

Actions Agreed

- CIP target relating to System-wide/STP savings to be allocated to Care Groups following Q1
- CIP update to be a monthly agenda item
- Update to be brought to the committee on future bed capacity following Exec 'Away Day'
- Coversheet for IPR to be discussed at Execs

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: Su Rai Non-Executive Director
Date of meeting: 25th April 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)37

Title of paper: Corporate Risk Register – April 2018

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

Summary:

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

- Have been identified and reported;
- Have been scored in accordance with the Trusts risk grading matrix;
- Any risks initially rated as high or extreme or increasing to high /extreme have been agreed with and reviewed by the appropriate Executive Director;
- Are regularly reviewed;
- Have an identified target risk score, which captures the level of risk appetite and has a mitigation plan that will realistically bring the risk to the target level.

This report covers the risks reported and reviewed in March 2018. The report shows:

- The total number of risks on the risk register is 767;
- 46% (350) of the Trusts risks are rated as Moderate or High;
- There are 13 high/extreme risks that have been escalated to the CRR

The spread of risks across the organisation is:

- 4 in the Medical Care Group;
- 1 in the Surgical Care Group;
- 2 in Clinical Support Care Group;
- 6 in Corporate Services.

The risk categories of the CRR risks are:

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

Corporate objectives met or risks addressed: The Trust has in place effective systems and processes to identify manage and escalate risks to the delivery of high quality patient care.
Financial implications: None directly from this report.
Stakeholders: Staff, Patients, Executive Committee, Trust Board, Commissioners.
Recommendation(s): The Trust Board 1. Notes the risk profile of the Trust and the risks that have been escalated to the CRR.
Presenting officer: Nicola Bunce, Director of Corporate Services
Date of meeting: 25th April 2018

CORPORATE RISK REGISTER REPORT

1. Purpose

The purpose of this report is to provide an overview of the changes to the Trust's risks, and to focus on those risks which score 15 or above which are included on the Corporate Risk Register (CRR). This report is based on DATIX reported risks until the end of March 2018.

2. Risk Register Summary for the Reporting Period

This table provides a high level overview of the "turnover" in the risk profile of the Trust compared to previous reporting periods.

RISK REGISTER	Current Reporting Period 03.04.2018	Previous Reporting Period 05.03.2018	Previous Reporting Period 06.02.2018
Number of new risks reported	19	17	18
Number of risks closed or removed	39	8	15
Number of increased risk scores	1	3	6
Number of decreased risk scores	7	8	6
Total Number of Datix risks	**767***	**790**	**781**

**Includes 2 new risks not yet scored*

3. Trust Risk Profile *(Based on 765 scored risks)*

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
61	**53**	**29**	**112**	**11**	**149**	**51**	**141**	**34**	**108**	**4**	**6**	**6**	**0**
143 = 18.69%			**272 = 35.56%**			**337 = 44.05%**				**13 = 1.7%**			

The risk profile for the Trust's Care Groups and for Corporate Services are;

3.1 Surgical Care Group

265 risks reported 34.64% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
9	**14**	**9**	**42**	**2**	**59**	**15**	**73**	**14**	**27**	**0**	**1**	**0**	**0**
32 = 12.08%			**103 = 38.87%**			**129 = 48.68%**				**1 = 0.38%**			

3.2 Medical Care Group

186 risks reported 24.31% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
22	**21**	**4**	**25**	**0**	**28**	**13**	**24**	**16**	**26**	**2**	**2**	**3**	**0**
47 = 25.27%			**53 = 28.49%**			**82 = 44.08%**				**4 = 2.15%**			

3.3 Clinical Support Care Group

46 risks reported 6.01% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
2	**3**	**0**	**5**	**0**	**3**	**4**	**8**	**2**	**17**	**1**	**1**	**0**	**0**
5 = 10.87%			**8 = 17.39%**			**31 = 67.39%**				**2 = 4.35%**			

3.4 Corporate (incl. Finance, HR, IT, Facilities, Quality & Risk, Operational, IG)

268 risks reported 35.03% of the Trust total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
28	**15**	**16**	**40**	**9**	**59**	**19**	**36**	**2**	**38**	**1**	**2**	**3**	**0**
59 = 22.01%			**108 = 40.30%**			**95 = 35.45%**				**6 = 2.24%**			

The split of the risks across the corporate departments is:

	High	Moderate	Low	Very low	Total
Health Informatics/ Health Records	1	26	5	4	**36**
Facilities (Medirest/TWFM)	0	1	12	5	**18**
Nursing, Governance, Quality & Risk	1	18	12	3	**34**
Finance	1	4	20	27	**52**
Medicines Management	0	19	46	13	**78**
Human Resource	3	27	13	7	**50**
Total	**6**	**95**	**108**	**59**	**268**

