St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 27TH JUNE 2018
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

PUBLIC BOARD AGENDA				Paper	Presenter
09:30	1.	Employee of the Month			Richard Fraser
		1.1.	May		
		1.2.	June		
09:45	2.	Apologies for Absence			
	3.	Declaration of Interests			
	4.	Minutes of the Previous Meeting held on 30th May 2018		Attached	
		4.1.	Correct Record & Matters Arising		
		4.2.	Action List	Attached	
Performance Reports					
09:50	5.	Integrated Performance Report		NHST(18) 54	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					
10.10	6.	Committee Report – Executive *(incl approval of Major Incident Plan)*		NHST(18) 55	Ann Marr
10:20	7.	Committee Report – Quality		NHST(18) 56	Val Davies
10:30	8.	Committee Report – Finance & Performance		NHST(18) 57	Jeff Kozer
Other Board Reports					
10:40	9.	WRES Survey Action Plan: further investigation of issues raised		NHST(18) 58	Anne-Marie Stretch
10:50	10.	Knowsley Council Public Health Annual Report		NHST(18) 59	Matt Ashton Director of PH

BREAK				
11:30	11.	Informatics Report and Strategy Update	NHST(18) 60	Christine Walters
11:45	12.	Fit & Proper Person's Regulations – Chairman's Declaration	NHST(18) 61	Richard Fraser
11:50	13.	Clinical Negligence Scheme for Trusts (CNST) incentive scheme - maternity safety actions	NHST(18) 62	Sue Redfern
12:00	14.	Draft Clinical & Quality Strategy 2018-21	NHST(18) 63	Nik Khashu *(for Kevin Hardy)*
Closing Business				
12:10	15.	Any Other Business		Richard Fraser
	16.	Effectiveness of Meeting		
	17.	Date of Next Public Board Meeting – Wednesday 25th July 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 30th May 2018 in the Boardroom, Whiston Hospital

PUBLIC BOARD

Chair:	Mr R Fraser	(RF)	Chairman
Members:	Ms A Marr	(AM)	Chief Executive
	Mr D Mahony	(DM)	Non-Executive Director
	Ms S Rai	(SR)	Non-Executive Director
	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
	Prof K Hardy	(KH)	Medical Director
	Mrs S Redfern	(SRe)	Director of Nursing, Midwifery & Governance
	Mr N Khashu	(NK)	Director of Finance
	Mrs C Walters	(CW)	Director of Informatics
	Mr P Williams	(PW)	Director of Facilities Management/Estates
	Ms N Bunce	(NB)	Director of Corporate Services
In Attendance:	Ms J Byrne	(JBy)	Executive Assistant *(Minute Taker)*
	Ms S Dowling	(SD)	Senior Research Nurse *(for Patient Story)*
	Mr T Foy	(TF)	St Helens CCG *(Co-opted Member)*
	Ms C Howarth	(CH)	Patient Experience Manager *(for Patient Story)*
	Cllr C Loftus	(CL)	Halton Council *(Observer)*
	Mr K Lomas	(KL)	Reporter, St Helens Star *(Observer)*
	Cllr A Lowe	(AL)	Halton Council *(Co-opted Member)*
	Mr C McNamara	(JM)	Acting Head of Purchasing/Supplies *(Observer)*
	Miss L Thomas	(LT)	Communications Officer *(Observer)*
	Dr F Andrews	(FA)	Asst Medical Director/Caldicott Guardian *(for item 15)*
Apologies:	Mrs V Davies	(VD)	Non-Executive Director
	Mr R Cooper	(RC)	Director of Operations & Performance
	Dr T Hemming	(TH)	Director of Transformation

1. Patient Story

The patient was unable to attend the meeting due to work commitments, but had given consent for his story to be shared. Clare Howarth, Patient Experience Manager, presented the background and Senior Research Nurse, Sue Dowling, spoke on the patient's behalf. The story dealt with the experience of agreeing to be involved in clinical trials to test new treatment options. In this case the trail therapy had led to a significant improvement in the patient's condition and quality of life.

2. Employee of the Month

The Employee of the Month for May 2018 was not available to attend the meeting; therefore May's award will be presented at the June Trust Board.

3. Apologies for Absence

Apologies were noted as above.

4. Declaration of Interests

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

5. Minutes of the previous meeting held on 25th April 2018

5.1. Correct Record

5.1.1. The minutes were accepted as a correct record.

5.1.2. NB updated Board members on minute 6.1.5 from the meeting on 25th April; 3 appeals for C.Diff had now been successful, therefore the total C.Diff cases for 2017/18 had reduced to 20. There is one further appeal relating to a case reported in 2017/18 which is being heard in June and if successful this would reduce the outturn figure again.

5.2. Action List

5.2.1. Action 1 - Minute 4.3 (28.02.18): *Analysis of Staff Turnover* – AMS to bring further analysis within the next HR Indicators report to the Board meeting on 25th July.

5.2.2. Action 2 - Minute 5.1.2 (28.02.18): *Nasogastric Tubing Never Event* – the investigation had now been completed and the recommendations and action plan have been considered by the Executive and would be reported to the Quality Committee. Action closed.

5.2.3. Action 3 - Minute 5.3.6 (28.02.18): *Maternity Reduction for Clinical Negligence Scheme for Trusts* – paper deferred to the June Board to allow more time to meet all the requirements before the approval deadline at the end of June.

5.2.4. All other actions were due in future months.

6. Integrated Performance Report (IPR) – NHST(18)41

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. NK explained that due to the Medway implementation there were a few indicators that could not be reported this month, as the data was being verified, but it was

anticipated that all indicators in the IPR would be fully reported from May onwards.

6.1. **Quality Indicators**

SRe presented the performance against the key quality indicators.

6.1.1. There were no MRSA bacteraemia cases in April 2018. The appeal against 1 of 2 the MRSA cases reported in 2017/18 had not been successful.

6.1.2. There were 2 C.Diff positive cases in April 2018.

6.1.3. There were no grade 3 or 4 avoidable pressure ulcers reported during 2017/18.

6.1.4. The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for March 2018, was 93.9%, giving an overall fill rate for 2017/18 of 93.9%.

6.1.5. During March there were 2 inpatients fall resulting in severe harm. 2017/18 total was 22.

6.1.6. Venous thromboembolism (VTE) performance in March was 93.69%. 2017/18 performance was 93.52% against the target of 95%.

6.2. **Operational Indicators**

6.2.1. NK presented performance against the key operational indicators.

6.2.2. The national cancer access targets had all been achieved in March and for the 2017/18 financial year.

6.2.3. A&E performance in April 2018 was 72.4% (type 1) and 84.0% (mapped STHK footprint – all types) against a target of 95%. A detailed analysis of the performance and changes in attendance patterns had been presented at the Finance and Performance Committee and further assurance was being sought that the actions taken to date were being sustained and having the required impact. A business case is being developed to propose a different staffing model to reduce the reliance on Junior Doctors and locum/agency staff and give capacity for the effective clinical management of increased activity levels.

6.2.4. Recent bed reconfiguration to create 21 additional medical beds at Whiston Hospital had been successful in reducing medical outliers and patient flow. There had also been substantial improvements in ambulance turnaround times from 20% > 1 hour in March to 6% > 1 hour in April.

6.2.5. RTT incomplete pathway performance was 94.3% in April against the national target of 92.0%.

6.3. **Financial Indicators**

6.3.1. NK presented the key financial performance indicators for April.

6.3.2. At month 1 there was an overall income and expenditure surplus of £2.0m, which was in line with agreed plans. Included within the financial position is the assumption of receipt of the full allocation of Provider Sustainability Fund (PSF) worth £0.6m. Failure to recover the A&E position by the end of Q1 could result in the Trust losing 25% of this allocation.

6.3.3. The Trust had delivered the CIP target for month 1 however it was important to note that the CIP profiles meant that the monthly target would increase throughout the remainder of the financial year.

6.4. **Workforce Indicators**

6.4.1. AMS presented the key workforce indicators.

6.4.2. Absence in April was 4.1% which was an improvement on the previous month, and below the Q1 target.

6.4.3. The 2017/18 final absence was 4.7%.

6.4.4. Mandatory training compliance for April was 95.9%. Appraisal compliance was 80.1% which was below the 85% but recovery plans were in place.

7. Committee Report – Executive – NHST(18)42

7.1. AM presented the Chair's report from the Executive Committee meetings held during April 2018.

7.2. **The Executive Committee had agreed:**

7.2.1. A feasibility study to explore the potential for investing in robotic surgical equipment.

7.2.2. Additional Histopathology staff to be able to respond to increases in demand and continue to meet the cancer diagnostic targets.

7.2.3. The final operational approval, following agreement by the Board for the Medway (Patient Administration System) implementation go live at the end of April.

7.2.4. AM also reported that NHS Improvement had informed the Trust the Use of Resources (UoR) Assessment of the Trust was to take place in July.

7.2.5. SR asked for further information about how the Trust compared to others in implementing the 7 day services standards. KH responded that the Trust had been placed in the cohort of Trusts required to

achieve the standards by 2020 and progress had recently been reviewed by NHSI who had felt that the Trust plans were robust and it remained on track to meet the standards.

8. Committee Report – Quality – NHST(18)43

8.1. DG presented the Chair's report to the Board (on behalf of VD), which summarised key issues arising from the Quality Committee meeting held on 22nd May 2018.

8.2. DG commented on the continued progress that was being made in improving the complaints management process.

8.3. The committee had received detailed reports on safer staffing, complaints, falls, the national inpatient survey action plan and the cancer work programme.

8.4. The Committee had received Chairs' reports from the Patient Safety, Patient Experience, Clinical Effectiveness and Workforce Councils and feedback from the Clinical Quality and Performance Group (CQPG) meeting with commissioners.

8.5. The Quality Committee had reviewed the final draft of the 2017/18 Quality Account and recommended it to the Board for approval.

8.6. Issues escalated to the Board were:

8.6.1. The continued staffing challenges and efforts being made to recruit staff against the backdrop of national staff shortages for key staff groups.

8.6.2. The request for NED attendance at the Mortality Surveillance Group.

8.6.3. Capacity to undertake the increasing number of national audits.

8.6.4. Cascade of the Learning from Inpatient Deaths key learning points.

8.6.5. DM commented on a recent Quality Ward Round to the stroke unit and the importance of clear communication with relatives as well as patients.

9. Committee Report – Finance and Performance – NHST(18)44

9.1. JK presented the Chair's report to the Board, which summarised key issues arising from the Finance and Performance Committee meeting held on 24th May 2018.

9.2. The committee reviewed the capital plans for 2018/19 and the recent bids that had been submitted to the Cheshire and Merseyside Health and Social Care partnership to access national capital funding to create additional community step down beds and increased ambulatory care capacity to support the winter plans for 2018/19. Future capital planning would

incorporate a 3 to 5-year forward programme.

9.3. The committee had undertaken an in depth review of A&E performance in April and were disappointed that there was no consistent improvement, despite the actions that had been taken. The review in attendances by CCG showed an increase in Halton patients arriving both by ambulance and walk in attendances, during April.

9.4. AM explained to Halton Council attendees that Halton attendances had gone up disproportionately compared to other providers. An audit was to be undertaken to understand the reasons for this and whether it was going to be a continuing trend.

9.5. The committee had requested further assurance of the measures to be taken to improve performance at the next meeting.

9.6. An overview of the Trust-wide CIP position was presented which showed an improvement of £1.63m in identified CIP compared to the previous month. Plans for the system collaboration CIP contribution to the Trust financial plan had also been requested.

9.7. The Medical Care Group had presented their approach to developing the detailed Care Group CIP plans, which had demonstrated the staff engagement in generating and developing the proposals.

9.8. The committee had also requested a review of the metrics of theatre productivity that were reported via the IPR to ensure that they reflected productivity more accurately.

10. Committee Report – Audit – NHST(18)45

10.1. **Adoption of Annual Accounts – NHST(18)46**

The Board ratified the approval by the Audit Committee of the Trust's financial accounts, the letter of representation and the annual report, for 2017/18.

10.2. **Approval of Audit Plan – NHST(18)47**

The Board ratified the approval by the Audit Committee of the Trust's 2018/19 internal audit plan.

10.3. **Annual Meeting Effectiveness Reviews of Committees**

The Board approved the findings of the annual meeting effectiveness reviews, as accepted by the Audit Committee.

10.4. The committee had also received the audit report on the Trust Quality Account for 2017/18, which was also very positive.

10.5. RF acknowledged the achievement of receiving an unqualified audit opinion and thanked everyone for their hard work.

11. Statutory and Regulatory Report – NHST(18)48

11.1. NB presented the report which provided an update on key policy and regulatory developments and the annual self-certificate declarations that the Board was required to make to comply with the NHS Improvement Single Oversight Framework (SOF).

11.2. The Trust had submitted its final operational plan to NHS Improvement (NHSI) on 30th April 2018, in accordance with the national timetable.

11.3. NHSI and the Freedom to Speak Up (FTSU) National Guardian had issued guidance setting out the expectations of Trust Boards. The Trust was reviewing its FTSU arrangements in light of this new guidance to ensure it continued to be fully compliant.

11.4. The NHSI Single Operating Framework required Trusts to make annual declarations in relation to compliance with the NHS Provider Licence.

11.5. Following a review of the sources of assurance the Board made the following declarations:

11.6. Licence Condition FT4 : The Board is satisfied that the licensee applies those principals, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

11.7. Licence Condition G6: The Directors of the licensee are satisfied that, in the financial year most recently ended, the licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

12. Quarterly Complaints, Claims and Incidents Report – NHST(18)49

12.1. SRe presented a summary of the complaints, claims and incidents report for September 2017 – March 2018.

12.2. The report analysed the top five reasons for complaints and the lessons that had been learnt from complaints and incidents.

12.3. The number of first stage formal complaints continued to fall with a substantial decrease compared to the same quarters last year, with an increase in cases dealt with by PALS. This performance was against the backdrop of the pressures experienced by the Trust over the same period.

12.4. In relation to a query from DM, SRe confirmed she would include benchmarking of 1st stage complaints data with other Trusts, but this would be retrospective due to the delay in publishing national data on complaints performance. This information would be included in the next quarterly report.

12.5. Board members noted the report.

13. Approval of Quality Account – NHST(18)50

13.1. SRe presented the final Quality Account for 2017/18 and sought formal Board approval.

13.2. DM asked the CCG attendees for any comments on the report. Cllr Foy stated that the CCG was aware of the Trust focus both on patients and staff. He believed the staff survey results stood out compared to others and there was a 'high performance culture'.

13.3. Formal feedback from commissioners and other stakeholders would be included in the final published document; this formal feedback was still being received from stakeholder CCGs, local councils and local Healthwatch offices, and was very positive.

13.4. RF believed the report was very positive despite the increased activity and winter pressures. He thanked the Non-Executive directors for their constructive challenge at the Board committees and the Executive for responding to these challenges. It was essential that this continued in order to get the right results for patients.

13.5. Board members approved the Quality Account.

14. Board and Committee Effectiveness Review – NHST(18)51

14.1. NB presented the paper.

14.2. The Trust had undertaken an effectiveness review of the Trust Board and its Committees.

14.3. The annual process helped to inform the future Board development programme, identify any skills gaps and make recommendations to strengthen the governance structure of the Trust.

14.4. Each Committee had received a detailed report and action plan and a summary had been presented to the Audit Committee. There were no substantial changes to any of the terms of reference for any of the committees this year.

14.5. This report set out the changes to the terms of reference and governance structure that were proposed for the coming year. The only material change to the governance structure was the creation of the Premium Payments Scrutiny Council, which reported via the Executive Committee.

14.6. The revised Terms of Reference and governance structure were approved.

15. Information Governance Annual Report – NHST(18)52

15.1. Dr Francis Andrews (Caldicott Guardian) presented the Information Governance (IG) Annual Report, which provided the Board with assurance that the Trust operated within the parameters defined in the Information Governance Toolkit and had completed the annual submission to

demonstrate this compliance. The report included the details of the data breach that had occurred in early 2017/18, which had previously been reported to the Board and had now been closed with no further action required by the Information Commissioners Office (ICO) because the Trust had responded appropriately and taken all necessary actions.

15.2. The report also contained a summary of the Freedom of Information Requests and performance for the year.

15.3. FA confirmed that, as Caldicott Guardian, he had access to the appropriate resources and support to be able to fulfil the duties of the position.

15.4. Mersey Internal Audit Agency (MIAA) had completed an audit of the Trust's toolkit submission and the Trust has maintained its 'Significant Assurance' opinion as it had for the previous 5 years.

15.5. The General Data Protection Regulations (GDPR) came into force on 25th May 2018 and the Trust was implementing an action plan to ensure it could meet the requirements of the regulations, which was monitored by the IG Steering Group.

15.6. SR asked if the Trust currently met all the GDPR requirements. FA confirmed there was a very robust action plan in operation. If the ICO came in we could evidence we are taking it seriously.

15.7. The Board approved the IG annual report.

16. Trust Objectives and End of Year Review – NHST(18)53

16.1. AM summarised the assessment of the Trust's performance against the 2017/18 objectives.

16.2. 23 objectives were rated green (achieved), 4 objectives were rated amber (partially achieved) and no objectives were rated red (not achieved).

16.3. RF asked AMS for clarification on the international recruitment figures. AMS confirmed the Trust had made 86 offers of employment but due to the complicated process, only 22 staff had started working in the Trust.

16.4. The Board approved the report

17. Any Other Business

17.1. DG asked for an update on the Royal Liverpool and Broadgreen University Hospital Trust build and the resulting effect on the Trust.

17.2. AM confirmed the issues with Carillion meant the whole build programme was behind and a new contractor had not yet been found to complete the hospital. The main issue for the Trust was that even when the build was complete there would be fewer beds in the local health system, so it was essential to work with other partners to ensure that bed capacity was managed and there was not a big increase in demand at other hospitals.

The current delays did mean there was more time for regional leadership to develop and alternative community services to be established to reduce the pressure on inpatient beds.

17.3. RF had attended a meeting with Ian Dalton, the new Chief Executive of NHSI, who had outlined his thoughts and objectives for the closer working relationship with NHSE. RF believed this was a positive development.

17.4. RF congratulated CW and her team for a successful transition to Medway, the new patient administration system. CW attributed the success to working extremely collaboratively as a team with colleagues across the Trust and the supplier and although some areas still needed more work she believed it gave a fantastic platform to build on.

18. Effectiveness of Meeting

18.1. RF asked those in attendance for feedback.

18.2. CMcN had found the meeting very interesting and in the context of his new role believed it had been useful personal development..

18.3. AL felt that the effectiveness of the Board was part of the reason the staff survey results were so good and CL added the care received within both hospitals inspired confidence and trust in the staff.

18.4. RF thanked everyone for their feedback.

19. Date of Next Meeting

19.1. The next meeting is scheduled for Wednesday 27th June 2018 in the Boardroom, Level 5, Whiston Hospital, commencing at 09:30 hrs.

Chairman: .....

Date: 27.06.18 .....

NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 30TH MAY 2018

No	Minute	Trust Public Board Action Log	Lead	Date Due
1.	28.02.18 (4.3)	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 to come to Board in July.	AMS	25.07.18
2.	28.02.18 (5.1.2)	Nasogastric Tubing Never Events: recommendations and action plan to be taken to Quality Committee in June.	SRe	19.06.18
3.	28.02.18 (5.3.6)	SRe to present paper regarding the Maternity Reduction for Clinical Negligence Scheme for Trusts (CNST)	SRe	27.06.18 (on agenda)
4.	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	27.06.18 (on agenda)
5.	30.05.18 (12.4)	First Stage Complaints – SRe to obtain data to show how the Trust compared with others in the region, for next scheduled report.	SRe	26.09.18

INTEGRATED PERFORMANCE REPORT

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: b l {¢ómyúpn
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

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

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

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

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

Patient Safety, Patient Experience and Clinical Effectiveness

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 have been no never events year to date (target = 0).

