St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 28TH MARCH 2018
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

PUBLIC BOARD AGENDA				Paper	Presenter
09:30	1.	Patient Story			Richard Fraser
09:45	2.	Employee of the Month			
		2.1	March		
10:00	3.	Apologies for Absence			
	4.	Declaration of Interests			
	5.	Minutes of the Previous Meeting held on 28th February 2018		Attached	
		5.1	Correct Record & Matters Arising		
		5.2	Action List	Attached	
Performance Reports					
10:15	6.	Integrated Performance Report		NHST(18) 20	Nik Khashu
		6.1	Quality Indicators		Sue Redfern
		6.2	Operational Indicators		Rob Cooper
		6.3	Financial Indicators		Nik Khashu
		6.4	Workforce Indicators		Anne-Marie Stretch
Committee Assurance Reports					
10.35	7.	Committee Report – Executive		NHST(18) 21	Ann Marr
10:45	8.	Committee Report – Quality		NHST(18) 22	David Graham
11:00	9.	Committee Report – Finance & Performance		NHST(18) 23	Jeff Kozer

Other Board Reports				
11:15	10.	Strategic & Regulatory Report	NHST(18) 24	Nicola Bunce
11:25	11.	Infection Control Report	NHST(18) 25	Sue Redfern
11:35	12.	Approval of Budget Plans	NHST(18) 26	Nik Khashu
11:45	13.	Board Effectiveness Review 2017/18	NHST(18) 27	Nicola Bunce
BREAK				
11:55	14.	Annual CQC Registration	NHST(18) 28	Sue Redfern
12:00	15.	Annual Mixed Sex Declaration	NHST(18) 29	Sue Redfern
12:05	16.	Review of Staff Survey	NHST(18) 30	Anne-Marie Stretch
12:20	17.	Trust Objectives 2018/19 for approval	NHST(18) 31	Ann Marr
Closing Business				
12:30	18.	Effectiveness of meeting		Richard Fraser
	19.	Any other business		
	20.	Date of next Public Board meeting – Wednesday 25th April 2018		
LUNCH				

St Helens and Knowsley Teaching Hospitals NHS Trust

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

PUBLIC BOARD

Acting Chair:	Mr D Mahony	(DM)	Non-Executive Director
Members:	Ms A Marr	(AM)	Chief Executive
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Ms S Rai	(SR)	Non-Executive Director
	Prof D Graham	(DG)	Non-Executive Director
	Mrs V Davies	(VD)	Non-Executive 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 R Cooper	(RC)	Director of Operations & Performance
	Ms N Bunce	(NB)	Director of Corporate Services
	Mr P Williams	(PW)	Director of Facilities Management/Estates
	Dr T Hemming	(TH)	Director of Transformation
	Dr F Andrews	(FA)	Assistant Medical Director *(for Prof K Hardy)*
In Attendance:	Cllr G Philbin	(GP)	Halton Council
	Mr G Appleton	(GA)	St Helens CCG
	Ms J Byrne	(JBy)	Executive Assistant *(Minutes)*
Apologies:	Mr R Fraser	(RF)	Chairman
	Mr J Kozer	(JK)	Non-Executive Director
	Prof K Hardy	(KH)	Medical Director
	Mr T Foy	(TF)	St Helens CCG

1. Employee of the Month

The Employee of the Month Award for February 2018 was presented by the Deputy Chair to Mrs Paula Hesketh, Nurse Clinician, Sanderson Suite, General Surgery, St Helens Hospital.

2. Apologies for Absence

Apologies were noted as above.

3. Declaration of Interests

There were no declarations of interest.

4. Minutes of the previous meeting held on 31st January 2018

4.1. Correct Record

The minutes were accepted as a correct record, once the words 'part-time' to indicate leaving the meeting before it ended were deleted following SR's name, as a note was inserted in the main body of the minutes.

4.2. Matters Arising

There were no matters arising, not included on the action list.

4.3. Action List

Action 1 - Minute 15.5 (27.09.17): *WRES report and action plan.* On the agenda. Action Closed.

Action 5 - Minute 13.3 (31.01.18): *AMS to contact local Trusts with lower staff turnover to ensure all good practice is being followed in relation to retention of staff.*

AMS reported that she had contacted the two local Trusts who were performing better than STHK, but they were not implementing any initiatives that were different from this Trust.

AMS reported a group of Cheshire and Merseyside HR directors were jointly working to implement the new NHS Improvement recruitment and retention toolkit across the region.

In terms of nurses, Cheshire and Merseyside Nursing Directors were exploring an initiative from London called 'Capital Nurses' which developed nurses and supported them to rotate between settings and progress their career in a planned way. It was felt if the Mersey 'brand' could be improved it would encourage more people into nursing.

In response to a query from AM, AMS confirmed an analysis had been completed on those leaving the Trust which had identified a number of nurses retiring to take advantage of changes to the pension scheme and then returning on more flexible working. Exit interviews indicated that some nurses were also leaving due to a lack of promotion or education opportunities. AMS acknowledged the Trust had difficulty in funding training following changes made to national training monies by Health Education England, and noted that at present the apprenticeship levy could not be used for one-off training. AM asked that AMS undertake further in-depth analysis for the Executive Committee of staff turnover and leavers, as well as the pipeline for recruitment in order that there was a way of monitoring net gains or losses in the nursing workforce and the pipeline of recruitment.

DM noted the increase in absenteeism in the month and asked how it was being managed. AMS confirmed that due to the incidence of flu and winter viruses amongst staff absence had increased, but the absence policy continued to be applied consistently and fairly across the Trust.

5. Integrated Performance Report (IPR) – NHST(18)11

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.

5.1. Quality Indicators

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

5.1.2. There was 1 reported never event in January, 2 cases year to date, both related to the incorrect insertion of nasogastric tubing. SRe confirmed the Risk Cause Analyses (RCAs) were due back and she would provide an update at the next meeting.

5.1.3. DM asked DG, as Chair of the Quality Committee, whether there was assurance that the Trust had done enough to ensure this would not happen again. DG confirmed the Medical Director (KH) had requested an external review be undertaken by the Royal College of Anaesthetists (RCoA) which may take several months to complete. Additionally, new training was being rolled out to increase awareness levels/education and only those staff that had completed the training were allowed to insert a nasogastric tube. There was also additional support in place from the Radiologist to interpret X-rays.

5.1.4. There were no MRSA bacteraemia cases in December and 2 cases year to date. Of the 2 cases, 1 is being appealed and 1 was a contaminated specimen.

5.1.5. There were 2 C.Diff positive cases in January, 19 cases year to date.

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

5.1.7. The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for January was 93.8%, year to date performance 94.0%.

5.1.8. During the month of December 2017 there was 1 inpatient fall resulting in severe harm. Year to date total is 13.

5.1.9. Venous thromboembolism (VTE) performance for December 2017 was 94.74%. Year to date performance is 93.35% against a target of 95%.

5.1.10. Final Hospital Standardised Mortality Ratio (HSMR) for 2016/17 is 102.4.

5.2. Operational Indicators

5.2.1. RC presented the update on the operational performance.

5.2.2. Performance against the 62-day cancer standard improved again in month to 90.6% against a target of 85.0%. Specialties are continuing to ensure delivery of specific action plan which are in place to maintain compliance against the standard.

5.2.3. The 31-day target was achieved in month at 96.1% against a target of 96.0%.

5.2.4. VD asked if any progress had been made on the head and neck cancer pathway. RC confirmed meetings had been held with the professor leading the pathway and also the Cheshire and Merseyside clinical lead. As a result, the Trust had committed to completing diagnostic tests by day 19 before handing the patient over to the specialist at Aintree. The Trust would continue to monitor this closely the attainment and impact of this change and report back in future months.

5.2.5. A&E performance deteriorated in month to 71.8% (type 1) and 86.0% (mapped STHK footprint – all types). This was due to a very difficult winter period above planned levels. Emergency admission demand lead to the need for escalation beds and increased use of agency and locum staff to maintain patient safety.

5.2.6. In relation to a query about managing the number of GPAU referrals from DM, RC confirmed the Trust were expecting to see some improvement when the single point of access was implemented for St Helens, which allowed for a discussion to take place before the patient arrived at hospital. However, Primary Care had experienced the same pressures at the acute sector and was seeing lots of poorly people who needed assessment.

5.2.7. RC informed members there was some concern in relation to junior doctors' absence in the A&E Department which was causing difficulty in maintaining the right level of cover. A deep dive to understand the causes and agree targeted support was being undertaken.

5.2.8. The Divisional Director for Elective Medicine and the Assistant Medical Director of Unscheduled Care were working on a weekend discharge team.

5.2.8. SAFER start command centre was in place for the first 2 weeks of January in conjunction with partners to support management of increased demand. The whole Trust had responded well to maintain patient safety and flow through the hospital, so that the sickest patients could be treated. RC confirmed that February continued to be very pressurised.

5.2.9. RTT incomplete performance was maintained at 93.3% in month against a target of 92.0%. In response to a query from DM, RC explained RTT had been maintained because the Trust had two sites and many day cases were completed at St Helens Hospital.

5.2.10. AM asked if the doctors were managed using the same Attendance Policy as all other staff. AMS confirmed that whilst working at the Trust this was the case, but as lead employer there was a reliance on other organisations to report and manage absence when they worked in their organisations. DG suggested that the most important action was to understand the underlying reasons for these periods of absence.

5.3. **Financial Indicators**

5.3.1. NK presented the update on the financial performance.

5.3.2. The Trust has reported an overall income and expenditure surplus of £6.6m at the time of writing. This included all assumed STF funding, use of all available non-recurrent risk mitigation resources and utilisation of appropriate Tranche 1 and 2 winter funding as agreed with NHSI. This was offset with exceptional run rate cost increases since December 2017, mainly in pay. The need for escalation beds, increased acuity of patients, challenging staff sickness levels and price increase of agency were the key drivers to increased run rates.

5.3.3. NK verbally updated the Board that NHSI had instructed the Trust, after submitting their financial numbers, to remove £0.8m of assumed STF in the YTD values. This was because of the system not achieving A&E performance overall (89.3% compared to the requirement of 90%) and represented Q3 loss of STF at 30%.

5.3.4. NK reported that the F&P committee had considered in detail the risk range in achieving outturn control totals. In summary this including continued run rate costs to maintain safety/flows, general sickness, impact on elective plan and the overall impact to CIPs.

5.3.5. The Board noted that at the January NHSI quarterly review meeting, the risks to the outturn position had been outlined and the position stated that the Trust was endeavouring to do all it could to achieve the planned outturn, subject to the risks outlined above.

5.3.6. The Trust has delivered £9.8m of the Cost Improvement Programme (CIP) and is £(2.6)m behind the year to date plan for January which is reflected in the Trust's overspend on expenditure. The delivery of the £15.3m CIP target has been compromised by the non-elective operational pressures in the Trust.

5.3.7. The Trust is still currently working to deliver the planned annual surplus of £8.5m, which equates to a £(0.6)m deficit excluding original allocation of STF funding of £9.1m, however the Board was asked to note the increasing level of financial risk that the Trust was having to manage.

5.3.8. The Trust's cash balance at the end of January was £18.6m, representing 19 days of operating expenses. The Trust has incurred £6.6m of capital expenditure in the 10 months to January.

5.3.9. NK reported the 2018/19 planning guidance had now been published and the Trust had just received the CCGs' commissioning intentions and contract offer. The Clinical Negligence Scheme for Trusts (CNST) has increased by £2.5m but there was potential to reduce this by implementing the national Maternity Strategy recommendations. The Trust had already achieved 9 of the 10 stipulations and was awaiting further national guidance to be able to address the last. SRe to bring a paper for Board approval in June to enable the Trust to qualify for the Maternity CNST discount.

5.3.10. GP had seen a press article in relation to procurement in the NHS and asked whether there was potential for more collaborative working between the Trusts in the Mersey City region. NK confirmed that collaborative buying frameworks already existed, however he was chair of the regional group and pushing for even more collaboration to

increase spending power. DM requested that a report on procurement benchmarking be presented to the Finance and Performance Committee to identify opportunities for greater efficiency.

5.4. **Workforce Indicators**

5.4.1. AMS presented the update on the workforce indicators.

5.4.2. Absence had increased in December to 5.7% against the Q4 target of 4.68%. Year to date absence is 4.6% against the last outturn of 4.8%.

5.4.3. Mandatory training compliance fell slightly in month to 88.2% and continued to exceed target by 3.2%. Appraisal compliance had improved to 86% and was now above target by 1%.

5.5. **Staff Survey**

In response to a query from VD, AMS confirmed the national results of the staff survey would be published on Thursday 1st March. A formal briefing report is scheduled to come to the Board meeting in March.

6. Committee Report – Executive – NHST(18)12

6.1. AM presented the report, which summarised Executive Committee meetings held during January 2018.

6.2. The Executive Committee had approved the extension of the Radiology Information System contract for a further 3 years, an updated 'Smoke Free' policy and Phase 1 of the Pharmacy business plan, which intended to increase clinical pharmacy presence on the wards to create more efficient pathways and discharge processes.

6.3. The impact of the CCG Referral Management Schemes on both referrals to the Trust and Referral to Treatment Targets (RTT) was being closely monitored by the Executive Committee.

6.4. The Executive Committee agreed the 'go live' date for Medway, the new patient administration system, for Friday 27th April 2018. Staff being released to attend the training was now the priority of the programme board.

6.5. Work had been undertaken to understand the costs of complex breast reconstruction operations. It was recognised that although the procedures undoubtedly offered the best outcome for patients both psychologically and physically and were more cost effective than 2 operations, the procedures were not currently reflected in the standard tariff. The Executive was continuing to explore how this could be addressed.

6.6. The Executive Committee considered a review of the effectiveness of the Hospital Charity. Proposals for growing the charity and attracting more donations were reviewed, as were the opportunities for a specific appeal.

6.7. Plans for the safe transfer of patients from the Orthodontics Service to other alternative providers and arrangements for staff affected by the closure of the service had been reviewed.

6.8. VD queried if there was a concern regarding newly qualified nurses being asked to give IVs. AM clarified that this item related to the Trust's policy in relation to staff receiving the necessary training before they would be put in a position to deliver IVs, and there was not a patient safety risk.

7. Committee Report – Audit – NHST(18)13

7.1. The Board noted SR's report, which summarised key issues arising from the Audit Committee meeting held on 7th February 2018.

7.2. Internal audit had given limited assurance for some ward audits and the committee had sought assurance that the recommendations were being addressed. The risks identified had been medium to low level risks, however the audit committee would monitor the implementation and report back to the Board following the next Audit Committee meeting.

8. Committee Report – Quality – NHST(18)14

8.1. DG presented the Chair's report, which summarised key issues arising from the Quality Committee meeting held on 20th February 2018.

8.2. The number of complaints totalled 14 in January 2018, the same as December 2017 and a 66% decrease on January 2017.

8.3. Lessons learned and actions undertaken were discussed, including a proposal to risk/severity rate complaints as advised by Mersey Internal Audit Agency (MIAA). The Committee had asked for this to be considered further and proposals developed.

8.4. The Integrated Performance Report was discussed and members noted £850k STF was to be withheld due to failing Q3 AED at 89.3% creating performance and financial risk to the start of Q4.

8.5. In relation to a recent national maternity inpatient survey, the Committee noted there a low response rate for the Trust compared to the national average, but the patient feedback had been disappointing and was not consistent with the F&FT and other feedback about the service. It was recognised that there was a significant time delay from when the sample of patients had been surveyed and many of the issues had already been addressed. The action plan in response to the survey had been reviewed by the Committee and would be monitored going forward.

8.6. The Fasting before Surgery policy was to be audited immediately to ensure that information was being accurately recorded and reported and then repeated. SRe reported that the audit had already begun an investigation of the cases reported to the Quality Committee indicated there were gaps in reporting which were being addressed to ensure that no patient was fasted for more than 6 hours, even if surgery was delayed.

8.7. The Learning from Inpatient Deaths policy had been updated by the Medical Director and reviewed by the Committee, the changes were recommended to the Board. It was agreed that the revised policy would be circulated to Board members and be formally approved at the March Board meeting, if all members agreed.

8.8. The increase in activity in PALS was noted, this was felt to be positive as more concerns were being raised and responded to informally. SRe to ensure the PALS workload remains manageable.

9. Committee Report – Finance and Performance – NHST(18)15

9.1. NK presented the Chair's report on behalf of JK, which summarised key issues arising from the Finance and Performance Committee meeting held on 22nd February 2018.

9.2. The Committee had approved the methodology for informing and developing the CIP programme for 2018/19 and noted a further update on identified schemes would be presented in March. The Board discussed the challenges of delivering CIP without impacting on the quality of patient care and agreed that the traditional approaches would have a limited yield and more transformational CIPs were required.

9.3. The Committee had discussed the forecast outturn position and changes to the risk profile at month 10, with particular reference to risks associated with the delivery of the CIP programme, STF funding in Q4 and the Trust's cash flow, as a result of winter pressures and the actions taken to increase bed capacity in response to the growing demand, and the increased staffing costs to maintain patient safety.

9.4. The Trust was forecasting to achieve the annual plan of £(0.581)m deficit excluding STF funding of £7.715m including winter monies, but this position was now at significant risk. The Committee had explored this risks and challenged the mitigation and management plans, to be assured that the Executive were taking action to maintain control of costs, whilst balancing an appropriate response to the increased demand and acuity of patients.

9.5. NHS Improvement (NHSI) had published the planning guidance for 2018/19 and had issued a revised control total for 2018/19 to the Trust of £(1.828m) deficit, which after Provider Sustainability Funding (PSF) of £12.821m equated to a £10.993m surplus. An indicative budget had been reviewed by the Committee which discussed possible income and cost assumptions in light of the planning guidance. The Board debated the control total and agreed the Trust would endeavour to do all it could to achieve the control total but recognised the very challenging period ahead.

10. Committee Report – Charitable Funds – NHST(18)16

10.1. NK presented the Chair's report, which summarised key issues arising from the Charitable Funds Committee meeting held on 22nd February 2018.

10.2. The implications of the General Data Protection Regulation (GDPR) were being worked through with involvement from the Information Governance team.

10.3. The Committee reviewed income and expenditure to the fund since the previous meeting.

10.4. The Committee discussed the best way to publicise the role of the Charity Officer and staff in relation to donations. A crib sheet was to be drafted for the use of both staff and the general public.

11. Statutory and Regulatory Report – NHST(18)17

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

11.2. The report provided a briefing on:

11.2.1. NHSI/NHSE joint planning guidance for 2018/19;
11.2.2. NHSI regulatory oversight of controlled providers;
11.2.3. Closer working between NHSE and NHSI;
11.2.4. The Government's response to the Naylor review;
11.2.5. A CQC consultation on the regulation of private healthcare providers.

12. Safeguarding Annual Reports – Adults and Children – NHST(18)18

12.1. The reports provided information and assurance for all aspects of safeguarding adults and children during the financial year 2016/17.

12.2. The Trust had been awarded significant assurance for its processes.

12.3. The focus for improvement recommendations had been to improve the rates of safeguarding training and ensure the targets were achieved. SRe confirmed that improvements had been made during 2017/18.

12.4. In response to DM's query about increased safeguarding referrals, SRe felt that this indicated increased awareness and understanding of the process and legal framework, particularly the requirements for Deprivation of Liberty (DoLs), rather than a big increase in cases.

12.5. The Board approved the reports.

13. Workforce Race Equality Standard (WRES) External Review and Action Plan – NHST(18)19

13.1. AMS presented an update on the Trust's WRES performance and proposed action plan. The report included benchmarking against other local and national acute Trusts. The Trust's results had been by reviewed by an external equality and diversity expert who had supported the formulation of the action plan in line with best practice.

13.2. Board members were concerned to note more Black, Minority and Ethnic (BME) staff entered the disciplinary process. The higher representation of BME staff amongst the Medical Staff group was to be investigated further, and AMS agreed to undertake more in-depth analysis of this issue to bring forward proposals for appropriate action.

13.3. DG suggested it may be useful to investigate who had completed equality and diversity training and the medical school of origin.

Subject to the further work required on WRES indicators 3 and 4 the Board accepted the report and approved the action plan.

14. Effectiveness of Meeting

DM asked the attendees for their feedback on the effectiveness of the meeting GA believed the meeting had great engagement and good challenge from all members. GP found the meeting to be extremely informative.

15. Any Other Business

DM asked if there was any update on the Royal Hospital build. AM confirmed that there was likely to be a substantial delay in appointing an alternative contractor to finish the new hospital. The delay would provide more time for the RLBUHT and Liverpool health system to develop its plans for coping with the planned reduction in beds.

16. Date of Next Meeting

The next meeting is scheduled for Wednesday 28th March 2018 in the Boardroom, Level 5, Whiston Hospital, commencing at 09:00 hrs.

Chairman: .....

Date: 28th March 2018

Agenda Item 5.1 – Matters Arising

Approval of Learning from Inpatient Deaths Policy

As discussed at the last Board meeting and further to the email attaching the policy on 28th February, the policy will be approved if members are happy with the changes.

St Helens and Knowsley Teaching Hospitals NHS Trust

Learning from Inpatient Deaths

Version No: 2

Document Summary:

This policy outlines the updated policy on Learning from Deaths in response to the *National Guidance on Learning from Deaths* published by the National Quality Board in March 2017.

Document type	Policy
Document number	STHK0605
Approving body	STHK Trust Board
Date approved	27th September 2017
Date implemented	1st October 2017
Next review date	**31st January 2020**
Accountable director	Professor Kevin Hardy
Policy author	Dr Terence Hankin (amended by Professor Hardy)
Applies to	STHK Trust Staff

The intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as "uncontrolled", as they may not contain the latest updates and amendments.

Quick Reference Guide

Total Deaths in Scope[1]

Check against NWB downloaded LD List **'Learning Difficulties Death'**	LeDeR Death Review[2]
Check against MHA and DOLS list **'Severe Mental Illness Death'**	SJR[3]
Check if age < 18 yrs., but > 28 days **'Child Death'**	SIRI & Regional Child Death Overview Panel (CDOP)
Check if < 28 days and > 24 weeks gestation **'Neonatal death or Stillbirth'**	Joint Perinatal Audit Meeting (SJR), & C&M 'Each Baby Counts' Panel
Check if spell includes obstetric code (501) **'Maternal Death'**	STHK STEIS/SIRI & National EMBRACE system (also perinatal)
Check against current year 'Alert List' **'Alert Death'**[5]	SJR
Check DATIX for SIRI Investigation **'SIRI Death'**	SIRI Investigation
Check DATIX for complaints/PALS/staff concerns **'Concern Death'**	SJR
Check against Surgical Procedures List **'Post-op Death'**	SJR
25% Sample, include all low risk deaths[4] **'Sample Deaths'**	SJR

1. All inpatient deaths at STHK, transfers to other hospitals or settings not included
2. LeDeR – nationally prescribed process for reviewing LD deaths
3. Structured judgement review, currently STHK tool (see Annex C) although the Trust may move to RCP SJR in due course
4. Low risk deaths as defined by Dr Foster/HED grouping
5. Alert deaths; include any CQC alerts or 12-month internal monitoring alerts from the previous financial year.

Version Control

Version	Date Approved	Brief Summary of Changes	Author (Title)
V1	27.09.17	Learning from Deaths	Dr Terence Hankin (Deputy Medical Director)
V2	28.02.18	Learning from Inpatient Deaths	Prof Kevin Hardy (Medical Director)

Document Control

Document Number:	**STHK0605**	**Title:**	Learning from Inpatient Deaths		
Equality analysis completed?	Yes	**Sent for 2 week consultation on Trust intranet and to relevant staff:**			
Approving Body:	STHK Trust Board		**Date of Approval:**	27th September 2017	
Author:	Dr Terence Hankin		**Status:**		
Brief Description of Amendments (if applicable): This policy outlines the updated policy on Learning from Deaths in response to the *National Guidance on Learning from Deaths* published by the National Quality Board in March 2017.					
Does the document follow the Trust agreed format?				Yes	
Are all mandatory headings completed?				Yes	
Does the document outline clearly the monitoring compliance and performance management?				Yes	
Approved?					
Approved after minor amendments? *Any amendments to be submitted to Approving Body Chair for final sign off*					
Not Approved?					
Policy Author Signature:				**Date:** 28th February 2018	
Chair of Approving Body	**Name / Title:**	RICHARD FRASER / CHAIR		**Date:**	
	Signature:				
		Review Date:	28th February 2018		

Withdrawal of Document

To be completed if a document has been superseded or no longer required

Date Document Withdrawn:		**Reason:**	No longer required/superseded
Policy Author Signature:			**Date:**
Lead Executive Director Signature:			**Date:**

Contents

1. Scope

This policy applies to all staff whether they are employed by the trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the Trust's behalf.