4. The Trusts Highest Scoring Risks – Corporate Risk Register

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

Appendix 1 - Corporate Risk Register – April 2018

KEY	Medicine		Surgical		Clinical Support		Corporate	

New Risk Category	Datix Ref	Risk	Initial Risk Score I x L	Current Risk Score I x L	Lead & date escalated to CRR	Target Risk Score I x L	Action plan in place
Governance	222	Risk of failure to ensure delivery of national performance targets	4 x 4 = 16	4 x 4 = 16	24/04/2017 Rob Cooper	4 x 2 = 8	Action plan in place
Governance	1772	Risk of Malicious Cyber Attack	3 x 4 = 12	4 x 5= 20	09/11/2016 Christine Walters	4 x 3 = 12	Action plan in place
Money	1555	Risk of unplanned cost pressures from the introduction of an apprenticeship levy.	3 x 5 = 15	4 x 5 = 20	01/04/2016 Anne-Marie Stretch	3 x 4 = 12	Action plan in place
Money	1955	Risk of failure to deliver the annual financial plan 2017/18	3x4=12	3x5=15	24/01/2018 Nik Khashu	Not stated	Action plan in place
Money	1152	Risk to the quality of care, contract delivery and finance due to increased use of bank and agency	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	4 x 3 = 8	Action plan in place
Patient Care	913	Risk to patient safety risk and operational effectiveness if staffing levels are below establishment on DMOP	3 x 5 = 15	3 x 5 =15	12/04/2016 Sue Redfern	2 x 2 = 4	Action plan in place
Patient Care	1285	Risk to patient safety risk and operational effectiveness if staffing levels are below establishment on Frailty unit	4 x 4 = 16	3 x 5 = 15	12/04/2016 Sue Redfern	3 x 3 = 6	Action plan in place
Patient Care	1569	Consultant Recruitment within Clinical Support Services	2 x 5 = 10	3 x 5 = 15	17/11/2016 Anne-Marie Stretch	3 x 4 = 12	Action plan in place
Patient Care	2247	Risk that if a critical mass of staff are not trained prior to Medway "go live" then there could be an impact on patient care	4 x 3 = 12	4 x 4 = 16	19/03/2018 Rob Cooper	4 x 1 = 4	Action plan in place
Patient Care	2259	Risk to patient safety risk and operational ability to admit and discharge patients on the Critical Care Unit	4 x 4 = 16	4 x 4 = 16	15/03/18 Sue Redfern	3 z 2 = 6	Action plan in place
Patient Care	1080	Risk to patient safety risk and operational effectiveness if staffing levels are below establishment on wards 2B &2C	4 x 5 = 20	4 x 5 = 20	15/08/2017 Sue Redfern	2 x 2 = 4	Action plan in place
Patient Care	2223	Risk that if A&E attendances and admissions increase beyond planned levels then the trust may not have sufficient bed capacity or the staffing to accommodate patients and provide safe care	4x3=12	4x5=20	09/01/2018 Rob Cooper	Not stated	Action plan in place
Staff	762	Risk that if the Trust cannot recruit sufficient staff to fill approved vacancies then there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	4 x 4 = 16	08/07/2015 Anne-Marie Stretch	4 x 2 = 8	Action plan in place

*blue text denotes new risks that have been escalated in March

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(18)38
Title of paper: Review of the Board Assurance Framework (BAF) – April 2018
Purpose: For the Board to review the BAF and agree any changes
Summary: The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its statutory duties, strategic plans and long term objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in January 2018. The Executive Committee review the BAF in advance of its presentation to the Trust Board and make proposed changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the proposed actions and additional controls are sufficient to mitigate the risks being managed by the Board, in accordance with the agreed level of risk appetite. **Key to proposed changes:** ~~Score through~~ = proposed deletions Blue Text = proposed additions Red = overdue actions **Recommended changes** The strategic aims have been reviewed and aligned to the 2018/19 Trust objectives and some wording changes are proposed to update these.
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to assure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSI, CQC, Commissioners.
Recommendation(s): To review and approve the proposed changes to the BAF.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 25th April 2018

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

Alignment of Trust 2018/19 Objectives and Long Term Strategic Aims

2018/18 Trust Objectives	Strategic Aims					
	We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes for the population	We will be the hospital of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will work in partnership to create sustainable and efficient health systems
Five star patient care – Care						
Five star patient care – Safety						
Five star patient care – Pathways						
Five star patient care – Communication						
Five star patient care – Systems						
Organisational culture and supporting our workforce						
Operational performance						
Financial performance, efficiency and productivity						
Strategic Plans						