There have been no MRSA bacteraemia cases year to date (target = 0).

There were 2 C.Difficile (CDI) positive cases in May 2018. The annual tolerance for CDI for 18-19 is 40.
The Trust originally recorded 28 C-Difficile cases for 2017/18. The Trust subsequently appealed 9 cases with all 9 cases being successful.

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 April 2018 was 95.6%. YTD performance is 95.6%.

During the month of April 2018 there were no inpatient falls resulting in severe harm .

Performance for VTE assessment for April 2018 was 95.13%. YTD performance is 95.13% against a target of 95%.

YTD HSMR (April to January) for 2017-18 is 99.7

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 18/19 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: нтúK WdzyŜ нлму

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (April 2018) at 94.2%. The 31 day target was also achieved with 100% performance against a target of 96%. 2 week rule compliance was also achieved with 93% performance.

A&E Type 1 performance was 71.8% which was a deterioration from the April position of 72.4%.
Activity was particularly high in May with 10,065 attendances - 8.8% increase compared with May 2017.
Medical staffing has been the main issue affecting performance. A business case is in development to convert locum/agency spend into substantive posts and provide additional clinical support to increase resilience and productivity.

Improvements in patient flow out of the department continue and as a result, bed capacity has not been an impediment to A&E performance. Work has continued to maintain low numbers of 'good to go' patients , supporting improved flow and resulting in no medical outliers.

Ambulance notification to handover compliance has been maintained for a further month, with an average of 14.32 mins against a 15 minute target.

RTT incomplete performance was delivered at 93.7% v target of 92.0%.

Financial Performance

At the end of May (M2) the Trust is reporting an overall deficit of £2.3m which is in line with agreed plans. Included within the financial position is the full allocation of Provider Sustainability Fund (£1.3m). Failure to recover the A&E position by the end of Q1 could result in the Trust losing an element of this allocation.

Within the YTD position the Trust has had a £0.8m benefit non-recurrently.

The Trust has delivered the CIP target for the month, the target will increase throughout the remainder of the financial year.

The Trust cash balances are above planned levels.

The Financial Performance for the month delivers a Use of Resources level of 3.

Human Resources

Absence in May increased slightly by 0.05% to 4.3% for all staff against the Q1 target of 4.25%. YTD absence is 4.2% which is 0.5% better than last years outturn of 4.7%. Qualified & HCA sickness remained at 4.8% against a target of 5.3%.

Mandatory Training compliance exceeds the target by 10.7% at 95.7%. Appraisal compliance is 80.1% and below the target by 4.9%.

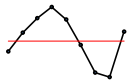
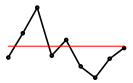
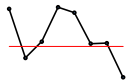
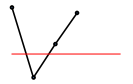
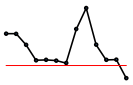
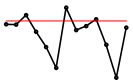
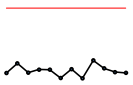
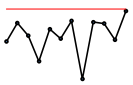
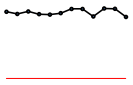
The following key applies to the Integrated Performance Report:

▲ = 2018-19 Contract Indicator
▲£ = 2018-19 Contract Indicator with financial penalty
● = 2018-19 CQUIN indicator
T = Trust internal target

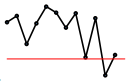
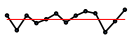
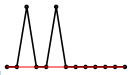
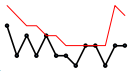
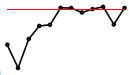
May-18

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

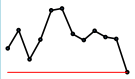
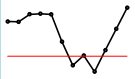
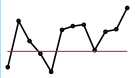
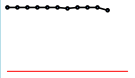
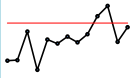
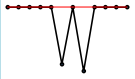
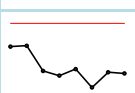
	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 31-37)												
Mortality: Non Elective Crude Mortality Rate	Q	T	May-18	2.0%	2.0%	No Target	2.4%		Overall SHMI and HSMR within control 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 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	▲	Jan-18	102.9		100.0	99.7					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Jan-18	98.8		100.0	96.4					
Readmissions: 30 day Relative Risk Score (HED)	Q	T	Dec-17	95.3		100.0	101.9		The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms. Readmissions have risen nationally in the last 2 years. 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		100.0	91.7		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		100.0	99.6					
% Medical Outliers	F&P	T	May-18	0.2%	0.8%	1.0%	2.3%		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 reconfiguration of some surgical beds to medical thus significantly reducing outliers.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	May-18	49.3%	39.3%	52.5%	48.7%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. 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	▲	Apr-18	68.7%	68.7%	90.0%	69.5%		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	▲	Apr-18	94.7%	94.7%	95.0%	89.5%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Apr-18	98.8%	98.8%	95.0%	99.1%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

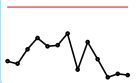
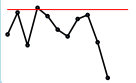
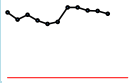
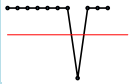
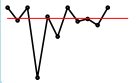
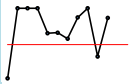
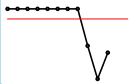
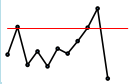
	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Apr-18	83.9%	83.9%	83.0%	90.3%		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	Following previous months deterioration, plans for improvement have resulted in achievement against the target	RC
PATIENT SAFETY (appendices pages 39-42)												
Number of never events	Q	▲£	May-18	0	0	0	2		The National safety standards for invasive procedures will provide further mitigation against future never events.	Quality and patient safety	No never event reported for 2018/19	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	May-18	99.6%	99.2%	98.9%	98.9%		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	May-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	▲£	May-18	0	0	0	2		Internal RCAs on-going with more recent cases of C. Difficile.	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	▲£	May-18	2	4	40	19					SR
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		May-18	3	4	No Target	22					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Apr-18	0	0	No Contract target	0		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	▲	Apr-18	0	0	No Contract target	22		No severe harm fall reported in April 2018.	Quality and patient safety	Falls action plan progressing and monitored through Strategic Falls Group. New initiatives and awareness session programmes planned.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲£	Apr-18	95.13%	95.13%	95.0%	93.67%		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	Apr-18	2	2	No Target	31					
To achieve and maintain CQC registration	Q		May-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	Apr-18	95.6%	95.6%	No Target	93.9%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	The next Shelford audit will be reported to June's Board.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Apr-18	0	0	No Target	1					

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	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	▲ £	Apr-18	93.0%	93.0%	93.0%	95.0%		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	▲ £	Apr-18	100.0%	100.0%	96.0%	97.7%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Apr-18	94.2%	94.2%	85.0%	87.4%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	May-18	93.7%	93.7%	92.0%	94.0%		In May 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 have now been 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	▲	Mar-18	100.0%		99.0%	100.0%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	May-18	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	May-18	0.8%	0.7%	0.8%	0.6%		The cancelled ops targets continue to be achieved in May	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.	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Apr-18	100.0%	100.0%	100.0%	99.4%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	May-18	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	May-18	71.8%	72.1%	95.0%	78.2%		May 2018 Type 1 performance was 71.8% which was a deterioration from April position of 72.4%. Activity was particularly high in May with 10,065 attendances - 8.8% increase compared with May 2017 (818 more patients). Medical staffing has been the main issue affecting performance (business case is being prepared to convert locum/agency spend into substantive). Bed capacity has not been an impediment to performance. Work has continued to maintain low numbers of 'good to go' patients and no outliers. Ambulance notification to handover compliance has been excellent at 14.32 mins on average against 15 minute target.	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	▲	May-18	86.4%	86.5%	95.0%						
A&E: 12 hour trolley waits	F&P	▲	May-18	0	0	0	0					

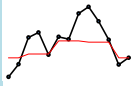
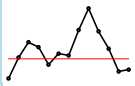
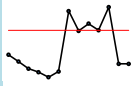
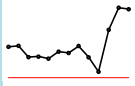
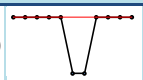
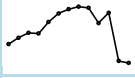
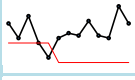
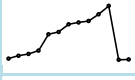
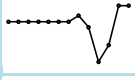
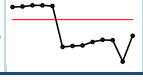
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲£	May-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	May-18	24	33	No Target	224		% new (Stage 1) complaints resolved in month within agreed timescales continues to improve overall. There has been an increase in the number of new complaints received in the last month bringing the year to date total in line with previous figures.	Patient experience	The Complaints Team continue to improve the timeliness of responses.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	May-18	19	35	No Target	270					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	May-18	89.5%	91.4%	No Target	67.0%					
DTOC: Average number of DTOCs per day (acute and non-acute)		T	May-18	10	10	No Target	20		In May 2018 the average number of DTOCS (patients delayed over 72 hours) was 10.		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	▲	Mar-18	81.6%		90.0%	87.5%		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 a decrease in recommendation rates in March 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	▲	Mar-18	95.9%		90.0%	95.8%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Mar-18	100.0%		98.1%	98.5%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Mar-18	100.0%		98.1%	97.9%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Mar-18	98.7%		95.1%	96.6%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Mar-18	93.8%		98.6%	98.1%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Mar-18	93.7%		95.0%	94.5%					

May-18

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 53-60)												
Sickness: All Staff Sickness Rate	Q F&P	▲	May-18	4.3%	4.2%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.7%		In May overall absence increased by 0.05% to 4.3% against the Q1 target of 4.25%. Qualified & HCA sickness remained at 4.8% against a target of 5.3%.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	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	May-18	4.8%	4.8%	5.3%	5.7%					
Staffing: % Staff received appraisals	Q F&P	T	May-18	80.1%	80.1%	85.0%	88.4%		Mandatory Training compliance exceeds the target by 10.7%. Appraisal compliance is below the target by 4.9%.	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 Mandatory Training & to improve the rate of compliance for Appraisals with non-compliance being reviewed by the Trusts Executive Committee on a monthly basis and also at department level finance & performance meetings.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	May-18	95.7%	95.7%	85.0%	92.5%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q4	92.0%		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.	Findings from the Q4 survey have been shared with Survey Champions in Clinical Support Services and Corporate areas following the publication of the results in April.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q4	76.7%		No Contract Target						
Staffing: Turnover rate	Q F&P	T	May-18	0.6%		No Target			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	May-18	3.0	3.0	3.0	3.0		At the end of M2 the Trust is currently delivering financial performance in line with agreed plans. The Trust is currently forecasting delivery of the plan but still has a proportion of the Cost Improvement Programme unidentified. Better payment compliance is currently not being achieved.	Delivery of Control Total	Weekly update to be provided to DoF on current progress of internal schemes. Divisions to report progress at Finance & Performance Committee. Executives to engage external stakeholders regarding progress of transformational programmes that will assist in delivering the Cost Improvement Programme. The approval of invoices within the Trust is impacting compliance. The Finance department will continue to work with areas of the Trust that need to improve.	NK
Progress on delivery of CIP savings (000's)	F&P	T	May-18	972	972	19,000	12,325					
Reported surplus/(deficit) to plan (000's)	F&P	T	May-18	(2,281)	(2,281)	10,993	5,001					
Cash balances - Number of days to cover operating expenses	F&P	T	May-18	18	18	2	12					
Capital spend £ YTD (000's)	F&P	T	May-18	202	202	9,516	9,180					
Financial forecast outturn & performance against plan	F&P	T	May-18	10,993	10,993	10,993	5,001					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	May-18	92.2%	92.2%	95.0%	91.4%					

APPENDIX A

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

			Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	2018-19 YTD	2017-18 Target	FOT	2017-18	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	100.0%	84.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	85.0%		97.0%		
	Total > 62 days		0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.5	0.0	0.0	0.0			3.5		
Lower GI	% Within 62 days	▲ £	76.9%	100.0%	100.0%	92.3%	84.6%	69.2%	88.9%	82.4%	78.6%	80.0%	91.7%	75.0%	100.0%	100.0%	85.0%		84.0%		
	Total > 62 days		1.5	0.0	0.0	0.5	1.0	2.0	0.5	1.5	1.5	2.0	0.5	1.5	0.0	0.0			12.5		
Upper GI	% Within 62 days	▲ £	100.0%	100.0%	100.0%	33.3%	88.9%	80.0%	100.0%	86.7%	100.0%	100.0%	63.6%	100.0%	80.0%	80.0%	85.0%		87.2%		
	Total > 62 days		0.0	0.0	0.0	1.0	0.5	0.5	0.0	1.0	0.0	0.0	2.0	0.0	1.0	1.0			5.0		
Urological	% Within 62 days	▲ £	92.7%	59.3%	82.1%	83.3%	81.3%	87.5%	77.4%	90.2%	96.6%	60.9%	96.8%	86.2%	93.8%	93.8%	85.0%		82.5%		
	Total > 62 days		1.5	5.5	3.5	3.0	4.5	1.5	3.5	2.0	0.5	9.0	0.5	2.0	1.0	1.0			37.0		
Head & Neck	% Within 62 days	▲ £	66.7%	66.7%	75.0%	75.0%	42.9%	20.0%	100.0%	83.3%	80.0%	33.3%	66.7%	100.0%	50.0%	50.0%	85.0%		64.6%		
	Total > 62 days		0.5	0.5	0.5	0.5	2.0	2.0	0.0	0.5	0.5	1.0	0.5	0.0	0.5	0.5			8.5		
Sarcoma	% Within 62 days	▲ £	66.7%		100.0%		0.0%	100.0%			50.0%	33.3%	100.0%	100.0%	100.0%	100.0%	85.0%		66.7%		
	Total > 62 days		0.5		0.0		0.5	0.0			0.5	1.0	0.0	0.0	0.0	0.0			2.5		
Gynaecological	% Within 62 days	▲ £	70.0%	83.3%	100.0%	68.8%	55.6%	83.3%	100.0%	94.1%	55.6%	90.9%	66.7%	77.8%	87.5%	87.5%	85.0%		78.2%		
	Total > 62 days		1.5	1.0	0.0	2.5	2.0	0.5	0.0	0.5	2.0	0.5	0.5	1.0	0.5	0.5			12.0		
Lung	% Within 62 days	▲ £	100.0%	73.7%	85.0%	100.0%	72.7%	71.4%	87.5%	66.7%	100.0%	80.0%	100.0%	100.0%	87.0%	87.0%	85.0%		84.7%		
	Total > 62 days		0.0	2.5	1.5	0.0	1.5	1.0	0.5	3.0	0.0	1.5	0.0	0.0	1.5	1.5			11.5		RC
Haematological	% Within 62 days	▲ £	100.0%	66.7%	50.0%	71.4%	100.0%	50.0%	100.0%	85.7%	76.9%	100.0%	88.9%	83.3%	100.0%	100.0%	85.0%		80.6%		
	Total > 62 days		0.0	1.0	1.0	1.0	0.0	3.0	0.0	0.5	1.5	0.0	0.5	1.0	0.0	0.0			9.5		
Skin	% Within 62 days	▲ £	92.5%	93.9%	98.1%	93.9%	93.0%	88.9%	95.2%	98.2%	97.7%	100.0%	95.5%	92.5%	100.0%	100.0%	85.0%		95.2%		
	Total > 62 days		1.5	1.0	0.5	1.5	1.5	2.0	1.0	0.5	0.5	0.0	1.0	2.0	0.0	0.0			13.0		
Unknown	% Within 62 days	▲ £	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%		75.0%	100.0%	100.0%	85.0%		78.4%		
	Total > 62 days		1.0	0.0	0.0	1.0	0.0	0.0	1.0	0.0	0.0	0.0		1.0	0.0	0.0			4.0		
All Tumour Sites	% Within 62 days	▲ £	88.2%	81.6%	91.4%	87.1%	84.5%	80.6%	89.5%	90.3%	90.6%	85.2%	89.1%	89.6%	94.2%	94.2%	85.0%		87.4%		
	Total > 62 days		8.0	12.5	7.0	11.0	13.5	12.5	6.5	9.5	7.0	15.0	8.0	8.5	4.5	4.5			119.0		
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%					85.0%		100.0%		
	Total > 31 days						0.0		0.0		0.0	0.0							0.0		
Acute Leukaemia	% Within 31 days	▲ £								100.0%							85.0%		100.0%		
	Total > 31 days									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)55

Title of paper: Executive Committee Chair's Report – May 2018

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 May 2018.

There were a total of 5 Executive Committee meetings held during May.

The Executive Committee agreed:

- The Use of Resources assessment evidence submission;
- The never events action plan;
- Initiation of the SafeCare implementation project;
- The Trust approach to the Lead Employer procurement opportunity and responses to the Lead Employer apprenticeship levy;
- Preparations for the CQC Well Led inspection.

The Executive Committee also received the regular assurance reports covering Marshalls Cross Medical Centre, the Integrated Performance Report, agency and locum usage, safer staffing and shift shortfalls, appraisal and mandatory training compliance, the Risk Management Council and Corporate Risk Register.

Trust objectives met or risks addressed:

All 2018/19 Trust objectives.

Financial implications:

None arising directly from this report.

Stakeholders: Patients, Patients Representatives, Staff, Commissioners, Regulators

Recommendation(s): That the report be noted

Presenting officer: Ann Marr, Chief Executive

Date of meeting: 27th June 2018

FEEDBACK FROM THE EXECUTIVE COMMITTEE
May 2018

1. Introduction

There were 5 Executive Committee meetings in May 2018.

2. 3rd May 2018

2.1 Benchmarking Data on Shift Shortfalls – March 2018

The Director of Nursing, Midwifery and Governance presented the report detailing the number of shifts which had been short of a registered nurse. This information analyses staffing differently from the Safer Staffing report calculations which are based on care hours per patient, and provides an additional source of assurance that the wards remained safe across all three shifts in a 24 hour period. In March 7.35% of shifts had been short of one qualified nurse, as a result of vacancies or staff absence. This was before mitigation via the agreed escalation process that enabled matrons to reallocate staff during the shift to provide safe levels of care on every ward.

The Executive Committee requested further detail about ward 1D, where staffing levels were most challenging.

2.2 eRostering Key Performance Indicators

The Deputy CEO/Director of Human Resources presented the report on the five key performance indicators for eRostering, for Quarters 3 and 4 of 2017/18. The five key metrics are: Trust roster approval lead time; Trust filled duty count; Trust hour's balances percentage; Trust bank and agency use percentage and Trust annual leave percentage. It was demonstrated that performance had improved and the Trust was now consistently achieving 6 weeks advance notice of the roster. Some wards needed some additional support to improve performance and a 90 day improvement programme was being initiated.

A weekly report showing the performance of each ward was discussed with matrons.

The next phase of the project was to implement the SafeCare programme to work alongside eRostering. SafeCare would provide information on patient acuity to facilitate more responsive and real time deployment of staff.

2.3 Marshalls Cross Medical Centre - Update

The Director of Transformation presented the monthly activity and assurance report in relation to the primary care service. The number of referrals to secondary care had increased and this would be investigated. Performance monitoring on appointment utilisation and attendance was now embedded.

The Executive Committee also reviewed the potential models of primary care provision for the future and it was agreed that the Director of Transformation should produce a paper for discussion.

2.4 Lead Employer Procurement

The Deputy CEO/Director of Human Resources provided an update on the changes to the Lead Employer procurement process. The specification had been revised by the Health Education North West (HENW) steering group to seek a single lead employer for Cheshire and Merseyside, Lancashire and Greater Manchester. The Executive Committee considered the implications of this change and the opportunities and risks for the Trust of bidding to be the lead employer for the whole North West region.