2. Introduction

St Helens & Knowsley Teaching Hospitals NHS Trust has an established mortality review process. The Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* was published in late 2016 and found that learning from deaths across UK Trusts was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The National Quality Board issued guidance in March 2017, following the CQC report and the process at STHK has been amended (and updated) to meet these new standards.

This policy sets out how the Trust will implement the national guidance and describes the governance that will assure consistency, reliability and resilience of delivery.

3. Statement of Intent

The Trust will implement requirements outlined in the Learning from Deaths framework to supplement the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of the Trust.

It describes how the Trust will support people who have been bereaved by a death at the Trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the Trust supports staff that may have been affected by the death of someone in the Trust's care.

It sets out how the Trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

This policy should be read in conjunction with the Trust's procedures: for reporting and managing incidents, Serious Incidents, quality improvement, complaints management and the existing mortality governance processes.

4. Definitions

Death certification
The process of certifying, recording and registering death and the causes of death. This process includes identifying deaths for referral to the coroner.

Case Screening
A review of all deaths in scope to help identify those that are more likely to generate learning from a more detailed structured judgement review (defined in the national guidance on learning from deaths as: deaths in people with learning difficulties, in serious mental illness, child deaths, neonatal deaths & stillbirths, maternal deaths, surgical deaths, 'alert deaths' (CQC mortality alerts and internal diagnostic groups or procedure groups under close monitoring), deaths subject to STEIS reporting or serious incident investigation and deaths where relatives, carers or staff have raised concerns). In addition, STHK has added a 25% sample of all other deaths in scope, including all 'low risk' deaths as defined by Dr Foster or HED.

Structured Judgement Review (SJR)
A systematic retrospective case record review using a structured or semi-structured methodology, to identify problems in care or healthcare systems with the aim of finding learning to improve future care.

Serious Incident
Serious Incidents in healthcare are adverse events where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or potentially avoidable death, unexpected or potentially avoidable injury resulting in serious harm (including those where the injury required treatment to prevent death or serious harm), abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. See the Serious Incident framework for further information: https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

Severe Mental Illness
There is no clinically practicable definition of severe mental illness (SMI) for the purpose of this work (and NHSI were unable to provide a definition). Until a national definition is forthcoming, it is proposed to pragmatically define SMI for the purpose of this policy as any patients who for part or all of their index inpatient stay were detained under the Mental Health Act or Deprivation of Liberties legislation.

Investigation
A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided or systems of care. Investigations draw on evidence, which may include physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce

the risk of similar events in the future. Investigation can be triggered by or follow case record review or may be initiated without a preceding case record review.

Death due to a problem in care or systems of health care delivery
A death that has been clinically assessed using a structured method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery and or service provision. (Note, this is not a legal term and is not the same as cause of death'). NHSI and the Royal College of Physicians have stated that the term 'avoidable mortality' should not be used, as it has a specific meaning in public health that is distinct from 'death due to problems in care'.

Quality improvement
A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

Patient safety incident
A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

5. Duties, Accountabilities and Responsibilities

Role	Responsibility
Trust Board	The National Guidance on Learning from Deaths places particular responsibilities on boards, as well as reminding them of their existing duties. Organisations must refer to Annex A of the National Guidance on Learning from Deaths.
Chief Executive	Ultimate accountability for all care and activities undertaken within the organisation.
Medical Director	The executive director with delegated accountability for compliance with this policy and the learning from deaths agenda.
Director of Nursing	Patient safety director responsible for serious incident investigations and Duty of Candour.
Non-executive Director	Responsibility for oversight of the investigation, review and learning process. In summary, non-executive director responsibilities relating to the framework include: understanding the review process; ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny; championing quality improvement that leads to actions that improve patient safety; assuring that published information fairly and accurately reflects the organisation's approach, achievements and challenges.
Mortality Surveillance Group (MSG)	A multi-disciplinary, multi-professional group responsible for overseeing the process of mortality reviews.
Principal Analyst	Senior Analyst responsible for reporting mortality indices and trends in HED data, etc to Clinical Effectiveness Council.
Chair Clinical Outcomes Group (COG)	To investigate deaths and other incidents (excluding SIRIs) referred to it by any member of Trust staff.

Paediatrics/children and young people clinical lead	Is informed of the death of any infant or child as defined in annex F of the national guidance.
Lead Clinician Palliative Care	To help inform the MSG of issues that may have influenced 'death' expectancy in palliative care patients.
Head of Maternity	To help inform the MSG of issues related to stillbirth or maternal death as defined in annex G of the national guidance.
Mental Health Lead	To help inform MSG in the assessment of deaths in LD & SMI.
Safeguarding Lead	To help inform MSG in the assessment of deaths in patients with LD (specifically) and all other deaths. The Learning Disabilities Mortality Review (LeDeR) Programme delivered by the University of Bristol is used to investigate LD deaths.
Patient Safety Manager	To ensure DATIX provides data to inform investigation of deaths associated with serious investigations, complaints, PALS or where staff or carers have expressed concerns.
Assistant Director of Patient Safety	To identify and report any patient safety concerns possibly leading to the death of a patient in the Trust's care.
All staff	All staff have a responsibility to report concerns to their line manager or the Trust Executive regarding perceived failures of care, in reference to this policy.

6. Process

6.1 The Process for Recording Deaths in Care

Currently all inpatient deaths are captured from the PAS system and reported monthly in the Integrated Performance Report (IPR) and also on Qlikview.

6.2 Selecting Deaths for Case Record Review

Cases will be identified for investigation using the algorithm in 6.3 below derived from national guidance and where appropriate, assigned to a trained consultant reviewer. Special group deaths will be reviewed by the appropriate nationally specified methodology.

6.3 Total Deaths in Scope1

Check against NWB downloaded LD List **'Learning Difficulties Death'**	LeDeR Death Review[2]
Check against MHA and DOLS list **'Severe Mental Illness Death'**	SJR[3]
Check if age < 18 years, but > 28 days **'Child Death'**	SIRI & Regional Child Death Overview Panel (CDOP)
Check if < 28 days and > 24 weeks gestation **'Neonatal death or Stillbirth'**	Joint Perinatal Audit Meeting (SJR), & C&M 'Each Baby Counts' Panel
Check if spell includes obstetric code (501) **'Maternal Death'**	STHK STEIS/SIRI & National EMBRACE system (also perinatal)
Check against current year 'Alert List' **'Alert Death'**[4]	SJR
Check DATIX for SIRI Investigation **'SIRI Death'**	SIRI Investigation
Check DATIX for complaints/PALS/staff concerns **'Concern Death'**	SJR
Check against Surgical Procedures List **'Post-op Death'**	SJR
25% Sample, include all low risk deaths[5] **'Sample Deaths'**	SJR

1. All inpatient deaths at STHK, transfers to other hospitals, or settings not included.
2. LeDeR – nationally prescribed process for reviewing LD deaths.
3. Structured Judgement Review currently STHK tool although the Trust may move to RCP SJR in due course.
4. Alert deaths include any CQC alerts or 12-month internal monitoring alerts from the previous financial year.
5. Low risk deaths as defined by Dr Foster/HED grouping.

6.4 Principles to be applied for case record reviews

The STHK SJR will be used to complete case record reviews initially although there may be a move to the Royal College of Physicians tool later, once the system is embedded.

Reviewers will be selected by the MSG to include expressions of interest from senior clinicians (fully registered for more than 5 years) from any discipline.

Reviewers will be trained in the use of the methodology to ensure consistency.

Case record reviews will be carried out by clinicians not directly involved in the care of the patient unless the expertise resides only in that specialty, in which circumstances the review should include clinicians not involved in the care of the deceased.

A quality assurance framework will be implemented by MSG to audit a proportion of the reviews to ensure consistency of reviewing and other aspects of quality assurance.

6.5 Structured Judgement Reviews (SJRs)

The sampled deaths will be reviewed using the STHK SJR (see below). The SJR is a critical evaluation of the clinical record by an experienced clinician which includes a section for lessons to be learned and the following assessments:

Health Records	Adequate ☐ Inadequate ☐	
NCEPOD Quality of Care Score (tick one box only)	☐	Good Practice
	☐	Room for improvement in clinical care
	☐	Room for improvement in organizational care
	☐	Room for improvement in clinical & organisational care
	☐	Poor aspects of clinical or organisational care
Balance of probability is that death did NOT result from problems in care delivery/service provision – CLOSE		☐
Significant doubt about whether or not, problems in care delivery/service provision contributed to death – reviewed by MSG		☐
Balance of probability is that death may have resulted from problems in care delivery/service provision – refer to Director of Nursing for SIRI investigation		☐

*NHS Improvement and the Royal College of Physicians advise **NOT** to use the term 'avoidability'.*

6.6 Actions following SJR

Outcome	Actions
Balance of probability is that death did NOT result from problems in care delivery/service provision.	• Lessons learned added to database; • Case is closed.
Significant doubt about whether or not problems in care delivery/service provision contributed to death.	• Second review undertaken by multi-professional Mortality Surveillance Group; • Lessons learned added to database.
Balance of probability is that death may have resulted from problems in care delivery/service provision.	• Referred to Director of Nursing for full SIRI investigation and StEIS reporting where appropriate in line with the Trust's Incident Policy: *http://nww.sthk.nhs.uk/MANAGE/library/documents/9854905_IncidentReportingPolicy.pdf*; • Lessons learned added to database.

6.7 Mortality Monitoring and Links with Existing Procedures

The Trust has an established governance system for managing untoward incidents.

There are systems in place for capturing, reporting and escalating untoward incidents via DATIX, Serious Incident (SI) reporting and Strategic Executive Information System (StEIS).

6.7.1 Clinical Effectiveness Committee (CEC)

CEC will continue to monitor and gain assurance about the wide range of mortality KPIs reported in the IPR, most notably, SHMI, HSMR and standardised mortality ratios broken down by condition (or group of conditions), procedure and directorate.

6.7.2 Mortality Surveillance Group (MSG)

The NED-chaired, multi-professional MSG will no longer duplicate this work, but will focus on evaluation of amber SJRs. The Mortality Surveillance Group (MSG) reports to the Board via the Quality Committee.

6.7.3 Clinical Outcomes Group (COG)

COG will continue to undertake forensic multi-professional reviews of any cases referred to it, excluding cases subject to StEIS/SIRI, but including prior amber reviews and prior special group reviews', as well as non-mortality cases.

6.7.4 Trust Board

In accordance with the National Quality Board guidance, from Q3 2017-18 a report will be published through a standard agenda item to a Public Board meeting each quarter (see Appendix 2 for sample report). This report will include:

- Total number of the Trust's inpatient deaths (including Emergency Department);
- Number of deaths that the Trust has subjected to case record review;
- An estimate of how many deaths reviewed were judged more likely than not to have been due to failures in care;
- The number of adult inpatient deaths for patients with identified learning disabilities and the number reviewed through the LeDeR methodology;
- The total number of deaths reviewed through the LeDeR methodology that was considered potentially avoidable.

In addition, the report will detail how we have responded to the requirements to learn from deaths in individuals with mental health needs or from an infant or child death and a stillbirth or maternal death.

The report will also detail how the results of investigations have been shared with the bereaved family and carers.

From June 2018 a summary of the data collected and lessons learnt will be published in the Trust's Quality Accounts.

7. Training (including Learning & Sharing)

7.1 Training for Reviewers

All reviewers will be trained in the use of relevant tools, eg LeDeR, SJR, etc.

7.2 Learning and Sharing

Much learning and sharing has been relatively ad hoc and difficult to substantiate. Ad hoc learning and sharing should continue, but this new process will systematise and standardise the STHK approach to learning and sharing and create an audit trail to substantiate its effectiveness.

Inevitably, there is a delay between identifying learning, demonstrating sharing and demonstrating effectiveness. The Board report will describes deaths and their evaluation one quarter in arears; sharing lessons from the previous quarter and learning effectiveness from the quarter before that.

The NHS is poor at learning. This is not because of any lack of desire to learn and improve, but because messages are often lost in the myriad of priorities and day-to-day pressures. The Board will require staff to concentrate on just two key priorities per report and to publicise them everywhere so that all staff know and can act upon current priorities.

Thematic analysis of all lessons to be learned from the database incorporating mortality reviews, complaints, PALS, litigation and serious incidents will be undertaken quarterly and cascaded via Care Group Governance Meetings (using a similar structure to that described in *Fig.1* below). Care Group Governance Leads will be responsible for undertaking an annual audit of this learning and sharing.

Fig. 1
Sharing: (Q1) Board (mins) □, Quality Committee (mins) □, F&P (mins) □, CEC (mins) □, PSC (mins) □, PEC (mins) □, MCG Governance (mins) □, SCG Governance (mins) □, Grand Rounds (mins) □, ED Teaching (record) □, FY Teaching (record) □, Team Brief (record) □, Intranet Message Board (record) □, Global Email (record) □, Directorate meetings (mins) □. Policies/procedures/guidelines changed:

Effectiveness: (Q2) Audit of DATIX □, SIRIs □, Complaints □, PALS □, Litigation □, Mortality Reviews for evidence of failure to deliver these priorities □.

7.3 Reviewing Outputs to inform Quality Improvement

The Chair of the MSG will review and agree the lessons learned for circulation to the relevant groups or individuals using established pathways and forums.

Clinical Directors will be accountable for ensuring that speciality-specific lessons learned are embedded in the practice of that speciality, and provide assurance to the MSG to that effect.

The Assistant Director will set up a network to share lessons learned across the region via Medical Directors.

The medical appraisal system will be reviewed by the Responsible Officer to encourage the recording and prioritising of ‘learning from deaths’.

Divisional Directors will ensure that ‘leaning from deaths’ is a fixed agenda item at all Mortality Meetings.

8. Support

8.1 Supporting and Involving Families and Carers

The *National Guidance on Learning from Deaths* specifies that providers should engage meaningfully and compassionately with bereaved families and carers at all stages of responding to a death, and details the key principles that Trusts should follow.

8.2 Supporting and Involving Staff

Staff involved in the care of a patient who may have died following a failure of care will be debriefed by their line manager and offered support by the Health, Work and Wellbeing Service. Referrals to Clinical Psychology may also be made where appropriate.

9. Monitoring Compliance

9.1 Key Performance Indicators (KPIs) of the Policy

Minimum Requirement to be Monitored	Lead(s)	Tool	Frequency	Reporting Arrangements	Lead(s) for acting on Recommendations
Review of random 25% sample of inpatient deaths	Medical Examiner /Deputy Medical Director	STHK SJR	3-monthly	CEC	Medical Examiner/ Deputy Medical Director Care Group Governance Leads
All deaths mandated to be reviewed such as death of a patient with a learning disability will have been captured and reviewed	Medical Examiner /Deputy Medical Director	STHK SJR	6-monthly	CEC	Medical Examiner/ Deputy Medical Director Care Group Governance Leads
Time from identification of a case for detailed review by the MSG to informing the bereaved where a failing of care has been identified by said review no more than 6 months in 90% of cases	MSG Chair	STHK SJR	6-monthly	MSG	MSG Chair
75% of inpatient deaths screened for concerns via the death certification/ medical certification for cremation process.	Medical Examiner		Monthly		Medical Examiner

9.2 Performance Management of the Policy

Responsibility for the operational performance management and reporting on the effectiveness of the policy will lie with the Medical Examiner and the Deputy Medical Director. The Medical Examiner will report directly to the Deputy Medical Director.

10. References/Bibliography

No	Author	Year	Title	Edition	Place of Publication	Publisher
1	NHS England Patient Safety Domain	2015	Serious Incident Framework *"Supporting Learning to Prevent Recurrence"*	https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf	Internet	-
2	NHS National Quality Board	2017	National Guidance of Learning from Deaths	https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf	Internet	-
3	Care Quality Commission	2016	Learning, Candour & Accountability	https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf	Internet	-
4	NHS National Reporting & Learning Service	2009	Being Open "saying sorry when things go wrong"	http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726	Internet	National Patient Safety Agency
5	NHS Resolution	2017	Saying Sorry	http://www.nhsla.com/claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf	Internet	-

11. Related Trust Documents

No.	Related Document	
STHK0082	Incident Reporting and Management Policy	http://nww.sthk.nhs.uk/pages/policies.aspx?iPageId=2543
STHK0057	Being open: A Duty to be Candid	http://nww.sthk.nhs.uk/pages/policies.aspx?iPageId=2516
STHK0482	MCG Incident/Near Miss Management	http://nww.sthk.nhs.uk/pages/policies.aspx?iPageId=19200

12. Equality Analysis Form

The screening assessment must be carried out on all policies, procedures, organisational changes, service changes, cost improvement programmes and transformation projects at the earliest stage in the planning process to ascertain whether a full equality analysis is required. This assessment must be attached to all procedural documents prior to their submission to the appropriate approving body. A separate copy of the assessment must be forwarded to the Patient Inclusion and Experience Lead for monitoring purposes cheryl.farmer@sthk.nhs.uk. If this screening assessment indicates that discrimination could potentially be introduced then seek advice from the Patient Inclusion and Experience Lead. A full equality analysis must be considered on any cost improvement schemes, organisational changes or service changes which could have an impact on patients or staff.

Equality Analysis				
Title of Document/proposal /service/cost improvement plan etc:	Learning from Trust Inpatient Deaths			
Date of Assessment	1st February 2018	**Name of Person completing assessment /job title:**	T Hankin	
Lead Executive Director	Prof Kevin Hardy		Deputy Medical Director	
Does the proposal, service or document affect one group more or less favourably than other group(s) on the basis of their:		**Yes / No**	**Justification/evidence and data source**	
1	Age	No		
2	Disability (including learning disability, physical, sensory or mental impairment)	Yes	Favourably: all LD and Mental Health deaths are subject to full screening and further investigation where required	
3	Gender reassignment	No		
4	Marriage or civil partnership	No		
5	Pregnancy or maternity	Yes	Favourably: all Paediatric and neonatal deaths are subject to full screening and further investigation where required	
6	Race	No		
7	Religion or belief	No		
8	Sex	No		
9	Sexual Orientation	No		
Human Rights – are there any issues which might affect a person's human rights?		**Yes / No**	**Justification/evidence and data source**	
1	Right to life	No		
2	Right to freedom from degrading or humiliating treatment	No		
3	Right to privacy or family life	No		
4	Any other of the human rights?	No		
Lead of Service Review & Approval				
Service Manager completing review & approval Job Title:		Dr Terence Hankin		
		Deputy Medical Director		

13. Appendix 1 – Example of Quarterly Trust Board Report

STHK Learning From Deaths Board Report

	Deaths in Scope [1]	Specified Groups									
		LD Deaths	SMI Deaths [2]	Child Deaths	Neonatal Deaths & Stillbirths	Maternal Deaths	CQC Alert Deaths	Diagnosis Group [3] Deaths	SIRI Deaths	Concern [4] Deaths	**Total [5]**
Apr-17	121	0	1	0	3	0	0	10	0	3	**17**
May-17	133	1	0	0	3	0	0	11	1	2	**17**
Jun-17	132	0	0	0	2	0	0	9	1	0	**12**
Jul-17	143	1	1	0	0	0	0	12	1	1	**16**
Aug-17	130	2	2	0	2	0	0	8	0	1	**14**
Sep-17	150	1	3	0	5	0	0	11	1	1	**22**
Total	**809**	**5**	**7**	**0**	**15**	**0**	**0**	**61**	**4**	**8**	**98**

	Specified groups			Non Specified Deaths Sample % Reviewed
	Total [5]	Reviewed	% Reviewed	
Apr-17	17	17	100.0%	28.8%
May-17	17	17	100.0%	31.9%
Jun-17	12	12	100.0%	26.7%
Jul-17	16	16	100.0%	26.8%
Aug-17	14	14	100.0%	31.9%
Sep-17	22	21	95.5%	18.0%
Total	**98**	**97**	**99.0%**	**27.1%**

	% of deaths		
	where no concerns	where significant doubt about whether or not, problems in care delivery/service provision contributed to death – refer to multi professional review	where balance of probability is that death may have resulted from problems in care delivery/service provision - refer to SIRI Investigation
Apr-17	97.6%	2.4%	0.0%
May-17	85.4%	14.6%	0.0%
Jun-17	97.6%	2.4%	0.0%
Jul-17	84.8%	13.0%	2.2%
Aug-17	88.9%	11.1%	0.0%
Sep-17	93.9%	6.1%	0.0%
Total	**91.0%**	**8.6%**	**0.4%**

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

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

[3] Diagnosis groups under internal monitoring

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

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

Learning & Sharing 2017/Q1 & Q2

2017/Q2 Key Priorities

(1) Monitor (check, action, repeat) blood gases in COPD

(2) If you can't get IV access, escalate to a senior immediately

Assurance

Sharing: (Current Q-1) Board (mins) ☐, Quality Committee (mins) ☐, F&P (mins) ☐, CEC (mins) ☐, PSC (mins) ☐, PEC (mins) ☐, MCG Governance (mins) ☐, SCG Governance (mins) ☐, Grand Rounds (mins) ☐, ED Teaching (record) ☐, FY Teaching (record) ☐, Team Brief (record) ☐, Intranet Message Board (record) ☐, Global Email (record) ☐, Directorate meetings (mins) ☐. List any policies/procedures or guidelines changed:

_____

_____

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

Comments:

NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 28TH MARCH 2018

No	Minute	Action	Lead	Date Due
~~1.~~	~~27.09.17 (15.5)~~	~~WRES report. AMS will bring a paper to Board following the external expert input. 31.01.18 The external reviewer was unwell so item has been postponed until 28th Feb.~~ Action closed.	~~AMS~~	~~28.02.18~~
~~2.~~	~~31.01.18 (13.3)~~	~~AMS to contact the local Trusts with lower staff turnover to ensure all good practice is being following in relation to retention of staff.~~ Action closed.	~~AMS~~	~~28.02.18~~
	28.02.18 (4.3)	Follow up action: AMS to undertake further analysis of leavers and pipeline for recruitment initiatives, for review by the Executive Committee and to include a waterfall analysis in the next HR Indicators Board report.	AMS	30.05.18
3.	28.02.18 (5.1.2)	Nasogastric Tubing Never Events – SRe to provide feedback on results of RCAs at next Quality Committee.	SRe	28.03.18
4.	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
5.	28.02.18 (5.5)	AMS to circulate results of Staff Survey on 06.03.18 and bring a formal report to the next Board meeting.	AMS AMS	06.03.18 28.03.18
6.	28.02.18 (8.3)	Quality Committee to develop proposals for a severity rating of complaints and bring recommendations to the Board.	DG	28.03.18
~~7.~~	~~28.02.18 (8.7)~~	~~Revised Learning from Inpatient Deaths policy to be circulated to Board members ahead of formal approval at the next meeting. Policy circulated.~~ Action closed.	~~DG~~	~~28.03.18~~
8.	28.02.18 (13.2)	AMS to undertake further investigation of the issues raised by the WRES survey action plan in relation to disciplinary action.	AMS	30.05.18

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: NHST(18)20
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

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

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

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

Patient Safety, Patient Experience and Clinical Effectiveness

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

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

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

There were 2 C.Difficile (CDI) positive cases in February 2018. The total number of confirmed CDI positive cases year to date is 21 (threshold = 41).

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

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

During the month of January 2018 there was 1 inpatient fall resulting in severe harm . YTD total is 16.

Performance for VTE assessment for January 2018 was 95.03%. YTD performance is 93.52% against a target of 95%.

Final HSMR for 2016-17 is 102.4

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 17/18 financial outturn will have implications for the finances of the Trust
Stakeholders: Trust Board, Finance Committee , Commissioners, CQC, TDA, patients.
Recommendation: To note performance for assurance
Presenting Officer: N Khashu
Date of Meeting: 28th March 2018

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month at 85.1%. A small number of patients did not meet the 31 day standard resulting in failure against the 96% target at 94.6%. Actions are underway at specialty level to address this, including ongoing improvements in booking patients by day 7 to allow for patient related delays.

Continued high volume NEL activity and acuity of patients presenting in ED, alongside trust bed occupancy levels of over 98%, resulted in a continued underperformance against the A&E 95% standard which was 73.6% (type 1) and 87.2% (Mapped STHK Footprint - all types) in month. Staffing of additional escalation bed capacity continues to be a challenge, utilising additional hours from medical and nursing staff from within the organisation plus agency staff.

The Emergency Care Improvement Programme team continue to support the trust, with further improvement work related to key actions focusing on both the Emergency Department and the Inpatient wards.