Risk Scoring Matrix

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

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

Risk 1 – Systemic failures in the quality of care	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause: • Failure to deliver the Clinical and Quality standards and targets • Failure to deliver CQUIN element of contracts • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting Effects: • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage Impact: • Harm to patients • Loss of reputation • Loss of contracts/market share	5x4= 20	• Quality metrics and clinical outcomes data • Safety thermometer • Quality Ward Rounds • Complaints and claims • Incident reporting and investigation • Quality Governance structure • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with lead CCG • NHSI Single Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC routine annual PIR return • Medicines Optimisation Strategy	To Board; • IPR • Patient Stories • Quality Board Rounds • Quality Committee and its Councils • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Staff Survey • Friends and Family scores • Nursing Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit • National Inpatient Survey Other; • National clinical audits • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Inspection Report • Learning Lessons League • IG Toolkit results • Model Hospital benchmarking	5 x2 = 10	Quarterly publication of avoidable deaths data (Jan 2018) Assurance of quality performance of new community and primary care services delivered by the Trust	~~Full Implementation of the midwifery led care pathway for women having low risk births (November 2017)~~ Plans to achieve 30% of discharges by midday Improvement plans for Falls, Infection Control and Pressure Ulcers in 2018/19 ~~Recovery plan for VTE ahead of IT solution (November 2017)~~	~~Complete the final CQC "should do" action on EOL care, with local system partners – March 2018~~ Implementation plans for the four key 7-day service standards Implementation of Stroke Service integration with WHH – phase 2 planned completion in 2018/19 Improve F&F response rates (March 2018) ~~Benefits realisation from the delivery of the St Helens community services contract - March 2018~~ Development of a new Clinical and Quality Strategy for the Trust (June 2018)	5 x 1 = 5	KH/ SR

Risk 2 –Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to deliver strategic financial plans and two year operational plan, including the agreed control total • Failure to control costs • Failure to implement transformational change at sufficient pace • Failure to continue to secure national PFI support • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • Failure to respond to new models of care (FYFV) • Failure to secure sufficient capital to support additional equipment/bed capacity Effects; • Failure to meet statutory duties • NHSI Segmentation Status increases Impact; • Unable to deliver viable services • Loss of market share • External intervention	5 x 5 = 25	• Two year Operational Plan and STP financial Modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 3 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSI annual provider Licence Declarations • PMO capacity to support delivery of CIP and service transformation • Signed Contracts with all Commissioners • Premium/agency payments approval and monitoring processes • Internal audit programme	To Board; • Finance and Performance Committee • Annual financial plan • Monthly finance report • IPR • Statement of Internal Control • Annual Accounts • Audit Committee • External Audit Reports Inc. VFM assessment • SLM/R Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports • Annual audit programme • PSF Targets and Control Total Other; • NHSI monthly reporting • Contract Monitoring Board • NHSI Review Meetings • Use of Resources reviews • Contract Review Boards with Commissioners • St Helens Cares Peoples Board	5 x 4 =20	~~Agree a shared health economy financial and sustainability strategy/control total~~ Develop 2017 - 19 detailed CIP plans and strengthen QIA monitoring to mitigate additional risk Establish a benchmarking and reference cost group ~~2017/18 financial recovery plan~~ ~~Assessment of the impact of national winter escalation plans on the 2017/18 financial plan (February 2018)~~ Transformational CIP contribution to the overall CIP target	Develop capacity and demand modelling and a consistent approach to service development proposals approval Foster positive working relationships with health economy partners to help create a joint vision for the future of health services Cash flow and prompt payment of invoices from other NHS providers ~~Prompt payment of lead employer invoices by other NHS organisations to maintain cash balances (October 2017)~~ Achievement of the Maternity CNST premiums risk reduction discount (June 2018)	Develop a detailed Health and Care Partnership ~~STP~~ implementation plan with C&M partners in line with the priorities outlined in the Next Steps FYFV plan Secure maximum PSF ~~SFT~~ funding in ~~2017/8 and~~ 2018/19 to achieve control total. Agree payment mechanisms to support the development of an Integrated care system for St Helens (October 2018) ~~Development of clear plans for the Trusts response to ACS/O development plans in St Helens, Halton and Knowsley, including legal form and risk/benefit analysis (February 2018)~~ Seek all possible sources of capital funding including national bids to support capacity planning	4 x3 = 12	NK