2.5 Medway Programme - Update

The Director of Informatics provided an update on the Implementation Programme. The system had gone live on 29th April as planned. The process had gone well but there were inevitably a number of teething problems that were currently being resolved. The staff had adapted to the system very easily, but the intensive support available from the Health Informatics Service would continue for as long as staff needed it.

3. 10th May 2018

3.1. MSSA Bacteraemia Action Plan

The Director of Nursing, Midwifery and Governance presented the action plan that had been developed to reduce avoidable MSSA Bacteraemia infections. MSSA is more prevalent in the general population than MRSA but can still be a serious infection for vulnerable patients. Many of the actions were to enforce infection control best practice and monitor compliance. Performance would be monitored via the new ward quality dashboard.

3.2 Gender Pay Gap Information

The Deputy CEO/Director of Human Resources presented the gender pay gap information that every NHS organisation has to publish annually. The Trust workforce is 85% female, which reflects the NHS nationally. The Trust information is similar to other Acute Hospitals. The Executive Committee reviewed the data and asked for further analysis for some staff groups and Agenda for Change grades, to assess if any specific actions needed to be taken at Trust level.

3.3 Agency Staffing Benchmarking

The Deputy CEO/Director of Human Resources presented a report on the 2017/18 agency spend and benchmarking on hourly rates for different types of staff. The top ten hourly rates paid by the Trust and the reasons why they had been agreed were reviewed. The plans in place for reducing agency spending in each case were acknowledged, with regular reviews of progress.

It was agreed that more detailed comparative information by Trust and by speciality would help to determine where further action should be targeted.

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

The Director of Corporate Services presented the Risk Management Council Chair's report and the risks escalated to the Corporate Risk Register during April 2018. A number of the risks now needed to be updated for the new financial year and the number of risks reviewed in accordance with the review dates had improved.

3.5 Trust Board Agenda

The Director of Corporate Services presented the draft Board agenda based on the annual business cycle and the action log. The Executive Committee agreed the draft agenda.

3.6 Use of Resources Assessment

The Director of Finance gave a presentation detailing the requirements for the forthcoming Use of Resources (UoR) assessment that would be undertaken by NHS Improvement on 5th July. The initial Trust evidence submission had to be made by 25th May 2018. The presentation also detailed the process for reviewing each of the key lines of enquiry and who would be the lead director for each section.

4. 17th May 2018

4.1 Medway Programme Update

The Director of Informatics provided an update on the Medway implementation and resolving the outpatient clinic booking issue that had been identified following the switch over. Operational management and the informatics team were working closely together and additional staff had been deployed to support recovery. The rest of the system was operating as planned and activity reporting from the system was starting.

4.2 CQC Provider Information Request

Following submission of the routine CQC PIR, an action plan was presented by the Director of Nursing, Midwifery and Governance to assist the Trust in preparing for the expected CQC inspection.

4.3 Review of Trust Policies

The Director of Nursing, Midwifery and Governance presented the regular assurance report. This identified that a number of policies were due to expire in May and June 2018 at the end of the 3 year cycle, and needed to be updated and re-approved via the appropriate governance committee or council. Monthly progress reports were requested until the position recovered.

4.4 Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme Submission

The Director of Nursing, Midwifery and Governance presented the progress made in achieving the 10 national maternity safety standards. Further work was required on 1 standard, which would be completed before the CNST deadline. To receive the CNST premium discount a report to the Trust Board was required by the end of June 2018.

4.5 Mandatory Training and Appraisals Report - April

The Deputy CEO/Director of Human Resources presented the monthly report by responsible Director for mandatory training and appraisal compliance against the Trust target of 85%.

4.6 Executive Committee Annual Effectiveness Review

The Director of Corporate Services presented the Executive Committee annual effectiveness review. This detailed changes to the terms of reference and annual work programme recommended for 2018/19 and a review of member attendance and experience of the committee during 2017/18. The recommendations of the report were approved.

4.7 Integrated Performance Report (IPR) Review

The Director of Finance presented the draft IPR for April and the Executive Committee reviewed each section and the accompanying commentary. The majority of indicators were reported as normal, with a few exceptions where the data available from the Medway system had not yet been fully quality assured. All stakeholders had been notified that there could be gaps in reporting as a result of the major change to the new patient administration system.

4.8 Lead Employer Procurement Update

The Deputy CEO/Director of Human Resources briefed the committee on the work to prepare a bid for the lead employer contract and the commercial considerations and financial modelling that were being undertaken. The proposals were to be discussed at the Trust Board in May, due to the value of the contract.

5. 24th May 2018

5.1 Use of Resources (UoR) Submission

The Executive Committee reviewed each of the domains and the latest reported information on the Model Hospital site, in preparation for the submission to NHS Improvement.

5.2 Apprenticeship Levy

The Deputy CEO/Director of Human Resources presented a paper detailing options for managing the apprenticeship levy as it applied to Lead Employers, who managed Junior Doctor and GP contracts on behalf of the

regional Deaneries. Discussions were also progressing at national level to resolve this issue, which was a potential barrier to collaborative working and the lead employer model.

5.3 CQC Project Plan

The Director of Corporate Services presented the revised project plan and gave an update on progress to date. This included revision of the advice booklet for staff explaining the new CQC inspection process.

5.4 SafeCare Implementation Project

The Interim Deputy Director of Nursing presented the paper, which outlined the implementation phase for the SafeCare module of the Allocate Rostering system. This will begin in July, with a pilot on one ward and if successful is scheduled to be fully implemented by November 2018. SafeCare will enhance the Trust's ability to deploy its staff effectively and is designed to increase patient safety.

5.5 Never Events Investigation Report

The Medical Director introduced a report detailing the findings of the Never Event investigations. The Executive Committee explored how the recommendations would be fully implemented and progress monitored.

5.6 Review of 2017/18 Trust Objectives

The Chief Executive presented the initial review of performance against the 2017/18 Trust Objectives, prior to presentation at Trust Board in May. The achievement of the majority of the objectives, despite the increased activity pressures experienced during the year, was noted.

5.7 Future of Primary Care

The Director of Transformation presented a paper that reviewed the primary care landscape locally and set out different models of primary care provision that could be developed as part of Integrated Care Systems. Further detail was requested with a view to the Trust Board developing a primary care strategy.

6. 31st May 2018

6.1 Safer Staffing and Vacancy Dashboard

The Director of Nursing, Midwifery and Governance presented the monthly safer staffing report including any wards where a 90% fill rate had not been achieved; the actions taken and any correlation with incidents of patient harm e.g. falls. The medical wards continued to have the highest vacancies and were more challenging to attract bank and agency staff. Changes to future reports were agreed that would enhance the assurance being provided.

6.2 Safer Staffing National Guidance Compliance

The Director of Nursing, Midwifery and Governance had reviewed the Trust processes against the revised national guidance and was able to confirm that the ward nurse staffing establishment complies with national guidance of 1:8 days and 1:11 at night. The majority of wards for day staffing when fully established equates to 1.6.7 registered nurses. These benchmarks demonstrated that the Trust is investing sufficiently in nursing but the challenge remains filling all the substantive positions because of the national shortage of qualified nurses.

6.3 Reporting of National Patient Surveys and Benchmarking Reports

The Director of Nursing, Midwifery and Governance had undertaken a review of the Trust's internal processes for receiving, reporting and responding to national patient surveys. It was agreed that all surveys should initially be received by the Chief Executive. A review of the effectiveness of each of the governance councils was also suggested to ensure that issues were being escalated to the appropriate committee in a timely manner.

6.4 eMews Audit

The Director of Nursing, Midwifery and Governance presented the findings of a recent eMews audit. Further analysis was required to ensure the findings of the audit were robust. The plan to move to electronic recording of the eMews and ePews assessments was discussed; this was to be a priority after the Medway implementation had been completed.

6.5 Paediatric Emergency Department Action Plan

The Director of Nursing, Midwifery and Governance outlined the learning identified from an incident investigation, and the actions that had already been put in place.

6.6 MSSA v MRSA

The Medical Director had clarified that the Trust reported incidence of MSSA is consistent with the incidence of MSSA in the general population. MSSA is not routinely screened for on admission, but the Trust action plan would be updated to include consideration of screening and increased awareness training.

6.7 Changes to Agency Staff Cap

The Deputy CEO/Director of Human Resources reported that NHS Improvement had issued revised guidance on the agency cap, which reduced the ceiling on the rate per hour. The Trust approval and escalation processes were being amended to reflect these changes.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)56

Title of paper: Committee report – Quality Committee

Purpose: To summarise the Quality Committee meeting held on 19 June 2018 and escalate issues of concern.

Summary: Key items discussed were:

1. Complaints

- There were 24 1st stage complaints were received and opened in May 2018; an increase of 15 from April 2018, when the lowest number of complaints was received for some time
- At the end of May 2018, there were 38 open 1st stage complaints, (an increase of 36%) in comparison to 28 at the end of April 2018
- The Trust responded to 89.5% of 1st stage complaints within agreed timeframes during May 2018; a slight decrease compared to 93.8% in April 2018
- Clinical treatment was the primary cause of complaint in May 2018, which is consistent with previous months
- 1 new case was referred to the PHSO in May 2018
- There was a 19.1% increase in PALS contacts (288) compared to the previous month which is putting strain on the department. A business case will be submitted in September to review the resources and potential for up skilling, also to review the management of 'Ask Ann responses'.
- Communications remains the main reason for enquiries to PALS
- Breakdown of complaint decision by theme was included in report. None of the complaints relating to clinic treatment were upheld; 3 were partially upheld and 5 were not upheld. Clinical treatment accounts for 30% of the complaints that were either partially upheld or upheld, similarly, complaints relating to Patient /Nursing care accounts for 30% of the complaints that were partially upheld, none were fully upheld.
- Better performance on agreed response times has been maintained but the situation will continue to be monitored.

2. IPR

A&E performance remains a key issue; infection control, finance & HR targets were also discussed.

- The Trust is reporting an overall deficit of £2.3m in line with agreed plans. The full allocation of Provider Sustainability Fund (£1.3m) is included. Failure to recover the A&E position by the end of Q1 could result in the Trust losing 25% of this money.
- CIP and cash balances are in line with plan

3. Safer Staffing

Overall Trust % staffing fill rates May were:

a. RNs on days 96.97%
b. RNs on nights 98.45%
c. Care staff on days 114.30%
d. Care staff on nights 115.02%

- 7 out of the 32 wards (compared with 13 wards in April) had a % fill rate of less than 90% for RN: Wards 1A, 1D, 2B, 3B, 3D, 5A and 5B.
- No wards had a % fill rate of less than 90% for care staff.

- The fill rates are below 90% in spite of Trust procedure being adhered to in order to backfill any staff shortages on shifts due to last minute staff absence and the on-going challenges with recruiting NMC registered staff. This is a particular challenge facing the adult medical specialities of respiratory, general medicine and care of the elderly, frailty and stroke and in spite of a proactive recruitment campaign.
- 7 adult inpatient wards were below the recommended 3 Registered Nurse (RN) Care Hours Per Patient Per Day (CHPPD): 1A, 1D, 2B, 3C, 3D, 5A, 5B and Duffy.
- 73% of bank care staff shift requests were filled during the month and only 29% of registered staff bank and agency requests were backfilled. Shifts that remain unfilled are filled whenever possible by Trust staff last minute agreeing to flex their off duty or working an extra or overtime shift.
- During the month of April 2018 there were 54.93 RN WTE vacancies for inpatient wards
- In May 2018 there were no patients who experienced severe harm following an inpatient fall.

4. CQC Update

It was confirmed by ARW that all outstanding actions from the previous CQC visit have now been completed.

ARW confirmed that in preparation for our next inspection which is imminent, all staff have received an information booklet, a list of key information together with a copy of the escalation process. Mock inspections, supporting by the Executive Team, are currently taking place on selected areas and departments. Feedback received to date has been very positive. Processes are being strengthened and any housekeeping issues rectified. All actions are being addressed by the CQC Operational Group and more importantly, immediately within the area/department.

5. Ward Dashboard

The current Ward Dashboard is under review. Other Trusts' dashboards have been analysed and we are reducing our 21 indicators down to 10. The dashboard will be presented to the Committee after finalisation by the Data Quality Team.

6. CNST Incentive Report

- The Maternity Safety Strategy has set out the Department of Health's target of halving the rates of stillbirths, neonatal and maternal deaths, and brain injuries associated with delivery by 2025. The first milestone in achieving the target is a 20% reduction by 2020.
- In order to incentivise improvement NHSR will be making a 10% reduction in the CNST maternity contributions of Trusts who are able to demonstrate compliance of the 10 agreed criteria.
- The Trust is fully compliant with all criterions.

7. The Continuity of Carer Initiative

- A plan has been developed to ensure that continuity of care in the antenatal, intrapartum and postnatal periods will be provided by a small midwifery team.
- A multi-disciplinary engagement event took place on 23 April to generate ideas and discussion on how we achieve the implementation of 20% of women receiving continuity of carer.
- Financial implications for the Trust discussed.
- The project will be overseen by the Quality & Safety team. The next meeting is set for 27 June 2017.
- Progress updates will be provided quarterly by the Head of Midwifery.

8. Freedom to Speak Up

- The Trust has developed a process and function of the Freedom to Speak Up Guardian role which is supported by the online platform, Speakinconfidence.
- In 2017/18 there were 11 concerns raised and reported to the National Guardians Office as required. 5 were via Freedom to Speak up referrals and 6 were anonymous.
- Benchmarking is challenging as the process varies between organisations, however based on annual data submitted the average number of concerns raised was 25.
- A review of the policy is currently being undertaken in the context of the national agenda utilising the FTSU policy template.
- The Trust is compliant in all aspects of the National Guardians Survey recommendations.

9. Medical Revalidation

- There are no key points or issues to be discussed, KH recommended the paper is approved by the Committee.

10. NG Tube Never Event Update

- Although progress was slow initially, all actions with the exception of 2 are complete with evidence uploaded.
- The 2 outstanding actions relate to trust wide NG tube Staff Training as the deadline was short.
- The training package is now available and is being rolled out across the Trust.

11. Shelford Audit Update

- Further analysis of the information is required before presenting the report to the Committee next month.

12. Medicine Optimisation Strategy Update

High priority objectives identified are:

- ePMA roll out – Dorset and Poole have now rolled the system out which indicates that the 'bugs' which prevented wider roll out have now been addressed.
- Minimisation of delayed and missed doses – this is difficult without ePMA. Actions to reduce risk remains a high priority.
- Minimisation of prescribing errors – pharmacists are providing formal feedback to prescribers regarding errors in line with PhD findings. Data is reported to the Medicines Safety Group.
- Safe storage and security of medicines – the trust wide audit is taking place end of June. Two weekly targeted audits have been regularly performed in ED the results of which have improved markedly.
- Novel methods of communication with clinical staff.
- Antimicrobial stewardship – the strategy was updated in June and methods of enhancing communication of key messages with care groups are being explored.
- Simon Gelder and the Pharmacy Team were commended for their excellent work over a period.

13. Feedback from Councils:

Patient Safety Council: The summary page was noted by the Committee and highlighted the following:

- Nasogastric training plan to be revised to focus on specific areas and staff; with key trainer cascade training methodology.
- Insulin training compliance recorded on ESR is sub optimal. Data correction and appropriate training is to be monitored. Discussion took place regarding appropriate

training for the appropriate staff. Head of Nursing & Quality to review staff requiring training.
- A recent CD audit storage results has highlighted areas which require improvement. Actions are in place but formal repeat audit is still under analysis. The policy has been updated.

Patient Experience Council: Summary page noted. No items to escalate.

Clinical Effectiveness Council – Verbal update given as follows:
- There are issues relating to ILS compliance for RNs. ***Action: SR to escalate.***
- DNACPR documentation non-compliance identified. This is being addressed by an action plan monitored by the End of Life workstream.
- Delays have been identified to maternity Antenatal bookings due to the implementation of the new Medway system. A resolution has now been developed.
- Issues relating to the Pharmacy Ascetic Unit: an action plan is now in place to address.
- Concerns highlighted relating to the reporting of Clinical Audit action plans. Discussion took place regarding capacity within the Clinical Audit department. Capacity may need to be enhanced; a business case is being prepared.

CQPG – the meeting took place on the same day.

- Policies/Documents Approved:

None discussed

14. AOB - None noted.

Items to be brought to the attention of the Board:

- A&E performance (whilst this is a key issue for the Trust, the Quality Committee seeks ongoing assurance that the service to patients remains safe)
- CQC Inspection and preparation
- NG Tube safety and training
- Insulin: safe administration and training
- Maternity: Continuity of Carer Initiative
- Medicines Optimisation Strategy progress (SG and Team to be commended)

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: 27 June 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)57

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance and Performance Committee, 21st June 2018

Summary:

Agenda Items

For Approval

- Reference Costs 2017/18
    - The paper was presented for the approval of the costing processes and procedures unpinning the Reference Costs submission. This is a requirement of NHSI before the submission deadline of 31st August 2018. This action was approved by the Committee.

For Information

- CIP Procurement Council
    - The briefings were accepted

For Assurance

- A&E Update
    - The Clinical Director for A&E presented the performance for May; it was highlighted that activity from Halton CCG has increased significantly compared to other areas and in various points of delivery. Further investigation will continue to understand the issues including assessing whether this increase is a movement from other Trusts or a spike in overall Halton CCG activity.
    - Initiatives tried within A&E to improve performance have included 'Doc in the Box', Senior ED sister taking charge of the shift overnight and a Consultant with two FY2's approach but these aren't being used consistently due to staffing issues. Business cases are currently in development to give the department a more sustainable staffing model with less reliance on the rotations from the Deanery.
    - Whilst the presentation was welcomed and reassuring the committee could not be assured on the ongoing performance. The committee noted that there had been days when beds and staffing were favourable but A&E performance was still not being achieved. Specific feedback was to be given to the A&E department and the clinical leaders were asked to present again in July with more evidence around the actual impact of the initiatives recently implemented.

- Integrated Performance Report Month 2
    - Discussion took place around operational performance with specific reference to MRSA and C-Diff. There have been two confirmed C-Diff cases to date after successfully appealing 9; our tolerance for the year is 40.
    - There was special recognition for the teams responsible for cancer performance, there has been significant achievement in the 62 day cancer targets which has been led by John McCabe.

- Finance Report Month 2 2018/19
    - The month 2 financial position was presented to the committee showing a £2.281m deficit position with includes all allowable PSF funding and is in line with

plan. To achieve the year to date position STHK has utilised £0.8m of non-recurrent options.

- Total Trust year to date expenditure on Agency at month 2 is £1.594m which is £0.397m over our planned trajectory, the NED's questioned the processes around approval and sought assurances that NSHI sign off processes are in place.
- The impact of the new PAS system was queried in relation to the reduction in outpatient activity. It was acknowledged there has been an issue during the implementation of Medway and Patient Booking Services staff are working to reduce the back log of patients not booked onto the correct clinics. Discussions need to continue with commissioners to ensure we don't lose payment for these patients under the current flex and freeze system.

- CIP Programme update
  - An overview of the Trust wide CIP position was presented which showed an improvement of £2.382m in value of transacted schemes from last month. The Trust now has recurrent plans of c. £15.5m including work in progress of £2.6m. Plans continue to develop within the Care Groups and a number of schemes have been identified with CIP lead officers and indicatives values.
  - It was noted that the Trust should not lose sight of the c£4.5m STP CIP programme and activity seek how this will be achieved.
- CIP Programme update – SCG
  - Surgical Care Group presented an update on their CIP programme highlighting the work done to date within the Care Group. The Care Groups overall target of £4.4m has been devolved to specialities using a pro-rata of budgets basis.
  - Formal CIP meetings are in place including the Divisional Medical Director, ADO, Finance Business Partner and CD's. A template has been devised to log the ideas generated including target dates for actions to be completed.
  - The committee queried whether an apportionment based on budgets was the best metric given the wealth of benchmarking data we have available to identity variation. The Care Group assured the Committee that while the targets had been set this way the specialties had used a variety of sources such as GIRFT, Model Hospital and SLR to identify opportunities to achieve that target.
  - It was also noted there were a number of income scheme which could be unaffordable for our host CCG but the Care Group gave assurances that this was focused on repatriation of existing work from other areas so should be cost neutral to the CCG.