Despite a continued reduction in the elective programme in month to support accommodation of NEL activity, RTT incomplete performance was maintained at 93.5% v target of 92.0%. Specialty level actions to maintain this achievement continue.

Financial Performance

Since December the Trust has continued to see very challenging operational pressures. This is over and above those supported by national winter money or estimated by the Trust. In summary adverse impacts have been seen in higher A&E attendances, greater acuity of patients requiring admission, elective programme reduction, challenges in discharges across the patch and worsening staff sickness levels. The Trust has endeavoured to maintain operational performance and financial management throughout this period whilst respecting the safety of our patients.

As at February 2018 (Month 11), the Trust is reporting an overall income and expenditure surplus of £3.5m (including all allowable STF worth £5.1m). Planned surplus was £7.5m, giving an adverse variance of £4m YTD to M11. This YTD adverse variance of £4m recognises £3m of STF now not allocated (not achieving A&E and financial performance) and exceptional net operational cost pressures from winter of £1m.

The Trust has delivered £11.4m of CIPs and is £2.4m behind the YTD plan which is reflected in the Trust's current financial performance. It is expected that the CIP plan will be in the region of £12.5m by year end, short of target by £3m.

Based on operational pressures, the Trust has reduced its forecast outturn to c£2.4m from our control total of £8.5m. £4m of this is the assumed non allocation of STF and the remaining £2m relating to the unprecedented net impact of winter, mainly through high pay costs. This means, excluding STF, the Trust is forecasting to have an adverse variance of £2m from its original control total of £0.6m. The YTD and Forecast financial position has been supported by the full utilisation of relevant reserves and balance sheet provisions.

The Trust recognises the risks to achieving the revised surplus, which include remaining CIP achievement, exceptional costs of winter, continued contract and CQUINs challenges from Commissioners and adverse impact of HRG4+ to this position.

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

Human Resources

Absence in February reduced from January by 0.4% but is above the Q4 target of 4.68% by 0.62%. YTD absence is 4.7% against last year outturn of 4.8%.

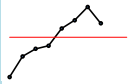
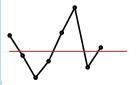
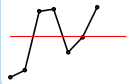
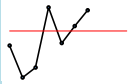
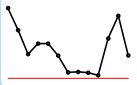
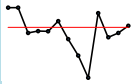
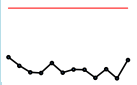
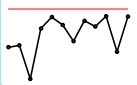
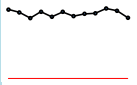
Mandatory training compliance is 86% and exceeds the target by 1.0%. Appraisal compliance is 85% which is on target.

The following key applies to the Integrated Performance Report:

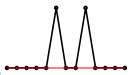
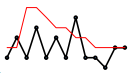
▲ = 2017-18 Contract Indicator
▲£ = 2017-18 Contract Indicator with financial penalty
● = 2017-18 CQUIN indicator
T = Trust internal target

Feb-18

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 31-37)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Feb-18	2.8%	2.4%	No Target	2.5%		Overall SHMI and HSMR within control limits. Mortality fluctuates month-to-month, but is stable medium-term. Crude mortality typically increases (nationally) in Winter. It is high in January. Latest NHS evidence supports previous work that patients admitted at weekends and out of hours are sicker. Specific diagnostic groups with raised mortality (e.g. COPD and stroke) are subject to intensive investigation	Patient Safety and Clinical Effectiveness	Trust is implementing an electronic solution to improve capture of comorbidities and to prompt palliative care review in those known to that service. Major initiatives to improve management of AKI and Sepsis are well underway to improve care and reduce mortality.	KH
Mortality: SHMI (Information Centre)	Q	▲	Jun-17	1.04		1.00						
Mortality: HSMR (HED)	Q	▲	Sep-17	105.5	103.1	100.0	102.4					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Sep-17	101.8	100.8	100.0	115.0					
Readmissions: 30 day Relative Risk Score (HED)	Q	T	Aug-17	104.8	102.1	100.0	97.7		The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms. Readmissions have risen in recent months which is being dominated by ambulatory care. It was suggested that ambulatory readmissions might have been a result of inappropriate coding of elective returns - audit has shown that this is not the case	Patient experience, operational effectiveness and financial penalty for deterioration in performance	There were a small number of misattributed elective returns and this process has been corrected.	KH
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Aug-17	97.9	91.7	100.0	93.8		Sustained reductions in NEL LOS are assurance that medical redesign practices continue to successfully embed.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Aug-17	109.7	99.6	100.0	92.1					
% Medical Outliers	F&P	T	Feb-18	2.3%	2.4%	1.0%	1.7%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in LoS, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place. Continued focused management of all patients requiring discharge support. A review of the Trust bed model has resulted in plans to reconfigure some surgical beds to medical thus reducing outliers.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Feb-18	53.2%	49.2%	52.5%	48.3%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. Critical care rep now attending all bed meetings to agree plan and to highlight patients who will require transfer over the coming 24 hours.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Jan-18	72.9%	69.5%	90.0%	75.7%		eDischarge performance poor - there is insufficient trainee doctor resource to hit this target with existing paper-based systems.		Pending ePR, we have devised an automated eDischarge notification which will be computer generated and send within 24 hours. Thereafter a full discharge summary will be sent within 14 days. Development time is days. We're seeking CCG approval at CQPG before implementation.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Jan-18	93.0%	89.3%	95.0%	90.0%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Jan-18	98.7%	98.9%	95.0%	99.0%					

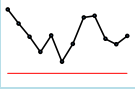
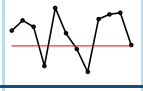
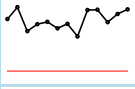
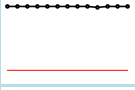
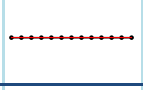
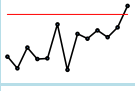
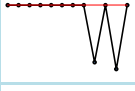
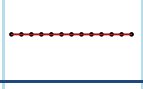
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Feb-18	91.2%	91.1%	83.0%	94.0%		Target is being achieved. With effect from April 2017, STHK is also treating patients from the Warrington Area.	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Target achieved	RC
PATIENT SAFETY (appendices pages 39-42)												
Number of never events	Q	▲£	Feb-18	0	2	0	2		The National safety standards for invasive procedures will provide further mitigation against future never events.	Quality and patient safety	The RCA for never events reported is being developed. Immediate actions have already been implemented including communication to staff, development of training (medical and non-medical) and policy revision.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Feb-18	99.3%	99.0%	98.9%	98.8%		Achieving standard	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	Feb-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	▲£	Feb-18	0	2	0	4		Two MRSA cases YTD (1 case under appeal and 1 contaminated specimen). Internal RCAs on-going with more recent cases.	Quality and patient safety	The Infection Control Team continue to support staff to maintain high standards and practices. They also monitor and undertake RCA for any hospital acquired BSI and CDI. CDI and Antibiotic wards rounds continue to be undertaken on appropriate wards.	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲£	Feb-18	2	21	41	21					SR
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Feb-18	3	20	No Target	17					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Jan-18	0	0	No Contract target	1		No grade 3 or 4 avoidable pressure ulcers YTD	Quality and patient safety	The Trust provides ongoing tissue viability training for all nursing staff including bank staff	SR
Number of falls resulting in severe harm or death	Q	▲	Jan-18	1	16	No Contract target	22		1 severe harm fall reported in January.	Quality and patient safety	Immediate review undertaken to implement immediate actions. Root cause Analysis being carried out. Strategic falls actions being implemented as plan .	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲£	Jan-18	95.03%	93.52%	95.0%	93.36%		VTE performance remains inconsistent. A recent survey of successful units showed that they all have electronic solutions. The ePrescribing solution implementation has been delayed because of problems with this version of the software.	Quality and patient safety	Every effort is being made to supplement routine reviews with additional activity to improve performance pending an electronic solution.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Dec-17	3	24	No Target	28					
To achieve and maintain CQC registration	Q		Feb-18	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Feb-18	93.9%	93.9%	No Target	94.9%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	Two Shelford audits were reported together in January 2018.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Feb-18	0	1	No Target	2					

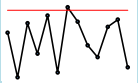
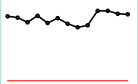
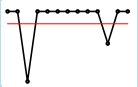
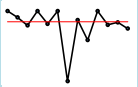
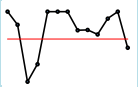
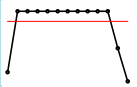
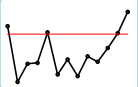
Feb-18

St Helens and Knowsley Teaching Hospitals NHS Trust

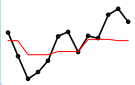
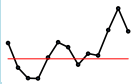
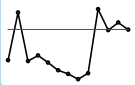
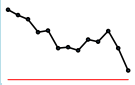
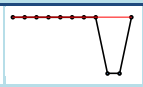
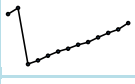
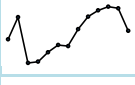
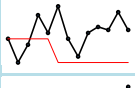
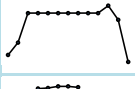
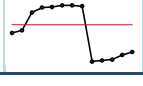
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 43-51)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Jan-18	95.2%	95.1%	93.0%	95.1%		Two week and 62 day target achieved. A small number of patients did not meet the 31 day standard in month resulting in the marginal failure of the standard. RCA review has been undertaken to identify opportunities for avoiding future performance breech	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	▲ £	Jan-18	94.6%	97.7%	96.0%	97.9%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Jan-18	85.1%	87.0%	85.0%	88.4%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Feb-18	93.5%	93.5%	92.0%	93.5%		4 specialties are currently failing the 92% incomplete target; General Surgery, 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	As we head into winter and there is an expectation that Surgical Beds will be handed to Medical Care Group. Bed availability to manage the Surgical demand will potentially risk the backlog increasing, causing more incomplete performance failures. Additional risk caused by impact of RMS and MCAS	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. A backlog management plan is in place and alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand. Actions to maintain and improve RTT performance reliant on theatre and bed capacity along with staff availability in collaboration with CCG's in ensuring RMS delivers in a sustainable and manageable way	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Feb-18	100.0%	100.0%	99.0%	100.00%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Feb-18	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Feb-18	0.9%	0.6%	0.8%	0.7%		The cancelled ops target continues to be achieved YTD. February underperformed due to NEL activity in both medicine and surgery. Underperformance against the 28 day metric relates to two patients, one in October and one patient in December. One patient required a bespoke ophthalmic lens and one patient was cancelled due to orthopaedic trauma and was unable to be accommodated in time.	Patient experience and operational effectiveness Poor patient experience	The planned increase in elective surgical activity in St Helens has commenced including increasing GA capacity on Saturdays. Potential to use external theatre and bed capacity continues to be progressed. Continued analysis of the referral drop and impact on RTT underway to include forecast year end position	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Jan-18	100.0%	99.2%	100.0%	100.0%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Feb-18	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Feb-18	73.6%	79.3%	95.0%	76.1%		February 2018 Type 1 performance was 73.6% which was a slight improvement on January. All types performance was 87.2%. Despite poor performance, we were ranked 1st in C+M and 53rd Nationally. It has been another challenging month due to continuation of flu , high volume of admissions and acuity - plus increased sickness amongst staff. Additional bed capacity was opened to support flow, additional medical and nursing staff were deployed. Work continued to maintain low numbers of 'good to go' patients.	Patient experience, quality and patient safety	The urgent and emergency care transformation plan has several interconnected work streams designed to improve overall 4 hour access performance. Emergency Department/Front Door processes in place including 'walk in' streaming, Stretcher Triage streaming and internal departmental efficiencies and exit from ED. GP streaming in place as per NHSE recommendations. Flow through the Hospital Continuation of use of the SAFER Care Bundle to increase hospital discharges before midday to 33% and standardisation of daily Red to Green board rounds and afternoon huddles. Twice weekly discharge tracking meetings to manage medically optimised and DTOC escalation. Monthly Executive Multi-Agency Discharge Events (MADE) continue across the whole system to remove barriers and blocks that prevent patients with complex needs being discharged safely from hospital. Following 6a ECIP event and system resilience planning, commenced daily AMU/ED huddles and Community Matron in reach which is proving beneficial. Frailty in-reach to ED commenced. 1pm Frailty/ED/SpR safety huddle in place.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Feb-18	87.2%		95.0%	85.1%					
A&E: 12 hour trolley waits	F&P	▲	Feb-18	0	0	0	0					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Feb-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	Feb-18	19	206	No Target	338		% new (Stage 1) complaints resolved in month within agreed timescales continues to improve overall. The decrease in the number of new complaints received in the last few months has continued for February with 19 received compared to 30 in February 2017.	Patient experience	The Complaints Team are continuing to work on reducing the small backlog of overdue complaints and to improve the timeliness of responses. There is now a stable central Complaints Team in place, with additional input from a senior clinician that is supporting this improvement.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Feb-18	12	251	No Target	293					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Feb-18	91.7%	66.1%	No Target	58.0%					
Friends and Family Test: % recommended - A&E	Q	▲	Feb-18	86.0%	88.1%	90.0%	86.6%		The YTD recommendation rates are slightly below target for A&E, maternity (birth, postnatal community) and outpatients, but are above target for in-patients, antenatal, and postnatal ward maternity services. Outpatients saw an increase in recommendation rates in February 2018.	Patient experience & reputation	Feedback from the FFT responses is fed back to individual areas to enable actions to be taken to address negative feedback, as well as using positive feedback to improve morale. The Patient Experience Manager continues to work with leads in each area where performance is below target, to identify specific themes for improvement, which are then displayed as 'you said, we did' posters.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Feb-18	96.2%	95.8%	90.0%	95.5%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Feb-18	100.0%	98.4%	98.1%	98.5%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Feb-18	96.9%	97.6%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Feb-18	93.5%	96.3%	95.1%	98.7%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Feb-18	90.0%	98.5%	98.6%	93.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Feb-18	95.5%	94.6%	95.0%	94.4%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2017-18 YTD	2017-18 Target	2016-17	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 53-60)												
Sickness: All Staff Sickness Rate	Q F&P	▲	Feb-18	5.3%	4.7%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.8%		Overall absence in February reduced but is still above the Q4 target of 4.68% by 0.62%. Qualified & HCA sickness also reduced in month to 6.5% against a target of 5.3%. National increases in the Flu/virus's has caused many staff to require 1-2 weeks off work	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	The absence support team have resumed ward audits and have been providing telephone/ward visit advice regarding opening/closing absence, recoding absence, reiterating advice from infection control & HWWB and also ensuring policy management. Each day an open ended report is generated from roster and ESR and the team follow up on the cough/cold/flu reasons as well as the unknown/other which is followed up with managers routinely. During March, the Absence Support team will support 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.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P	T	Feb-18	6.5%	5.7%	5.3%	5.9%					
Staffing: % Staff received appraisals	Q F&P	T	Feb-18	85.0%	85.0%	85.0%	87.4%		Mandatory Training compliance exceeds the target by 1%. Appraisal compliance is currently at 85%.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The Education, Training & Development and Workforce Planning teams continue to work with managers to monitor non-compliant staff to ensure on-going maintenance of compliance for both Mandatory Training & Appraisals.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Feb-18	86.0%	86.0%	85.0%	91.6%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2	85.0%		No Contract Target			Whilst response rates fluctuate we remain in the top 3 acute Trusts in our region for both response and recommendation rates.	Staff engagement, recruitment and retention.	Continue to expand the number of local FFT trainers to scrutinise comments; ensure FFT posters are widely disseminated; and expand the use of "You said, we did" posters. Results for the Q2 survey completed in the Surgical Care Group with results having been circulated to relevant managers for action planning. The Q4 survey has been launched in Clinical Support Services and Corporate areas.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2	76.1%		No Contract Target						
Staffing: Turnover rate	Q F&P	T	Feb-18	0.8%		No Target	9.8%		Staff turnover remains stable and well below the national average of 14%.		Turnover is monitored across all departments as part of the Trusts Recruitment & Retention Strategy with action plans to address areas where turnover is higher than the trust average. Further action is required by Ward Managers to provide more support to newly qualified nurses.	AMS
FINANCE & EFFICIENCY (appendices pages 61-66)												
UORR - Overall Rating	F&P	T	Feb-18	3.0	3.0	3.0	3.0		The Trust's forecast for year end performance is in line with original plan. The Trust has significant contractual agreements with other NHS organisations which may impact on our ability to achieve Better Payment compliance.	Financial	Achievement against the submitted plan and delivery of CIP. Maintaining controls on Trust expenditure and delivering the planned activity while managing the variable costs. Agreeing with Commissioners and NHSE a more advantageous profile for receipt of planned income. Reducing agency expenditure in line with NHSI annual cap.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Feb-18	11,354	11,354	15,315	15,248					
Reported surplus/(deficit) to plan (000's)	F&P	T	Feb-18	3,509	3,509	8,536	4,861					
Cash balances - Number of days to cover operating expenses	F&P	T	Feb-18	13	13	2	2					
Capital spend £ YTD (000's)	F&P	T	Feb-18	7,769	7,769	8,015	3,519					
Financial forecast outturn & performance against plan	F&P	T	Feb-18	2,470	2,470	8,536	4,861					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Feb-18	91.5%	91.5%	95.0%	94.3%					

APPENDIX A

			Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	2017-18 YTD	2017-18 Target	FOT	2016-17	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲£	100.0%	96.2%	94.4%	100.0%	84.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	85.0%		95.2%		
	Total > 62 days		0.0	0.5	0.5	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0			6.0		
Lower GI	% Within 62 days	▲£	91.7%	93.3%	100.0%	76.9%	100.0%	100.0%	92.3%	84.6%	69.2%	88.9%	82.4%	78.6%	80.0%	84.1%	85.0%		89.3%		
	Total > 62 days		0.5	0.5	0.0	1.5	0.0	0.0	0.5	1.0	2.0	0.5	1.5	1.5	2.0	10.5			8.0		
Upper GI	% Within 62 days	▲£	81.8%	0.0%	87.5%	100.0%	100.0%	100.0%	33.3%	88.9%	80.0%	100.0%	86.7%	100.0%	100.0%	90.0%	85.0%		78.7%		
	Total > 62 days		1.0	4.0	0.5	0.0	0.0	0.0	1.0	0.5	0.5	0.0	1.0	0.0	0.0	3.0			10.0		
Urological	% Within 62 days	▲£	95.7%	100.0%	67.6%	92.7%	59.3%	82.1%	83.3%	81.3%	87.5%	77.4%	90.2%	96.6%	60.9%	80.9%	85.0%		81.4%		
	Total > 62 days		0.5	0.0	6.0	1.5	5.5	3.5	3.0	4.5	1.5	3.5	2.0	0.5	9.0	34.5			36.5		
Head & Neck	% Within 62 days	▲£	100.0%	80.0%	80.0%	66.7%	66.7%	75.0%	75.0%	42.9%	20.0%	100.0%	83.3%	80.0%	33.3%	61.0%	85.0%		67.3%		
	Total > 62 days		0.0	0.5	0.5	0.5	0.5	0.5	0.5	2.0	2.0	0.0	0.5	0.5	1.0	8.0			8.0		
Sarcoma	% Within 62 days	▲£			100.0%	66.7%		100.0%		0.0%	100.0%			50.0%	33.3%	54.5%	85.0%		93.3%		
	Total > 62 days				0.0	0.5		0.0		0.5	0.0			0.5	1.0	2.5			0.5		
Gynaecological	% Within 62 days	▲£	100.0%	85.7%	100.0%	70.0%	83.3%	100.0%		55.6%	83.3%	100.0%	94.1%	55.6%	100.0%	79.4%	85.0%		90.1%		
	Total > 62 days		0.0	0.5	0.0	1.5	1.0	0.0	2.5	2.0	0.5	0.0	0.5	2.0	0.0	10.0			5.0		
Lung	% Within 62 days	▲£	68.2%	77.8%	100.0%	100.0%	73.7%	85.0%	100.0%	72.7%	71.4%	87.5%	66.7%	100.0%	80.0%	82.0%	85.0%		82.7%		
	Total > 62 days		3.5	1.0	0.0	0.0	2.5	1.5	0.0	1.5	1.0	0.5	3.0	0.0	1.5	11.5			13.0		RC
Haematological	% Within 62 days	▲£	66.7%	100.0%	100.0%	100.0%	66.7%	50.0%	71.4%	100.0%	50.0%	100.0%	85.7%	76.9%	100.0%	79.2%	85.0%		77.6%		
	Total > 62 days		1.0	0.0	0.0	0.0	1.0	1.0	1.0	0.0	3.0	0.0	0.5	1.5	0.0	8.0			8.5		
Skin	% Within 62 days	▲£	95.7%	100.0%	100.0%	92.5%	93.9%	98.1%	93.9%	93.0%	88.9%	95.2%	98.2%	97.7%	98.2%	95.3%	85.0%		96.5%		
	Total > 62 days		1.0	0.0	0.0	1.5	1.0	0.5	1.5	1.5	2.0	1.0	0.5	0.5	0.5	10.5			9.5		
Unknown	% Within 62 days	▲£	66.7%	0.0%	50.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	79.3%	85.0%		82.6%		
	Total > 62 days		0.5	0.5	1.0	1.0	0.0	0.0	1.0	0.0	0.0	1.0	0.0	0.0	0.0	3.0			2.0		
All Tumour Sites	% Within 62 days	▲£	89.1%	87.6%	89.3%	88.2%	81.6%	91.4%	87.1%	84.5%	80.6%	89.5%	90.3%	90.6%	85.1%	87.0%	85.0%		88.4%		
	Total > 62 days		8.0	7.5	8.5	8.0	12.5	7.0	11.0	13.5	12.5	6.5	9.5	7.0	15.0	102.5			107.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲£			100.0%					100.0%		100.0%		100.0%	100.0%	100.0%	85.0%		83.3%		
	Total > 31 days				0.0					0.0		0.0		0.0	0.0	0.0			1.0		
Acute Leukaemia	% Within 31 days	▲£											100.0%			100.0%	85.0%		100.0%		
	Total > 31 days												0.0			0.0			0.0		
Children's	% Within 31 days	▲£															85.0%				
	Total > 31 days																				

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)21
Title of paper: Executive Committee Chair's Report – March 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 in February 2018. There were a total 4 Executive Committee meetings held during February. The Executive Committee agreed: • The final St Helens Shared Care Record Business Case to present to Board for approval. • The actions to be taken in response to the initial never event investigation report. The Executive Committee received assurance reports covering Marshalls Cross Medical Centre, safer staffing, agency and locum usage, appraisal and mandatory training compliance, the Integrated Performance Report (IPR), from the Risk Management Council, the Corporate Risk Register and the Medway Implementation Programme.
Corporate objectives met or risks addressed: All 2017/18 Trust Objectives.
Financial implications: None arising directly from this report.
Stakeholders: Patients, Patients Representatives, Staff, Non-Executive Directors, Commissioners, Regulators.
Recommendation(s): That the report be noted
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 28th March 2018

EXECUTIVE COMMITTEE CHAIR'S REPORT
February 2018

1. Introduction

There were 4 Executive Committee meetings in February 2018, and this report provides feedback on the agenda items considered at each meeting.

Several of the items have already been reported at Committee or Trust Board meetings in February, so where this is the case they are noted for information only.

2. 1st February 2018

2.1 Premium Payments Scrutiny Council

The Deputy CEO/Director of HR confirmed that the Premium Payments Scrutiny Council was now firmly established, and from February a Chair's report would be presented to the Executive Committee following each meeting, to provide assurance on the Council's work and to escalate any matters for approval or issues of concern.

2.2 Safer Staffing and Shift Shortfall reports for December

The Director of Nursing, Midwifery and Governance presented the safer staffing report for December. On 13 of the 32 wards the shift fill rate had been less than 90%. There was one incidence of severe patient harm following a fall, but this had not occurred on the wards with the lower fill rates. The Executive Committee, whilst acknowledging the challenges of staffing over the Christmas holiday period were very concerned and explored how the SafeCare system and designated nurse would be able to improve the allocation of staff. A report on the expected benefits and how these can be measured will be developed to provide a level of assurance that this investment will help improve the situation.

2.3 Maternity Patient Survey Results and Action Plan

The Director of Nursing, Midwifery and Governance reported on the national maternity survey result for the Trust. The results had been very disappointing and were inconsistent with other measures of patient satisfaction such as the maternity friends and family test feedback. The Executive Committee also reviewed the actions that had been taken to the service since the survey had been undertaken (with mothers who had given birth in February 2017). An action plan had been developed to address the areas of concern, and it was agreed that the survey should be repeated locally, for mothers experiencing the service now, to assess if the recent developments had addressed some of the poor scores.

Regular progress reports would be made to the Executive Committee and assurance reports escalated to the Quality Committee.