Risk 3 - Sustained failure to maintain operational performance/deliver contracts	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to deliver against national performance targets (ED, RTT, Cancer etc.) • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand Effects; • Reduced patient experience • Poor quality and timeliness of care leading to poorer outcomes • Failure of KPIs and self-certification returns • Increases in staff workload/stress Impact; • Potential patient harm • Loss of reputation • Loss of market share/contracts • External intervention • Loss of PSF funding • Increases in staff sickness rates	4 x 4 = 16	• NHS Constitutional Standards • Care group activity profiles and work plans • System Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • A&E Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events re DTOC patients	To Board; • Finance and Performance Committee • IPR • System Resilience Plan • Annual Operational Plan • Data Quality audits Other; • Contract review meetings/CQPG • NHSI monitoring and escalation returns/sit reps • CCG CEO Meetings • CQC System Reviews e.g. Halton, Liverpool	4 x 5= 20	Improvement plans for 62 day cancer target, where this is not consistently achieved in every month. Theatre productivity improvement plan monitoring.	Long term health economy emergency access resilience and urgent care services plans re NEL admissions and DTOC Health economy winter resilience plan for 2018/19 which identifies additional capacity - Sept 2018	Improvement Event Action Plans and Internal Improvement strategy – on going ~~Work with NHSI and ECIP for practical intensive support to achieve 4-hour trajectory – March 2018~~ Delivery of the ECIP concordat 5 key targets for 2018/19 ~~Recruitment of additional HCA's to support packages of care (January 2018)~~ Full Implementation of the new frailty pathways for all CCGs – Sept 2018 ~~Impact and recovery assessment of winter pressures on elective activity and RTT – March 2018~~	4 x 3 = 12	RC

Risk 4 - Failure to protect the reputation of the Trust	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Good Rating • Failure to report correct or timely information Effect; • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff • Increased external scrutiny/review • Delay in FT application timetable Impact; • Reduced financial viability and sustainability • Reduced service safety and sustainability • Reduced operational performance • Increased intervention	4 x 4 = 16	• Communication and Engagement Strategy • Communications and Engagement Action Plan • Workforce, Recruitment and Retention Strategy • Publicity and marketing activity • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports	To Board; • Quality Committee • Workforce Council • Audit Committee • Charitable funds committee • Communications and Engagement Strategy • IPR • Staff Survey • Complaints reports • Friends and Family • Staff F&F Test • PLACE Survey • National Cancer Survey • Referral Analysis Reports • Market Share Reports • CQC national patient surveys • CQC Inspection ratings • Annual assessment of compliance against the CQC fundamental standards • Compliance review against the NHS Constitution Other; • Health Watch • CQC • NHSI Segmentation Rating	4 x 3 = 12	Regular media activity reports , including social media, to the Executive Committee Development of a new Patient Experience Strategy	Action plan to improve understanding of patients and carers' views – June 2018 ~~WRES Action Plan for 2017/18 (January 2018)~~	~~New Trust intranet to be developed and launched - July 2017~~ New Trust internet site – March ~~Achievement of 90% complaints response times target for 2017/18 – March 2018~~ Staff engagement and leadership strategy review (January 2018) ~~Hospital Charity effectiveness and ROI review – January 2018~~ Maternity Patient Survey Action Plan Implementation – May 2018 Delivery of the Well Led Action Plan (May 2018)	4 x 2 = 8	AMS

Risk 5 – Failure to work effectively with stakeholders	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Different priorities and strategic agendas of multiple commissioners • Unable to create or sustain partnerships • Competition amongst providers • Complex health economy • Poor staff engagement • Poor community engagement • Poor patient and public involvement Effect; • Lack of whole system strategic planning • Inability to secure support for IBP/LTFM • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff Impact; • Unable to reach agreement on collaborations to secure sustainable services • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff • Failure to win new contracts • Increase in complaints and claims	4 x 4 = 16	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCC/ Workforce Council • Patient and Public Engagement and Involvement Strategy • CCG CEO Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • CCG Board to Board Meetings • St Helens Cares Peoples Board • Involvement in Halton and Knowsley ACS development • CCG Representative attending StHK Board meetings • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Merseyside and Cheshire Sustainability and Transformation Planning governance structure • Exec to Exec working • StHK Hospitals Charity annual objectives	To Board; • Quality Committee • Charitable Funds Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports from external events • NHSI Review Meetings • Quality Account • Review of digital media trends • Monitoring of and responses to NHS Choices comments and ratings • Participation in the C&M STP leadership and programme boards • Partnership working with NWB NHSFT to deliver the St Helens Community Nursing Contract • Membership of the St Helens Peoples Board • Collaborative working with Halton and Knowsley CCGs to develop plans for Integrated care systems in these Boroughs • Achievement of the integrated working CQUIN	4 x 3 = 12	Annual programme of engagement events with key stakeholders to obtain feedback and inform strategic planning	C&M STP performance and accountability framework ratings and reports	~~C&M STP shared implementation plans and accountability structures - to meet the requirements of Next Steps for the FYFV~~ St Helens Cares - development of financial and governance models – October 2018 ~~Agree membership of the One Halton Partnership – January 2018~~ Work with Knowsley and Halton on development of their Integrated Care Systems – March 2019	4 x2 = 8	AMS