Risks noted

- Assumed PSF in our income position noting the current A&E performance.
- Back ended CIPs profile and STP element of CIP
- Impact of Medway for OP activity and in particular OP procedures.
- Sustained growth in attendances, especially within non-elective care

Actions Agreed

- Five key actions to be agreed to monitor A&E progress and improvement for review at each F&P meeting
- RTT figures by CCG

Issues to be raised at Board

- Limited assurance on initiatives in A&E at this stage to improving A&E performance in a

sustainable manner. • Continued growth in A&E attendances and non-elective patients.
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: Jeff Kozer, Non-Executive Director
Date of meeting: 27th June 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)58
Subject: Workforce Equality, Diversity & Inclusion Update
Purpose: To inform the Board regarding the planned approach to all aspects of Equality, Diversity & Inclusion relating to the Trust's Workforce and to provide an update to the Board regarding actions relating to the WRES
Summary: Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS provider organisations. The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The Trust is monitored against the nine indicators of the WRES and this report provides an update on action taken to date. A review of all action plans relating to Equality, Diversity and Inclusion has prompted a new approach, to bring all associated actions together into a three-year Equality, Diversity & Inclusion Action Plan that will go through the normal approval route (Equality & Diversity Steering Group and Workforce Council) and reported to the Board when completed.
Corporate Objective met, or risk addressed: Developing organisational culture and supporting our workforce
Financial Implications: N/A
Stakeholders: Staff, Managers, Executive Board, Patients.
Recommendation(s): The Trust Board are requested to note and approve the updated WRES report and actions.
Presenting Director: Anne-Marie Stretch, Deputy CEO & Director of Human Resources
Board Date: 27th June 2018

1. Introduction

The focus on Equality, Diversity and Inclusion for the workforce, has increased significantly in recent years and legislation in this area has also increased in response. The most recent legislation being, the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017. The NHS has to comply with this legislation as with any other employer and in addition, has also introduced through the NHS Standard Contract, its own mandated reporting requirements – the Workforce Race Equality Standard (WRES) introduced in 2015 and the Workforce Disability Equality Standard (WDES) due to be introduced In the Autumn of 2018.

Across the Trust, there exist several action plans/actions relating to the Workforce Race Equality Standard (WRES), Equality Delivery System (EDS2), the Trust's Equality Objectives, Gender Pay Gap and in preparation for, the Workforce Disability Equality Standard (WDES) together with the recommendations of an independent Equality and Diversity expert. Despite the distinct nature of these mandated systems they are complementary.

Following a review of the associated action plans, it has become clear that several of the recommendations and activities that have been undertaken overlap and are capable of achieving more than one, of the stated aims or objectives.

To coordinate all activity for the Equality, Diversity and Inclusion agenda and to broaden the scope of that activity to meet the Trust's overall objective of Promoting Inclusion and Valuing Diversity and to meet the requirements of the Equality Act 2010, all existing action plans are being collated into a three-year plan. To enhance the breadth of activity, research has been undertaken by speaking to other organisations and learning from their experiences and successes.

While the governance arrangements for reporting on Equality, Diversity and Inclusion are being reviewed, the new three year action plan (currently in draft form) will be agreed and approved through the normal routes - at the Equality, Diversity and Inclusion Steering Group that reports into the Workforce Council & then through Quality and Performance Committee. The Equality, Diversity and Inclusion Steering Group have an extensive and inclusive membership including a Non-Executive Director. It is envisaged that the Plan will be a living document, populated by suggestions from our staff and particularly from protected characteristic groups. When the first draft has been agreed and approved it will be submitted to the Board for information and noting.

There will continue to be separate reporting, as mandated, of the nine WRES indicators and an update of the report and actions that went to Board in February 2018, can be found below. A reminder of the WRES indicators can be found at Appendix 2.

2. WRES actions update (since February 2018)

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

Links to EDS2 3.1: *Fair NHS recruitment and selection processes lead to a more representative workforce at all levels*

VSM is defined as 'Chief Executive', 'Finance Director', 'Other Executive Director', 'Board Level Director', 'Clinical Director - Medical', 'Medical Director', 'Director of Nursing', 'Director of Public Health'

Action 1: Analyse the data provided in Table 1 further by care group, job role and disaggregation by ethnic origin to identify any trends or gaps.

Update 18/06/2018:

In the previous update information was provided of initial analysis however, the data required further analysis due to the relatively basic profile of the data. Further raw data has been requested so that more in-depth analysis can be carried out to identify trends or gaps in particular groups, job roles or ethnic origins.

Additional Action:
1. The Trust Equality, Diversity & Inclusion Group to oversee the required analysis and a future update to be provided with actions arising from it to be included in the Equality, Diversity and Inclusion Action Plan.

Action 2: To include a positive statement supporting applications from BME applicants on all advertisements. To also seek alternative advertisement methods via regional BME networks to capture a wider audience.

Update 18/06/2018:

The Trust includes a wide range of diversity footers within all of their advertisements examples of which have been included below:

"St Helens & Knowsley Teaching Hospitals NHS Trust are committed to providing an environment and services which embrace diversity and which promote equality of opportunity, we welcome applications from all sections of the communities we serve to enable us to reflect their diversity and improve the delivery of the services we provide."

"Any information gathered during the application process relating to protected characteristics as defined by the Equality Act 2010, is gathered for statistical purposes only and is not made available to recruiting managers at any stage of the recruitment process."

"As a 'Disability Confident Employer' we offer a guaranteed interview scheme for applicants who consider themselves to have a disability and who meet the minimum selection criteria (essential) at each stage of the selection process. You can indicate your wish to submit an application under the Trust's guaranteed interview scheme in the personal information section of the online application form."

"If you consider yourself to be disabled or have any other long term health issues and have special support needs in applying for a job, attending for an interview or in undertaking any tests as part of a selection process, please inform us of any reasonable adjustments you require in order for us to support you in maximising your ability to gain employment with us."

Additional Action:

1. To circulate advertisements to regional BME networks for wider circulation.

2. To consider use of advertisements in ethnicity media to maximise access to BME groups.

Action 3: Develop positive employee case studies of BME staff across ethnic origins to profile career progression success stories and encourage existing managers and individuals, as well as attracting potential staff to apply for vacancies.

Update 18/06/2018:

The Equality, Diversity & Inclusion Group will oversee the following:-

Additional Actions:

1. Review information available to first identify any potential case studies

2. Contact identified individuals to gain permission to use their 'story'

3. Interview identified individuals to get their 'success story'

4. Develop promotional material

It is envisaged that this will be completed by the end of December 2018.

Workforce Disability Equality Standard (WDES)

Action 4: In preparation for the introduction of WDES together with ongoing performance monitoring against the WRES, the Trust workforce will be encouraged to update all their data (including equality data on ESR self-serve) via the online ESR Portal. Communication to staff regarding who has access to this information, why we need it and what we do with it, will be provided.

Workforce Planning and Human Resources will lead on this and monitor progress via the ESR Steering Group and Equality & Diversity Steering Group.

This will also ensure the data in Indicator 1 for the WRES 2018 is as accurate as possible.

Update 18/06/2018:

A campaign is planned with effect from September 2018 to actively encourage staff to log onto self-service and update their personal information. This is the most appropriate mechanism to review the data held, regarding individuals. The campaign and information collected will be used to undertake the following actions:

Additional Actions:

1. Raising awareness campaign of the WDES, its purpose and what it means for individuals and employers

2. Raising awareness campaign of the importance and purpose of providing Equality information to the Trust

2. Provide data for the WDES and WRES reporting requirements

3. Enable the Trust to develop a WDES action plan to address any gaps identified and update its WRES action plan

- **<u>WRES Indicator 2</u>:** Relative likelihood of BME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts.

***Links to EDS2 3.1*:** *Fair NHS recruitment and selection processes lead to a more representative workforce at all levels*

Action 5: Review Equality & Diversity training provision across the Trust and introduce e-learning where appropriate. Ensure staff are provided with an understanding of the Equality Act, protected characteristics and signposting to further literature but also more in-depth training for those staff involved in recruitment and selection training and equality impact assessments.

Update 18/06/2018:

Equality and diversity training is provided to all staff at corporate induction and ongoing within the current one day mandatory training update. Work has been undertaken to identify a suitable e-learning alternative via OLM for both the current provision and for more in depth training for managers and those involved in the recruitment of staff. Technical incompatibilities between OLM and Trust IT infrastructure has prevented its launch, however a resolution is expected with a national update to ESR/OLM in July. In the meantime, staff who require Level 1 and Level 2 training have already been identified and this has been added to their competency modules. The additional actions below have also been identified.

Additional Actions:

1. Review the data already recorded and reported at Trust level for Equality Information purposes on shortlisting, interviewing and appointments for further monitoring. If the data allows, further drill down to Care Group and service level to monitor any trends that may show potential bias or discrimination.

2. Provide quarterly monitoring reports to Workforce Council on any trends identified by protected characteristic.

3. Where trends are identified, provide further intensive training to managers in those areas.

Action 6: Recognise the benefits of informal experience during the recruitment process and amend person specifications as appropriate.

Update 18/06/2018:

Person specifications have/are amended to include equivalent experience where appropriate and possible as an alternative to a recognised qualification.

- **WRES Indicator 3:** Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Indicator Guidance Note: this is calculated by cases entering the formal disciplinary process as measured by entry into a formal disciplinary investigation. This refers to staff who have entered a formal investigation as prescribed by the local disciplinary process. Any occasional cases where disciplinary action is not preceded by an investigation should also be included in this definition. Staff who have been subject to an investigation, but for whom no further action was taken should be counted.

Action 7: The introduction of the Employee Relations Tracker System in January 2018, will ensure accurate data collection and verification rather than the current system of an excel spreadsheet.

Update 18/06/2018:

The Employee Relations Tracker System introduction has been delayed due to some system glitches. These have now been resolved and data is shortly to be uploaded into the Tracker in order to 'go live'. It is expected that this will be prior to the end of September 2018.

Action 8: Further analysis of factors such as location, role, band, reason for disciplinary of all and BME staff to identify any trends or information gaps.

Update 18/06/2018:

In February 2018, the data for 2017 showed that BME staff were 3.68 times more likely to enter the formal disciplinary process when compared with white staff, although this indicator had improved slightly since the previous year.

The previous update referred to circulation of unconscious bias literature and undertaking case file reviews. The review of cases did not highlight any areas of concern however further work is planned to reduce the potential for any bias or discrimination.

***Additional Actions** as identified in the Draft Equality, Diversity & Inclusion Action Plan are:*

1. raise awareness of managers through specific training on areas such as unconscious bias and informal routes for settling issues/differences such as mediation

2. raise awareness with BME staff and managers of the different cultural acceptable norms for behaviour, etc which may be a contributing factor to a case. The increase in requirement to look at international recruitment may also influence the need to review this.

3. raise the profile of (and where appropriate re launch) BME staff networks

- **WRES Indicator 4:** Relative likelihood of BME staff accessing non-mandatory training and Continuing Personal Development compared to White staff.

Links to EDS 3.3: *Training and development opportunities are taken up and positively evaluated by all staff*

Action 9: The Oracle Learning Management (OLM) is the training administration module of the Electronic Staff Records (ESR). This can be utilised to undertake further analysis and categorisation of non-mandatory training and Continuing Personal Development (CPD) accessed by BME staff and undertake comparative analysis across BME and white staff.

Update 18/06/2018:

Data is recorded on mandatory/non-mandatory training and CPD through OLM in ESR. However, it is not currently recorded in a format that is compatible for undertaking robust comparative analysis or information reporting requirements under the Public Sector Equality Duty (PSED). This would currently require a significant amount of manual manipulation.

Additional Actions:
1. The information collected will be reviewed during 2018/19 in order to be able to produce a Business Intelligent Report that will allow the Trust to electronically manipulate and produce further analysis and reporting in time for annual Equality Information Reporting in March 2019.

2. While this is being undertaken, the Learning & Development Prospectus will be widely advertised and promoted throughout the Trust. The Trust is currently re launching its BME staff network and has recently sent out a staff questionnaire to gauge interest. Once set up, the Prospectus will also be circulated through this specific network and where appropriate regional networks.

- **WRES Indicators 5-8**: relate to Staff Survey findings.

National NHS Staff Survey indicators For each of the four staff survey indicators, compare the outcomes of the responses for white and BME staff	
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Links to: EDS2 3.4: *When at work, staff are free from abuse, harassment, bullying and violence from any source.*

Links to: EDS2 3.6: *Staff report positive experiences of their membership of the workforce.*

Links to: Trust 2017 staff survey findings. KF25, KF26, KF21, Q17b

Indicator 5 (KF 25) (Lower score = better) showed a slight increase for BME staff from 26% to 27% and also a slight increase for White staff from 24% to 25%. Both results were lower than the average for Acute Trusts.

Indicator 6 (KF26) (Lower score = better) showed an increase for White staff from 17% to 19% and a considerable increase for BME from 13% to 26%. Both results were lower than the average for Acute Trusts.

Indicator 7 (KF21) (Higher score = better) showed an increase for White staff from 92% to 95% and also a similar increase for BME staff from 81% to 84%. Both results were significantly higher than the average for Acute Trusts.

Indicator 8 (Q17b) (Lower score = better) showed an increase for White staff from 3% to 5%, although this is lower than the national average for Acute Trusts. There is also an increase for BME staff from 13% to 16%, however this score is higher than the national average by 1%.

As a result of the above scores the actions below were identified, particularly in relation to Indicator 8 and Q17b. In addition, there are several actions in the Equality, Diversity and Inclusion Action Plan currently under development that have been identified to help eliminate discrimination towards any staff but particularly BME. These include further interrogation of data, provision of specific training for managers and staff, staff networks, review of policies and practices including BME representatives on recruitment

and disciplinary panels and raising awareness of cultural differences and individual actions that either could be interpreted as or are, discriminatory.

Action 10: Assess what the Trust currently promotes and has clearly displayed as the Trust's message to the public regarding harassment or bullying of staff via the Promoting Personal Safety Group.

Update 18/06/2018:

The Promoting Personal Safety Group has an action plan covering a number of areas relating to the personal safety of staff. This includes actions such as: the review of policies, listening events with staff to gain feedback about the type of events, etc, review of Datix, links with external agencies such as the Police and review of Trust literature available such as signage, posters, publication of data, etc.

The Group has agreed that the positioning of key messages should be realigned to positively promote personal safety in the workplace. In addition the Director of Nursing has requested that the use of sanctions for drug/alcohol use on site should be discussed with Executives.

At Workforce Council in May 2018, Dyan Clegg explained that due to an increasingly wider remit, the Group would now be renamed as the Strategic Safety & Security Group with new Terms of Reference and a refreshed action plan.

Action 11: Interrogate available data further, to undertake useful cross analysis for example, how do numbers of formal bullying & harassment based issues compare with the staff survey results.

Update 18/06/2018:

Due to the nature of how this information is currently recorded (manual spreadsheet) this would require a considerable amount of manual interrogation of the data. The new Employee Relations Tracker, when implemented (by end of September 2018), will provide for electronic manipulation of data available and will provide better visibility for cross analysis with staff survey results.

It is envisaged that a further update will be available, by the latest in Quarter 3.

Action 12: Include these four questions to reflect these Indicators within newly revised Appraisal documentation to capture a wider workforce audience and provide an opportunity for further discussion regarding how incidents are reported, and to whom. Promote the Freedom to Speak Up mechanism in place across the Trust.

Update 18/062018:

The Trust has revised its appraisal paperwork into an 'e' form incorporating prompts, promoting the opportunity to speak up. The new form, launched in November 2017 has consistently received positive feedback from managers and appraisees, for its ability to facilitate a productive and focused conversation on ensuring a high quality appraisal experience.

Additional action:

1. To further raise the profile of ACE Behavioural Standards through induction, training, appraisal and promotional material on global emails, etc.

2. To further raise awareness of the methods of raising concerns about 'Respect at Work'.

3. To review best practice and methods amongst regional networks on raising concerns about 'Respect at Work'.

- **<u>WRES Indicator 9</u>:** Percentage difference between the organisations' Board voting membership and its overall workforce.

Links to EDS2 3.1: *Fair NHS recruitment and selection processes lead to a more representative workforce at all levels.*

Action 13: Appoint Non-Executive to Equality, Diversity and Inclusion Steering Group to ensure the Board are fully engaged with and updated regarding the Equality, Diversity and Inclusion agenda.

Update 18/06/2018:

A Non-Executive was appointed to the Equality, Diversity & Inclusion Steering Group and was an active member. As this individual has now left a new Non-Executive link needs to be appointed. The Deputy CEO/Director of Human Resources is a member of the NAVAJO Steering Group.

In May 2016 the Trust was awarded the NAVAJO Charter Mark. This is an equality mark supported by LGBTI Community networks across Merseyside. Further to achievement of the Charter Mark, the remit of the Steering Group is to ensure that Trust can continue to demonstrate that it:-

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

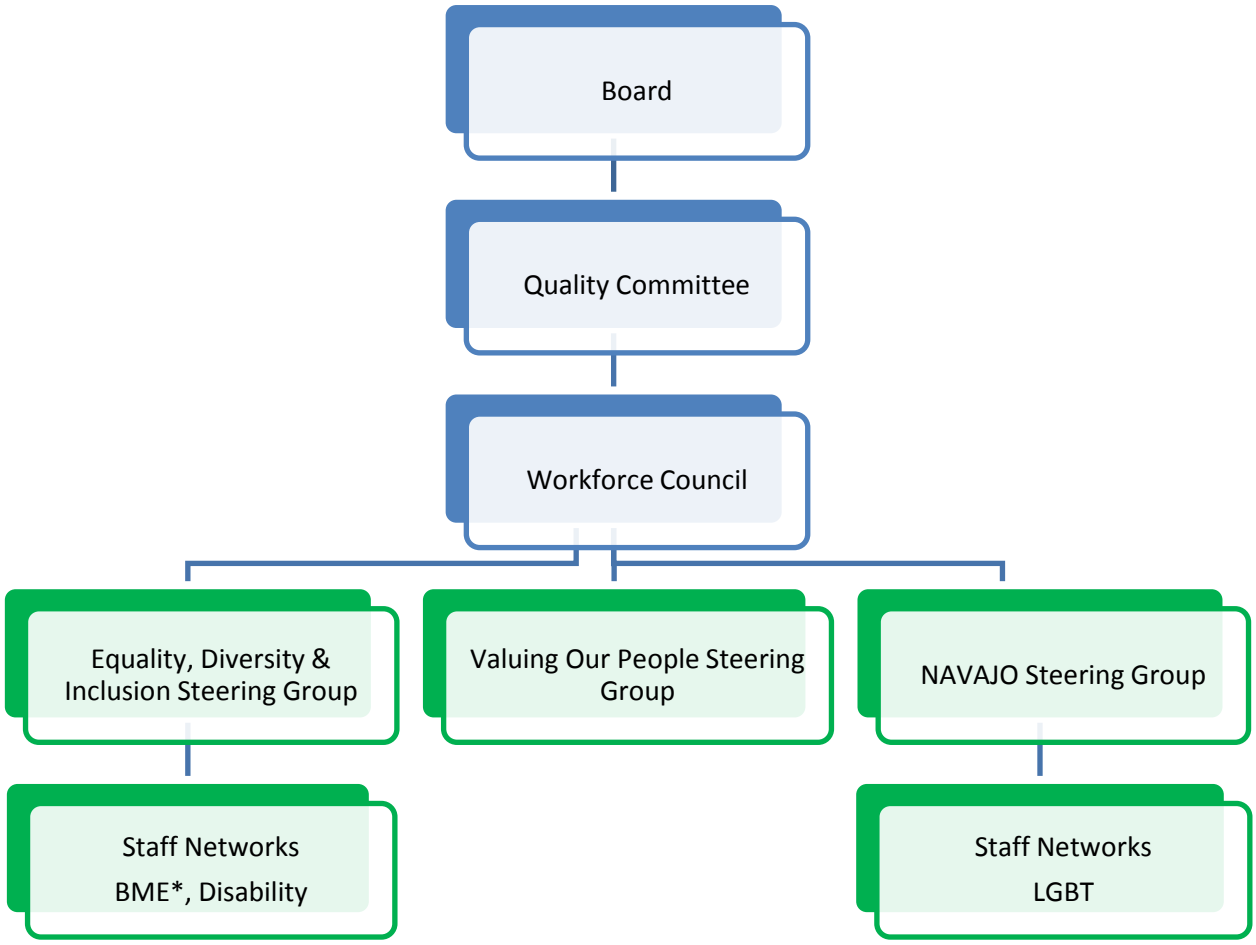
The Director of HR/Deputy CEO is the Equality, Diversity & Inclusion Champion.