2.4 Medicines Storage and Security – Audit Results

The Director of Nursing, Midwifery and Governance presented the December audit results. These showed a significant improvement compared to the previous audit undertaken in August, but compliance was still not at a satisfactory level. The Heads of Quality in each Care Group were now working with the worst performing wards and Lead Nurses were undertaking daily reviews. The Medicines Management Team would also to repeat the full audit in the near future to provide assurance of continued improvement and compliance with safety policies. The audit results would also be reported to the Quality Committee.

2.5 Internal Audit – Limited Assurance Reports

The Director of Finance and Information reported on three recent internal audit reports, where the Trust had only received limited assurance. These were; Quality Spot Checks, Department Locality Review and Medical Devices. The lead Directors and Managers had been asked to attend the Audit Committee to report on progress in responding to the risks identified and actions to address the recommendations.

2.6 Upgrade of the Pathology iLab system

The Director of Informatics reported that the iLab technical system upgrade that was undertaken as part of the 2017 -18 capital programme, had successfully taken place on 27th January.

3. 8th February 2018

3.1. Draft Board Agenda

The Executive Committee reviewed the draft Board agenda.

3.2 2018 -19 Operational Planning Guidance

The Director of Finance and Director of Corporate Services gave a briefing on the 2018 -19 planning guidance that had been jointly issued by NHSI and NHSE on 2nd February. A similar briefing was subsequently given to the Finance and Performance Committee and Trust Board.

3.3 Medway Implementation Programme Board Report

The Director of Informatics presented the monthly report from the Medway Implementation Programme Board. Overall the project status was reported as amber, with risks being managed and the project remaining on track for "go live" at the end of April. Training for staff on use of the new system was the next key phase of the project and would commence on 26th February. The implementation team were also to move on site at Whiston Hospital during the next phase of the project.

3.4 St Helens Cares – Shared Care Record Business Case

The system business case developed on behalf of the three partners (St Helens CCG, St Helens Council and the Trust) was reviewed by the Executive Committee with some of the financial detail concerning VAT treatment, access to the Estates and Technology Transformation Fund (ETTF) allocation and the risk share arrangements, to be further clarified before the business case was presented to Board.

3.5 Marshalls Cross Medical Centre

The Director of Transformation presented the monthly assurance report on progress in implementing the new service model and the start of the substantive contract (the caretaker contract ran from 1st September to 28th February). Recruitment of permanent staff continued to present the greatest challenge. Patient numbers were also being monitored and a campaign to promote the practice was planned.

3.6 Bed Reconfiguration

The Director of Operations presented an update on plans to make ward 3C a medical ward to increase the overall number of medical beds available. It was noted that both Medical and Surgical Care Group leadership teams were supportive of the plans, but further assurance was needed that the staffing rotas were robust enough to make the ward swap safe.

4. 15th February 2018

4.1 Mandatory Training and Appraisal Monthly Report

The Deputy CEO/Director of HR presented the position at month 10, aligned to each Director. The improvement in performance across the care groups for both mandatory training and appraisals had been sustained, despite the challenges of December and January.

4.2 Integrated Performance Report (IPR)

The Executive Committee reviewed the draft IPR for January.

4.3 Never Event

The Director of Nursing reported on the initial investigation into the never event that had occurred in January, and the immediate actions that had been put in place to improve training and change standard working practices. This was subsequently discussed at both the February Quality Committee and Trust Board meetings.

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

The Director of Corporate Services presented the Chair's report from the Risk Management Council and the 13 risks that had been escalated to the CRR during January. The two new risks escalated in month related to the

increase in A&E attendances and non-elective admissions, and the resulting increased pressure on delivery of the Trust's financial plan.

4.5 Car Parking

The Director of Estates and Facilities presented an update on the work to increase the car parking facilities at the Trust, through several capital schemes. Options for how the new facilities would be used and the implications for the Trust's car parking charges, to cover the costs of providing car parks, were also debated. A full review of the charging structure to maximise the use of the new facilities is to be undertaken.

5. 22nd February 2018

5.1 Quality Account – Improvement Priorities for 2018/19

The Executive Committee reviewed the proposed quality improvement priorities, for consultation with staff and stakeholders. The consultation would be electronic (Survey Monkey) and the final proposed priorities for 2018/19 would be presented to the Quality Committee in accordance with the agreed timetable for developing the Quality Account.

5.2 Safer Staffing and Vacancy Dashboard

The Executive Committee reviewed the safer staffing reports and nursing vacancy dashboard for January. A 90% fill rate had again not been achieved on 13 wards during the month. The processes in place to maintain safe staffing were discussed and the plans to increase nursing capacity via recruitment and retention initiatives, reviewed.

5.3 Apprenticeship Levy – Implication for Lead Employer

The Deputy CEO/Director of HR briefed the Executive on the potential detriment to Trusts who were part of the lead employer arrangements, in respect of access to apprenticeship levy funds. The rules put in place by the Education Skills Funding Agency (ESFA) could be detrimental to any collaborative employment arrangements, which is contrary to current NHS policy direction. The issue has been escalated nationally via Health Education England and NHS Employers.

5.4 Bank Staff Pay

The Deputy CEO/Director of HR reported on the cost analysis of paying point to point, in line with substantive contracts for HCA bank staff as had previously been agreed for qualified nurses. Overall the financial impact was not material and the Executive Committee agreed that, on the basis of equity and to maintain recruitment to the bank, this was the right thing to do.

5.5 St Helens Shared Care Record – Business Care

The Director of Finance presented an update on the financial risk share agreement between the partners to achieve the planned system benefits,

and the implications for the Trust. Following the discussion it was agreed that the Director of Finance would produce an additional briefing note to accompany the business case, when it was presented to the Board.

5.6 CQUIN and Contract Update

The Head of Income and Contracting attended the meeting and presented the 2017 -18 quarter 3 update. The Trust had incurred contract penalties of £1.144m (mainly as a result of reduced STF for A&E performance) and achieved 100% of CQUIN income.

5.7 CQPG Feedback

The Director of Nursing provided feedback on the CQPG meeting of 21st February. The never event that had occurred in January had been discussed, in particular the similarities to the never event that had occurred in November and how this could have been prevented. Other items discussed at the meeting were cancer waiting times, A&E performance and system pressures, including assurance that the Trust had no 12 hour trolley waits, and safeguarding.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)22

Title of paper: Committee report – Quality Committee

Purpose: To summarise the Quality Committee meeting held on 20th March 2018 and escalate issues of concern.

Summary: Key items discussed were:

1. Complaints

- 19 first stage complaints were received; this is 5 more than received in either of the previous 2 months. It is a 37% decrease on February 2017 when 30 complaints were received.
- At the end of February 2018, there were 36 open 1st stage complaints (a decrease of 5). At the time of reporting there were no overdue complaints; a decrease of 4 compared to January 2018.
- The Trust responded to 91.7% of 1st stage complaints within agreed time frames during February 2018, an increase compared to January 2018 (66.7%), and the highest single month figure in the last 23 months.
- The top complaint theme during February 2018 remained as clinical treatment.
- There were 222 PALS contacts/enquiries during February 2018; a slight decrease in comparison to January 2018 but a significant increase in comparison January 2017.
- The majority (89.7%) of PALS contacts were concerns or complaints resolved locally, as opposed to signposting or dealing with enquiries (10.3%).

2. IPR

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

- Income and Expenditure was reported in February at a surplus of £3.5m (including all allowable STF worth £5.1m). Planned surplus was £7.5m giving an adverse variance of £5m YDT to M11. The YTD and Forecast financial position has been supported by the full utilisation of relevant reserves and balance sheet provisions.
- The cash balance at the end of February was £12.531m which represents 13 days of operating expenses. The Trust has incurred £7.8m of capital expenditure in the 11 months to February.

3. Safer Staffing

- Overall Trust % staffing fill rates for February were:
  - RNs on days 92.92%
  - RNs on nights 95.86%
  - Care staff on days 110.07%
  - Care staff on nights 114.45%
- 11 of 32 wards had a % fill rate of less than 90%
- 2 wards had a % fill rate of less than 90% for care staff
- 11 adult inpatient wards were below the recommended 3 RN care hours per patient per day
- Newton and Duffy ward were also below the 3 RN CHPPD which is appropriate for intermediate care wards with a slightly lower RN to care staff funded skill mix staffing

establishment.

- 69.7% of bank care staff requests and 48.5% of registered bank staff and agency requests were filled to backfill staffing shortfalls. 72.61 WTE RN shifts were backfilled using bank, agency or overtime and extra time to address shift shortfalls in month.
- In February, 3 patients experienced severe harm following an inpatient fall, two when correct staffing levels were on duty and one fall when the shift was short of one registered nurse.
- An active recruitment programme continues to address RN shortfalls. 27 RN posts were offered at the Recruitment Open Day on 24.2.18 targeting students completing in September 2018. 77 posts were offered through the Global Learner Campaign to date.

4. Draft Quality Account

The draft QA was submitted for information at this stage as year-end data is to be added.

5. Falls Audit & Actions

Falls audit results identified 3 areas for improvement: delirium, lying and standing blood pressure and vision. The report made 15 recommendations, 14 of which have already been implemented or form part of the falls strategy action plan. The one remaining action, to ascertain whether there is a gap between the number of reported and actual falls, will be discussed at the next Falls Action Plan Strategy meeting.

6. QIA Report

The QIA review highlighted that the system used to record QIAs is being used inconsistently and recommends further work to strengthen the process.

7. Feedback from Councils:

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

a. Changes have been made to the NG policy with a training requirement for all staff and medical staff training for x-ray interpretation of NG tubes to be limited from CT1 grade and above.
b. The communication of safety information to various staff groups and hard to read groups to be supported.

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

c. Positive feedback was reported by Healthwatch relating to staff, cleanliness and waiting times.
d. Actions are being taken to improve the effectiveness of discharge processes, including proactive management to reduce any delays for patients.

Clinical Effectiveness Council – Summary page noted, the following escalated:

e. There has been a significant increase in SMR for pneumonia. Chris Yates is analysing the data further. There has been a significant reduction in SMR for COPD.
f. LeDer Death Review shows a total of 19 deaths met the criteria for investigation. None were due or contributed to by failings of care.

CQPG – Summary page noted, nothing to escalate.

Workforce – Summary page noted, nothing to escalate.

Executive Committee – Summary page noted, nothing to escalate.

8. Policies/Documents Approved:

- Mixed Sex Declaration
- CQC Registration

9. AOB

None noted.

Items to be escalated to the Board:

1. Preventing falls is one of the Trust's top Quality objectives and so it is disappointing we have been graded poorly for screening in relation to Delirium, Standing and Lying Blood Pressure and Vision. There will be an update report in May on these issues.

2. The QIA review process is not robust. Inconsistent consideration of quality impact and CIP results. There is an action to look at this with an update report in May.

3. In order to improve governance arrangements, the National Benchmark Surveys are to be brought to the Committee for review before going to the Council.

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 Board members note this report.

Presenting officer: David Graham

Date of meeting: 28 March 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)23

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance and Performance Committee, 22nd March 2018

Summary:

Agenda Items

For Information

- A&E Update
  - The Committee reviewed current performance in terms of volumes of patients and ambulances attending ED; a slide was shared with the committee showing the prevalence of flu and an age demographic of those testing positive within the hospital. Discussion centred on the proportion of our patients attending or being admitted by their commissioning CCG. The presentation also included an update on key actions within the department.

- Forecast Outturn 2017/18
  - There was a detailed and robust discussion on the outturn position. The committee were aware of the operational pressures since December which were noted as risks to achieving financial plans previously. Escalation beds, acuity of patients, staff sickness from flu and elective plans reducing all impacted on the Trust run rates. It was noted the biggest cost driver was in pay costs to manage the escalation beds and acuity of patients.
  - The committee acknowledged the severity of winter and the log period its impact has been compared to previous years. Even in March, there are escalation beds and patients being admitted with flu.
  - The Trust is forecasting to achieve a £ (2.636) m deficit excluding STP, £2.470m including STP and Tranche 1 and Tranche 2 Winter monies.
  - This £2.6m deficit means the trust was only £2m away from achieving its control total deficit of £0.6m in probably its most challenging operational year.
  - In summary the trust planned for a £8.5m deficit, however with the loss of £4m STF and the adverse operational impact of £2m shortfall in planned deficit it will be able to achieve a predicted £2.5m surplus.

- Budget Setting 2018/19
  - The financial plan for 2018/19 was reviewed by the Committee, which detailed the planned income and expenditure, CIP and capital.
  - The plan is for the Trust to achieve a £1.8m deficit in line with the control total advised by NSHI. This would then give access to £12.8m of STF funding.
  - Committee discussed the risks within the plan in particular the £19m (c5.2% of operational costs) CIP programme.
  - The committee discussed the robustness of the plans developed to date and the need to really drive collaborative and system wide opportunities which have seen limited impact to date
  - Further risks included the completion of the contracting negotiations, activity being greater than commissioned levels again, no winter funding being planned for and the continued pressure of staffing for beds and acuity of patients.

- CIP Programme Update 2018/19

- The committee reviewed the methodology underpinning the current CIP plans, which have been based on the model hospital.
- £14.4m was identified within the report with further discussions that the remaining £4.6m being around collaborative working so at scale and pace.
- There was excellent clinical input in both possible productivity opportunities but also championing the CIP agenda.
- The committee agreed that QIA should be monitored given the task ahead.

- Briefing on Trust Loans
  - The contents of the report were noted

- Annual Meeting Effectiveness Review
  - Members were asked to complete the questionnaire if they hadn't done so already and return to Nicola Bunce.

- CIP Council and Procurement Council
  - The Briefings were accepted.
  - Disposal of Assets policy tabled at Procurement council was approved.

For Assurance

- Integrated Performance Report Month 11 was reported
  - Discussion took place around operational performance with specific reference to the MRSA and C difficile cases year to date, VTE and RTT performance.
  - 62 Cancer performance for February was above target at 85.1% although it was noted the 31 day cancer standard was below target. Actions were underway at speciality level to improve this.

- Finance Report Month 11 2017/18
  - Behind the year to date deficit of £0.577m excluding STF (surplus of £7.476m including STF) by £1.0m.
  - The value of the lost STF at month 11 is £2.947m. (£5.106m achieved against £8.053m available).
  - The Trust has delivered £279.964m of Clinical Income which is £2.672m above plan.
  - The Trust has delivered £11.4m of CIP against a target of £13.8m and this continues to be monitored at a departmental level.
  - The Cash and Capital positions were also discussed.

Actions Agreed

- E-Rostering rollout to Medical workforce to be reviewed by committee in 6 months.
- MRSA appeal to be completed by 1st April 2018
- Update on A&E initiatives implemented over previous 12 months
- Deep dive into growth in attendances from Knowsley, Halton & St Helens

Escalation to Board

- Note the adverse variance to plan of the financial position YTD and forecast. This was from unprecedented operational pressures starting in December and still continuing.
- F&P committee proposed to accept the control total for 2018/19 with the understanding this will require a CIP in the region of £19m (5.2% of operating expenditure). As in previous years this is based on the following assumptions:-
  - No additional growth over the commissioned levels
  - Assessment and discharge to alternative out of hospital settings is improved for medically optimised patients and the number of medically optimised patients on the shared master control plan does not exceed 40 for more than 72 hours at any

point in time or cumulatively for more than 14 days o Commissioners attendance and admission avoidance schemes deliver the planned decreases in activity for each CCG population o The regional and national initiatives around collaborative working are adopted as part of our efficiency assumptions o This is still subject to the final contract agreement and sign off which will be concluded within the next week.
Corporate objectives met or risks addressed: Finance and Performance duties
Financial implications: None as a direct consequence of this paper
Stakeholders: Trust Board Members, NHSI
Recommendation(s): Members are asked to note the contents of the report
Presenting officer: Su Rai Non-Executive Director
Date of meeting: 28th March 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(18)24
Title of paper: Strategic and Regulatory Update Report – March 2018
Purpose: To provide the Board with assurance that the Trust continues to take account of external strategic developments that could impact the future direction of the organisation and all regulatory requirements to comply with governance good practice.
Summary: The report provides a briefing on the key developments and issues of importance since the last Trust Board meeting in February, covering; 1. Operational Planning – update 2. Reporting and Rating of Use of Resources assessments 3. Special Measures – Finance Guidance 4. Wholly owned subsidiaries in the NHS
Corporate objectives met or risks addressed: Provide high quality sustainable services
Financial implications: This paper does not include a request for additional funding
Stakeholders: Patients, Staff, C&M FYFV, Commissioners, Regulators
Recommendation(s): The Board is asked to note the report
Presenting officer: Nicola Bunce, Director of Corporate Services
Date of meeting: 28th March 2018

Strategic and Regulatory Update Report – March 2018

1. Operational Planning – update

The Trust submitted its draft operational plan on 8th March. Across Cheshire and Merseyside the plans from both commissioners and providers are being discussed collectively by NHS England and NHS Improvement. To date no formal feedback has been received in relation to the Trust's submissions, however it is anticipated that there may be feedback following the conclusion of the contract discussions on 23rd March 2018.

The final Board approved plan must be submitted to NHS Improvement by 30th April 2018, and will be reviewed by the Finance and Performance Committee prior to being presented to the Trust Board in April.

2. Reporting and Rating of Use of Resources assessments

Following a period of consultation the Care Quality Commission (CQC) have now determined how the Use of Resources (UoR) rating for non-specialist acute Trusts will be combined with the quality ratings to give an overall rating for the organisation.

Board members will recall that the UoR assessments are to be carried out by NHS Improvement, whilst the quality assessment will be undertaken by the CQC.

Once both assessments have been undertaken the ratings will be combined to give an official overall Trust rating, which will appear on the CQC website and must be displayed by the Trust.

Therefore non-specialist acute Trusts will be assessed on the basis of 6 domains, rather than 5, which will each carry equal weight in the rating assessment.

The CQC has amended its guidance on the rating principles to reflect this;

Combined trust ratings*: Where six Trust-level ratings are being aggregated for a combined rating (the five key quality question ratings plus a use of resources rating), the aggregated rating will normally be limited to 'requires improvement' where three or more of the underlying ratings are 'requires improvement' and;*

Number of underlying ratings*	Principle	Principle
	Limited to requires improvement where there are (X) number of underlying inadequate ratings	Limited to inadequate where there are (Y) number of underlying inadequate ratings
1 – 3	Not applicable	1 or more
4 – 8	1	2 or more
9+	2	3 or more

*underlying ratings are those for both core services and Trust sites

At this stage only a small number of UoR assessments have been completed, so the impact on the overall CQC ratings of non-specialist acute Trust's cannot be accurately predicted.

However, this is something that the Board needs to be aware of as we approach the next planned CQC inspection and the Trust UoR assessment by NHS Improvement.

3. Special Measures – Finance Guidance

In January NHS Improvement issued new guidance detailing the process for Trusts being put into special measures for reasons of quality, and how it would work with the CQC.

In March parallel guidance has been published for Trust's being put into special measures for financial reasons.

Both routes are mandated by NHS Improvement's regulatory framework – the Single Oversight Framework.

Trusts will be put into financial special measures to achieve accelerated financial recovery and improve financial governance, it involves;

- Rapid planning and delivery of accelerated recovery activities, through greater control by NHS Improvement.

- Helping Trusts achieve and maintain sustainable finances and the best possible financial outturn.

- Trusts delivering significant financial recovery through actions within their own control.

- Improvements to finance cannot be made at the expense of quality.

- Improvements to finance cannot be at the expense of other areas monitored under the Single Oversight Framework (such as NHS Constitution operational performance standards).

The triggers for placing a Trust in financial special measures are;

The Trust has not agreed a control total and is planning or forecasting a deficit (or has recently delivered a significant year-end deficit).
Or:
The Trust has agreed a control total but:
– has a significant negative variance year to date against the control total plan and
– is forecasting (or has recently delivered at year-end) a significant deficit.
Or:
The Trust has an exceptional financial governance failure (e.g. significant fraud or irregularity).

4. Wholly owned subsidiaries in the NHS

There has been a lot of media interest in NHS organisations creating wholly owned subsidiaries (WOS) and NHS Providers has recently published a briefing note to set out the reasons why WOS are used by some NHS organisations.

Many Trusts do already have WOS and they are increasingly being viewed as a suitable legal vehicle to enable transformational change to the way services are delivered and support collaboration between NHS bodies.

There has been provision in legislation since 2006 for the NHS to create WOS, although NHS Trusts require permission from the Secretary of State (unlike Foundation Trusts). There have been calls for these powers to be extended to NHS Trusts.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)25

Title of paper: Infection Prevention and Control Annual Report 2016/17

Purpose: To present the 2016/17 Infection Prevention and Control Annual Report, to provide assurance that the Trust is taking the necessary action to monitor and prevent hospital acquired infections.

Summary:

1. Infection prevention and control is a statutory duty of the Trust Board and an annual report must be made annually on performance in the previous year.
2. This report covers the 2016/17 financial year.
3. Health care acquired infections (HCAIs) are reported every month via the Integrated Performance Report (IPR) and the Board via the Quality Committee also gains assurance via regular in depth reports of the actions taken and lessons learnt.
4. During 2016/17 the IPC performance improved in comparison to the previous year and the following were reported:
    a. 27 cases of Clostridium difficile infection (CDI) against an objective of no more than 41 (of which 6 were classified as unavoidable);
    b. 4 cases of Meticillin Resistant Staphylococcus Aureus (MRSA) 3 true bacteraemias (ie clinical infections) and 1 contaminant;
    c. 17 cases of Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia;
    d. 50 Hospital Acquired E coli bacteraemia;
    e. Zero cases of CPE bacteraemia;
    f. 13 surgical site infections following surveillance of 813 procedures in orthopaedics;
    g. There were 17 outbreaks of infection: MRSA colonisation (2) diarrhoea (4) MDRP (1) flu (6), and VRE colonisation (4).
5. The annual report also sets out the planned improvements for 2017/18 and given the time of reporting comments on the progress in achieving these improvements.
6. Further improvement in performance has been achieved in 2017/18, and this will be reported in the Quality Account and the next IPC annual report

Trust objective met or risk addressed: Assurance of robust reporting, training and governance for IPC to meet regulatory and contractual quality standards, and improve the safety of patient care.

Financial implications: None directly as a result of approving this report.

Stakeholders: Staff, patients and the public, regulators

Recommendation(s): To approve the 2016/17 IPC annual report.

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

Date of meeting: 28th March 2018.

St Helens and Knowsley Teaching Hospitals NHS Trust

Infection Prevention and Control Annual Report 2016-2017

CONTENTS

EXECUTIVE SUMMARY

1 This is a two-part document; a report on the developments and performance related to Infection Prevention and Control (IPC) during 2016/17 and the work plan for 2017/18 to reduce the risk of healthcare associated infections (HCAIs) in Appendix 1. The report outlines the challenges faced in-year and the Trusts approach to reducing the risk of HCAI for patients.

2 The annual report for Infection Prevention and Control outlines the Trusts IPC activity in 2016/17. In addition, it highlights the role, function and reporting arrangements of the Director of Infection Prevention and Control (DIPC) and the IPC team.

3 A zero tolerance approach continues to be taken by the Trust towards all avoidable HCAIs. Good IPC practice is essential to ensure that people who use the Trust's services receive safe and effective care. Effective IPC practices must be part of everyday practice and be applied consistently by everyone. The publication of the IPC Annual Report, which is a requirement in accordance with The Health and Social Care Act (2008), should be publicly available on the website as outlined in 'Winning ways: working together to reduce healthcare associated infection in England' to demonstrate good governance and public accountability.

4 The report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in improving the quality of patient and stakeholder experience as well as helping to reduce the risk of infections. Additionally the Trust continues to work collaboratively with a number of outside agencies as part of its IPC and governance arrangements including:

- Clinical Commissioning Groups (CCG);
- Cheshire and Merseyside Public Health England (PHE);
- Community IPC teams.

Summary of key performance indicators for 2016/17

- The Trust has remained registered with the Care Quality Committee (CQC) as having appropriate arrangements in place for the prevention and control of infections.

- There were 27 cases of Clostridium difficile infection (CDI) against an objective of no more than 41 cases for 2016-17. Six cases were agreed as unavoidable after review by CCG CDI appeals panel i.e. there were 21 avoidable cases of CDI. The objective for CDI was therefore met. However the learning outcomes from CDI Root Cause Analysis (RCA) indicated that stool specimens were not being sent for testing in a timely manner, resulting in several cases being Trust attributable. Following introduction of a stool collection algorithm there has been a downward trend in the number of CDI cases within the Trust. Use of the stool collection algorithm continues to be embedded across all wards through targeted training sessions.

- Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia is a key performance indicator with a target of zero tolerance set by NHS England.

  - The objective for MRSA bacteraemia has not been met. There were 4 cases of MRSA bacteraemia, 3 true bacteraemia (ie clinical infections) and 1 contaminant. All cases of MRSA bacteraemia undergo a multi-disciplinary Post Infection Review (PIR);

  - The learning outcomes indicate a need for improvement in Aseptic Non-Touch Technique (ANTT), blood culture taking, Visual Infusion Phlebitis (VIP) scoring, MRSA screening and topical suppression compliance and blood culture contamination rate reduction;

  - All cases of MRSA bacteraemia were subject to a multi-disciplinary Post Infection Review (PIR). The learning outcomes indicate a need for improvement in Aseptic Non-Touch

Technique (ANTT), blood culture taking, Visual Infusion Phlebitis (VIP) scoring, MRSA screening and topical suppression compliance and blood culture contamination rate reduction. A Trust wide MRSA Action Plan has been generated and monitored through the Hospital Infection Prevention Group (HIPG), Patient Safety Council (PSC) and the Clinical Quality Performance Group (CQPG).

- There was a 39% reduction in the number of Meticillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia reported for 2016-17 (n =17) compared to 2015-16 (n = 28). In comparison, PHE has seen a general increasing trend in all reports rates of MSSA bacteraemia since July 2012.

- There was an 18% reduction in Hospital Acquired E coli bacteraemia reported for 2016-17 (n=50) compared to 2015-16 (n=61). In comparison, PHE has seen an overall increasing trend in both counts and rates of E coli bacteraemia since July 2012.

- There were no cases of CPE bacteraemia.

- Surgical site infection surveillance in orthopaedics:

April 2016 – March 2017	**STHK**	**National**
Hips 327/4 infections	1.2%	1.1%
Knees 486/9 infections	1.9%	1.5%

- Outbreaks: There were 17 outbreaks of infection: MRSA colonisation (2) diarrhoea (4) MDRP (1) flu (6), and VRE colonisation (4).

- The management and control of an outbreak of Multi Drug Resistant Pseudomonas Aeruginosa (MDRP) on the Burns Unit and ICU through collaboration between Public Health England (PHE).

- Hand hygiene continues to be strongly promoted throughout the Trust. Monthly audits of hand hygiene were undertaken on all wards throughout the year. Covert hand hygiene surveillance has also been undertaken.

- Training**:** Infection control induction and mandatory training sessions were provided for all clinical staff.

- Infection Control Link Nurse training occurs every 2 months.

- Antibiotic prescribing: The Trust intranet interactive antibiotic guidelines were updated (intranet website and app) in August 2015. The antibiotic penicillin allergy chart was also updated. Numerous audits were undertaken including AMT ward rounds, point prevalence audits, missed dose audit, time to first dose of antibiotics, impact of ready-made antibiotics from the aseptic unit and joint replacement antibiotic prophylaxis . All ward pharmacists check patients MRSA, VRE, CPE and *Clostridium difficile* status against appropriateness of antibiotic therapy.

- The expansion of the aseptic unit to produce more ready-made IV preparations saves considerable time, money and reduces potential risk to patients. This service has been promoted to clinical and directorate leads.

- Communication**:** Infection prevention and control messages were reinforced with the use of many different means of communication including global emails, intranet messages, screen savers, Team Brief, meetings, posters, additional training sessions, and personal communication.

- Successful collaboration with whole health economy with regards to all issues relating to infection prevention.

- Introduction of a MSSA Patient Group Directive (PGD) for all orthopaedic joint replacement patients identified as colonised with MSSA pre-operatively for suppression therapy prior to surgery.

- Information technology**:** The ICNet NG electronic infection prevention surveillance and case management system went live in December 2014. In the second phase of the project, in April 2015, ward reporting of data related to infection prevention was implemented. Clinical staff now have real time access to health care associated infection and audit data specific to their own clinical areas as well as for the rest of the Trust.

- Engagement at ward level**.** Twenty five consultants from all specialities are Consultant Leads in Infection Prevention and control for their own areas. Root cause analyses (RCA) of infections continue to be presented by consultants to the Executive Panel.

- E coli bacteraemia RCA undertaken on all hospital cases.

Developments in 2017/18

- Zero tolerance of MRSAb and other avoidable blood stream infections.

- ANTT programme continues to ensure that Trust staff reaches the target of 85% annual compliance for ANTT competency.

- Further roll out of the Trust Line Care Course using a new E-Learning package to ensure best evidence based practice and ensure patient safety;.

- To use information technology to facilitate best practice and improve current practice specifically in relation to CPE risk assessment/screening and Bristol Stool Chart monitoring by incorporating these into the electronics medical early warning score (eMEWs) system, Patientrack.

- To further embed the concept of ‘One Together’ programme for reducing risk of surgical site infection into the Trust in the surgical division and theatre department.

- To explore the introduction of water coolers into non-augmented care areas of the Trust to improve patient experience whilst minimising risk of water born infection.

- Collaborate with the healthcare community on the implementation of a toolkit to reduce the risk of E.coli and other gram negative bacteraemia.

- Work alongside the sepsis team on the correct detection, reporting and management of sepsis.

- Continued input into refurbishment projects as required, together with infection prevention and control advice.

- Continued education on the standards relating to antimicrobial use and re-audit to monitor compliance with national antimicrobial stewardship guidance.

BACKGROUND

1. Infection Prevention and Control Arrangements

1.1. As recommended in the Health and Social Care Act 2008, there is a duly constituted Hospital Infection Prevention Group (HIPG) which meets bi-monthly. The HIPG is a sub-group of the Patient Safety Council (PSC) which reports to the Quality Committee (QC). The current Trust clinical management arrangement consists of Care Groups in which the IPCT sits within the Corporate Care Group.

1.2 IPC Governance

1.2.1. The Board of Directors has collective responsibility for keeping to a minimum the risk of infection and recognises its responsibility for overseeing IPC arrangements in the Trust.

1.2.2. The Trust Director of Infection Prevention and Control (DIPC) role is incorporated into the role of the Chief Nurse.

1.2.3. The DIPC is supported by the Assistant DIPC, IPC Doctor, and the Trust Antimicrobial Pharmacist. The wider IPCT structure is tabled below.

1.2.4. The DIPC delivers an Annual HCAI Reduction Report to the Board of Directors and the forthcoming HCAI Reduction Delivery Plan based on the national and local quality goals.

1.2.5. The Executive Committee and Care Group clinical leads receive monthly updates on patients with Clostridium difficile infections, MRSA and MSSA.

1.2.6. IPC performance is reported monthly in the Integrated Performance Report presented at Team brief and all governance meetings.

1.2.7. The Trust has 25 Consultant Infection Prevention and Control Leads ('Consultant Champions') and 70 link nurses.

1.2.8. The IPCT also works closely with the Matrons, Infection Prevention and Control Link Professionals and Facilities Management.

1.2.9. The Trust returns a monthly Assurance Framework to the Cheshire and Merseyside Commissioning Support Unit; this framework outlines performance against a number of key performance indicators (KPIs). This in turn is used as part of a performance pack for the relevant CCGs.

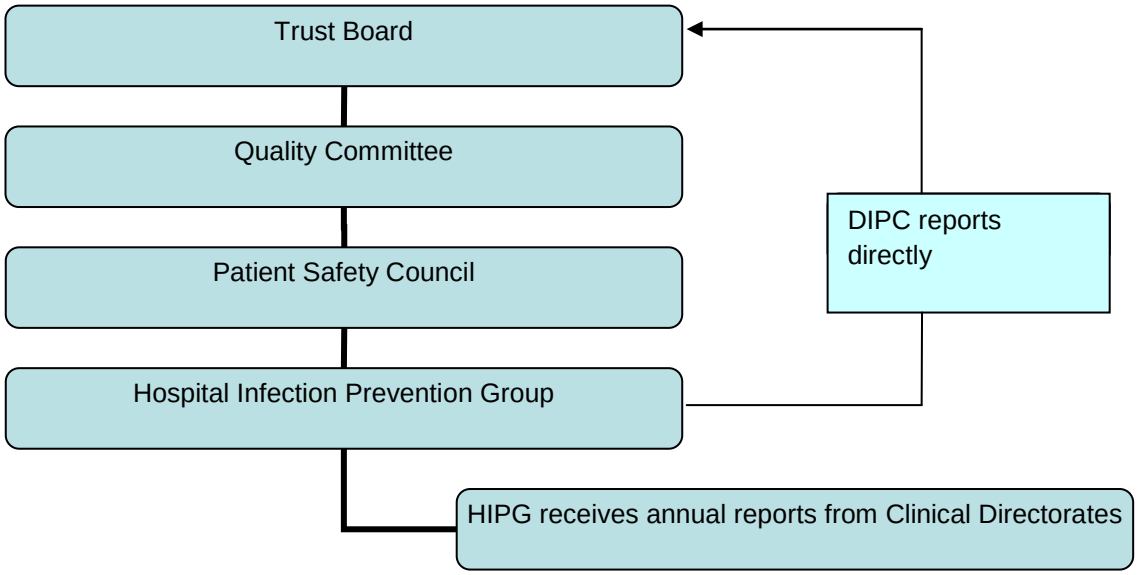
1.2.10. Infection Control Standards and Assurance- The annual reduction aspirations were agreed by the Trust Board in the trust objectives 2016/17 and the Clinical and Quality Strategy Annual Delivery Plan for 2016/17.

1.2.11. The Trust continues to undertake a number of interventions in relation to infection prevention and control as detailed within the HCAI Reduction Plan 2016/17. This work is led by the Director of Infection Prevention and Control (DIPC) and supported by the

Infection Prevention Doctor.

1.3 Hospital Infection Prevention Group (HIPG)

1.3.1 The Hospital Infection Prevention Group reporting line to the Trust Board is shown below:



1.3.2 The Terms of Reference are reviewed annually and were amended in 2016.

1.3.3 The Infection Prevention and Control Team (IPCT) consisting of nurses, doctors, assistant practitioner, audit and surveillance assistant and a secretary to support delivery of the IPC strategy and action plan. The IPCT is located on the Whiston Hospital site but attends the St Helens site on a regular basis.

1.3.4 Infection prevention and control is an essential component of care and one of the Trust's key clinical priorities.

1.3.5 The IPCT's objectives are to protect patients, visitors and staff from the risks of healthcare associated infections. Infection prevention is the responsibility of every member of staff and the role of the IPCT is to support and advise them to ensure that high standards are maintained consistently across all sites.

1.3.6 Isolation facilities

The current proportion of single rooms is 50% which supports the prompt isolation of patients with suspected or confirmed infections

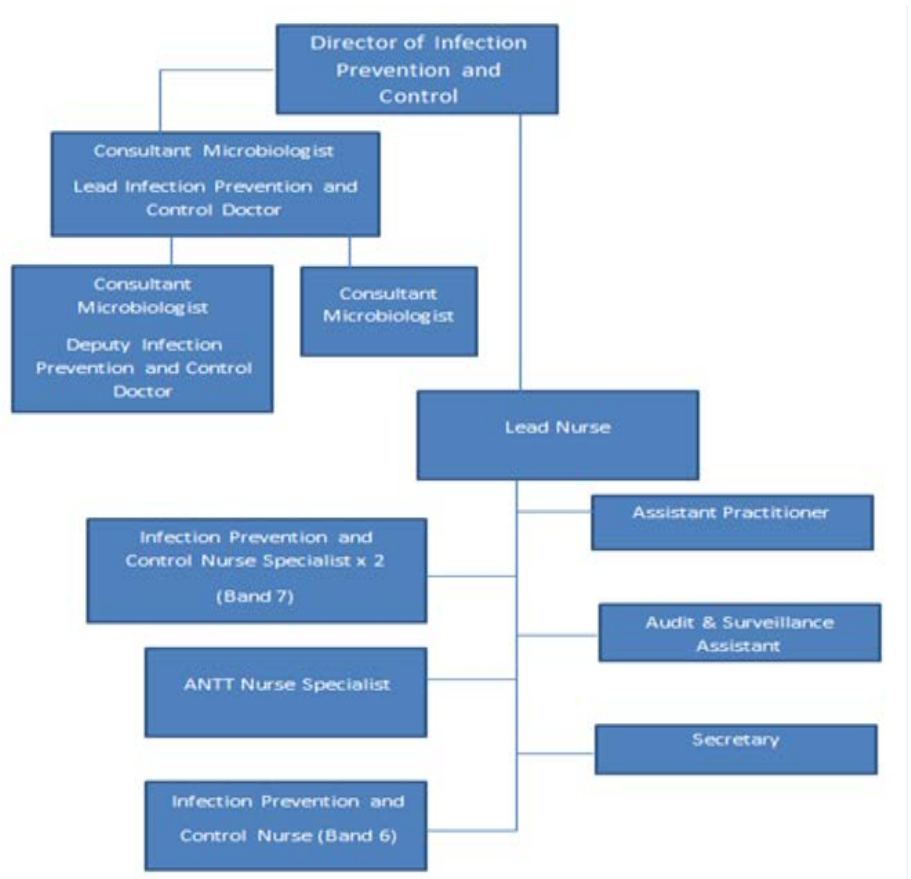
The target time for isolating patients with unexplained (and potentially infectious diarrhoea) is less than two hours. This is monitored by the IPC team weekly and reports to the IPC Group monthly via the IPC Board Report. Compliance ranged from 80-100% throughout the year.

Each ward/clinical department maintains an isolation plan and the IPCT send out a Trust wide side room plan daily. This identifies who is managed in a side room and the reason for their isolation. This is used by the wards and the site team to enable the correct placement of patients.

1.3.7 The core members of the IPCT consist of:

- Director of IPC (DIPC) - this role has been covered by a Consultant Microbiologist until her retirement at the end of November 2016 when the role was incorporated into the Director of Nursing, Midwifery and Governance post;
- Lead Infection Prevention and Control Doctor;
- Deputy Infection Prevention and Control Doctor – currently vacant position however, recently appointed to;
- 8A Lead Nurse IPC (1.0 wte);
- Band 7 Specialist IPC Nurses (2.0 wte);
- Band 7 ANTT Specialist Nurse (0.5 wte);
- Band 6 IPC Nurses (1.0 wte);
- Band 4 Assistant Practitioner (1.0 wte);
- Band 4 IPC Secretary (1.0 wte);
- Band 3 Audit and Surveillance Assistant (0.6 wte);
- Antimicrobial Management Pharmacists - 0.5 wte band 8b and 0.5 wte band 8A.

1.3.8 IPC organisational structure



1.3.9 In addition, the IPCT has a Link Nurse programme of over 70 personnel with study days/ meetings planned on a bi-monthly basis.

1.3.10 The IPCT meets bi-weekly to discuss and minute progress, and map actions against the Annual Plan. Representatives from other Departments attend as required including the Antimicrobial Pharmacist.

1.3.11 The IPC team continue provide a 5 day service and an on call microbiology service is available out of hours.

1.4 Committee representation by members of the IPCT

- Hospital Infection Prevention Group
- Patient Safety Council
- RCA Executive Review Panel Meetings
- Health Economy Healthcare Associated Infection Group (Knowsley)
- Health and Safety Group
- Sharps Safety Group
- Water Safety Group
- Drugs and Therapeutics Group
- Decontamination Group
- Medical Device Group
- Matrons' Infection Prevention and Control and Facilities Meeting
- Cheshire and Merseyside Public Health England Healthcare Associated Infections (HCAI) Group
- Trust IV Access and Therapy Group
- St Helens and Knowsley NHS Trust Major Incident Planning
- North West Antibiotic Pharmacy Group
- North West IV Forum Group
- Cheshire and Merseyside Antimicrobial Resistance Group
- Medical and Surgical Care Group Governance Meetings

2. Healthcare Associated Infections

2.1 Healthcare associated infections (HCAIs) are infections that are acquired as a result of health care interventions. Surveillance of HCAIs infections allows the continuous monitoring of diseases in a population so that data can be analysed and trends identified in order to introduce and maintain effective mechanisms to facilitate patient safety and care. High quality information on infectious diseases, HCAIs and antimicrobial resistant organisms is essential for monitoring progress, investigating underlying causes and applying prevention and control measures.

2.2 Since April 2001, it has been mandatory for all acute NHS Trusts in England to report all cases of bacteraemia caused by S aureus as well as the proportion of these cases due to MRSA. Mandatory surveillance of MRSA and C difficile was introduced in 2004. Since April 2007, all NHS Trusts in England are required to participate in the Department of Health's mandatory CDI reporting system and to report all cases of Clostridium difficile infection (CDI) in patients over 2 years of age. Escherichia coli bacteraemia was added to the enhanced mandatory data reporting from June 2011.

2.3 All HCAI surveillance and reporting has been carried out in line with the NHS England and Public Health England mandatory reporting requirements.

2.4 The IPC Team visit all patients at regular intervals according to their infection or possible infection, such infections/conditions are listed below:

Target/Alert Organisms

- MRSA
- Clostridium difficile
- Group A Streptococcus
- Salmonella species
- Campylobacter species
- Mycobacterium tuberculosis
- Glycopeptide resistant Enterococci
- Multi - resistant Gram negative bacilli e.g. extended spectrum beta-lactamase (ESBL) producers
- Carbapenemase-producing Enterobacteriaceae (CPE)
- Neisseria meningitides
- Aspergillus
- Hepatitis A
- Hepatitis B
- Hepatitis C
- HIV

Alert Conditions

- Scabies
- Chickenpox and shingles
- Influenza
- Two or more possibly related cases of acute infection e.g. gastroenteritis
- Surgical site infections

2.5 Meticillin-resistant Staphylococcus aureus (MRSA)

2.5.1. MRSA can cause substantial morbidity e.g. wound infections, line infections, bacteraemia, chest infections, urinary tract infections, osteomyelitis.

2.5.2. Since 2004, the Department of Health has set objectives for all Hospital Trusts to reduce their MRSA bloodstream infection rates e.g. by 60% by 2007/2008 against the 2003/4 baseline.

2.5.3. Since 2013/2014 there has been a zero tolerance target for MRSA nationally. The objectives for this Trust are shown below:

Year	Actual MRSA Bacteraemia	Objective
The following objectives apply to hospital-acquired cases only		
2010/11	8	5
2011/12	5	5
2012/13	10	3
2013/14	4	0
2014/15	2	0
2015/16	0	0
2016/17	2	0

2.5.4. All 2 cases of Trust acquired MRSA bacteraemia underwent thorough multi-disciplinary root cause analysis and were reviewed by the Executive Root Cause Analysis Panel. Both were deemed avoidable.

2.5.5. RCA findings of the cases:

- Emergency Department – Blood culture contaminant from a patient previously known to be MRSA colonised. Staff member who took the blood cutlure had received ANTT training but had not undergone competency assessment.

- 1D – Lower respiratory tract infection in a patient was known to be MRSA positive previously from another Trust - details of which were not communicated to the GP or the Nursing Home. Delayed commencement of supression therapy after a positive screen on this admission. Delayed taking of blood cultures. Delayed administration of IV antibiotics.

2.5.6. Lessons identified were:

- Staff must be aware of infection related alerts on the patient medical records;

- Ensure that MRSA screen includes all relevant samples i.e. wound sites/catheter urine if patient catheterised/sputum if chest productive;

- Ensure patients with MRSA (newly diagnosed or readmissions) are started promptly on colonisation suppression;

- MRSA cover must be for empirical treatment of infection in patients with a history of MRSA;

- Ensure that antibiotics are given in a timely manner for any patient prescribed antibiotics;

- Trust blood culture policy must be followed when taking blood cultures including adherence with aseptic not touch technique (ANTT).

2.5.7. A trust-wide action plan owned by the care groups was implemented to address the issues identified.

2.6 MRSA Screening

2.6.1. The Trust continues to use a robust approach to screening the majority of patients, either pre operatively or on admission.

2.6.2. Screening compliance is monitored on a monthly basis. It is based on all admissions who are screened on day 0, 1 or 2 (day 0 being day of admission).

2.6.3. The contractual target for MRSA screening is 100% of eligible patients requiring screening.

2.6.4. The Trust has achieved 100% compliance throughout 2016/17.

2.7 Clostridium difficile toxin infection (CDI)

2.7.1. Targets for CDI were introduced in 2008/2009.

2.7.2. The CDI NHS England target for 2016/17 was no more than 41 cases.

2.7.3. In total there have been 21 cases of CDI, excluding 6 cases which have been successfully appealed as having no lapses in care and therefore are not included in the year-end performance figure.

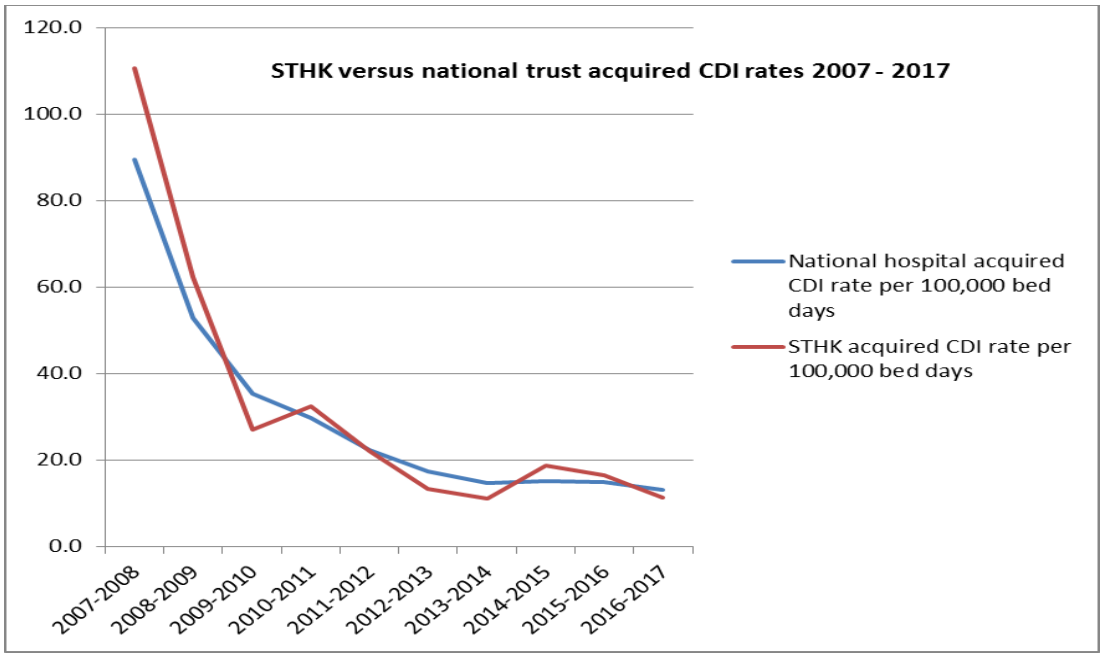
2.7.4. There continues to be a decrease in the overall number of patients with Trust apportioned CDI.

2.7.5. Each case has been investigated by the clinical teams using a standardised post-incident review (PIR) process and fed back to the IPC Operational Group. Any lapses in care are discussed and actions agreed and their delivery monitored through Hospital Infection Prevention Group. If there are no lapses in care, the case is heard by the CCG CDI Appeals Panel with a view to removing the case for performance purposes.

2.7.6. The table below demonstrates year on year reduction:

Baseline data	334		
	Targets	**Actual**	
2008/09	302	170	
2009/10	235	75	
2010/11	169 (DOH target) 71 (PCT target)	74	
2011/12	65	52	
2012/13	37	31	
2013/14	31	26	
2014/15	19	35	avoidable cases (excluding 9 cases which were deemed unavoidable by the CCG CDI appeals panel)
2015/16	41	26	avoidable cases (excluding 13 which were deemed unavoidable by the CCG CDI appeals panel)
2016/17	41	21	avoidable cases (excluding 6 cases which were deemed unavoidable by the CCG CDI appeals panel)

2.7.7. STHK apportioned CDI rate per 100,000 bed days in comparison with the overall national trust-apportioned CDT rate is as below:



2.7.8. Lessons identified from RCA:

- Ensure that patient's bowel habit is documented on Bristol Stool Chart at least once daily;
- Isolate any patient with diarrhoea in a single room promptly and if patient has no other reason for diarrhoea send stool specimen for C difficile testing without delay;
- Adhere to Trust Antibiotic Policy and review previous positive microbiology when prescribing any antibiotic;
- Review the need to continue the drug on patients prescribed proton pump inhibitors.

2.7.9. Lessons learnt have been disseminated Trust wide using multiple modalities including Infection Prevention and Control Monthly Report, Team Brief, Infection Prevention Link Professional Educational Days, Infection Prevention and Control Consultant Champions' meetings and teaching for medical/non-medical prescribers and nursing staff.