Risk 6 - Failure to attract and retain staff with the skills required to deliver high quality services	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment Effect; • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff Impact; • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	5x4 = 20	• Team Brief • Staff Newsletter • Mandatory training • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCC/Workforce Council • Francis Report Action Plan • Education and Development Plan • HR Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews • Workforce KPIs • Recruitment and Retention Strategy action plan • Nurse development programmes • Agency caps and usage reporting • LWEG/LETB membership • Speak out safely policy • ACE Behavioural standards	To Board; • Quality Committee • Workforce Council • Finance and Performance Committee • Premium Payments Scrutiny Council • IPR - HR Indicators • Staff Survey • Monthly Nurse safer staffing reports • Workforce plans aligned to strategic plan • Monitoring of bank, agency and locum spending • Monthly monitoring of vacancy rates and staff turnover • Staff F&FT snapshots • WRES report and action plan • Quality Ward Rounds Other • Annual workforce plans • HR benchmarking • Nurse staffing benchmarking • C&M HR Work Stream	5x4= 20		Specific strategies to overcome recruitment hotspots e.g. International recruitment and working closely with HEE's Plans to optimise opportunities from the apprenticeship levy to create new roles and qualifications to address skills and capacity gaps	Complete E-Rostering roll out to all Medical Staff (June 2018) Development of a C&M collaborative staff bank – Sept 2018 Plans to maximise the ROI from the apprenticeship levy – June 2018 Annual review of Departmental OD plans – June 2018 Implementation of the NHSI Recruitment and Retention Framework and evaluation of the return on investment (March 2019) Develop workforce strategy in relation to new roles e.g. Nurse Associates to maximise potential – September 2019 Development of specific nursing workforce recruitment strategy and infrastructure – business case (May 2018)	4 x 2 = 8	AMS

Risk 7 - Major and sustained failure of essential assets or infrastructure	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire Effect; • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric o equipment • Increase in complaints Impact; • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 4 = 16	• New Hospitals / Vinci Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • Capital programme • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups	To Board; • Finance and Performance Committee • Finance Report • Capital Programme • Audit Committee • I.P.R. Other; • Major Incident Plan • Business Continuity Plans • ERIC Returns • PLACE Audits • Model Hospital • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee, to capture: ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance	4 x 2 = 8	~~The estates strategy will need to be continually refreshed as the configuration of clinical, clinical support and back-office functions across a wider footprint develops.~~ Development of a 10 year strategic estates development plan to support the Trusts service development and integration strategies. Development of estate options for cancer services, urgent care and surgical care are being developed	Membership of the C&M 5-year forward view programme strategic estates workstream. Maximise the potential from the GP Streaming investment to improve the A&E department flows.	PLACE assessment of Intermediate Care Ward at Newton Hospital (May 2018)	4 x 2 = 8	PW

Risk 8 - Major and sustained failure of essential IT systems	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage • Lack of effective risk sharing with HIS shared service partners • Major incident e.g. Cyber Attack. Effect; • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Inability to record activity and duplication due to reliance on back up paper or manual systems. • Loss of data or patient related information Impact; • Reduced quality or safety of services • Increased costs • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4x5=20	• HIS Management Board and Accountability Framework • Procurement Framework • Health Informatics Strategy • HIS performance framework and KPIs • HIS customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plan • Disaster Recovery Policy • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • Availability and capacity management framework	To Board; • HIS Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • Executive committee • Risk Management Council • Information Security Assurance Group • Health Informatics Service Operations Board • Programme/Project Boards • Information Governance Steering Group Other; • Internal/External Audit Programme • Information Governance Toolkit Submissions • Information Security Dashboard • External Accreditation – CareCert, Cyber Essentials, External Penetration Test • Service Level Agreements • NHS IT Health Check (CareCert) • HIS Strategy	4x4=20	Annual Financial plan agreed with all partners Cyber Security Business Case approval Infrastructure Replacement Programme to be agreed Corporate Governance Structure established Staff Development Plan Technical Development Annual Audit Assurance Report	ISO27001 Cyber Essentials Plus NHS IT Health Check (CareCert) Annual Service Delivery Assurance Report Service Improvement Plans Communications Strategy Digital Maturity Assessment Independent systems reviews Penetration Testing Exercise	ISO27001 (Sept 18) Cyber Essentials Plus (Sept 18) CareCert Accreditation (July 18) Cyber Security Strategy (May 18) Delivery of PAS Replacement programme (April 18)	4x2=8	CW

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)39
Title of paper: Learning from Inpatient Deaths – Q3 Report
Purpose: To provide assurance to the board that the Trust is seeking to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.
Summary: The paper details the data to Q3 on deaths, including the method for sharing and learning, in accordance with the Learning from Inpatient Deaths Policy.
Corporate objectives met or risks addressed: To deliver safe care
Financial implications: None as a direct consequence of this paper.
Stakeholders: Patients, the public, patient representatives, commissioners, regulators
Recommendation(s): 1. The board is assured that the Trust can respond appropriately and learn lessons from unexpected deaths.
Presenting officer: Professor Kevin Hardy, Medical Director
Date of meeting: 25th April 2018