Appendix 1 outlines the Equality, Diversity & Inclusion Groups the Trust currently operates and is seeking views to re-launch.

Appendix 1:

Workforce Equality, Diversity & Inclusion Groups

(showing Governance structure)



* BME Staff Network currently being re-launched

Appendix 2: The Workforce Race Equality Standard Indicators

Workforce indicators For each of these four workforce Indicators, compare the data for white and BME staff	
1.	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: • Non-Clinical staff • Clinical staff - of which - Non-Medical staff - Medical and Dental staff Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of Medical and Dental staff, which are based upon grade codes.
2.	Relative likelihood of staff being appointed from shortlisting across all posts Note: This refers to both external and internal posts
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two-year rolling average of the current year and the previous year.
4.	Relative likelihood of staff accessing non-mandatory training and CPD
National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for white and BME staff	
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7.	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
Board representation indicator For this indicator, compare the difference for white and BME staff	
9.	Percentage difference between the organisations' Board membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board Note: this is an amended version of the previous definition of Indicator 9

NHST(18)59 – Knowsley Council Public Health Annual Report

This will be available at the Trust Board meeting on Wednesday 27th June 2018.

The Public Health Annual Report for 2017/18 has been produced as a **short film** which explores the emotional wellbeing and mental health of children and young people and the services and resources which are available to support them. The film recognises the importance of building resilience and promoting good mental health and wellbeing enabling children and young people to live, healthier, happier lives long into adulthood.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)60

Title of paper: Informatics Strategy Update

Purpose: To describe the progress made during the first year of the St Helens and Knowsley Teaching Hospitals NHS Trust Informatics Strategy 'Digital Transformation at the Heart of Patient Care', 2017 to 2020.

Summary: – Excellent progress has been made since the launch of the strategy in 2017. In line with Trust and National Strategy, all objectives set out in the strategy for the financial year 2017/18 have been achieved as well as additional significant pieces of work:-

- The Medway Patient Administration System replacement programme was successfully implemented in A&E, inpatients and outpatients.
- Electronic Prescribing and Medicines Administration (EPMA) commenced on two 'test bed' wards and will be rolled out over the course of 2018/19.
- The Opera Theatre System was implemented in theatre areas and surgical wards on both Whiston and St Helens sites and is now embedded.
- Following a successful bid for funding from the Innovation Agency, the Telehealth project has been very well received by both patients and clinicians in Burns and Plastics and Stroke Clinics.
- Optimising the use and functionality of existing systems, the Medical Early Warning Scores project (Patientrack) also now includes Nursing Assessment Forms. In addition, EDMS workflows were enhanced allowing clinicians to auto-sign correspondence.
- Keeping our hospital systems safe and secure, the Trust has achieved Cyber Essentials Accreditation, Level two of the Information Governance Toolkit and 'Significant Assurance' from Mersey Internal Audit. In addition, we purchased a Cyber Security Tool, known as Sophos Unified Threat Management (UTM).
- In line with the drive towards Place Based Care, the Informatics Department has been integral to the development and approval of the Business Case for the St Helens Shared Care Record which will make a huge difference to the citizens of St Helens. The department continues to play a major role in the development of the Cheshire and Merseyside Shared Care Record.
- Several Websites have been successfully launched including 'Lead Employer'.
- The Library & Knowledge Service attained a score of 100% compliance in the annual Library Quality Assurance Framework, one of only ten in the country to achieve this.
- Efficiency and productivity projects have included a new Service Desk implementation. Service and Product catalogue and tools to track and manage the Digital assets of the organisation.

All of the above initiatives have helped to improve the Trust's Digital Maturity scores which have improved in 13 out of the 15 assessed areas, showing significant improvement (>50%) in the areas of Asset and Resource Optimisation, Business and Clinical Intelligence, Decision Support, Medicines Optimisation, Strategic Alignment and Transfers of Care. The foundations have been laid to enable the Trust to further improve using the Model Hospital guidelines which focus on improving cost per device, cost per WTE and on network and system availability and, as well as meeting local and national objectives, this is reflected in our objectives for 2018/19 as follows:-

- Working in partnership with other local care providers (Local Authorities, CCGs, GP

Practices initially) develop and implement the St Helens Shared Care Record.

- A programme of stabilisation, optimisation and modernisation for the new Medway PAS system.
- Procurement of a Clinical EPR system, meeting the requirements of Five Star Patient Care.
- Roll out of the EPMA system across the hospital.
- Implementation of public Wi-Fi across the hospital.
- The Telehealth solution will be further expanded, subject to the successful achievement of a further bid to the Innovation Agency.
- Supporting the model hospital objectives, leverage the opportunities that Cloud Services provide will have many benefits including supporting rapid service provision. Cloud cost models support pay as you use requirements as opposed to up-front investment.
- Performance reporting tools already purchased will also allow the service to be benchmarked more effectively against other organisations.
- Implementation of the next phase of the Service Desk System which will include a supplier contracts management module and alignment with the elements required for the Model Hospital to enable tracking of progress against objectives.
- Further cyber security work is planned, ensuring that the Hospital systems remain safe and secure.

Corporate objectives met or risks addressed: Systems, Finance

Financial implications: Significant financial investment will be required to meet the objectives for Year Two of the strategy and each piece of work will be subject to usual Trust governance processes. Business cases will clearly demonstrate the return on investment and wherever possible will be self-funding, as a minimum.

Stakeholders: St Helens and Knowsley Teaching Hospitals NHS Trust Patients, Clinicians, Staff, Carers, Partner organisations – CCGs, Local Authorities, GPs

Recommendation(s): To receive the interim update to the Informatics Strategy, note the contents and approve plans for 2018/19.

Presenting officer: Christine Walters, Director of Informatics

Date of meeting: 27/06/18

<ends>

St Helens and Knowsley Teaching Hospitals NHS Trust

Interim Informatics Strategy update

Digital Transformation at the Heart of Patient Care

JUNE 2018

Contents

1.0 Introduction

The following document provides an update of year one of the St Helens and Knowsley Teaching Hospitals NHS Trust Informatics Strategy 'Digital Transformation at the Heart of Patient Care', 2017 to 2020. The Trust hosts the St Helens and Knowsley Health Informatics Service and this benefits patients and clinicians, making a significant contribution to the overheads of the organisation. As a shared service, overheads are considerably lower than if the service was working for the Trust alone. As a shared service, the Informatics service has a breadth of expertise which can be called upon to meet current and future requirements.

During the last year, Informatics has driven the implementation of many major system changes which will enable safe and efficient patient care and services, within the challenges of operational and financial pressures faced by the Trust.

The most significant step towards improving care and outcomes for our patients has been the implementation of the Medway PAS system, A&E and Order Communications. Its successful implementation, through a consolidated effort between technical, operational and clinical teams has enabled the building blocks to be put in place for the clinical EPR which is the next step described in our three year strategy.

The Informatics service has continued to ensure the safety and security of our infrastructure and clinical systems through robust Cyber Security actions and we continue to collaborate with our partners and other local NHS to ensure that the infrastructure can support new and innovative ways of working.

Telehealth clinics been introduced for Burns and Plastics and Stroke clinics in the hospital, an innovation that has been extremely well received by both patients and clinicians and this will continue to be rolled out over the course of the next two years across the organisation. This means that appointments between clinicians and patients can take place over a secure IT link, with both parties talking to each other via a camera on their device. This innovative approach will enable the strategic aim of Place-based Care and further reinforces the fact that patients and carers continue to be at the heart of this strategy.

The next major steps in our journey are to implement systems that have already been purchased, the procurement of the Clinical EPR and the implementation of the St Helens Shared Care Record. Now is the perfect time for this transformation with clinicians driving the required changes. The transition will be challenging but ultimately this strategy will deliver the best system for our patients as information will be available in less systems and available in the most appropriate locations, reducing duplication and putting the patient at the centre. Indeed, patients continue to be at the heart of this Informatics strategy.

2.0 Background

2.1 Trust Objectives

The Health Informatics Service continues to prioritise achievement of the Trust objectives of 5 Star Patient Care, to deliver systems that are efficient, patient-centred, reliable and fit for purpose. Specifically:-

- To introduce and implement a new Patient Administration System which will support improvements to the patient journey and will offer decision support capability.
- To develop new systems to support clinical transformation across a wider footprint, fostering positive working relationships with health economy partners. This will include the implementation of Phase One of the Shared Care Record in St Helens, providing better care to patients wherever they are treated.

In addition to the Trust Objectives, there are a number of external drivers.

2.2 Place-based Care

The Kings Fund advocates that services should work together to improve the health and care of the population they serve. A shared vision and objectives should be developed that cut across traditional organisational and service boundaries with a combined set of measures.

2.3 System Focussed

Systems are at the heart of the Trust Objectives. Electronic systems support changes in pathways of care, changes in service models and are the catalyst to enable clinical best practice and improved patient outcomes. I.T. systems should support the clinical decision making process with simple and efficient ways to input data and to review that information. The ability to work flexibly is intrinsic to this strategic aim.

2.4 Paper Free at the Point of Care

NHS England has set out its vision of paper free at the point of care. The guidance stipulates that local digital roadmaps are developed to drive IM&T maturity to the stage where patient care is digital first and captured once, removing the need for and reliance on legacy paper processes.

2.5 Five Year Forward View (5YFV)

The NHS faces unprecedented challenges to reduce the quality of care gap and achieve financial sustainability. The 5YFV vision describes how the sharing of electronic information and joining up pathways of care across different NHS organisations will transform regional healthcare into a sustainable, future-proof healthcare system.

2.6 Safe and Secure Systems

Following the Wannacry cyber-attack in May 2017, all NHS organisations have a requirement to further secure their clinical information systems. In addition, every year the Hospital Trust must demonstrate compliance with Information Governance requirements by completing the NHS Digital 'Information Governance Toolkit'. There is a requirement for all NHS organisations to meet the minimum of Level 2 across all requirements within the Toolkit.

2.7 Putting patients first

NHS England first published its business plan 'Putting patients first: the NHS England business plan for 2013/14 – 2015/16 in which it describes the need for a fundamental culture change within the NHS that puts patients at the centre and focus of all clinical care.

2.8 Personalised Health and Care 2020

All patients must have health care by 2020 that is specific to them and their individual health issues. NHS England has set out a framework to transform care outcomes for citizens through effective use of data and technology. It aims to give patients and citizens more control over their health and well-being and reduce the administrative burden for care professionals. Systems and services must encourage patients to be more involved in their care and provide opportunity

2.9 Model Hospital

The Model Hospital is a new digital information service provided by NHS Improvement to support the NHS to identify and realise productivity opportunities. NHS trusts are able to explore their comparative productivity, quality and responsiveness. For IM&T, metrics are around cost per WTE, cost per device and network and system availability.

3.0 Goals and Ambitions

In the Strategy document 'Digital Transformation at the Heart of Patient Care' 2017-2020, the informatics service presented a number of key areas, which over the three years of the strategy will support the Trust to improve its digital maturity, acting as a catalyst and enabler for service improvement and meeting both internal and external objectives and drivers.

A number of key developments were specified in the strategy. These have been achieved. In addition, the Trust informatics service has also achieved other

successes over the last financial year, within existing resources whilst meeting the required CIP target of £334,456.

3.1 What we said we would do in 2017/18

	2017/18	2018/19	2019/20
PAS, ED and Order Communications replacement programme commences	✓		
Electronic Prescribing and Medicines Administration (ePMA) Commenced	✓		
Opera Theatre System Deployment	✓		
Service Desk System Replacement	✓		
Electronic Combined Risk Assessment Forms, Fluid Balance, CPE and Bristol Stools Chart Deployed	✓		
Telehealth for Patient Consultations	✓		
Cyber Essentials Accreditation	✓		
The Trust Intranet website was launched	✓		
Systems Optimisation (Patientrack, EDMS)	✓		
Productivity and Value for Money Initiatives – Product and Service Catalogue, Asset Management	✓		
Information Governance Toolkit Level 2 achievement and 'Significant Assurance' from Mersey Internal Audit Advisory Group	✓		
Work towards alignment with LDS and LDR shared goals	✓		

3.2 Additional achievements in 2017/18

	2017/18	2018/19	2019/20
Integral to the development of the business case for the St Helens Shared Care Record	✓		
Cyber Security Tool purchased, known as Sophos Unified Threat Management (UTM)	✓		
Electronic Transfer of Prescriptions to Community Pharmacies (eTCP) Pilot	✓		
Sexual Health (Lille) and Audiology (AuditBase) system upgrades completed	✓		
Telepath system upgrade completed	✓		
Replacement Hardware as an enabler for the Medway PAS project	✓		
The Library & Knowledge Service attained a score of 100% compliance in the annual Library Quality Assurance Framework, one of only ten in the country to achieve this.	✓		

The Library and Knowledge Service was highly commended in the Trust's staff awards and introduced its Discovery Service, providing streamlined searches for clinicians	✓		
The Informatics Service won ISD Best Improvement in Patient Safety for eMEWS and Paul Siner, Project Manager, won "IT Unsung Hero of the Year".	✓		
Lead employer website was launched	✓		
The Scanning Department scanned 10,043,549 pages in c1,800 health records, c416,000 out-patient Health Records Summaries and c91139 inpatient Health Records Summaries.	✓		
St Helens and Knowsley Health Informatics Service partnered with Salford Royal NHS Foundation Trust to provide peer support and critical analysis for the Digital Maturity submission in which 13 out of 15 sections improved from the 2016 submission to the 2017 submission.	✓		
The EDMS clinical correspondence and clinical workflow project has introduced efficiencies and enables clinicians to auto-sign correspondence to patients.	✓		
The electronic delivery of Outpatients correspondence to in-area GP Practices in St Helens, Knowsley and Halton was enabled via the EDMS system.	✓		
Active participation in the Cheshire and Merseyside Shared Care Record	✓		
Video conferencing for the Cancer Network	✓		

3.3 What is planned in 2018/19?

	2018/19
Develop and implement a St Helens Shared Care Record	✓
Electronic Prescribing and Medicines Administration (ePMA) roll out commences in A&E and outpatients	✓
Service Desk System - Phase 2	✓
NEWS2	
Public Wi-Fi	
Mobility and Flexibility of systems (Virtual Desktop)	✓

Call Recording and Monitoring in relevant Trust areas	✓
Telehealth expansion	✓
Systems Optimisation (Medway)	✓
Align with STP shared goals	✓
GDPR implementation and support	✓
Service Development (Staff Development Programme)	✓
Innovation Academy Full Business Case (including App development)	✓
Further Hardware Upgrades (subject to funding)	✓
Implementation of the SNOW system for Asset Management	✓
Network Upgrades	✓
Storage/Back-up Solution	✓
Cyber Security planned work	✓
Support for the e-Referral Service paper-free project	✓

3.4 Adjustments to the 2017/18 programme

As with all large scale programmes of work, sometimes strategic decisions and improvements in technology alter objectives. A Trust strategic decision was taken not to further develop and deploy the Clinical Portal. In 2017, the Trust agreed to replace the Maxims PAS system and procure a clinical EPR system. In addition, the Shared Care Record development has commenced with Health and Social Care partners in St Helens. These three new developments will provide a much richer data set for clinicians, across a wider partner base and with much less local maintenance and development requirements than a single organisation Clinical Portal would have been able to provide.

A case for establishing the Innovation Academy within the HIS was taken to the local health economy Informatics HIS Board. Following the feedback from the HIS Board, we are re-evaluating our offerings which may include acting as a “hub” that partners can come to with ideas or problems to which we can offer Innovative offerings, not only for Apps but which may potentially range from market scanning and managing relationships with vendors on behalf of our partners.

It is also worth pointing out that the LDS has been superseded by a wider STP Cheshire and Merseyside ambition and the Informatics service is heavily involved and leading on aspects of shared infrastructure on behalf of local organisations.

4.0 Main Achievements 2017/18

4.1 Replacement of the Patient Administration System (PAS)

On Sunday 27 April 2018, following migration of 27,780,336 pieces of patient information from the Maxims and Hearts systems to the new Medway system, the System C Medway PAS was **implemented** in A&E and Inpatients, followed the next day in Outpatients on both sites. This meets a key Trust Objective, the national objective of Paper Free at the Point of Care and is a major building block for the St Helens Shared Care Record. Replacement of the PAS forms the basis and platform for the development of a Clinical EPR, which is a key ambition in Year Two of the strategy.

The Medway system manages all patient contacts and referrals including outpatients, inpatients and waiting lists. The implementation was over and above a standard Patient Administration System. Additional fully integrated modules were implemented for Emergency Care, VTE, Order Communications and for Social Care referrals. The Medway information system has a flexible reporting tool, data warehouse and management information system.

To support the implementation 156 desktop computers were upgraded across the organisation.

For **Patients**, the introduction of the new Medway PAS provides the following benefits:-

- ✓ Improved demographics and data quality with links to the National Spine Patient Demographic Service, patients will only need to 'tell us once' and this information follows the patient.

- ✓ There is much improved visibility of where the patient is at any point through their journey, which helps to improve patient flow.

- ✓ Real time data is available, in the right place, at the right time wherever the patient is seen, with patient history available via EDMS and PACS at the click of a button from within Medway.

- ✓ Improved patient alerting with improved visibility of medical alerts such as MRSA, helping to provide timely and appropriate treatment to patients.

- ✓ The Integrated Discharged Team (IDT) can now maintain a live tracking document which enables the production of a report showing medically fit patients and reasons for delays.

For **Clinicians**, the introduction of the new Medway PAS can be best summed up with the following post implementation quotes:-

Lynsey Hamer – Paediatrics Sister *"Medway is Faster, more user friendly, has much more detail and a much better user interface with lots of potential".*

Debbie McTighe – Associate Directorate Manager

"We have just run a time ordered clinic report - this is run daily and used to take 1 hour it now takes 5 minutes".

Dr Francis Andrews - Assistant Medical Director/Consultant in Critical Care and Emergency Medicine

"I did an ED shift yesterday and it's becoming much clearer to me and colleagues just how much better system C is for our work down there.