2.7.10. Outbreaks of CDI:

- There were two outbreaks of CDI confirmed in 2016-2017:
    - Ward 5D – ribotype 023 (2 patients);
    - Ward 3E Medicine – ribotype 005 (2 patients).
- Both wards were deep cleaned and the IPCT performed weekly high impact intervention audits until compliance with the required care elements achieved >90%.

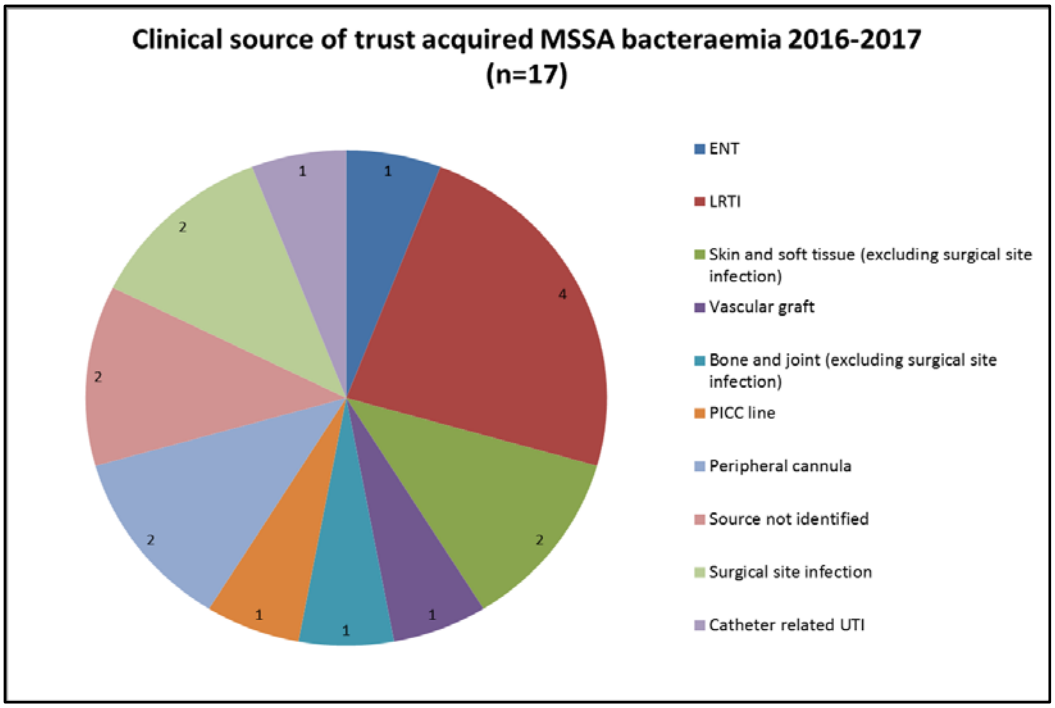
2.8 Meticillin-sensitive Staphylococcus aureus (MSSA)

2.8.1. MSSA bacteraemia mandatory surveillance commenced in January 2011, but national objectives have not yet been set.

2.8.2. There were 17 cases of Trust acquired MSSA bacteraemia in 2016-2017 compared to 28 in 2015/16.

2.8.3. All cases of MSSA bacteraemia using the Post Infection Review Framework. Clinical Teams present each case to the weekly IPC Operational Group.

2.8.4. The provenances of infections associated are identified below:



2.8.5. Following root cause analysis investigation 10 of the 17 cases were deemed avoidable.

2.8.6. Lessons identified from RCA:

- Document details peripheral cannula on VIP chart (at insertion and of monitoring at least once per shift);
- Peripheral cannula must be re-sited every 72 hours unless there is a clear indication to leave them in place for longer (e.g. a patient with difficult IV access) in which case this must be documented in the patient's notes;
- Adhere to ANTT during insertion and care of any invasive devices;
- Take blood cultures in a timely manner (and whenever possible before starting antibiotics) in patients with sepsis: Follow Trust Blood Culture Policy including checking the correct patient identifiers before taking specimens;
- Document clearly in patient's case notes (medical or nursing) all interventions/reviews of the patient;
- Check that the identification of the patient is correct when taking and labelling samples.

2.8.7. The key areas for focus in 2016/17 included:

- Improving Aseptic No Touch Technique (ANTT) practices;
- ANTT Cascade Trainers were launched and it was included as part of the Quality Care Accreditation Tool (QCAT) assessment criterion;
- Development of an Intravenous Line Care Course, incorporating Peripheral and Central line care and Blood Culture requirements commenced for staff on the wards;
- Maintaining the quarterly aseptic non-touch technique (ANTT) Key Trainer programme. Since July 2015 the number of Key trainers in the Trust has risen from 24 to 181;
- ANTT (aseptic non-touch technique) training and annual competency assessments have been promoted throughout the Trust.

2.9 Escherichia coli

2.9.1. E. coli bacteria are frequently found in the intestines of humans and animals. There are many different types of E. coli, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment and can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. E. coli bacteraemia (blood stream infection) may be caused by primary infections spreading to the blood.

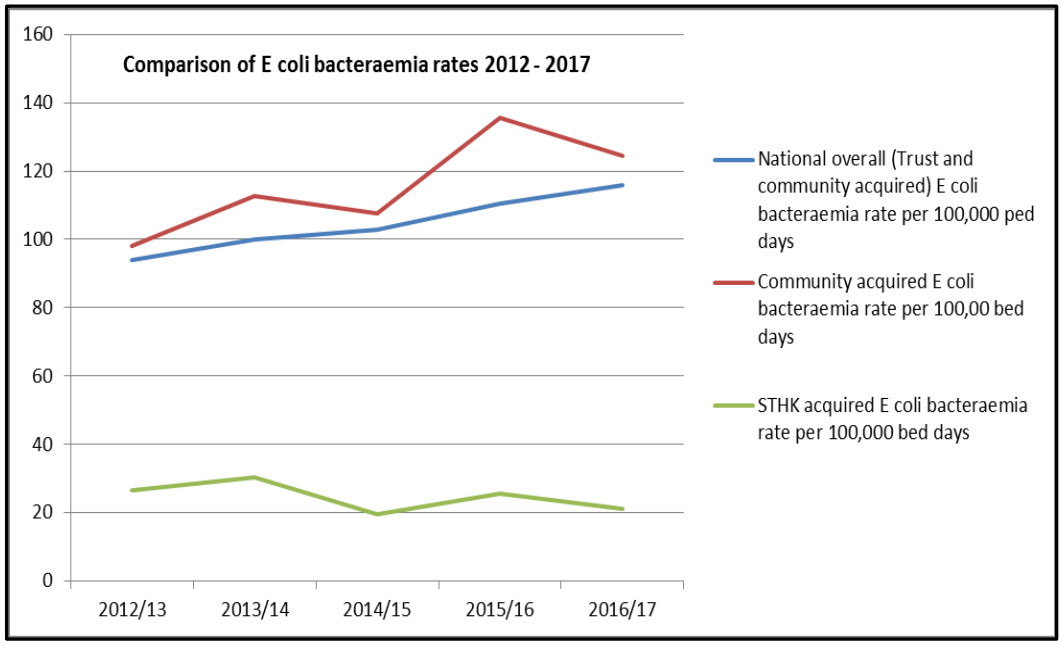
2.9.2. E.coli bacteraemia are reportable to Public Health England (PHE) as part of the mandatory surveillance system. All cases are reported to PHE and although nationally there is no option to report by non-trust or trust, we are able to do so locally.

2.9.3. E coli bacteraemia mandatory surveillance commenced in April 2011. Reduction targets have not yet been set by Department of Health although it is expected that these will be introduced in 2017-2018. The majority of cases of E coli bacteraemia are community-acquired.

2.9.4. The Trust has been undertaking RCA for all BSI including E.coli since January 2017.

2.9.5. In 2016-17 there were 50 cases compared to 61 the previous year.

2.9.6. STHK apportioned E coli bacteraemia rate per 100,000 bed days in comparison with the overall national E coli bacteraemia rates and rate for community acquired cases identified in our Trust are as below:



2.9.7. UCAM (Urinary Catheter Assessment and Monitoring) was introduced in 2011 in order to reduce urinary catheter associated urinary tract infection. All urinary catheter care is documented with the aim of:

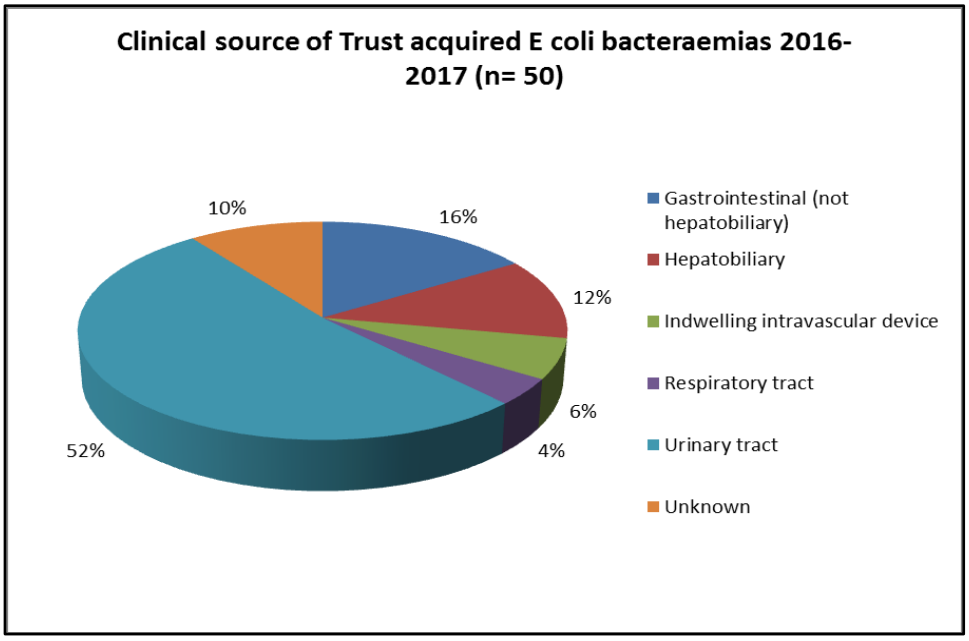
- Preventing unnecessary catheterisation;
- Prompting daily review of patients with catheter to encourage the earliest possible removal of catheter;

- Providing evidence of quality of patient care (insertion and ongoing care) as per High Impact Intervention No.6 catheter care bundle (Saving Lives);

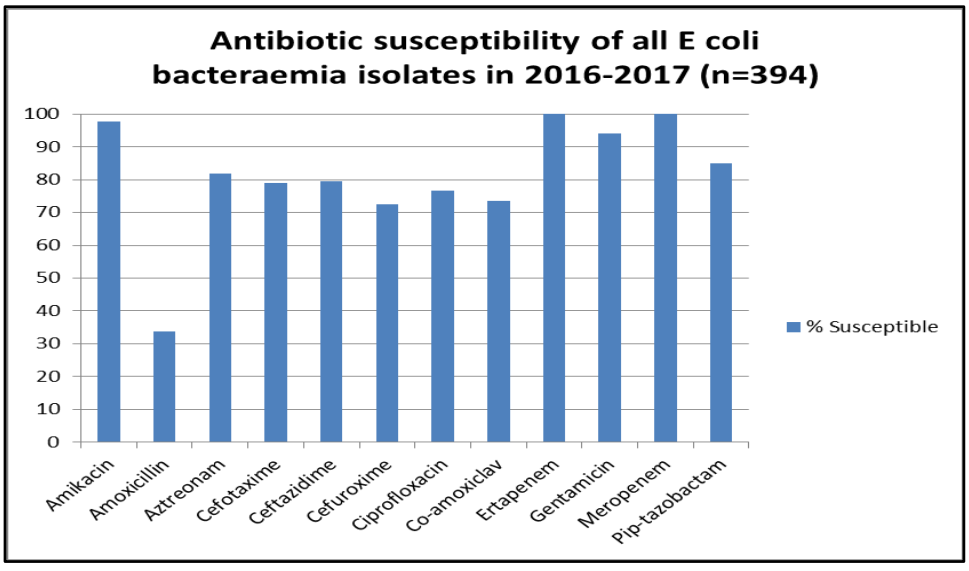
- Teaching sessions for urethral catheterisation are available through Learning and Development;

- A Trust wide UCAM audit is conducted on an annual basis by the IPCT and the Continence Nurse;
- Multi-disciplinary work (led by a Consultant Urologist) is ongoing to produce an evidence based policy on best practice in relation to all aspects of urinary catheter management;
- The Urinary Catheter Passport has been implemented within the Trust.

2.9.8. The clinical sources of Trust acquired E coli bacteraemia in 2016-2017 are as below:



2.9.9. The overall antibiotic susceptibilities for all E coli bacteraemia (i.e. community and Trust acquired) identified at the Whiston Hospital Microbiology Laboratory in 2016-2017 are as below:



2.9.10. Given the increasing concern about rising incidence of Gram negative bacteraemia (specifically E coli bacteraemia) nationally as well as concern about rising levels of antibiotic resistance in this group of organism, in anticipation of the reduction targets likely to be introduced for E coli bacteraemia in 2017-2018, in January 2017, the Trust made the decision to include hospital acquired E coli bacteraemia in the formal root cause analysis review process for alert healthcare associated infections.

2.9.11. Lessons identified from RCA (for cases from January 2017 onwards):

- Document details urinary catheters on UCAM chart (at insertion and of monitoring at least once per shift);
- Adhere to Trust Antibiotic Policy and review previous positive microbiology when prescribing any antibiotic. Trimethoprim is not an appropriate first line empirical treatment of urinary tract infection due to high levels of resistance;
- Take blood cultures in a timely manner (and whenever possible before starting antibiotics) in patients with sepsis: Follow Trust Blood Culture Policy including checking the correct patient identifiers before taking specimens.

2.10 Vancomycin-resistant enterococcus (VRE)

2.10.1. VRE is multi-drug-resistant enterococcus (usually Enterococcus faecalis or Enterococcus faecium). Enterococci live in intestines and on skin, usually without causing problems. But they can cause serious infections, especially in patients who are more vulnerable e.g. following surgery, multiple antibiotics, invasive devices etc. Infections include urinary tract infection, intra-abdominal infection and line infection.

2.10.2. As VRE are resistant to many antibiotics, these infections are more difficult to treat. Therefore ppatient's found to be colonised with these organisms are isolated to avoid transmission of infection.

2.10.3. There has been a nationwide increase in the number of patients with VRE. It has been postulated that this may be related to VRE in the food chain e.g. meat from animals exposed to antibiotics.

2.10.4. The proportion of isolates showing vancomycin resistance among all Enterococcus species from bacteraemia in England and Northern Ireland increased each year from 12% in 2012 to 17% in 2015 before decreasing to 15% in 2016.

2.10.5. In 2016-2017 9% of enterococcal isolates from blood cultures at STHK were resistant to vancomycin.

2.10.6. There were 4 outbreaks due to VRE in 2016-2017. 3 cases of Trust acquired VRE bacteraemia and 1 community acquired bacteraemia.

2.10.7. There were 62 hospital acquired cases of VRE (non-bacteraemia) most of which were asymptomatic colonisation detected on screening as well as 64 cases of community acquired non-bacteraemia cases of VRE.

2.10.8. VRE rectal screening (on admission and then weekly) was continued on 4D, 4E and 2A. In the absence of national guidance on extending VRE screening further, the HIPG agreed to continue with current practice with regards to VRE screening.

2.11 Carbapenemase-producing enterobacteriaceae (CPE)

2.11.1. CPE have similarities to ESBLs but with a wider range of effects on antibiotics – breaking down the carbapenem group of antibiotics.

2.11.2. In 2013, the DH issued guidance in the form of a toolkit9 and the Trust developed its own guidance initial guidance. The guidance has been reviewed in 2016 building on our learning experiences and those from other Trusts.

2.11.3. The guidance concentrates on prevention, isolation of high-risk individuals and screening being of particular.

2.11.4. There were no cases of CPE bacteraemia.

3. Outbreaks and Incidence of Periods of Increased Incidence (PII)

3.1 There have been 4 periods of PII of infection on the wards.

3.2 The PIIs were monitored at the IPC Weekly Operational Group and actions were put in place as per national guidance.

3.3 There were 17 confirmed outbreaks in 2016/17:

Year/ Month	No of outbreaks	Organism	Ward/Unit and No of cases	No of bed days lost
2016				
Apr	1	Diarrhoea and vomiting – no pathogen identified	3E medical (5 patients)	0
May	0			
Jun	1	Multi drug resistant Pseudomonas aeruginosa (MDRP)	4D - Ongoing outbreak* since Nov 2015 (2 new cases). Extensive investigation and action plan including independent review by PH England.	16
Jul	0			
Aug	2	VRE	3D (3 patients)	0
		CDI	5D (2 patients)	0
Sep	2	CDI	3E Medical (2 patients)	0
		MRSA	1A (2 patients and 2 staff)	0
Oct	1	Diarrhoea and vomiting – no pathogen identified	5A (5 patients and 2 staff)	0
Nov	0			
Dec	1	Influenza A	Duffy Suite (3 patients)	20
2017				
Jan	3	Influenza A	3E Medical (3 patients)	0
		Influenza A	1E (3 patients)	0
		Influenza A	3C (2 patients)	0
Feb	3	Influenza A	Flu A - 1A (2 patients)	0
		Influenza A	3E Medical (3 patients - index case community acquired)	0
		VRE	1D (3 patients)	0
Mar	3	VRE	1B VRE (2 patients)	0
		VRE	2A VRE (3 patients)	0
		MRSA	1A (2 patients, 2 staff)	0
		MDRP*	4D (1 patient)	0
Total	**17**		**47 patients and 6 staff**	**36**

3.4 Multi drug resistant Pseudomonas aeruginosa (MDRP)

3.4.1. The management of the multi-drug resistant pseudomonas outbreak on the Mersey Regional Burns Unit involved significant multi-disciplinary input from not only the Trust IPCT and the ward clinical team but also other relevant colleagues within and outside of the Trust including from Medirest, Vinci Facilities and Public Health England (PHE).

3.4.2. The outbreak originated from the index case who was colonised with the strain on admission at the time of an inter-hospital transfer from abroad in November 2015. Following this, there were 3 further cases in burns patients up to the end of March 2016 and 4 other cases in 2016/17 (one of which is a cross transmission outside the Trust in a care home setting from a patient who was discharged who was known to be colonised with the organism prior to discharge).

3.4.3. The source is likely to be environmental contamination (including the specialised burns bath as well as water drains).

3.4.4. An extensive Level 2 STEIS investigation was carried out by the Trust and as well as comprehensive investigation by PHE which included a multi-disciplinary peer review visit which occurred in June 2016 to review the environment and practice in relevant areas of the Trust. An action plan resulting from the above was formulated and actioned.

4. Aseptic Non-touch Technique (ANTT)

4.1 Trust-wide ANTT continues to monitor compliance and for 2016-2017 is just below the trajectory of 85%. Actions are in place to improve this:

- ANTT: Each ward and department has a key trainer who is responsible for cascading training to all staff in their areas. Responsibility for training has been undertaken by the ANTT Nurse and assisted by the nominated lead from the IPCT and the Lead Nurse for IPC;

- ANTT practical competencies - since August 2015 these competencies are mandatory assessed by the Key trainers on an annual basis and are monitored by the ANTT Nurse, IPC lead nurse and IPC secretary;

- ANTT stickers, which are attached to the staff name badge, have been introduced since August 2016 to identify who has been assessed as competent in ANTT procedures and when their annual competency assessment is due;

- New cannulation packs, non-ported cannula, needle free devices and giving sets have been introduced in the Trust;

- IV Access and Therapy Group are held on a monthly basis and co-chaired by the Lead Nurse IPC and Medical Emergency Team Consultant Nurse. The aims of the group are to:

    - To ensure that the use of intravenous devices complies with best evidenced based practice and is cost effective within the Trust;

    - To facilitate and lead a Trust wide multidisciplinary approach to improvements in IV access and therapy;

- To provide a forum for collaboration across Directorates and specialities, monitoring of quality indicators and facilitate the development of Trust wide Intravenous guidelines.

5. Infection prevention and control policies/publications

5.1 No new IPC policies have been required.

5.2 The existing IPC policy and SOPs have been reviewed in line with Trust policy.

6. Education and training

6.1 Staff Education

All staff, including those employed by support services, must receive training in prevention and control of infection. Infection prevention and control is included in induction programmes for new staff, including support services. There is also a programme of on-going education for existing staff, including update of policies, feedback of audit results, with examples of good practice and action required to correct deficiencies, and Root Cause Analysis (RCA) reviews and lessons learned from the process and findings. Records are kept of attendance of all staff who attend infection prevention and control training/teaching programmes.

6.1.1. Training Sessions/Courses

- Trust Induction;
- Infection Prevention and Control Mandatory Update;
- The IPCT also provide training sessions on the Band 5 and HCA rolling education programme;
- The IPCT also provide training for Student, Cadet and Bank Nurses;
- The Team also provide additional ad hoc education sessions held in seminar rooms in main hospital building. These sessions address current HCAI problems identified within the Trust. Topics have included MRSA, CDI and CPE;
- FFP3 Face Fit testing The IPCT have face fit tested those staff required to wear FFP3 masks following a risk assessment. Face fit testing sessions have taken place in 2016-2017.

6.1.2. Link Personnel Programme

Link personnel meetings were held bi-monthly. An education session, usually from a guest speaker is incorporated into the meeting. Numerous topics were covered, including hand hygiene, CDI, MRSA, CPE, ANTT etc. In addition the link personnel have been encouraged to continue to undertake their own ward audits. New audit Indicators were introduced in January 2017 to address specific IPC concerns on the wards /departments.

6.1.3. Hand hygiene

The Trust continues to strongly promote optimal hand hygiene practices. Covert surveillance from outside companies continued on an annual basis. Wards, Matrons and Link personnel are also encouraged to audit each other.

Compliance with “bare below the elbows" dress code is continually monitored by the IPCT, Matrons and Senior Management.

Monthly observational audits are conducted of hand-washing to determine compliance with the Infection Prevention and Control Manual Hand Decontamination Policy.

6.1.4. Infection Prevention and Control Quiz

An interactive, locally-developed (jointly with IT) quiz is available http://iicquiz.shk.nhs.uk/ on the infection prevention and control intranet website under Infection prevention and control training section. There is instant feedback on the results of each question and a score provided at the end of each section. The questions are devised to get across key messages in infection prevention and control.

6.1.5. Training Activities for Infection Prevention and Control Specialists

The IPCT have attended national meetings, eg Infection Prevention Society (IPS), ANTT and various meetings/study days throughout the year, including meetings of North West Infection prevention and control Group (NORWIC).

7. Information Technology

7.1 The ICNet NG electronic infection prevention surveillance and case management system was implemented in December 2014 which has enabled the IPCT to review and manage a much broader range of cases in a timely and time efficient manner.

7.2 In 2016, ICNet NG was successfully upgraded to version 7.4 which will strengthen the surveillance utility within the software in relation patient and ward specific audit.

7.3 Due to the current delay in the GE Opera Theatre Management System implementation, the expected interface with that system and ICNet had been on hold however although Opera is now live. However, Informatics Department has identified that there is no funding to configure the Opera-ICNet interface from an Opera point of view (although there is funding available to configure the ICNet side of this interface). Therefore the ICNet-Opera interface has been shelved for now pending launch of the electronic patient record (EPR) in 2018 which may be able to support some of the functionality required for surgical site infection surveillance.

7.4 Patientrack electronic Bristol Stool Chart (BSC) and CPE assessments.

7.4.1 Over the last 18 months, work has been carried out by the IPCT to support the incorporation of the BSC and CPE risk/screening assessments onto the Patientrack system which records electronic patient observations within the Trust for inpatients.

7.4.2 It is anticipated that by making the forms electronic with automated/algorithm based scheduling and advisory prompts for staff will improve reliability of documentation and aid correct and timely patient management. The forms are expected to be launched in the latter half of 2017 after development and testing have been completed.

8. Audits and Surveillance

8.1 Surveillance: The Infection Prevention Team (IPCT) undertakes continuous surveillance of target organisms and alert conditions. Patients with pathogenic organisms or specific infections, which could spread, are identified from microbiology reports or from notifications by ward staff. The IPCT advises on the appropriate use of infection control precautions for each case and monitors overall trends.

8.2 Audits

8.2.1 Environmental audits using the IPS audit tools are carried out unannounced by the IP&C Practitioners and where possible accompanied by a member of departmental staff.