STHK Learning From Deaths Board Report

	Deaths in Scope [1]	Specified Groups									
		LD Deaths	SMI Deaths [2]	Child Deaths	Neonatal Deaths & Stillbirths	Maternal Deaths	CQC Alert Deaths	Diagnosis Group [3] Deaths	SIRI Deaths	Concern [4] Deaths	**Total [5]**
Apr-17	121	0	1	0	3	0	0	10	0	3	**17**
May-17	133	1	0	0	3	0	0	11	1	2	**17**
Jun-17	132	0	0	0	2	0	0	9	1	0	**12**
Jul-17	143	1	1	0	0	0	0	12	1	1	**16**
Aug-17	130	2	2	0	2	0	0	8	0	1	**14**
Sep-17	150	1	3	0	5	0	0	11	1	1	**22**
Oct-17	128	1	0	1	3	0	0	14	0	4	**23**
Nov-17	130	2	1	0	2	0	0	12	0	1	**18**
Dec-17	149	0	0	0	1	0	0	9	0	2	**12**
Total	**1216**	**8**	**8**	**1**	**21**	**0**	**0**	**96**	**4**	**15**	**151**

	Specified groups			Non-Specified groups		
	Total [5]	Reviewed	**% Reviewed**	Total	Reviewed	**% Reviewed (Target 25%)**
Apr-17	17	17	100.0%	104	30	28.8%
May-17	17	17	100.0%	116	37	31.9%
Jun-17	12	12	100.0%	120	32	26.7%
Jul-17	16	16	100.0%	127	34	26.8%
Aug-17	14	14	100.0%	116	37	31.9%
Sep-17	22	22	100.0%	128	23	18.0%
Oct-17	23	23	100.0%	105	28	26.7%
Nov-17	18	18	100.0%	112	29	25.9%
Dec-17	12	11[7]	91.7%	137	40	29.2%
Total	**151**	**150**	**99.3%**	**1065**	**290**	**27.2%**

	% of reviews with RAG review [6]		
	Total Reviewed	RAG Reviewed [6]	**% RAG Reviewed**
Apr-17	47	42	**89.4%**
May-17	54	48	**88.9%**
Jun-17	44	41	**93.2%**
Jul-17	50	46	**92.0%**
Aug-17	51	45	**88.2%**
Sep-17	45	33	**73.3%**
Oct-17	51	44	**86.3%**
Nov-17	47	41	**87.2%**
Dec-17	51	46	**90.2%**
Total	**440**	**386**	**87.7%**

	Outcome of RAG Reviewed deaths			Outcome % of RAG Reviewed deaths		
	where no concerns	where significant doubt about whether or not, problems in care delivery/service provision contributed to death – refer to multi professional review	where balance of probability is that death may have resulted from problems in care delivery/service provision - refer to SIRI Investigation	where no concerns	where significant doubt about whether or not, problems in care delivery/service provision contributed to death – refer to multi professional review	where balance of probability is that death may have resulted from problems in care delivery/service provision - refer to SIRI Investigation
Apr-17	41	1	0	97.6%	2.4%	0.0%
May-17	41	7	0	85.4%	14.6%	0.0%
Jun-17	40	1	0	97.6%	2.4%	0.0%
Jul-17	39	6	1	84.8%	13.0%	2.2%
Aug-17	40	5	0	88.9%	11.1%	0.0%
Sep-17	31	2	0	93.9%	6.1%	0.0%
Oct-17	41	3	0	93.2%	6.8%	0.0%
Nov-17	35	6	0	85.4%	14.6%	0.0%
Dec-17	41	5	0	89.1%	10.9%	0.0%
Total	**349**	**36**	**1**	**90.4%**	**9.3%**	**0.3%**

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

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

[3] Diagnosis groups under internal monitoring

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

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

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

[7] The 1 specified group death that hasn't had a completed review relates to a neonatal death. This death is due to be heard at the perinatal audit meeting in June-18.

Learning & Sharing 2017/Q3

2017/Q3 Key Priorities

(1) AF causes stroke. AF strokes are bigger. AF strokes have higher mortality. AF strokes leave more disability. AF strokes are PREVENTABLE. If you find AF, do a CHADS2-VASC score and anticoagulate if indicated.

(2) 'Difficult relatives' are typically frustrated people trying to do the best for their loved ones. Show compassion - it might be you one day.

Sharing: (Q 1 & 2) Lessons have been shared with: Board, Quality Committee, Finance & Performance Committee, Clinical Effectiveness Council, Patient Safety Council, Patient Experience Council, Grand Rounds, Team Brief, Intranet Home Page, Global email, Medical Care Group (Governance), Surgical Care Group (Governance), Medical Care Group Directorate Meetings, Surgical Care Group Directorate Meetings and Clinical Support Directorate meetings. Initial sharing was opportunistic and wasn't consistently captured in relevant meeting minutes, but there is now an systematic distribution process which is being managed and will be audited by Dr Hendry, Assistant Director.