You've definitely got the configuration right and it is so much faster, and easier than Maxims. I particularly like some of the efficiencies around discharge and coding which nudges you into getting the right information down on the discharge letter & there are many other functions that are really useful"

For the **Hospital Trust**, the introduction of the new Medway PAS means:-

- ✓ **Clinical Coding Improvements** lead to clinical efficiency from automatic capture of patients' comorbidities and real time coding of activity.
- ✓ **Enhanced Patient Alerting** which improves the management of patient care.
- ✓ **Improved Bed Management Views** for scheduled and unscheduled care will improve patient flow.
- ✓ **Reduction in number of systems** clinicians have to refer to and search
- ✓ **Reduction in time spent training** staff on multiple systems
- ✓ **Reduction in dual entry of information** into multiple disparate systems
- ✓ **Reduction in time** taken to record clinical information as patient history and other information will be available.

Although the deployment of the Medway PAS went extremely well, some issues were experienced in Patient Booking Services where it was discovered after go live that some clinic schedules had not been captured in the new Medway PAS system. This led to slots appearing as if they were 'open' when in fact they were not clinically available. A combined Informatics, Information and Operational team joined forces to resolve the issue with many members of Informatics staff working over in PBS to support the team.

In addition, continued collaboration with Clinicians through the deployment and in the subsequent weeks has led to the establishment of a series of workstreams – to stabilise, optimise and modernise the system and already some changes have been made to the system to improve its usability for clinicians.

4.2 Deploy the Electronic Prescribing and Medicines Administration (EPMA)

In line with the strategic objective of **Paper Free at the Point of Care**, the pilot wards (5D & 2A) have now moved into 'Early Adopter' status and planning is under way to realign the wider implementation of EPMA across the Trust later this year, commencing in A&E and outpatients.

For **patients** this will mean:-

- ✓ Appropriate medication is given.
- ✓ Reducing unnecessary life threatening exposure to adverse drug related accidents.
- ✓ Delayed and Missed Doses will reduce.

For **clinicians** this will mean:-

- ✓ Decision Support at the point of prescription.
- ✓ Improved legibility and a reduction in transcription errors.
- ✓ Improved and effective communication between pharmacy, medical and nursing staff.
- ✓ Clinicians will not have to find the patient's Kardex, which does take time, not will they need to write on them.

4.3 Opera Theatre System Deployment

In July 2017, the Opera Theatre System was deployed in theatre and ward areas, replacing the existing Ormis system. The new system integrates with the new Medway PAS and provides visible alerts, all improving safety within the theatre setting. Theatre checklists can also now be recorded on the system which is also auditable and can be used for training and improvement initiatives.

4.4 Integration of Health and Social Care

Supporting the Trust Objectives and in line with the national objective of **Place Based Care, Putting Patients First and Personalised Health and Care 2020**, in June 2017 partners from Health and Social Care agencies across St Helens met to agree the vision for a model of integrated care. As is the case across the UK, health, social care and community services in St Helens are currently being delivered within a fragmented system. This is a result of a complex web of services developing not as one, well organised and personalised plan, but independently. There is a need for a single operating model which articulates how care can be delivered most effectively across organisational boundaries.

The integrated local care system, St Helens Cares, seeks to further develop person centred services and support, delivered in the most appropriate locations. Organisations involved included St Helens and Knowsley Teaching Hospitals NHS Trust, St Helens Local Authority, St Helens CCG, North West Boroughs Healthcare NHS Foundation Trust, Bridgewater Community Healthcare NHS Foundation Trust, Helena Housing Association, Police, Fire Service and several voluntary agencies.

Intrinsic to the vision is the development of an integrated Shared Care Record using the Graphnet CareCentric system which can provide the seamless sharing of relevant patient information to appropriate care providers. The business case for the CareCentric Shared Care Record was approved by St Helens and Knowsley Teaching Hospitals NHS Trust, St Helens Council and St Helens CCG in February 2018.

The business case demonstrated that the Shared Care Record will:-

- ✓ Provide rich citizen information at the point of care, allowing the correct decisions to be made at first point of contact to meet the person's needs. The shared record will fill some of the gaps in the information currently available to staff. In addition, there will be no need to ask the person to repeat information they have previously provided to other services.
- ✓ Allow care planning to be done that is complimentary to services already being delivered by others and encourage collaboration. The shared record should allow all sight of support already being offered in the system to the person, allowing improved decision making.
- ✓ Decrease duplication and the need for manual transfer of paper based information. Automated access to information provided at request is a key element to the shared record.
- ✓ Reduce needless admission to hospital and bring care closer to home.
- ✓ Provide reporting and analytical capability – real time analytics at the point of care

4.5 Systems Optimisation Programme

In line with the Trust objectives and the national drivers of **Paper Free at the Point of Care,** the **Patientrack** system is now widely used across the hospital trust. This system automatically calculates Medical Early Warning Scores from a standardised set of input criteria. Nursing assessment forms have also been launched using this

software including a ‘Combined Risk Assessment Form’ which automates and reduces duplication across five assessments.

Following the implementation of the Medway PAS, there will be instances where improvements in operational processes, or adoption of best practice, can be enabled with the new system capabilities. These can only be achieved through close collaborative working between Informatics and the operational teams, which has been particularly borne out through the recent remediation work in Patient Booking Services.

Listening to clinicians, improvements have already been made to the Order Communications module of the EPR to provide Patient Level Ordering. The availability of patient level ordering means that clinicians can place a pathology or radiology order without the patients being attended on the Medway system. This is particularly useful for, amongst other specialties, pre-op, ward attenders, GPAU, Maternity services and patients who are under the care of a consultant from another Trust (e.g. Clatterbridge).

Finally, improvements have been made to the EDMS workflow and clinicians can now authorise letters electronically, improving efficiency and reducing the requirement for paper. In addition improvements have been made to the delivery of correspondence to in area GP practices reducing paper & duplication.

4.6 Alignment with other STP partners and infrastructure to enable data sharing, agile working and mobility

The Informatics service actively participates in developments at STP level. Within the STP structure, the Health Informatics Service is leading on a converged infrastructure workstream with the objective of consolidating the infrastructure and providing a single Wi-Fi solution across the Cheshire and Merseyside footprint. Work will continue this year to maximise the investment in shared systems. Having a shared infrastructure across a wider footprint will benefit staff and patients who have to attend more than one hospital for multiple conditions. The shared infrastructure forms the basis for the wider sharing of patient information. For clinicians, joining infrastructures will improve mobility and flexible working.

St Helens and Knowsley Health Informatics takes an active role in the STP and is involved in the planning for the Cheshire and Merseyside Shared Care Record. The Director of Informatics, Christine Walters, chairs the Cheshire and Merseyside Five Year Forward View (5YFV) I.T. sub-group.

In addition, the Informatics Service has been working closely with the Cheshire & Merseyside Cancer Alliance, who work together as a Multi-Disciplinary Team (MDT) to review, diagnose and treat a variety of cancers within the Cheshire and Merseyside localities. An MDT is a group of doctors and other health professionals with expertise in a specific cancer, who together discuss and manage an individual patient's care. The video conferencing equipment used by the 14 organisations in the MDT meetings was end of life, providing poor quality video and audio and challenging for IT departments to service and maintain.

A bid was submitted by the Cancer Alliance for funding to replace the aged equipment in late December 2017 with the hosting of required infrastructure at STHK HIS.

This bid was subsequently approved in March 2018 with a procurement exercise completed to procure full replacement MDT video conferencing equipment in two locations at each of the 14 organisations along with infrastructure to enable centralised collaboration through virtual meeting room ability, safe and secure access and management of virtual meeting rooms through appointment management.

The project is expected to run through to late Summer, the design of the technology has been completed along with provision of the required server infrastructure.

STHK Hospital has always led the way and invested in the technologies.
Although initial investment has been made, for example in a core network monitoring solution, significant additional investment in infrastructure will be required over the course of this strategy. This is particularly important with the impending implementation of the Clinical EPR and Shared Care Record.

The Informatics Service now offers Office 365 as a product and service offering. The Health Informatics service has also recently invested in cloud-based desktop services. These two new initiatives will allow clinicians to work flexibly across the STP footprint. Over the remainder of this strategy period, the innovative use of technologies will continue to be used for the benefit of patient care.

Work to improve the Trust's Digital Maturity (which demonstrates the extent to which healthcare services are supported by the effective use of digital technology), started in 2017/18 with the successful implementation of PatienTrack, an early adopter implementation of ePMA within Wards 5d and 2a and the replacement of the legacy Hearts Patient Administration System (PAS) with a modern referral based Medway PAS.

The most recent Digital Maturity Results show that the Trust has improved in 87% of areas with six out of fifteen of the areas improving by more than 50%. These include Asset and Resource Optimisation, Business and Clinical Intelligence, Decision Support, Medicines Optimisation, Strategic Alignment and Transfers of Care. The foundations have been laid to enable the Trust to further improve using the Model Hospital guidelines.

This work will continue throughout the life of this strategy. The focus moving forward will be to deliver on the benefits of Medway through stabilisation, optimisation and modernisation activities. This will ensure the system is optimised to support the trusts care pathways and operational activities. Building on the early adopter status of ePMA, Informatics will deliver ePMA fully across the Trust and focus on leveraging additional Medway EPR functionality supported by robust business cases which will further enhance the Trust's Digital Maturity level.

4.7 Safe and Secure Systems

In line with the strategic ambition of **Safe and Secure Systems**, underpinning all infrastructure services is the Cyber Security workstream across the STP. As all organisations share information around their own operating systems, there are opportunities to consolidate contracts and, as contracts come to an end, influence what is purchased. Pro-active monitoring of the clinical systems we currently have

is critical to ensure safety and security and Informatics have invested in new technologies to enable this such as Solarwinds Monitoring. Significant additional investment will be required if we are to continue to meet the standards being set by NHS Digital.

The NHS Information Governance Framework is the means by which the NHS handles personal identifiable information about patients and employees. The Information Governance Toolkit (IG Toolkit) is the means by which the NHS demonstrates implementation of good practice. There is a requirement for all NHS organisations to meet the minimum of Level 2 across all requirements within the Toolkit which the Trust has achieved for the last 5 years.

Mersey Internal Audit Agency (MIAA) completed an audit of the Trust's Toolkit submission (as required of larger NHS organisations) and the Trust maintained their rating of **'Significant Assurance'**

- ✓ The Trust has maintained their rating of which it has held over the last 5 years. This assurance rating once again demonstrates the Trust's commitment to the ever evolving Information Governance Agenda.

STP Cyber Security Workstream

Following last year's cyber-attack on the NHS, the STP has provided a firm commitment to enhancing cyber security awareness, capability and responsiveness throughout Cheshire and Merseyside. This is delivered through a dedicated Cyber Security workstream and Informatics continues to provide a significant input and commitment. Informatics has worked collaboratively in shaping the workstream agenda and priorities and has returned cyber security baseline data on behalf of the Informatics service and its partners.

The workstream is placing significant focus on building a collaborative and comprehensive response plan to potential future threats including a robust network of communication and contacts. The workstream is committed to identifying funding opportunities that help address gaps in security and threat protection; using the ethos that 'you are only as strong as the weakest link'. Additionally, the workstream is tasked with identifying data flows and dependency of clinical services across C&M,

so that a considered and measured response is enacted to reduce the impact to clinical services through network disconnection. Finally, Informatics are working with the cyber security workstream on the national agenda to ensure appropriate controls, processes and security patches are in place.
The Hospital Trust was also successful in achieving Cyber Essentials Accreditation.

4.8 Innovation and New Technologies

The Trust has invested in cloud based technologies to support the **Telehealth** test bed project in Stroke and Burns and Plastics, supporting mobile and flexible working and complimenting the funding secured from the Innovation Agency to start this important project.

The pressures of modern living can make it difficult for patients to attend appointments through travel difficulties, work or childcare commitments or condition and health issues. Additionally, there is a cost associated with missed appointments to the Trust, including the inefficient use of Trust resources when patients do not attend.

Better than telephone consultations, TeleHealth allows clinician and patient to see each other in real time, using every day devices such as laptops, tablets or smart phones that most people own or can access. TeleHealth provides consultants and nurses with true flexibility as this agile working opens up more locations that can be used to deliver consultations, and reduce waiting times for patients who need to see clinicians.

Following a successful bid for Innovation funding, the hospital has started to introduce video consultations for outpatient appointments, radically improving patients' experience and choice, and helping patients get the right care, promptly, in the right place. Telehealth is now being used consistently in Burns and Plastics Drains follow-up clinics and in Stroke follow-up clinics. 100% of eligible stroke and drains patients offered this option, opted for a telehealth appointment.

The benefits to patients are clear:-

- ✓ Patients can struggle to attend outpatient appointments for many different reasons and many of these patients are frail and elderly. Others include full time workers, parents, carers and people with restricted mobility. They all need more flexibility when booking medical appointments.

- ✓ As a regional burns unit, we treat patients that require post-op drains inserted to drain fluid from the wound following major cancer reconstruction. Patients can be under the care of this unit from all over the North West and North Wales and the telehealth clinics mean that outreach workers can assess the status of patients whilst not having to travel.

This has made a big difference for patients:-

- ➢ One patient described the convenience and improvement in his experience. Without the change he would have had to get multiple buses to visit the hospital, as he did not drive.

- ➢ Another was able to have his appointment whilst at work. This meant that he no longer needed to book time off work to attend hospital.

From a **clinician's** perspective:-

'Telehealth has offered a range of benefits for our patients and for our team. Many stroke survivors find it difficult and time-consuming to come to hospital for appointments: patients using our telemedicine clinic have found this process much more convenient and adapted to the different style of consultation really well. We continue to find unexpected benefits from being able to access patients directly in their own home – from patients being able to simply fetch their own medication if they have forgotten it, to being able to visibly see if a patient has issues in their own environment. We have been really pleased with the way this project has changed how we run the clinic and can see lots of future potential to use telehealth in other parts of the service'.

Dr Andrew Hill, Consultant Stroke Physician

4.9 Productivity and Value for Money

As part of the Informatics Service Improvement plan, a new **IT Service Desk Self-Service Portal** went live on 1st February 2018 and allows all users of HIS services to:

- Quickly log new calls themselves rather than ringing the Service Desk.
- Track and update calls logged with the Service Desk.
- Access ***"How to….."*** guides (Knowledge Base), giving answers and guidance on some commonly asked questions.

The self-service portal is available to all users through an icon on the desktop of any Trust PC, Laptop or Tablet. The uptake of use of the system has been good and will be further promoted in order that the efficiency objectives of the project can be fully realised.

The Informatics Service and Product catalogue was developed over the course of 2017 and will be applied within the Service Desk tool over the course of 2018. This will ensure that our standard service and product offering is widely available and regularly updated.

This year Informatics has strengthened existing systems for asset management, enabling the Informatics service to track devices and provide the opportunity for the Trust to re-use devices that are no longer used.

In 2017 the Informatics service developed a Service and Product Catalogue, standardising and streamlining the products and services that we provide to our customers. These will be further developed over the course of the next two years.

The Library & Knowledge Service attained a score of 100% compliance in the annual Library Quality Assurance Framework, one of only ten in the country to achieve this. In addition, the Service was highly commended in the Trust's staff awards and introduced its Discovery Service, providing streamlined searches for clinicians

4.10 Electronic Transfer of Prescriptions to Community Pharmacies (ETCP) Pilot

Sponsored by the Innovation Agency, the ETCP process is designed to allow Acute care clinicians to refer appropriate inpatients for medication reviews (MURs) by Community pharmacists. The Community Pharmacist then visits the patient at home to carry out a medication review. This has been shown to improve patient compliance with medication and therefore reduce the risk of avoidable readmission to hospital.

This is now in place in the 1A (Frailty) ward and will now be rolled out throughout the rest of the ward areas, starting with Wards 2B and 2C (Respiratory).

5.0 THE FOCUS 2018/19

5.1 Medway Patient Administration System (PAS)

Clinicians have found the Medway system intuitive and easy to use. Following its successful, in line with the Trust Objectives of optimising the systems we have in place, and in line with the Five Year Forward View, a programme of stabilisation, optimisation and modernisation will continue to take place to ensure that the system is used to its full capability and is as efficient for clinicians as possible.

5.2 Clinical EPR

In line with the Trust Objectives and the national drivers of **Paper Free at the Point of Care and System Focussed**, the implementation of the Medway Patient Administration System has provided the foundations for a single Clinical EPR which will help to address a number of challenges that the hospital trust shares with other NHS organisations including:-

- ✓ Patient information being held across a number of systems
- ✓ Clinical Access to the right information in a timely way
- ✓ Improved, consolidated information that will better support systematic clinical decision making and promote best practice.

The clinical EPR will act as a strategic enabler for integrated care to deliver the **local digital roadmap, enabling 5 star patient care and integrating with the Shared Care Record and the Cheshire and Merseyside Shared Care Record** with key clinical information. Key system benefits will be:-

- ★ Safety – All clinical care will be provided within a single system with no duplication of work or data input, providing a single version of clinical information which will aid clinical decision making and help to streamline workflows.
- ★ Care – A Trust wide view of clinical information will improve co-ordination of patient care across different teams both inside the Hospital Trust and, through the integration with CareCentric, will enhance a rich clinical dataset to inform clinicians in any location regardless of the organisation they work for through a Clinical Portal.
- ★ Systems – The EPR will be implemented in a phased approach, taking into account Trust priorities and the practicalities of when existing contracts come to an end.
- ★ Pathways – The EPR will reduce variations in care pathways and offer opportunities for joint working with local partners, especially through the interface with St Helens Cares.
- ★ Communication – A patient portal, online consultations and telehealth integration will ensure that patients can choose how to communicate with their care providers, have access to their own health records, receive 'joined-up' care from teams working together and have more input and responsibility for their own healthcare.

5.3 Integration of Health and Social Care

Supporting the Trust Objectives and in line with the national objective **of Place Based Care, Putting Patients First and Personalised Health and Care 2020**, the CareCentric system will be delivered in a phased approach from the Summer of 2018 and will enable the seamless sharing of patients' data across health, social care, housing, third sector and voluntary providers in the Borough. It will remove some of the existing complexity, duplication of data collection and data entry,

improving efficiencies and giving professionals more time to provide quality, safe care to people in St Helens.

During 2018/19, read only access for users will facilitate the improvement and consistency of care pathways between agencies, removing duplication and removing the variance of data and information.

5.4 Roll out the Electronic Prescribing and Medicines Administration (EPMA)

During 2018, the EPMA system will be rolled out from the initial test bed areas to the rest of the Hospital Trust wards, commencing with ED and outpatients. A more robust VTE process will also be rolled out from within the JAC EPMA product.

5.5 Innovation and New Technologies

Putting Patients First aims to give patients and citizens more control over their health and well-being. New assistive care technologies will help patients to manage their own care, avoiding hospital visits. Informatics will explore opportunities to deliver focussed assistive care technologies and wearables within a controlled cohort of patients. Identified opportunities will be supported with business cases and appropriate project governance.

Public Wi-Fi is already available in some key areas of the hospital trust. Timescales for implementation into the wider hospital are aligned to the national Wi-Fi programme targets which have been launched since the approval of this strategy in 2017. This development will be subject to the availability of national funding.

The Telehealth solution will be further expanded and an additional bid has been made to the Innovation Agency to enable this in other Stroke Clinics such as Speech and Language Therapy and Occupational Therapy.

In addition, and delivering true innovation, we intend to deploy Telehealth across services to the local ambulance service, (NWAS), integrating with their new signposting app to allow a Telehealth session to open up from the ambulance using a paramedic mobile device and linking to ED personnel at the receiving hospital, to

allow early diagnosis of suspected stroke patients, preparation to be done to receive the patient and start care immediately, reducing the “time-to-needle” for patients who need urgent tests and treatment.