8.2.2 There is an extensive IPC Audit plan in place which includes audits undertaken by the clinical staff on their wards and also audits undertaken by the IPC team. The results are feedback to the Divisions on a monthly basis.

8.2.3 Monthly ward audits continue and continue to demonstrate good compliance. However some of that compliance can be questioned due to bias.

8.2.4 Audits by Infection Prevention and Control Team

The following annual Trust-wide audits were carried out by the IPCT:

- Sharps audit – February 2017;
- Peripheral cannula (PIVC) trust wide audit – May 2016 then monthly;
- Isolation audit – December 2016, during winter period daily side room audit to support patient flows and timeliness of isolation ;
- Leaflet audit – Sept and Nov 2016;
- UCAM audit – November 2016.

In addition, the following audits were carried out monthly by the IPCT:

- Commodes audit;

- Mattresses audit - Mattress audits are completed in all areas in the Trust. The audit examines cleanliness and mattress integrity this is led by the tissue viability team and supported by IPCT. There is a system in place for the provision and storage of replacement mattresses across the Trust. The IPC team work with the external supplier to ensure compliance with standards.

- MRSA screening compliance.

- Hand Hygiene Audits and Compliance - Compliance rate varies for 80-100%.

8.3 Mandatory Surgical Site Infection Surveillance (SSI).

8.4 PHE requires surveillance to be performed for at least one type of procedure (total hip replacement, hip hemiarthroplasty, total knee replacement and open reduction of long bone fracture) for at least one quarter of the year.

8.5 Mandatory surveillance covers the period up to discharge or 30 days following the procedure, whichever comes first. Additionally with surgery where a device is inserted follow-up is required after 12 months.

8.6 A summary of the infections of total hip and knee replacements and actions completed by the multi-disciplinary team (Orthopaedics, Infection Prevention and Control, Theatres, Tissue Viability and Pharmacy).

8.7 2015/16 data indicated that:

- There were 108 Hip operations performed of which 4 infections were noted (3.7% compared to 1.1% national average);
- There were 183 Knee replacements completed of which 5 infections were reported (2.7% compared to 1.5% national average);

8.8 April 2016 – March 2017 data indicates:

	STHK	National
Hips 327/4 infections	1.2%	1.1%
Knees 486/9 infections	1.9%	1.5%

We are still above the national in hip replacement infections by 0.01%.

8.9 Actions completed:

- RCA documentation has been revised to include the number of points taken from NICE guidance and One-Togetherness Toolkit;
- To ensure a proper senior attendance, regular root cause analysis meetings now conducted in the Executive Boardrooms every month which is attended by the Consultant Orthopaedic Surgeons, Microbiologist, Ward Team and Infection Control Team;
- Audit on Antibiotic prescription and delivery for total joint replacements performed and findings presented in the Audit Meeting.

9. Antimicrobial Stewardship

9.1 Antibiotic Management Group (AMG) – the AMG meets and reviews all aspects of antimicrobial use throughout the Trust. The antimicrobial management team (AMT) includes antimicrobial pharmacists and clinical microbiologist(s) who are all members of the AMG. The team update and maintain the Trust's antimicrobial formulary, the stewardship strategy/policy and raise agenda items to be discussed at the AMG.

9.2 The AMG reports to Drug and Therapeutic Group (DTG) and Hospital Infection Prevention Committee (HIPG).

9.3 Following the launch of the Trust interactive antibiotic guideline on the intranet site in early 2013 the site has continued to be developed. The guideline has been hyperlinked to information sources such as online British National Formulary (BNF) and drug company data sheets (SPC).

9.4 The antibiotic policy has been updated regularly in 2016/17 in line with updated national guidance and local requirements and is due a full review in August 2018. The intranet base

has been update in 2017 and will hopefully be launched in mid-2017 improve the speed and ease of access to policies and guidelines including the antibiotic guideline.

9.5 In 2016, members of the Antimicrobial Management Team (AMT) were major contributors to reviewing and writing the Pan Mersey community antibiotic prescribing guideline for GPs. These guidelines are continually circulated through GPs.

9.6 The Mersey Micro smart device app with MHRA approved calculators continued to be updated and developed 2016 by the AMT.

9.7 Trust Clinical and Quality Strategy Action plan and also the Nursing and Midwifery Strategy were launched in 2014 continues to run till 2018. The goal is to reduce Hospital Acquired Infections (HAIs) and promote a culture of safety throughout the Trust. The strategy is on the intranet under antimicrobial stewardship strategy.

9.8 Throughout 2016 the AMT continued to respond to NICE guidance 15 updates – Antimicrobial stewardship: systems and processes for effective antimicrobial use. The goal is to implement this action plan over 2016 period resources allowing.

9.9 A new antimicrobial pharmacist came into post in late 2016.

9.10 In 2016 the Trust has participated in the national CQUIN targets for both sepsis and total antibiotic consumption per 1000 inpatient admissions.

9.11 The AMT continued in 2016 on General Surgical, Orthopaedics wards and Acute Medical Unit (AMU) with engagement from ward clinical teams.

9.12 The Trust-wide antibiotics point prevalence audits continued in 2016. Audits continued to include completion of course length/review date endorsement, documentation of antibiotic indication, % missed doses and due to Trust CQUIN targets a senior practitioner review of patients antibiotic therapy was added within the first 72 hours of treatment.

9.13 All data was analysed trust wide and subdivided into medical and surgical directorates.

9.14 The data findings indicated that there was:

- 97% compliance documented review within 72 hours (adherence to Trust policy/microbiology advice being 92%);
- Documentation of indication was 99%.

9.15 Throughout 2016 smaller antibiotic point prevalence audits were conducted and reported on a monthly basis as a part of the Trust's infection prevention and control performance framework and submitted to the CCGs as part of the CQUIN program contract variation.

9.16 OPAT (outpatient parenteral antibiotic therapy) services for Halton and St. Helens continued to grow in 2016. Utilising the OPAT service activity in 2016 has increased on the 2015 figures.

9.17 The Trust saved over 5700 bed days compared to 4912 bed days in 2015. This is a potentially saving of in excess of £1.7 million which is an increase on £1.4million in 2015. The number of patient referrals has also continued to rise from 52 patients in 2010 to 373 patients in 2016.

9.18 The successful completion rate of therapy under OPAT to the desired outcome over 7 years' audits has continued to be over 90%. Over this period more than 1300 patients have been referred to OPAT with more than 22,300 bed days saved.

9.19 The landscape for OPAT therapy has seen considerable shifts in both types of patient referrals and therapies utilised. More intravenous (IV) ceftriaxone and teicoplanin have been used. In addition more patients have been referred for OPAT as part of ambulatory care services and also admission avoidance directly from clinics.

9.20 The Consultant Microbiologists have continued to be integral to the Antimicrobial Management Team (AMT) and developing and maintaining the interactive antibiotics guideline and developing the Mersey Micro application. AMT ward rounds will continue to expand resources allowing focusing on areas of high use antibiotics, increased rates of healthcare associated infection or areas that were performing poorly in point prevalence audits.

9.21 In 2016, the AMT continued to contributing to the Executive Root Cause Analysis Review Panels for significant HCAIs, specifically reviewing the use and appropriateness of antimicrobial therapy.

9.22 In 2016 the Trust took part in the European Antibiotic Awareness Day (EAAD). This included an educational stand for both staff and patients to come and meet the antimicrobial management team. There were posters of Trust related initiatives such as antimicrobial resistance, Trust initiatives including the Mersey Micro app, antibiotic guardianship was promoted and education resources from Public Health England (PHE) distributed with the goal to promote good antimicrobial stewardship. The stand was attended by a high number of both staff and patients and was advertised on global emails and team brief. There has also been a good following on social media sites such as Facebook and Twitter.

9.23 The national CQUIN for AMR and Sepsis was published in March 2016. The CQUIN is in two parts. Part one asks the Trust to report the number of Day 3 antibiotic reviews (50 prescriptions each month).

9.24 This data is already reviewed, and will become part of the monthly point prevalence audit. Part two will be reporting antibiotic consumption data with the aim of reducing total antibiotics, IV Tazocin and carbapenem defined daily dose (DDD's)/1000 admissions by 1%.

9.25 This Trust achieved the AMR and Sepsis CQUIN in 2016/17.

10. Health, Work and Wellbeing (including Sharps)

10.1 The Health, Work and Well-being (HWWB) provides pre-employment health assessments and assessment of immunity and provides vaccinations for new staff. There is also a recall system in place in which staff are recalled (if appropriate) for vaccinations when due to ensure that they are kept up to date and our compliant.

10.2 The service has also supported advice and treatment in the event of outbreaks or incidents requiring staff screening or treatment. The Trust Health & Wellbeing Department report monthly to the IPCC including vaccination updates.

10.3 Staff have historically been screened for TB, Hepatitis B and Rubella immunity. Guidance on measles, chicken pox, HIV and hepatitis C have been incorporated for all 'new starters' and a catch up exercise is in place for staff already employed. The IPCC supports the Health & Wellbeing Team in ensuring that workers in designated areas have appropriate vaccinations and immunity.

10.4 The Occupational Health Service leads the seasonal flu vaccination campaign. The flu campaign commenced September 2016 with the aim of completing the campaign by the end February 2017.

10.5 Key Achievements:

- 82% of all frontline staff had the flu vaccine;
- All new staff are screened at pre-employment;
- Vaccines offered to all new starters before commencement of new post;
- Health Work and well Being Team support to any outbreaks that may occur in wards/departments;
- Sharp safety devices have been introduced to the Trust to reduce the number of sharps incidence;
- Provision of one to one education of staff e.g. dermatological issues;
- Education is given regarding the safe disposal of sharps to reduce injury;
- Support and follow up of staff with blood borne diseases;
- Introduction of new Policy for the Management of Exposure to Body Fluids and Sharps Injury for STHK Trust Employees.

Actions taken to overcome the challenges and issues To secure funding for sharp safety devices:

- A reduced supply of BCG vaccine and healthcare workers are low on the priority list for the BCG under PHE Guidance;
- To adopt new ways of working to free HWWB staff to support outbreaks;
- To ensure that staff whose Tb immunity is not known have been given information so that they do not put themselves at risk. Managers are informed accordingly.

11. Decontamination

11.1 Decontamination audits are organised and carried out by the Decontamination Manager/ Trust lead for Decontamination in accordance with an annual work plan which is agreed by the Decontamination Group. The results are discussed at the Trusts Decontamination Group, which turn reports to the IPC Group.

11.2 All decontamination and sterilisation of reusable medical devices is carried out off site by the Trust sterile services partner (Synergy Health PLC).

11.3 Central decontamination and high level disinfection of flexible endoscopes however there are a small satellite units who operate to local SOP's and are audited bi-annually as part of the decontamination managers work plan.

11.4 Key Achievements:

- The interim Endoscope Decontamination Unit at St Helens Hospital was opened in May 2016 giving the much needed extra capacity to allow full use of three Endoscopy treatment rooms and to give some reassurance against failure of the now aged equipment in the current units at St Helens site;

- All Automatic endoscope reprocesses have undergone full maintenance, validation and microbiological testing on a quarterly and annual basis throughout the past year to current guidelines;

- The Endoscope Decontamination departments have undergone a change in structure during the past year. A quality manager has been appointed and under the new structure we now have a supervisor at each site and 3 senior technicians across both sites. This will ensure a quality regime is in operation for the service;

- A review of the pre-dosing of the water used for endoscope decontamination at St Helens has taken place and a new system has been recently installed to improve the quality of the water. A microbiological improvement in water quality has been observed since this installation.

12. Estates, Facilities and Waste Management

12.1 Facilities performance management, estates, pest control, utilities, waste management, domestic services, catering, linen and laundry, portering, car parking security and helpdesk services.

12.2 The teams have continued to comply with the required legislation, service specifications and develop all services in line with the ever changing requirements of today's healthcare environments.

12.3 The Estates and Facilities Department ensured that the IPCT have been regularly involved, consulted and engaged in the planning stage of numerous work projects. This has enabled IPC expertise to actively influence improvements to IPC in the built environment.

12.4 IPC are asked for input on two broad aspects of work:

- Planning – IPC are asked for input in reviewing plans to ensure that any refurbishments or new builds offer the best facilities to reduce the risk of infections in line with any relevant Health Building Notes and Health Technical Memorandum; and

- Operation – IPC are asked to review methods to reduce the risk of any infections presented by the actual refurbishment/build process.

12.5 Key infection prevention and control achievements:

- Excellent PLACE scores for both 2016 and 2017 inspections with condition and appearance, infection prevention and control and cleaning categories all achieving 100% compliance in the 2017 inspection;

- Implemented specific cleaning schedules and in-depth work instructions for the regional burns unit and critical care;

- Conducted ward redesign works with minimal impact to the ward environment;

- Achieved excellent food hygiene ratings on both hospital sites.

13. Water Safety

13.1 The Water Safety Group continues to refine systems to ensure water safety at ward level, in particular within augmented care areas.

13.2 The Estates team provided bespoke training for clinical teams to monitor little used outlets and identifying non-compliance with systems.

13.3 Key Achievements:

- Trust Water Safety Plan drafted and agreed;

- Six monthly sampling for Pseudomonas aeruginosa in augmented care areas as per HTM 0401 on-going according to rolling program with predominantly negative results since the installation of Abulox (halogen based biocide system) in 2015;

- Installation of signs about appropriate use of hand wash sinks in all relevant sinks on augment care areas;

- Assessing the Water Logic 3 UV purified water cooler system including a trial at Outpatients Department Whiston Hospital to review suitability for Trust-wide implementation (except in augmented care areas).

Glossary of abbreviations

AMT	Antibiotic Management Team
ANTT	Aseptic non-touch technique
AQ	Advancing Quality
BBE	Bare below the elbow
CAP	Community-acquired pneumonia
CCG	Clinical commissioning group
CDI	Clostridium difficile infection
CQC	Care Quality Commission
CVAT	Central Venous Access Assessment Tool
DDD	Defined daily dose
DOH	Department of Health
DTC	Drugs and Therapeutics Committee
ED	Emergency Department
HII	High impact intervention
HIPG	Hospital Infection Prevention Group
IPCT	Infection Prevention and Control Team
IV	Intravenous
MRSA	Meticillin-resistant Staphylococcus aureus
MSSA	Meticillin-sensitive Staphylococcus aureus
MET	Medical Emergency Team
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
OPAT	Outpatient parenteral antibiotic therapy
PGD	Patient Group Directive
PPE	Personal protective equipment
PFI	Private Finance Initiative
PLACE	Patient-led assessments of the care environment
PPI	Proton pump inhibitor
RCA	Root cause analysis
SSI	Surgical site infection
TTFD	Time to first antibiotic dose
UCAM	Urinary catheter assessment and monitoring
VIP	Visual infusion phlebitis
WHO	World Health Organisation

Appendix 1 – Infection Prevention and Control Workplan 2017/18

See overleaf

Appendix 1. Infection Prevention and Control work plan 2017/2018

St Helens and Knowsley Teaching Hospitals NHS Trust

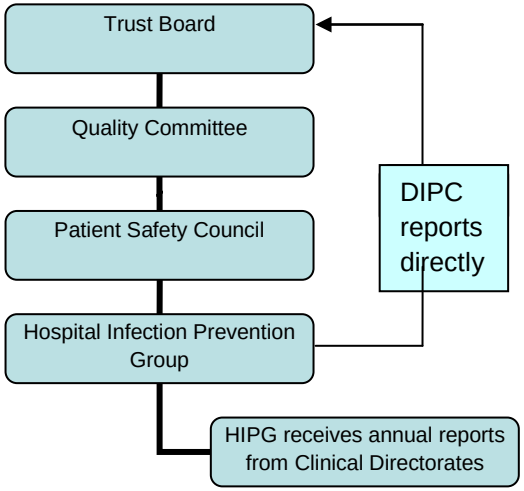
Infection Prevention and Control Annual Work Plan 2017-2018

The table below is the 'Code of Practice' for all providers of healthcare and adult social care on the prevention of infections under The Health and Social Care Act 2008 (revised 2015). This sets out the 10 criteria against which a registered provider will be judged on how it complies with the registration requirements related to infection prevention. This work programme below has been linked to these codes and to the Trust's Objectives 2016-2017.

Executive Led DIPC

Compliance criterion	What the registered provider will need to demonstrate
1.	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2.	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3.	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4.	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.
5.	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of passing on the infection to other people.
6.	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7.	Provide or secure adequate isolation facilities.
8.	Secure adequate access to laboratory support as appropriate.
9.	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10.	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Infection Prevention and Control Work Programme 2017-18.

IPC Code and Trust Objectives	Plan and Priority Activities 2017/18	Lead(s)	Deliverables	Q1	Q2	Q3	Q4
IPC Code:1, 3, 4, 8 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**1. IPC Staffing and reporting structure** 	**DONM&G /DIPC Infection prevention consultant**	**To ensure staffing with in establishment**				

	Hospital Infection Prevention Group (HIPG)					
	The IPC reports to the Board via the HIPG. The HIPG meets 6 times per year. The reporting line to the Trust Board is shown below. The Terms of Reference were reviewed and amended in February 2017.					
IPC Code:1, 3, 4, and 5. **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**2. Surveillance**					
	Alert organisms	Microbiology and IPCT	To maintain and alert Trust staff to any potential risks from pathogenic organisms. To provide IPC advice and support in order to minimise the risks to patients, staff and visitors.			
	Mandatory Reporting It is a mandatory requirement for the Trust to report a variety of pathogenic organisms/infections to PHE for monitoring purposes.					
	MRSA/ MSSA/VRE/E Coli/Klebsiella/Pseudomonas aeruginosa Bacteraemia	Microbiology, IPCT and Executive Review Panel , AMT	To identify, communicate and instigate investigations by the clinical teams for all Trust apportioned cases. All cases to be reviewed under the Post Infect Review (PIR) and Root Cause Analysis (RCA) processes, through the Executive Review Panel and to disseminate lessons learned for the process.			
	Clostridium difficile/PTP	Microbiology and IPCT	To identify, communicate and instigate investigations by the			

			clinical teams for all Trust apportioned cases. All cases to be reviewed under the Post Infect Review (PIR) and Root Cause Analysis (RCA) processes, through the Executive Review Panel and to disseminate lessons learned for the process. The IPCT in conjunction with Microbiology will undertake a weekly CDI ward round to review all active CDI and specifically identified PTP cases within the Trust.				
	CPE	Microbiology and IPCT	To monitor the screening of identified risk patients (as per Trust policy) and to ensure that appropriate action is taken. To identify, communicate and instigate appropriate actions when the organism is identified.				
	Matching Michigan – ICU (4E)	ICU lead nurse	To include data collected by the ICU team in the IPC Monthly report. To discuss data and trends at the HIPG. To monitor results and instigate investigation if required.				
	Surgical Site Investigation (SSI) for	Microbiology,	To support the investigation and				

	Orthopaedics	Orthopaedic Team and Executive Review Panel	presentation of incidences of SSI through the RCA process at the Executive Review Panel meetings and to support the dissemination of lessons learned to the relevant staff. To collect and submit data for SSIs in orthopaedics. To disseminate reports to the relevant clinical staff. To include data and reporting in IPC Monthly Report. To support the orthopaedic team to take more ownership of their SSI data – through attendance at the SSI teaching sessions at Colindale London.				
	Multi Drug Resistant Pseudomonas (MDRP)	Microbiology and IPCT / Burns clinical lead	To report and investigate all incidences of MDRP. To monitor incidences of MDRP and to identify recent outbreak strain through typing as deemed necessary after investigation.				
IPC Code:1, 2, 5, 6 and 9 **Trust Objectives:** Care, Safety,	**3. Hand Decontamination**						
	Introduction and dissemination of new hand hygiene posters for all clinical areas to replace existing poster	Lead Infection Prevention and Control (IPC)	Development of new hand hygiene poster incorporating further steps of hand hygiene				

Pathways, Systems and Communication			New Hand Hygiene Posters to be produced by Diversey				
			New Hand Hygiene Posters to be distributed and displayed by Medirest				
	Piloting and introduction of new hand hygiene audit tool incorporating glove usage to replace existing hhot tool	Lead IPC Nurse and IPCT (	Piloting of new hand hygiene tool by Assistant Practitioner and Audit and Surveillance Assistant				
			Introduction of new hand hygiene audit tool to IPCT				
			Dissemination of new hand hygiene audit tool to link personnel through meetings and training				
			Introduction of new hand hygiene audit tool as part of monthly audit indicators				
IPC Code:1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and	**4. Policies and patient information leaflets**	DIPC	To ensure audit programme for policy and patient leaflets review completed within the agreed time frames .				

Communication							
	System to be devised and implemented to remind nominated policy reviewers of when Policies are due.	IPC audit	Electronic system in place to inform nominated policy reviewer of timing of policy review.				
	To provide advice and support on policies where IPC is an integral component.	IPCT	Participation in updating relevant IPC related policies.				
	To review and update current patient leaflets. To devise further patient leaflets as required.	IPCT					
IPC Code:1, 2, 4, 5 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**5. ANTT/ Intravascular Access and Therapy.**						
	Monitor Trust wide compliance and increase compliance rates.	ANTT lead nurse	Provide updated compliance figures to the relevant care groups and for HIPG.				
	Provide Key Trainer training	Lead IPC Nurse and ANTT lead	Key Trainer Training half day sessions are provided 4 times per year. The aim would be to increase this number to 6 times per year. However, this is dependent on facilitator and room availability. Extra sessions are provided as required.				
	To provide advisory and support role for vascular access and therapy related issues.	Lead IPC Nurse. Nurse Consultant MET/IV access lead	Lead IPC nurse to Co-chair along with Nurse Consultant ICU, the Intravenous Access				

	Monitor and communicate all cases vascular access device related infections	Lead IPC Nurse Nurse Consultant MET/IV access lead	and Therapy Group – monthly. To provide IPC expert advice on matters relating to vascular access and therapy. To identify, communicate and instigate investigations by the clinical teams for PIVC and CVC line infections				
IPC Code:1, 2, 3, 4, 5, 6, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**6. Training**						
	To ensure that IPC staff are kept updated with IPC evidence based practice.	DIPC and Lead IPC Nurse	To ensure that a member of IPCT attends the North West Infection Prevention Society (IPS) meetings at least once per year. To regularly attend local HCAI whole health economy meetings. To attend local and National IPC/relevant conferences as the service will allow.				
	To ensure that Trust staff are kept updated with IPC evidence based						

	practice: **Please see plan below:**						
	Induction	IPCT	At least twice per month				
	Mandatory	IPCT	For all staff annually, at least 2-3 times weekly				
	Preceptorship	IPCT Antimicrobial Management Pharmacists	6 times per year				
	ANTT Key Trainers	Lead Nurse IPC	4 x per year				
	Line Care Course	Lead Nurse IPC	6 x per year				
	Link Personnel	IPCT	Bi-monthly				
	Fit Testing Key Trainers	IPCT	Monthly				
	IPC antibiotic prescribing	Antimicrobial Management Pharmacists/ Consultant Microbiologists	AMU junior doctor teaching; Surgical junior doctor teaching (both minimum 2 times per year); Fourth year medical student teaching (6 times per year); all medical staff inductions; Grand Rounds as required; pharmacist clinical meetings at least updates every month and clinical educations sessions twice per year Pharmacist teaching for FY1 and FY2 junior doctor cohorts each at least twice per year				
	Ad hoc training to include: Volunteer Student Cadet Fundamental Training	IPCT	As required, 2 – 3 times a year				
IPC Code: 1, 2, 3, 4, 5, 6, 7, 9 and 10	**7. Audit**						

Trust Objectives: Care, Safety, Pathways, Systems and Communication							
	To provide assurance to the Board and relevant committees of adherence to high quality IPC practices. All findings are communicated to the relevant clinical staff and reported via the IPC Monthly Report and the HIPG. All lessons learnt are disseminated to the relevant staff and other agencies as appropriate in a timely manner.	IPCT: Lead Nurse,					
	2 x IPC Specialist Nurses, IPC Nurse and Assistant Practitioner follow the audit plan that was revised and commenced in January 2017. Audit programme revised annually.  INFECTION CONTROL AUDIT PRC	IPCT					
	Further audits are undertaken by the IPCT as set out in the work plan and as the service requires	IPCT Lead Nurse,					
	Wards and identified departments	IPCT Lead Nurse,	Audits undertaken on an annual basis and are re-audited/ re-visited dependant on				

			concerns/scores.				
	Peripheral Intravenous Vascular Catheters (PIVC) and Central Vascular Catheters (CVC). Visual Infusion Phlebitis (VIP) Scoring	IPCT Matrons and Link Personnel	Annually – reported to the HIPG and Clinical Leads. Monthly reporting via IPC Audit Indicators.				
	Urinary Catheters	IPCT Lead Nurse, Continence specialist Nurse Matrons and Link Personnel	Annually – reported to the HIPG and Clinical Leads. Monthly reporting via IPC Audit Indicators.				
	Isolation	Audit nurse IPC	Quarterly				
	MRSA Pathway	Audit nurse IPC	Quarterly				
	CPE assessment and screening.	Infection control Dr EMEWs lead	To be reported via EMEWs when system goes live.				
	Bristol Stool Chart	Audit nurse IPC EMEWs lead	Quarterly audits to be undertaken and reported to matrons, ward managers and Quality leads via e mail until EMEWs system goes live. To be reported via EMEWs when system goes live.				
	Blood Culture Contamination Rates	Infection control Dr Audit nurse IPC	ED rates reported weekly and communicated to Clinical Leads via e mail. Trust rates reported on a monthly basis via IPC Monthly report to clinical Leads.				