Effectiveness: (Current Q 1-2) Audit of DATIX ☐, SIRIs ☐, Complaints ☐, PALS ☐, Litigation ☐, Mortality Reviews for evidence of failure to deliver these priorities ☐.

Comments: Systematic assessment of effectiveness is necessarily 2 quarters behind priorities and won't therefore appear until the next quarterly report, but ad hoc evidence suggests improvement.

St Helens and Knowsley Teaching Hospitals NHS Trust

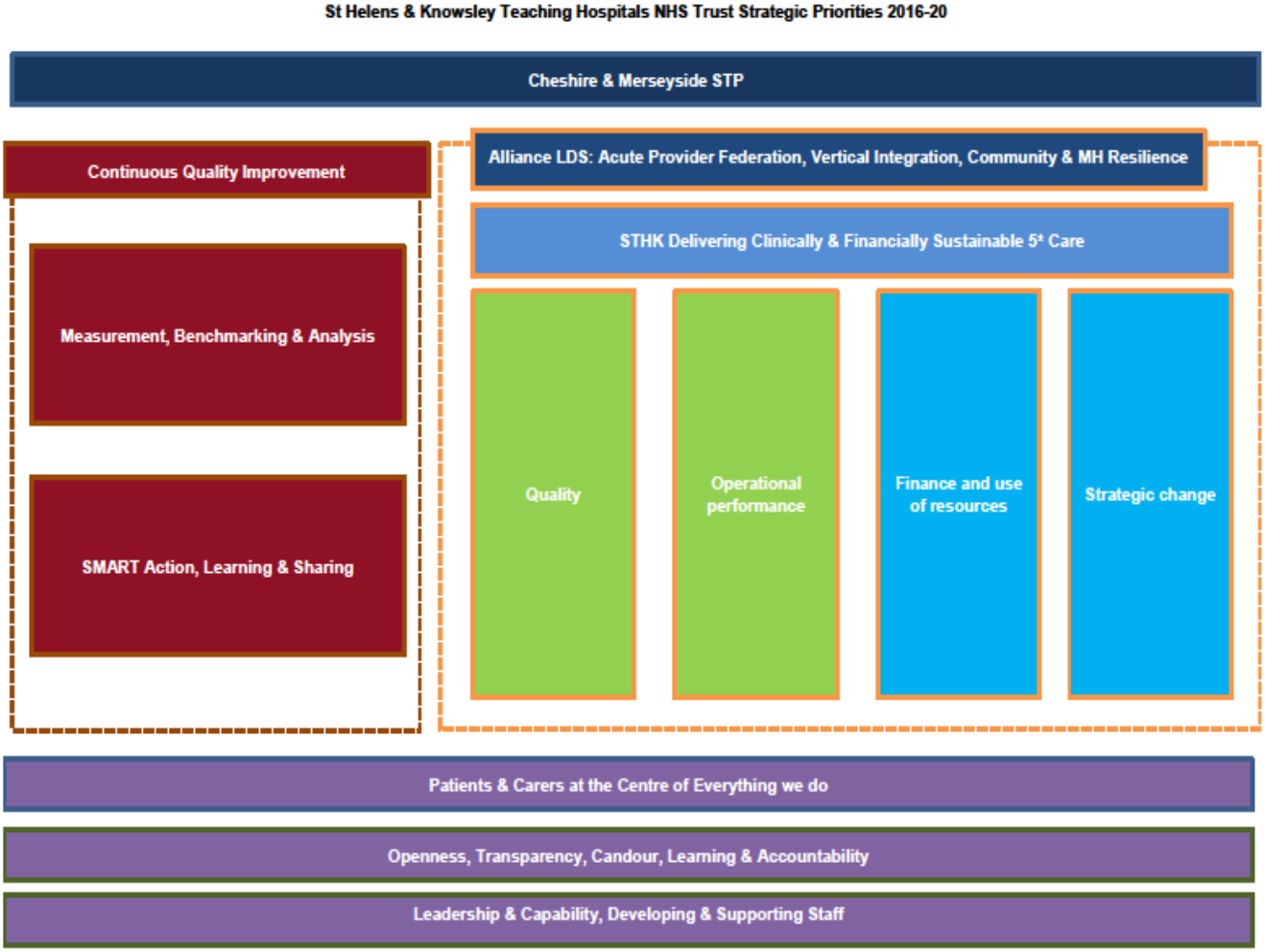
TRUST BOARD

Paper No: NHST(18)40
Title of paper: Clinical Quality Strategy – Biannual Update
Purpose: To update the Board on the progress of the Clinical Quality Strategy (CQS) continuous improvement KPIs.
Summary: STHK performs very strongly against many national, regional and local targets and the purpose of the CQS KPIs was to target those areas where performance has been less strong with challenging stretch targets to drive Quality Improvement towards our 5 Star aspirations for patients. Details of plans to address these targets have been extensively discussed and reported at Quality Committee or Finance & Performance Committee. This summary is position statement which is reported to the Trust Board and will be included in the 2017/18 Quality Account. The action plan for 2018/19 is included for Board review and approval.
Corporate objectives met or risks addressed: **Operational Performance –** *we will meet and sustain national and local performance indicators.*
Financial implications: None directly from this report.
Stakeholders: Staff, Patients, Executive Committee, Trust Board, Commissioners.
Recommendation(s): • The Trust Board to note the content of the report.
Presenting officer: Professor Kevin Hardy, Medical Director
Date of meeting: 25th April 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

STHK Clinical & Quality Strategy

Update Report
April 2018



1. **5-STAR (STRETCH) KPIs**

	Metric	Exec	Value	Trend	Target
1.	4 hr Perf (mapped)	RC	87.2%	Improving	≥95%
2.	Weekend Mortality SMR	KH	97.9	Improved	<100
3.	62-day Cancer (all)	RC	88.4%	Strong	≥85%
4.	VTE Assessment ≤ 24 hr	KH	93.52	Improving	≥95%
5.	eDischarge sent ≤ 24hr	RC	69.5%	Worsening	≥85%
6.	Serious Harm Falls	SR	16	Improving	11
7.	Complaints in timeframe	SR	67%	Improving	>80%
8.	A/Bs in Sepsis in ≤ hr ED	KH	93%	Very strong	>90%
9.	#NOF to Surgery ≤ 48hr	KH	80.9%	Improving	>90%
10.	Critical Care SMR	KH	1.14	Improving	100

STHK performs very strongly against national, regional & local targets and the purpose of the CQS KPIs was very specifically to target those areas where performance has been less strong with challenging stretch targets to drive Quality Improvement towards our 5 Star aspirations for our patients.

Details of plans to address these targets are typically discussed at Quality Committee or Finance & Performance Committee so below is a brief summary of the progress during 2017/18;