By the third year of this strategy it is hoped that this technology will be used across the partners of St Helens Cares.

5.6 Infrastructure to enable data sharing, agile working and mobility

Leveraging the opportunities that Cloud Services provide, will influence the Informatics Strategy moving forward. Cloud Services have many benefits including supporting rapid and quick service provision and is underpinned with transparent cost models. Cloud cost models support pay as you use requirements as opposed to upfront investment and therefore enables different financial profiles: revenue as opposed to capital funding. Therefore, exploiting Cloud Services for suitable infrastructure service and funding use cases will enable Informatics to offer the Trust a number of service offerings to meet requirements.

During 2018/19, new technology will be introduced that allows clinicians to move to any PC within their area of work and immediately resume their previous session. This is particularly important in areas such as A&E where clinicians move about the department seeing different patients in different zones. For this reason, A&E and Pharmacy will be early adopters in this project, subject to the availability of appropriate funding.

5.7 Productivity and Value for Money

Performance reporting tools during last financial year, will allow the service to be benchmarked more effectively against other organisations. This will assist the service and Trust departments to take forward the work around the IM&T elements within the **Model Hospital.**

In line with the Trust objectives, the Health Informatics team is assisting the implementation of the SafeCare system which uses patient acuity/dependency to identify the staffing numbers and skill mix required to avoid over or under staffing.

During the course of 2018 the SNOW system will be implemented for software licensing asset management. The benefit of this system will provide transparency and assurance regarding the Trusts software licensing estate and mitigate financial risks associated with non-compliance. The system will provide robust reporting which will help inform future software investment requirements.

5.8 Service Improvement

Service improvement plans within each business unit in Informatics will take shape this year. Various systems have been commissioned to improve the internal processes from initial lead to completion and will ensure improved reporting and more efficient use of expert resource, improving the capacity of the Informatics teams.

Phase Two of the Self-Service Portal (ITSM) implementation will see further development across all areas of Health Informatics including Information Governance and the Medway project team. There will be new call categories, training for staff and new dashboards for each section to allow call management.

A supplier contracts management module will be implemented in ITSM. This will allow central visibility and management of supplier contracts and agreement with automatic notifications of supplier contract deadlines and costs so that timely contract negotiations can be undertaken. Reporting from the new Service Desk tool (Sostenuto) will be aligned to the elements required for the Model Hospital, thereby providing more robust Trust Information to inform this process and will enable tracking of progress against initiatives.

In addition, together with the Trust Learning and Development, a development programme for Informatics staff has been developed which promotes communication between teams, the importance of I.T. for front line staff (bridging the gap between technical and clinical teams) and ensures excellent customer service is delivered in line with the vision of Health Informatics:

'We will be a customer focused Informatics service providing agile, innovative solutions to improve efficiency, enabling and supporting the delivery of safe, first-class patient care'

6.0 Technical Enablers

6.1 Enhanced telephony platform

A project has been initiated in Primary Care to implement call recording and replay using a unified communications platform, which is also capable of supporting instant messaging and video conferencing technologies. The infrastructure is now in place and work has already started within the Diabetes department where call recording will be implemented in the Summer of 2018. The roll-out of these technologies from this technical platform will happen over the course of the remaining strategy period.

6.2 Health and Social Care Network (HSCN) National Procurement

The N3 contract for wide area data network services in the NHS ended as planned on 31 March 2017. A HSCN Transition Network is currently in place. In order to exit the transition network and migrate to a full HSCN connection, procurement of HSCN connections are required. The customer/site identifier and HSCN requirements documentation has been submitted to HIS, updated and returned to NHS Digital as well as HSCN GDPR considerations (for management of procurement) submitted for review and sign

No firm dates have been confirmed at this point but there is a drive that has moved the NW procurement up the procurement priorities.

7.0 Safe and Secure Systems

7.1 General Data Protection Regulation (GDPR)

Informatics will continue to submit the IG Toolkit on behalf of the Trust this year and will support the Trust to complete the obligations of GDPR, which came into play on 25th May 2018. Principles are broadly similar to the Data Protection Act 1998 (the 1998 Act). Data Protection Impact Assessments (previously known as Privacy

Impact Assessments) MUST be used for all changes in high level systems and processes to identify risks. These documents must now be approved by the Senior Information Risk Owner (SIRO), and accompanied by data flow documents which will identify any risks in sharing or transferring data.

Personal data is any data about an individual that could identify them. The definition of personal data is expanded under GDPR to include NHS Numbers and Hospital numbers for the purpose of secondary use. We **MUST** anonymise / pseudonymise data under this new legislation.

There will be more guidance issued in time from the Information Commissioner's Office once they themselves have had time to digest the new legislation. This is a journey the Trust along with other NHS organisations must take as we work together to create a consistent approach, especially in as the Shared Care Record develops.

8.0 Summary

The objectives of Year One of the St Helens and Knowsley Teaching Hospitals NHS Trust Informatics Strategy 'Digital Transformation at the Heart of Patient Care', 2017 to 2020 have been met and exceeded. In addition, the work undertaken has helped to improve the Trust's Digital Maturity status in 87% of categories, all in light of the work to plan and implement a large scale change – the new Medway Patient Administration System, and in the context of meeting the Cost Improvement Programme target.

The programme of work this year is just as intense, building on the new PAS to continue the work with local partners across St Helens to implement the Shared Care Record. This will be the single most important development that has ever taken place in terms of the correct clinicians receiving appropriate patient information at the right time and represents a step change in the delivery of patient care and the opportunities it presents to redesign care pathways. Other developments to improve the infrastructure across the STP footprint will allow this work to expand as will Informatics involvement in the Cheshire and Merseyside Shared Care Record.

The Electronic Prescribing and Medicines Administration (EPMA) roll out across the hospital will improve patient safety and ensure appropriate medication is given and the complexity and scale of this implementation cannot be underestimated.

We will continue to optimise the use of the existing systems, particularly Medway where a programme of Optimisation, Stabilisation and Modernisation has commenced and internal developments around the new Service Desk Tool and Staff Development Programme will provide additional efficiencies.

Digital Innovations will continue to be pursued and Telehealth will be expanded into other clinics, again putting the patient at the heart of all developments and helping to provide the right care, by the right professionals at the right time.

We will continue to ensure the safety and security of our systems through the Trust's robust Information Governance Framework and we will work closely with the Trust this year to implement the requirements of GDPR.

Following last year's cyber-attack on the NHS, the STP has provided a firm commitment to enhancing cyber security awareness, capability and responsiveness throughout Cheshire and Merseyside. This is delivered through a dedicated Cyber Security workstream and Informatics continues to provide a significant input and commitment to this. The workstream is placing significant focus on building a collaborative and comprehensive response plan to potential future threats including a robust network of communication and contacts. Finally, Informatics are working with the cyber security workstream on the national agenda to ensure appropriate controls, processes and security patches are in place.

9.0 Glossary of Terms

Abbreviation	Description
5YFV	Five Year Forward View (NHS England Strategy)
C&M	Cheshire and Merseyside
CIP	Cost Improvement Programme
ED	Emergency Department (A&E)
EDMS	Electronic Document Management System
eMEWS	Electronic Medical Early Warning Scores (Patientrack)
ePMA	Electronic Prescribing and Medicines Administration
EPR	Electronic Patient Record
ERS	e-Referral System
GDPR	General Data Protection Regulation (came into force 25/05/18)
I.G.	Information Governance
IDT	Integrated Discharge Team
MRSA	Methicillin-resistant Staphylococcus aureus
NEWS2	National Early Warning Scores (will replace eMEWS)
OCS	Order Communications System (for ordering and viewing Pathology and Radiology results)
PACS	Picture Archiving Communications System
PAS	Patient Administration System
STP	Sustainability and Transformation Partnership

<ends>

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)061

Title of paper: Fit and Proper Persons Regulations – Chairman's Declaration

Purpose: To provide assurance to the Trust Board that the Trust has met the requirements of the Care Quality Commission (CQC) Fit and Proper Persons Regulations (Regulation 5).

Summary:

The Fit and Proper Persons Regulations have been in place since 2014, with additional guidance being issued by the CQC in January 2018.

The Trust has a robust F&PPR Policy and this was reviewed in light of the new guidance and approved by the Board in April 2018.

The regulations require that all providers of NHS services;

"*are able to show evidence that appropriate systems and processes are in place to ensure that all new and existing directors are, and continue to be, fit and that no appointments meet any of the unfitness criteria*"

In order to meet the requirement the Trust policy has put in place a process whereby every Director makes an annual declaration of their fitness to be a Director. In addition annual checks are undertaken by the Human Resources Department, to ensure that no new information has come to light that could affect the Directors "fitness" for the role.

The Chairman reviews the declarations and the results of the checks and provides assurance to the Board that the organisation continues to meet the requirements of CQC regulation 5.

Appendix 1 – Fit and Proper Persons Regulations Annual Declaration 2018.

Trust objectives met or risks addressed:

The Trust is compliant with all the CQC regulations and can maintain registration.

Financial implications:

None arising directly from this report.

Stakeholders: Members of the public**,** Patients, Staff, Commissioners, Regulators

Recommendation(s): That the annual declaration be noted

Presenting officer: Richard Fraser, Chairman

Date of meeting: 27th June 2018

Appendix 1

St Helens and Knowsley Teaching Hospitals NHS Trust

Annual Fit and Proper Person Requirement 2018

The table below certifies that the appropriate checks and self-declarations have been completed for all the Board Directors and that these have been reviewed by the Chairman who has confirmed that, based on the evidence presented, all Directors meet the requirements.

Board Member	Position	F&PPR Checks Completed	F&PPR Self-Declaration Reviewed	Meets Requirements /Comments
Richard Fraser	Chairman	22/06/18	22/06/18	NHSI Process
Denis Mahony	Non-Executive Director	22/06/18	25/04/16	✓
Su Rai	Non-Executive Director	22/06/18	21/06/18	✓
David Graham	Non-Executive Director	22/06/18	19/06/18	✓
Val Davies	Non-Executive Director	22/06/18	19/06/18	✓
Jeff Kozer	Non-Executive Director	22/06/18	21/06/18	✓
Ann Marr	Chief Executive	22/06/18	13/06/18	✓
Anne-Marie Stretch	Deputy Chief Executive	22/06/18	18/06/18	✓
Kevin Hardy	Medical Director	22/06/18	08/02/18	✓
Sue Redfern	Director of Nursing, Midwifery and Governance	22/06/18	18/06/18	✓
Nik Khashu	Director of Finance and Information	22/06/18	19/06/18	✓
Rob Cooper	Director of Operations	22/06/18	13/06/18	✓
Tiffany Hemming	Director of Transformation	22/06/18	20/06/18	✓
Christine Walters	Director of Informatics	22/06/18	18/06/18	✓
Peter Williams	Director of Estates and Facilities	22/06/18	18/06/18	✓
Nicola Bunce	Director of Corporate Services	22/06/18	18/06/18	✓

Chairman's Signature:

Date: 22/06/2018

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)62

Title of paper: St Helens and Knowsley Teaching Hospital NHS Trust's progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions.

Purpose: To provide an overview and assurance of the maternity services current position to meet the 10 mandated criteria of the outlined CNST maternity safety actions.

Summary: To provide a positon and relevant action plans with regards meeting the requirements as identified by NHS resolution and the Department of Health. The expectation is that the Trust will be able to demonstrate the required progress against all 10 of the actions outlined.

The 10 criteria are as follows:

- Use of the National Perinatal Mortality Review Tool to review perinatal deaths ***Achieved.***
- Submitting data to the Maternity Services Data Set to the required standard ***Achieved.***
- Demonstrating transitional care facilities are in place and operational to support implementation of the ATAIN programme ***Achieved.***
- Demonstrating an effective system of medical workforce planning ***Achieved.***
- Demonstrating an effective system of midwifery workforce planning ***Achieved.***
- Demonstrating compliance with the four elements of the Saving Babies' Lives Care Bundle ***Achieved.***
- Demonstrating a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership forum, and regularly acting on feedback ***Achieved.***
- Evidencing that 90% of each maternity staff group have attended an in-house multi-professional maternity emergencies training session within the last training year ***Achieved***.
- Demonstrating that trust safety champions are meeting bi-monthly with board level champions to escalate locally identified issues ***Achieved.***
- Reporting 100% of qualifying 2017/18 incidents under NHS Resolution Early Notification scheme ***Achieved.***

Corporate objectives met or risks addressed: Care; Safety; Pathways; Communication and Systems

Financial implications: Yes, A minimum of a 10% rebate (£266,357) on the CNST maternity premium for 2018/19.

Stakeholders: Trust; staff; patients, commissioners

Recommendation(s): To provide assurance that information submitted as evidence for the 10 mandated criteria is accurate. Members are asked to note and approve the report.

The paper will be submitted to NHS Resolution at contributions@resolution.nhs.uk by the deadline **Friday 29th of June 2018.**

Presenting officer: Sue Redfern. Director of Nursing, Midwifery and Governance

Date of meeting: 27 June 2018

Summary

The Maternity Safety Strategy has set out the Department of Health's target of halving the rates of stillbirths, neonatal and maternal deaths, and brain injuries associated with delivery, by 2025. The first milestone in the process of achieving that target is an expectation of a 20% reduction by 2020.

In order to incentivise improvement in the delivery of best practice, NHS Resolution will be making a 10% (at least) reduction in the CNST maternity contributions of Trusts who are able to demonstrate compliance with the 10 criteria agreed by the National Maternity Champions by trialling the CNST incentive scheme for 2018/19 This is also directly aligned to the intervention objective in the *Five year strategy: Delivering fair resolution and learning from harm.* Trusts who cannot demonstrate full compliance may be eligible for a smaller discount providing that savings are used to take action towards meeting the criteria.

The 10 criteria are as follows:

1. Use of the National Perinatal Mortality Review Tool to review perinatal deaths.
2. Submitting data to the Maternity Services Data Set to the required standard.
3. Demonstrating transitional care facilities are in place and operational to support implementation of the ATAIN programme.
4. Demonstrating an effective system of medical workforce planning.
5. Demonstrating an effective system of midwifery workforce planning.
6. Demonstrating compliance with the four elements of the Saving Babies' Lives Care Bundle.
7. Demonstrating a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership forum, and regularly acting on feedback.
8. Evidencing that 90% of each maternity staff group have attended an in-house multi-professional maternity emergencies training session within the last training year.
9. Demonstrating that trust safety champions are meeting bi-monthly with board level champions to escalate locally identified issues.
10. Reporting 100% of qualifying 2017/18 incidents under NHS Resolution Early Notification scheme.

Appendix 1*: Evidence of the Trust's progress against the 10 safety actions*

Safety action	Evidence of Trust's current progress	Action Met?
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	• The NPMRT is currently embedded into the risk management process. The Maternity Risk Management Strategy (version 15) is reflective of this process. • All relevant members of the Quality and Safety team current have access to the tool. • Eligible cases are identified as all deaths from 22+0 until 28 days after birth (excluding TOP and those with a birthweight <500g, although Trusts should aspire to include them too). • The MBRRACE-UK guidance states: it is recommend that in the first instance the deaths of all term intrapartum stillbirths and intrapartum related neonatal and post-neonatal deaths are reviewed, once the reviewing process is established that reviews should quickly expand beyond the deaths of babies born at term. • The number of eligible cases from January 2018 - April 2018 is 8 and a summary of progress with the use of the NPMRT is identified below: <u>Stillbirths since January 2018</u> **January 2018**: 2 A/N IUD's, PMRT not used. 2 PMRT's opened 14/5/18. Need to convene a panel for the reviews. **February 2018:** 1 A/N IUD. PMRT commenced, incomplete. Awaiting pathology and will then arrange further review to complete the tool. **March 2018**: 2 A/N IUD's. PMRT commenced X2, incomplete. Awaiting pathology	Yes

	and will then arrange further review to complete the tool. **April 2018:** 2 A/N IUD's. PMRT X1 commenced, incomplete. Awaiting pathology and will then arrange further review to complete the tool. 2nd PMRT opened but not commenced as need to convene a panel; however this was a fetal abnormality incompatible with life which the mother did not wish to terminate. **May 2018**: 1 A/N IUD to date. Risk review undertaken 14/5/2018 and tool opened. Need to convene a Panel for review.	
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	• The CNST threshold to achieve CNST standard 2 is set at submitting 8 out of the 10 criteria for the MSDS- 80% target**.** • STHK have achieved this standard by May 2018	Yes
3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	• The mandating of the ATAIN e-LFH module is currently in progress which is demonstrated in the Maternity Specialist Training (TNA), Version 4.1. The intended roll out of the mandated E-learning module will be June 2018. • Current service provision has been assessed and it has been agreed by directorates that as part of Wave 2 of the Maternity and Neonatal Safety Collaborative (April 2018-March 2019). The projects aim is to reduce the number of unexpected term baby admissions to neonatal unit by 50% by March 2019. Neonatal Intravenous (IV) antibiotic provision will be moved from paediatrics to maternity as part of the Quality Improvement process, and alongside the projects aim of reducing the number of unexpected term baby admissions to neonatal unit by 50% by March 2019. This will involve regular input and guidance from NHS Improvement to achieve the desired outcomes (Monthly Summary Report 30/4/18). • Local polices and best practice clinical guidelines have been updated in accordance with best practice.	Yes

	• STHK has core professional membership from both paediatrics and maternity at the North West Operational Delivery Network) NWODN special interest group for Reducing the Number of Babies Separated from their Mothers (RNBS). The aim of the special interest group is to design a Cheshire and Merseyside regional policy to keep mums and babies together, the special interest group is to work on reviewing the transitional care provision across the region which will impact and aim to improve transitional care facilities at STHK (C & M RNBS TOR). • An action plan to support the safer care for full term babies has been completed (August 2017). Further meetings have progressed with a draft/provisional action plan for moving neonatal IV antibiotic administration as transitional care provision within maternity (minutes of meetings from February 2018 and April 2018). It was decided from this meeting that the project would be commenced as part of the Maternity and Neonatal Safety Collaborative Quality Improvement Project (April 2018-March 2019). • Weekly MDT reviews of full term baby admissions to NNU from the end of April 2018 using the ATAIN and NHS proforma for assessment of term admission cases. This proforma assess if admission could have been avoided by transitional care provision and this will be reviewed as part of the Maternity and Neonatal Safety Collaborative Quality Improvement project (April 2018-March 2019).	
4). Can you demonstrate an effective system of medical workforce planning?	• No middle grade sessions on labour ward at STHK are filled by consultants acting down from other sessions. • A self-assessment using the Royal College of Obstetricians and Gynaecologists (RCOG) work force monitoring tool was undertaken in March 2018. The data has been sent to the RCOG to complete the process in April 2018.	Yes
5). Can you demonstrate an effective system of midwifery workforce planning?	• Midwifery staffing at STHK is calculated using a recognised systematic and evidence process for safe staffing utilising the BIRTHRATE PLUS® tool. • Following a review of midwifery staffing in March 2017 Trust Board approval has facilitated recruiting an additional 8wte midwives by 'recruiting to turnover' from August 2017. Midwifery workforce review for 2018 is being undertaken and is due for completion in June 2018. Midwifery workforce staffing is reviewed 6 monthly.	**Yes**

	• Delivery Suite BIRTHRATE PLUS® acuity tool is utilised and evaluated to ensure that the labour ward coordinator has supernumery status (December 2017 – February 2018 report), when this is not achieved this is to be reported as a red flag in real time and by Datix report to the maternity unit bleep holder (Helicopter bleep) in which case a resolution will be sought. There have been no red flags reported from December 2017-March 2018 (April report due May 2018). • The Maternity Services and Paediatric (Neonatal) services operate as separate directorates both producing an annual workforce plans for 2017, any future workforces plans will be merged for 2018/19.	
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	• Fulfilment of the following elements has been confirmed in the Saving Babies Lives Executive Committee paper April 2018. Confirmation of implementation of all 4 Elements with the care bundle has been achieved. Local policies and guidelines have been updated to reflect recommendations and best practice. ➢ Element 1-Reducing smoking in pregnancy *100%* ***achieved****.* ➢ Element 2-Risk assessment and surveillance for fetal growth restriction *75%* ***achieved*****.** Not all staff are compliant with GAP/GROW training, percentage compliance for training is 69%. ➢ Element 3-Raising awareness of reduced fetal movements *100%* ***achieved.*** ➢ Element 4-Effective fetal monitoring during labour *75%* ***achieved.*** STHK do not have a buddy system to review intermittent auscultation. The 2016 SBL's interventions paper identifies that we are 100% compliant; however the quarterly survey identifies the requirement for the intermittent auscultation review system. Currently awaiting guidance from the NWCSCN.	Yes
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such	• Bi-monthly Local Maternity Voices Partnership meeting has been initiated with attendance from service users, specialist midwives and commissioners. • A daily ward round is undertaken by the Maternity Matron or 2E Ward Manager to	Yes

as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	discuss women's experience, and any actions from feedback are instigated immediately. Feedback has been positive (How are you doing Ward Round paper 13th of March 2018). • Friends and Family Test (FFT) displayed in ward areas, any actions that arise from the FFT results are responsive using a variety of methods e.g. Ward Meetings. FFT review is undertaken monthly by each clinical area in the Maternity Services. • Maternity Inpatient survey action plan following the National Maternity survey 2017 which is currently ongoing, a snapshot audit is to be undertaken of women who birthed in January 2018 (Snapshot survey paper of Women's Experience's April 2018).	
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	• Use of the CNST local training record for 'in-house' multi professional maternity emergencies training. For January, March and April Training 2018. • MODSS study day is annually mandated for all relevant maternity staff (Multi-disciplinary obstetric drills and skills session) and assurance has been provided that a minimum of 90% attendance has been achieved for the following staff groups: Midwives, HCA/MSW's, anaesthetists and doctors as at the end of April 2018 (Evidenced in local database training records and Saving Babies Lives paper April 2018). • Fetal monitoring training is mandated by the K2 e-learning package and the annually mandated Midwifery Study Day 2 has 1hr and 45 mins designated to fetal surveillance and monitoring in labour. Obstetricians are required to complete the package to ensure learning is standardised. K2 compliance for eligible maternity staff for April 2018 is 89%. • Multi-disciplinary audit meetings share information from audits and case reviews. • Weekly multi-disciplinary CTG review meetings to share and disseminate learning and teaching are ongoing.	Yes
9). Can you demonstrate that the trust safety	• Identified safety champions are Val Clare (HoM) and Tennyson Idama (Clinical Director), both attend bi-monthly meetings with Board Safety champion (Sue Redfern DoNM&G) to discuss and actions any pertinent issues relating to	Yes

champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	maternity safety. Meetings have taken place in January and April 2018.	
10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?	• All eligible cases have been reported to the NHS Resolutions Early Notification Scheme, the number of cases that have been reported is 9. Process for identification of eligible cases is referred to in the Each Baby Counts SOP Version 1 and the Claims Policy.	Yes

Appendix 2: Sign-off

For and on behalf of the Board of St Helens and Knowsley NHS Teaching Hospital's Trust confirming that:

- The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.
- The content of this report has been shared with the commissioner(s) of the Trust's maternity services
- If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B

Position:

Date:

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)63
Title of paper: Draft STHK Clinical & Quality Strategy, April 2018-21
Purpose: For approval.
Summary: This draft Clinical & Quality Strategy is a replacement for our earlier one. Following discussions at Board and extensive stakeholder engagement the draft strategy describes our collective vision for clinical care and quality improvement and our 10 key priorities. It is NOT an action plan. There will be a separate SMART action plan later in the process (details in the paper).
Corporate objectives met or risks addressed: All Trust objectives
Financial implications: There are no explicit financial implications associated with the development and approval of this strategy. It aims to ensure that we continue our journey of quality improvement cognisant of the financial challenges facing the NHS and describes the promotion of the concept of 'Value' (Quality/Cost).
Stakeholders: All Trust staff and external stakeholders (see stakeholder list in document)
Recommendation(s): That the Board approves the strategy and that the named individuals then start to work on the SMART action plan for Year 1 delivery.
Presenting officer: Nik Khashu, Director of Finance
Date of meeting: 27th June 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

DRAFT STHK Clinical & Quality Strategy

April 2018-2021

Acknowledgement

We are particularly grateful to external partners who were consulted in the development of this strategy: St Helens GP Federation & St Helens CCG, Halton CCG, Knowsley CCG, Healthwatch St Helens, Healthwatch Halton, Healthwatch Knowsley, Halton GP Federation, Halton Heath & Wellbeing Board, Knowsley Health & Wellbeing Board, Alderhey Childrens Hospital, Aintree University Hospitals, Liverpool Heart & Chest Hospital, Northwest Boroughs Partnership, Royal Liverpool & Broadgreen University Hospitals, Southport & Ormskirk Hospitals, Warrington & Halton Hospitals and the Cheshire & Merseyside Health & Care Partnership (STP). We would like to offer particular thanks to the following people who gave up their time to contribute: Councillor Derek Long, Leader of St Helens Council, David Fillingham and colleagues from AQuA, Stephen Brown on behalf of NHSI, Dr Kieran Murphy on behalf of NHSE, David Valentine, Medical Director of Bridgewater Community Healthcare, Brian Finney patient representative, Sarah James, patient representative, the group that included: inpatients, outpatients, visitors, parent & toddler groups, community café, Dementia friends & carers; and many STHK staff.

Executive Summary

In 2012/13, after extensive consultation with a wide range of stakeholders, St Helens & Knowsley Teaching Hospitals NHS Trust (**STHK**) Board launched its 5-year clinical & quality strategy.

The strategy proved to be highly successful, with sustained clinical and financial achievement, a transformed relationship with our lead commissioner and a plethora of national awards. Whilst emergency access has proved challenging, we have consistently achieved national performance targets, including referral to treatment targets and national cancer targets (best in England at the time of writing).

Not only was STHK care rated Outstanding by Care Quality Commission (CQC) and patient experience rated the best in the NHS, but the organisation was rated a top 100 employer by the Health Service Journal, best in the NHS on every domain of the 2017 Patient Led Assessment of Care & Environment (PLACE) and top NHS Staff Survey results 2018, but more importantly, safety and clinical outcomes improved, health inequalities narrowed and healthcare experience was excellent.

The health and care environment is changing rapidly. Sustainability & transformation partnerships have emerged, integrated care systems offer contiguous local health and social care; and integration with and of providers offers an opportunity to tackle the twin challenges of demand and clinical & financial sustainability.

Locally, deprivation, unemployment, smoking, drug and alcohol misuse remain high, health outcomes are still poor relative to more affluent areas, health inequalities

persist and emergency attendances and admissions to hospital are amongst the highest in England.

Much has been achieved……. but much remains to be achieved.

There is consensus within our local community that it is only by working together towards our common goals that we will achieve health & wellbeing for our public.

At STHK, our aspiration is simple: to provide best quality (5-star) patient care.

Aim

The aim of this Clinical Strategy is to promote a culture of continuous value improvement, underpinned by robust systems and processes and individual and collective accountability.

Ownership

The Clinical Strategy is held by the Board, but co-created and co-owned with our workforce and our external partners. It informs and is informed by local plans and our broader collective strategic goals. The Board is clear: sustainable safety and value, good health outcomes and a positive healthcare experience remain our priorities and underpin all trust activities.

Background

For much of the last decade, the NHS has focussed successfully on continuous quality improvement – and rightly so. The NHS has to manage a widening gap between cost and income and we believe the time has come to draw greater attention to the concept of ***value*** (where value = quality/cost). Quality must improve, but we must be mindful of cost. Our approach will be to continue to drive quality improvement but simultaneously clinicians and managers will focus more attention on efficiency and productivity; our aim is to shift the dialogue to '*continuous value improvement*' without detriment to patient experience, to make best use of limited resources to enhance the health and wellbeing of local people. Quality must be safeguarded, however, and we will remain vigilant and never allow normalisation of poor care or outcomes despite the NHS financial challenge.

Informed by work with Institute for Health Improvement (IHI), our last Clinical & Quality Strategy focussed on 20 or so key performance indicators that were surrogates for the quality improvement we sought (and achieved). The present strategy focusses more on promoting and developing our underpinning vision, our culture, distributed leadership for improvement at every level and the capability,

behaviours, systems, processes and accountability that are the hallmark of successful organisations.

We are describing a transition from improvement projects to an embedded culture of improvement; from our central QI team (that ensures that we employ a relatively consistent, systematic and structured approach to quality improvement) to alignment of the aspirations, behaviours and approach of *all* of our staff to our value improvement agenda. Though both are important, we transition from prioritising our compliance dashboard (how we compare to others) to our transformation dashboard (are we on track to deliver our aims).

We will we accelerate transformation of our culture by *demonstrating* our priorities (actions speak louder than words): what gets board attention and reward; how are we are seen to react to critical incidents, complaints, litigation and organisational crises; how are we're seen to prioritise resources (and praise), role modelling, teaching, coaching and what we're seen to prioritise when we recruit and promote.

We will take a fresh look at our systems of governance that have served us well since their refresh in 2012; we will strengthen the golden thread of assurance and delegation board to ward to board and refresh the work plan for councils and groups, with enhanced focus on evidence of action beyond the committee level; our minutes will continue their transition from 'aide memoire' to 'assurance audit trail'.

Our organisation and the health and social care economy in which it sits have matured and so must our approach to our Clinical Strategy.

We have appointed some 5000 quality leads because every member of the organisation from the car park attendant to the chief executive is responsible for co-delivering our 5-star vision.

The Wider Context

Major progress has been made in improving the performance of the NHS in recent years, but against a backdrop of significant national financial challenge, the current health and social care system has struggled to keep pace with the needs of an ageing population, the changing burden of disease and rising patient and public expectation.

NHS health outcomes are the best they've ever been, but national performance targets are not being met, cancer outcomes can be improved; inequalities persist, workforce planning needs to improve and there are very major clinical and financial sustainability challenges.

As a self-critical, learning and sharing organisation, the NHS still has much to improve.

The Local Context

The CCGs, the Local Authorities (LAs) and the Trust serve a relatively deprived population of some 360,000 whose standardised mortality rate is 15% above the English average. Unemployment is twice the national average, one third of children live in one-parent families, over half the population is overweight or obese and take up of elective care is low.

Much of the local population has historically viewed the hospital as a first port of call during acute illness and A&E attendances and emergency admission rates are amongst the highest in England.

In recent years, CCGs, LAs and Trusts have increasingly worked collaboratively to break down organisational barriers that hamper timely, efficient and effective care and instead offer an increasingly integrated health and care system focussed on prevention, timely intervention and care closer to home.

Joint Strategic Needs Assessments (JSNAs) and stakeholder engagement

Our JSNAs and extensive stakeholder engagement prioritise improved life expectancy and better health by:

- giving every child the best start in life
- better supporting young people
- tackling obesity, smoking and alcohol-related harm
- detection and effective intervention in mental health problems, including dementia and parity of esteem for mental health problems.
- prevention, early detection and effective management of longterm conditions
- prevention, early detection and effective management of cancer
- increasing physical activity and building community resilience
- better unplanned care, with a ‘left-shift’ to improve timeliness of local care delivery and prevention of unnecessary hospital attendance and admission
- better end of life care

Clinical priorities

From the JSNAs come our clinical priorities:

- safe and harm-free care
- improved health and quality of life
- prevention of premature illhealth and death
- improved recovery from illhealth
- a positive patient/user experience
- Clinical & financial sustainability

Implementation of Clinical Priorities

The goals of the Peoples Board, Health and Wellbeing Boards, Clinical Commissioning Groups and STHK mirror the NHS Outcomes Framework. We share a common vision and hospital care typically starts and ends in the community with outcomes and experiences of inpatient and outpatient hospital care inextricably bound up in social care and the overarching community context.

STHK Vision 5-Star Care

STHK Values Kind & Compassionate, Respectful & Considerate, Listening & Learning, Friendly & Welcoming

STHK Safe, Timely, Healthy, Kind

SAFE CARE

Safety is our first concern. Our aim is to make our hospital a safer place and to prevent harm and potential harm. Indeed, during our consultation NHSI proposed that we aim to be the safest hospital in England. We accept this challenge.

Our approach can be summarised in a DH 5-point plan:

1. Prevent problems
2. Detect problems quickly and be open about them
3. Take prompt action when problems occur
4. Ensure robust accountability
5. Ensure staff share and learn and are trained and motivated

We will use better information systems and sound judgement to share good practice and to identify care failure. Where we find poor care, we will acknowledge it swiftly and fully, we will apologise and we will tackle it. We will release our clinicians from the burden of unnecessary bureaucracy to allow them to focus on what's important – our patients; and we will promote a robust safety culture that attempts to eliminate avoidable harm.

Safety for our patients, carers (and staff) includes: safe (harm-free) care, preventing healthcare associated infections, falls, pressure ulcers, hospital acquired venous thromboembolic events and medication errors.

TIMELY CARE

Contemporary society places emphasis on timeliness and expects its healthcare to be delivered promptly. Where there is a tension between speed and safety or best health outcomes, we will be measured in our approach, but where we can we will strive to deliver care in a timely manner, whether that be initial assessment and investigation, admission to hospital or other treatment, an outpatient appointment or operation or discharge from hospital or clinic. Moreover, we will endeavour to communicate about care, planned and delivered in partnership with patients and carers, by timely and preferably electronic means.

HEALTHY

Every patient is an individual and should receive care tailored to their individual needs and circumstances, but unwarranted variation leads to poor care. Respecting the needs of the individual, we will increase standardisation of (inter)nationally recognised best quality, evidence-based care by strengthening our use of and adherence to NICE (and other) best practice guidance and Quality Standards. We will expect variance from these standards to be minimised and to be explained as a matter of course.

We will work with commissioners and others to eliminate waste to ensure that we are able to deliver best quality, best value health outcome focussed care locally to local patients – ensuring that care is delivered by an appropriately trained, qualified and experienced clinician in the most appropriate setting.

We will promote good health and proritise wellbeing and prevention wherever we can.

KIND CARE

Much has been written in the Francis report about a lack of kindness. Arguably, society's preoccupation with individualism and a pressure to deliver a myriad of externally imposed and strenuously performance managed objectives at any cost has undermined kindness.

Kindness in times of illhealth or stress (and indeed for fellow staff) is a basic human right and not something we dispense when we're not too busy. We will promote a culture of kindness, not least through our ACE Behavioural Standards, and we will take steps to ensure that assessment for and of kindness forms part of the selection processes we use to appoint and promote our staff.

Kindness includes: listening to and working with our patients and carers to be more accessible and deliver best healthcare in partnership and in an environment of trust and mutual respect; it means being ever conscious of the impact of illhealth and healthcare on quality of life for the individual and their loved ones and taking all available opportunities to understand and improve that quality of life; it means doing what we can to promote and improve basic care and dignity at every opportunity – ensuring patients have access to and can get food and drink (no more out of reach jugs of water or trays of food left before a frail elderly patient who cannot feed themselves) and responding immediately to requests for the toilet; it means better care for those with dementia and those who lack capacity; it also means better understanding and use of the Mental Capacity Act and Deprivation of Liberty arrangements, better safeguarding (for adults and children) and better care and support for patients nearing the end of their lives and their families and carers.

Realising the STHK 5* Vision: Our 10 Priorities

1. We will continue to build on our ambition to ensure that every patient contact, including end of life care, results in a 5* experience, best possible outcomes and best value.

2. We will continue to value our staff, not only by rigorously adhering to our ACE behavioural standards ('An ACE Place to Work'), but also by prioritising learning and development (including new ways of learning). We will actively promote retention and timely succession planning, aligned to the Trust's strategic direction. We are already a top 100 employer, can we become a top 10 employer?

3. Horizontal Integration: we will work with and within our STP to transform the Merseyside & Cheshire Health & Care environment to one that is clinically and financially sustainable and free from unwarranted variation and health inequality without compromising our 5* aspirations.

4. Vertical Integration: we will collaborate with commissioners and other local health and care partners, most notably stronger collaboration & partnership with patients & public, families & carers and the 3rd Sector to realise our collective vision of an integrated, PLACE-based system that prioritises prevention, supports self-care and offers timely intervention and value for money.

5. We will review and refresh our structure and systems of governance to embrace our widening responsibities within our local health and care community, to refresh its purpose and to strengthen the golden thread between board and ward….clinic…. community care setting…. and primary

care practice.

6. We will refresh and systematise learning and sharing from deaths, near-misses, serious incidents, complaints, litigation….and good practice across our wider footprint (and beyond).

7. We will simultaneously strengthen our culture of openness and candour that promotes learning and quality improvement with a greater focus on individual and collective accountability that helps learning embed and achieve traction.

8. We will strengthen our systems for patient and public engagement, stakeholder involvement and public accountability.

9. We will increase, celebrate and capitalise on diversity within our workforce and within our workplace, whilst simultaneously eliminating unwarranted variation to improve the richness of our offer and the consistency of our experience and outcomes.

10. We will ensure that our care environment remains the best the NHS can offer and that our buildings, equipment and facilities enable our staff to reaslise our collective 5* culture.

Recognising Success

How will the Board (and relevant external stakeholders, for example the NHSI, NHSE and local elected representatives and commissioners) know STHK has achieved its strategic priorities?

The organisation already monitors (and is monitored on) national, local and internal performance measures, including: national benchmarks, CQUIN, NHS R&D & CRN reports, complaints monitoring, serious untoward incidents and never events, patient and staff feedback, national, regional and local clinical audits, CAS alert monitoring, NCEPOD reports, QIPP monitoring, workforce metrics, NHSLA reporting, HENW, GMC and trainee feedback, response to national reports, national safety thermometer and much more within the integrated performance report and is held to account by local commissioners and health and social care partners (including the People's Board) and national regulators.

SMART Assessment

Each year, working with the Executive Directors and the Board, the Deputy Medical Director, Deputy Director of Nursing, Deputy Director of HR and Deputy Director of Operations will draw up a **SMART action plan** with KPIs that will be monitored by Quality Committee for the Board.

Timetable for Implementation

Action	Lead	Comments	Status
Write first draft of revised strategy for presentation to Exec Dirs by 10/5/18.	**MD**	Shared by email 10/5/18.	
Comments from Exec Directors collated by CEO by 17/5/18	**CEO**	Bulleted list for MD to be emailed by CEO by 17/5/18. Nil received exc from DoF.	
Create 2nd draft of revised strategy incorporating comments by 24/5/18	**MD**	Feedback from DOF incorporated.	
Share 2nd draft with external stakeholders by 30/5/18 for comments (2 week turnaround).	**MD**	2nd draft shared via email.	
Create 3rd draft of revised strategy incorporating comments by 20/6/18	**MD**		
Final draft of revised strategy to Board 27/6/18	**CEO**	MD on A/L. On agenda√	
Final version of Strategy incorporating Board comments by 4/7/18 shared with 4 deputies.	**MD**		
DMD, DDoN, DDoOps, DDirHR to draw up 2018-19 Action Plan and present to Exec Committee 2/8/18	**DDoN**		
Quarterly Reports to Quality Committee, starting 11/18.	**DDoN**		
Annual Board Update, March 2019.	**MD**		