1. 4-hour performance is the only major national standard that STHK has consistently failed to achieve of late. We have agreed with NHSI an improvement trajectory for 2018/19 and intensive work is underway to ensure we hit this trajectory. F&P receives frequent, detailed briefings.

2. Weekend mortality has fallen significantly. Recent (published) evidence suggests that most of the variance nationally can be explained by patient factors rather than workforce factors.

3. Overall 62-day cancer performance is consistently strong. Several pathways, typically involving other hospitals and teams are less consistent and are subject to intensive improvement work, scrutinised by Quality Committee.

4. VTE assessment has been subject to intensive support and is of late performing above the required standard (i.e. >95%). YTD position reflects earlier suboptimal performance. Implementation of an electronic solution has been delayed by factors out with Trust control.

5. eDischarge targets are not possible with the present system, but implementation of a new Patient Administration System (PAS) goes live April 2018 and will be followed by our ePrescribing solution. An interim solution with truncated discharges has gone live (March 2018) for backlog reports and will then be used for real-time reports.

6. All falls fell slightly in the last 12 months and year to date, falls causing moderate or severe harm are also reduced, but not by the ambitious 50% stretch target we set ourselves. Quality Committee continue to scrutinise this target.

7. Timeliness of Complaints performance is very substantially improved with new systems and processes and leadership. Quality Committee continues to scrutinise this target.

8. Investment in the Sepsis Team by Execs has resulted in very strong performance, not only for ED patients (reported) but also for ward inpatients. Early treatment saves lives.

9. Time to theatre for fractured neck of femur patients is improving but not yet at the 95% standard. Improvement work is ongoing. A second tier anaesthetic on call rota has been resourced by the Executive Team to strengthen timely emergency surgery.

10. Critical care mortality has remained with national control limits, but was nevertheless higher than the English average – this has further improved. Nevertheless, the Trust has commissioned external review critical care services.

2. 2018/19 Action Plan and Monitoring Arrangements

Action	KPI from	Monitoring Committee	Leads	Exec
4hr Performance	IPR	F&P	DD/ADO Med	Dir Ops
Weekend Mortality	IPR	Quality	DD/ADO Med	MD
62-day Cancer	IPR	Quality	Cancer Leads	Dir Ops
VTE	IPR	Quality	VTE Leads Med & Surg	MD
eDischarge	IPR	F&P	DD/ADO Med & Surg	Dir Ops
Falls	IPR	Quality	DDoN Safety	DoN
Complaints	IPR	Quality	Gov Leads Med & Surg	DoN
Sepsis	IPR	Quality	Sepsis Lead	MD
#NOF Surgery	IPR	Quality	CD T&O/ADO Surg	MD
ICU Mortality	ICNARC	Quality	DD/ADO Med	MD

ENDS