	Mattresses	IPC	Mattresses on the warded areas are audited once a month. Air mattress cleaning (externally managed) is audited on a bi-annual basis at Drive Wigan				
IPC Code:1, 3, 4, and 5 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**8. Antibiotic Prescribing**						
	Participate in CQUIN program for antimicrobial resistance strategies	AMT	Reported monthly to executive leads and quarterly to HIPG and DTG				
	Undertake AMT ward rounds on AMU, general surgical and orthopaedic wards	AMT	Immediate feedback to be provided on wards rounds to staff or twice yearly to directorate, HIPG and DTG				
	Twice yearly antibiotic point prevalence audits focusing on policy adherence, missed doses, review of antibiotics within 72 hours of commencement	AMT	To be circulated Trust wide twice yearly				
	Participate in OPAT audit	AMT	To be circulated Trust wide annually				
	Presentation of antimicrobial expenditure information	AMT	Quarterly to HIPG and DTG				
IPC Code: 1, 2, 3, 4, 5, 6, 7, 9, and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**9. Communications**						
	IPC Monthly Report	IPCT and AMT	New unified IPC monthly report, combining monthly reports for the Medical and nursing staff.				
	Communication with the Whole Health Economy	IPCT Lead Nurse,	To attend HCAI/IPC meetings across the local area.				
	Communication with other Trusts and agencies such as Public Health England (PHE)	IPCT Lead Nurse,	To attend local meetings. Communication and information gathering with other Trusts and agencies to assist in IPC investigations.				
	Trust Intranet	IPCT Lead Nurse,	To maintain and update the Trust Intranet site with relevant and up				

			to date information for Trust staff.				
	Mersey Micro smart device app	AMT and Infection control Dr	To maintain and update the Mersey Micro app in line with changes to Trust antibiotic policy.				
	Administration	IPC Admin	To provide administrative support to the IPCT to include: Co-ordination of relevant IPC Meetings Diary management Taking and distribution of minutes for relevant IPC meetings Co-ordination of IPC documentation				
IPC Code: 1, 3, 4, 5, 8, and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**10. Information Technology** To interface with new technology, including Pharmacy alerts.						
	EMEWS	IPCT and Infection control Dr	To introduce CPE screening and Bristol Stool Charts onto the EMEWs system.				
	ICNet	IPCT Lead Nurse, and Infection control Dr	To continue to work with the ICNet system. To introduce further functions to the system as they become available via ICNet – next version (1.5) - which includes audit and surveillance. To maintain ICNet administration				
	Electronic prescribing	Infection control Dr Lead pharmacist	To help develop the functionality of the JAC 2016 EPMA system				
	Develop e-learning package for appropriate antimicrobial prescribing	AMT	To introduce new eLearning packages in 2017-18 into ESR				

			for IPC and antibiotic prescribing for staff development				
	Interactive Trust antibiotic policies	AMT	To develop and maintain Trust intranet antibiotic policy and Mersey Micro app				
IPC Code:1, 2, 3, 4, 5,6, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**11. IPC Engagement at Ward and Department Level** To continue to communicate, advise, support and educate all staff within the Trust on IPC related issues.						
	• Link Personnel	IPCT	To continue to communicate, support, advise and educate IPC link personnel via Bi-monthly meetings and ad hoc training. To ensure that link personnel are aware of the responsibilities. To ensure that link personnel undertake the monthly audit indicators on wards and departments in a timely manner and that results are sent to the IPCT.				
	• Work collaboratively with ward and department staff.	IPCT	To identify IPC issues in a timely manner and supporting staff in resolving these issues. A specific member of the IPCT (as identified in the audit programme) will support staff in				

		Lead IPC Nurse	that area on IPC issues. To Co-chair the Estates and Facilities IPC meetings – meetings attended by the staff from estates and facilities and matrons.				
IPC Code: 1, 2, 3, 4, 5, 6, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**12. Interface with relevant groups** IPC to attend and provide expert opinion for topics related to IPC. Escalate issues to DIPC as necessary. To review new equipment/ environmental utilisation						
	Patient Safety Council	Lead Nurse or ICN to deputise	To provide on a monthly basis an update of IPC surveillance and safety issues via a monthly report and attendance at Patient Safety Council.				
	Decontamination	Infection control Dr Lead IPC Nurse	To attend quarterly scheduled decontamination meetings. To provide expert advice and support as required.				
	Waste	IPC	To attend scheduled meetings. To provide expert advice and support as required.				
	Water Safety	Infection control Dr	To attend meetings as required. To provide expert advice and support as required.				
	Built Environment	IPCT Infection control Dr	For Lead nurse to co-chair Estates and Facilities IPC Meetings along with a nominated Matron from the care groups.				

			To attend further required meetings as required.				
	Estates and Facilities	IPCT	To provide expert advice and support as required.				
	Health Work and Wellbeing	IPCT	To provide expert advice and support as required. To attend and represent IPC at Trust Sharps meetings.				
	Medical devices	IPC	To provide expert advice and support as required				
	Health and Safety	Lead Nurse IPC,	To provide expert advice and support as required				
	Emergency planning	DIPC	To provide expert advice and support as required				
	Care group governance meetings	Lead Nurse HOQ	To provide expert advice and support as required				
	Trust Team Brief	Infection control Dr DIPC	To attend and disseminate information given out at Trust Team Brief				
	Ad hoc meetings	All as relevant	To provide expert advice and support as required				

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)26

Title of paper: Approval of Budget Plans 2018/19

Purpose: For the Trust Board to approve the Budget Plan for 2018/19

Summary:
The purpose of this paper is seek approval of the Budget Plan for 2018/19 from the Trust Board

The NHSI planning guidance for 2018/19 was issued on 2nd February and the draft plan was submitted on 8th March 2018, with the final plan due on 30th April 2018.

All iterations of the Trust budget will be reviewed and approved by the Trust Board and the final budget will be submitted to NSHI in line with the published timetable and will be consistent with the technical planning guidance.

The Trust has signed Contracts with both CCG and NHSE Commissioners which covered the two year period from April 2017 to March 2019 but will be subject to variation to incorporate the Forecast outturn for 2017/18. Any material change as a result of contractual negotiations will be reflected in the final plan or noted in the F&P Committee.

This paper summarises 3 financial plan "statements":-

- Indicative income and expenditure plans, noting CIP to achieve control total deficit of £1.8m.
- Indicative CIP plans, with a level of unidentified CIPs still outstanding.
- Agreed capital programme within resource limits.

The paper also summarises key risks with relevant RAG ratings in achieving these proposed plans.

This Trust has not concluded contract variation discussions at this stage which may impact on some of the assumptions within this plan. Main one being demand/growth highlighted within the plan as this is directly impacted by CCG delivery of their QIPP schemes.

This plan has been reviewed by the F&P committee who proposed it is accepted, noting the risks in achieving it but also the ramifications if not.

Corporate objectives met or risks addressed: Financial Sustainability

Financial implications: Achievement of Control Total

Stakeholders: Internal and external

Recommendation: For Decision

The Board are asked to approved the proposed budget plan, which would confirm our acceptance of planning to achieve the control total.

Presenting officer: Nik Khashu Director of Finance and Information

Date of meeting: 28th March 2018

1. Introduction

This paper outlines the indicative Annual Plan for 2018/19 based on expected assumptions in the planning guidance to be issued by NHSI and the financial impact of identified changes to the Trust's cost base.

2. Bridge between 2017/18 Forecast outturn (M11) and 2018/19 Plan*

		Income	Expenditure	EBITDA	ITDA	Net S/(D)	Technical	Annual Plan Adj S / (D)
1	**2017/18 Forecast Outturn as at Month 11**	**377.147**	**-350.303**	**26.844**	**-19.627**	**7.217**	**-4.747**	**2.470**
2	Remove Non Recurrent support	-4.658	-3.878					**-8.536**
3	Impairments				-4.815		4.945	**0.130**
4	Removal of STF 2017/18	-5.106						**-5.106**
5	2018/19 National cost pressures		-6.600		-1.000			**-7.600**
6	2018/19 Local cost pressures		-3.100					**-3.100**
7	Executive Contingency		-1.000					**-1.000**
8	2018/19 Tariff Inflation	3.100						**3.100**
9	2018/19 Economy Risk Share	1.500						**1.500**
10	Impact of Non-Recurrent CIP in 2017/18		-2.686					**-2.686**
	Adj Surplus / (Deficit)	**371.983**	**-367.567**	**4.416**	***-25.442***	**-21.026**	***0.198***	**-20.828**
11	18/19 CIP **5.2%**	8.500	10.500					**19.000**
	Adj Surplus / (Deficit) excluding STF	**380.483**	**-357.067**	**4.416**	**-25.442**	**-21.026**	**0.198**	**-1.828**
12	***Provider Sustainability Funding 18/19***	*12.821*						***12.821***
	Annual Plan 2018/19 including STF (£10.993m surplus)	**393.304**	**-357.067**	**4.416**	**-25.442**	**-21.026**	**0.198**	**10.993**

****Revised Control Total was issued by NHSI on 6th February 2018***

Notes:

1. Forecast outturn as reported at month 11 (£2m behind our control total excluding STF)
2. Non Recurrent support includes Winter Funding, Balance Sheet and Reserves
4. Forecast achieved STF at month 11. Full STF value was worth £9.117m
5. National cost pressures - per planning Guidance 2.1% (Pay Award, Increments, Drugs, other non pay & capital charges)
6. Local cost pressures include PFI (RPI increase) £1m and CNST£2.1m
8. Tariff inflation is per Planning Guidance 2017/18
11. CIP is currently at 5.2% - growth at 2.7% and theatre productivity are expected to contribute £4.4m towards the £19m target.
12. Provider Sustainability Funding (STF) available for 2018/19

3. Contracting

The Trust agreed Contracts with both CCG and NHSE Commissioners for 2017/18 & 2018/19 on the 23rd December 2016, based on agreed principles covering (but not limited to):

- 2016/17 FOT Contract & Activity Baselines
- 2017/18 & 2018/19 Growth based on Commissioner STP price assumptions
- Baseline principles for the marginal rate activity threshold and readmissions
- Joint agreement to utilise the long stop and contract variation process
- CQUIN and Service specifications
- Local quality, SDIP and Information requirements
- Activity planning and Local price list assumptions

However release of contracting guidance in February 2018 has resulted in contract negotiation meetings taking place, to vary in material changes as a consequence of 2017/18 outturn compared to 2017/18 and growth assumptions. Negotiations are still ongoing and national timetable for sign off is scheduled for 23rd March 2018.

4. CIP

The Trust has an indicative cost improvement programme target of circa £19 million for 2018/19. This is in the region of 5% efficiency against its planned operating expenditure of

£368m, below is a high level summary of the programme areas (see paper FC(18)011 for further information).

Description	Logical CIP Value	% of Operating Expenditure
Pharmacy/Drugs	1.0	
Procurement/prices & volume	1.0	
Contribution from assumed growth (£4.5m) @ 30%	1.4	
Theatre & Productive Days (£4m income @ £1.0m cost)	3.0	
Outpatients Optimisation 5 days	1.0	
Corporate Services (Finance/HR/IT/Legal/Governance etc)	1.0	
Hard & Soft FM Services	0.5	
Clinical Support Services (direct access, growth, skill mix, contracts)	1.0	
Agency reduction to control total (£7.2m)	2.0	
Over Time	0.5	
Sickness / Annual Leave planning	0.5	
WLIs	0.5	
CNST Discount	0.3	
Sub Total	**13.7**	**4%**
System Transformation Opportunities	5.4	1%
Total	**19.0**	**5%**

5. Capital

The Trust's Capital Plan includes PFI lifecycle replacement costs, estimated finance lease renewals and an allowance set aside for new and replacement equipment. Bids for capital have been consolidated and there has been a meeting with the Director of Operations during February to agree prioritised projects for 2018/19. The agreed list will then be presented to the Executive Committee for approval, ahead of final budget submission to NHSI.
The draft Capital programme includes an indicative £1.5m for those prioritised schemes.

	2017/18 Outturn £m	2018/19 Plan £m
PFI and Finance Leases		
MES Lifecycle Replacement	3.0	2.73
Finance Leases	0.6	0.94
	3.6	3.67
Other		
Contingency	0.5	0.50
Technical Cap / Rev	0.5	0.50
Combined Heat & Power scheme	2.1	0.54
Donated Assets	0.1	0.00
Primary Care Streating Capital allocation	1.0	0.00
All other (to be determined for 2018/19)	1.5	1.50
	5.7	3.04
TOTAL EXPENDITURE	9.3	6.72

6. Risk

This budget is predicated on the assumptions built into the annual plan, namely:

Risk	Value	Rag Rating
Full achievement of our agreed CQUINs	c.£6.7m	Amber
Recurrent delivery of CIP requirement	£19.0m	Red
Delivery of our access & performance targets (STF)	£12.8m	Amber
Management of capital expenditure within resource limit	£6.72m	Green
No contractual penalties	c. £3m at 15/16 levels	Amber
Income Growth/Productivity delivered at 48% cost	£4.4m	Red

Outside of the income/expenditure risks noted above, cash is also a risk. Internally, if the Trust was unable to deliver its plan then there would be cash pressures. We also have cash risks from shared services we host and payment from other NHS Trusts.

The draft financial plans will mean that the Trust would achieve the following Use of Resources Rating Ratings:

Use of Resources Risk Rating	FOT 2017/18	Plan 2018/19
Capital Service Cover rating	3	3
Liquidity rating	3	3
I&E Margin rating	1	1
Variance from Control Total rating	1	2
Agency rating	3	3
Plan Risk Rating after overrides	2	2

7. Key Dates and Tasks

The final version of the plan for 2018/19 will be presented to the Trust Board for approval in April 2018.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)27

Title of paper: Annual Board Effectiveness Review

Purpose: To inform the Trust Board of the arrangements for the 2017/18 annual Board and Committee effectiveness review

Summary:

1. Each year, in line with best practice and good governance principles, the Trust undertakes an effectiveness review of the Trust Board and its Committees.
2. The effectiveness review is in three parts;
    a. an effectiveness questionnaire completed by members
    b. a review of attendance at the meetings held during 2017/18
    c. a review of the terms of reference and annual work plan with the meeting Chair and lead director.
3. Following analysis of the findings a report is made to each of the meetings and an overarching report is made to the Audit Committee and Trust Board.
4. The report to the Trust Board will help inform the Board development programme for 2018/19, identify any skills gaps and make recommendations to strengthen the governance structure of the Trust.
5. The annual effectiveness review has already commenced and core members have been sent the effectiveness questionnaire for the Board and each Committee they are a member of.
6. Meetings are also taking place with the Chairs and lead directors.
7. The attendance statistics will inform the annual governance statement in the 2017/18 annual report.
8. Reports will be presented at Committee meetings in April and the overarching findings to the Audit Committee and Trust Board in May.

Trust objective met or risk addressed: Assurance of robust Board governance; a learning culture and compliance with the NHSI Single Oversight Model Well Led Framework

Financial implications: None directly as a result of approving this report.

Stakeholders: Staff, patients and the public, regulators

Recommendation(s): To note the arrangements and timetable for the annual effectiveness review.

Presenting officer: Nicola Bunce, Director of Corporate Services.

Date of meeting: 28th March 2018.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18) 028

Title of paper: Care Quality Commission (CQC) compliance and registration

Purpose:

This paper provides a summary of policies, process and practices across the Trust to demonstrate how on-going compliance is maintained with the fundamental standards required by the CQC (Appendix 1), to enable the Quality Committee to provide assurance to the Board.

Summary:

The Trust is required to register with the CQC and has a legal duty to be compliant with the fundamental standards set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). In 2015, the Trust underwent a comprehensive Chief Inspector of Hospitals' visit and was found to be compliant with the fundamental standards, with no requirement for enforcement action in any area. The Trust was rated as good overall with outstanding features and has remained registered with the CQC without conditions. The Trust has now registered additional services for the intermediate care inpatients at Newton Hospital and primary care at Marshalls Cross Medical Centre. In order to gain registration it was necessary to provide information about the Trust and how we maintain on-going compliance with the required standards.

Appendix 1 provides an updated summary of compliance against each of the relevant standards.

Corporate objectives met or risks addressed:

Care, safety and communication

Financial implications:

The CQC charges all providers an annual registration fee to cover its regulatory activities. The fee for 2017-18 was £245,652

Stakeholders: Trust Board, patients, carers, staff, regulators, including the CQC and commissioners

Recommendation(s):

For the Trust Board to:

- Review the information provided to confirm compliance with the fundamental standards and on-going CQC registration requirements and to determine if further information or evidence is required, prior to submission to the Board.

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

Date of meeting: 20th March 2018

Appendix 1

St Helens and Knowsley Teaching Hospitals NHS Trust

Compliance with CQC Regulations and Fundamental Standards

Key	This paper was updated on 14th March 2018
	Full assurance in place in STHK
	Process in place, further work required until full assurance can be given
	No assurance in place
	Position not yet assessed and, therefore, not known.
	Not applicable

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Comment including any further actions to strengthen compliance if required
No FS maps to this regulation	5 - Fit and proper persons: directors	People with director-level responsibility for meeting the standards are fit to carry out this role.	**Well-led**	Remuneration	DoHR		Process in place for confirming all current Directors including Non-Executive Directors meet the required standard, which is applied to all new appointments and renewed annually.	Chair approved process in place and adhered to for existing post-holders and all new starters.
No FS maps to this regulation	6 - Requirement where the service provider is a body other than a partnership	Provider is represented by an appropriate person nominated by the organisation who is responsible for the management of regulated activity.	**Well-led**	Executive	DoNMG		Director of Nursing, Midwifery and Governance is the Accountable Person registered with the CQC.	Director of Nursing registered with the CQC as responsible officer and confirmed in updated certificate received May 2016.

Appendix 1

No FSs map to this regulation	8 - General	Registered person must comply with regulations 9 to 19 in carrying on a regulated activity	**Well-led**	Quality	DoNMG		See information below for compliance	See below
1	9 - Person-centred care	Providers must do everything reasonably practicable to put patients at the centre and to reflect personal preferences, taking account of people's capacity and ability to consent.	Safe, **Caring,** Responsive	Quality	DoNMG		All patients are assessed on admission and have comprehensive treatment/care plans in place. Trust has examples of adjustments made to meet individual needs, including electronic alerts, health passports, side-rooms, additional staffing where needed, carer beds, hearing loops & communication aids. In outpatients, double, early and late appointments are used with desensitising visits to clinics. Specialities have developed their own pathway supporting people with additional needs and include imaging, endoscopy and pre-operative assessment. For complex patients, best interest decision-making and journey planning involving multi-disciplinary teams are routine. This was demonstrated in a patient story to the Board in January 2017. Mental Capacity Act included in mandatory training with 88.2% compliance achieved year-to-date in 2017-18, above the target of 85%. Consent Policy in date and available on the Trust's intranet. Compliance with nursing care indicators is regularly audited and reported to each ward and the Patient Experience Council on a quarterly basis.	The Trust received an overall rating of outstanding for the caring domain, with examples of compliance sited in the CQC inspection report, including the fact there were sufficient numbers of trained nursing and support staff with an appropriate skill mix to ensure that patients' needs were met appropriately and promptly. The CQC observed positive interactions when staff were seeking consent.

Appendix 1

2	10 - Dignity and respect	Have due regard to the Equality Act 2010 protected characteristic – staff demonstrating compassion and respect. Maintain privacy **at all times**, including when sleeping, toileting and conversing.	Safe, **Caring,** Responsive	Quality	DoNMG		The Trust's values include respectful and considerate and these are reiterated at interview, on induction and during appraisals. Privacy and dignity assessed as part of CQC inspection and external PLACE assessments. Any areas of concern highlighted through the complaints process are responded to and actions taken to address shortfalls. Additional structural changes were made in 2016 to the Coronary Care Unit to enhance privacy and dignity of patients. Eliminating Mixed Sex Accommodation Policy in place, which requires any breaches to be reported via the Datix system. Annual mixed sex declaration submitted to the Board each March.	Trust rated best nationally in latest PLACE assessment. On-going observation through internal quality inspections.

Appendix 1

3	11 - Need for consent	All people using the service or those acting lawfully on their behalf give consent. (Meeting this regulation may mean not meeting other regulations eg this might apply in regard to nutrition and person centred care. However, providers must not provide unsafe or inappropriate care just because someone has consented.)	**Safe,** Responsive	Quality	MD		Consent Policy in place and patients are consented using standard Trust forms for all procedures. Annual consent audit undertaken as part of the clinical audit programme which is reported to the Clinical Effectiveness Council, with individual results presented locally at the relevant specialties audit meeting (there are two rounds undertaken for each specialty included in the programme during the year).	Audit of patient records and compliance with consent policy and Mental Capacity Act (MCA) 2005 and report through Clinical Effectiveness Council to the Quality Committee. CQC observed positive interactions when staff were seeking consent

Appendix 1

4	12 - Safe care and treatment	Assessing risks against health and safety standards, mitigating risks, staff providing care have relevant qualifications, competence, skills and experience, ensure premises and equipment used are safe for intended purpose. Ensure sufficient quantities of medicines/ equipment to remain safe. Proper oversight of safe management of medicines. Infection prevention and control (IPC).	**Safe**	Quality; Workforce Council; Executive	DoHR, DoNMG, DoCS,		H&S risk assessments in place and outlined in H&S Policy & supporting documents. Work place inspections reported to Health and Safety Committee which reports to Workforce Council and programme of environmental checks in place reporting to Patient Experience Council. Relevant checks against job description/ person specification undertaken as part of recruitment process for all staff. Missed doses of medication are recorded in patient notes, on Datix and are audited. Pharmacy undertake audits of missed doses and security, providing feedback to individual wards for improvement. Improvements noted in the latest medicines security audit (December 2017) Programme of medical device maintenance in place. Compliance with infection prevention and control is audited monthly.	Redesigning the process for embedding lessons learnt from incidents and complaints remained as a quality improvement priority for 2017-18.

Appendix 1

5	13 - Safeguarding service users from abuse and improper treatment	Zero tolerance approach to abuse and unlawful discrimination and restraint, including neglect, degrading treatment, unnecessary restraint, deprivation of liberty. All staff to be aware of local safeguarding policy and procedure and actions needed if suspicion of abuse.	**Safe**	Quality, Workforce	DoNMG, DoHR		The Trust has a zero tolerance approach to abuse, discrimination and unlawful restraint. The Trust has a Raising Concerns Policy and also Disciplinary Policy and Procedure in place for any staff who fail to meet the Trust's values and ACE behavioural standards. Each clinical area has a Safeguarding file with key information to ensure all suspicions are reported appropriately. Safeguarding level 1 is the minimum mandatory requirement for all staff, with level 2&3 targeted at those who require it, ie those working with children and young people and those in decision-making roles respectively. Current compliance with training is meeting the target for level 1 and level 3, with significant improvement in level 2 compliance, with children's at 89.1% and adults at 85% against targets of 90%. Awareness of Deprivation of Liberty Safeguards (DoLS) is included in induction and mandatory training. The Trust provides training in conflict resolution (Customer Service Training).	CQC inspection report highlighted that the relevant policies and procedures are in place, with robust training and support from the Safeguarding Team to ensure patients receive appropriate care. On-going actions required to deliver the recovery plan for safeguarding training for levels 2.

Appendix 1

6	14 - Meeting nutritional and hydration needs	People who use services have adequate nutrition and hydration to maintain life and good health.	**Effective**	Quality	DoNMG		Nutrition and hydration screening tools in place (MUST) and relevant patients have food charts. There is a red tray and red jug system in place for patients who require additional support with eating and drinking. All general wards operate protected mealtimes. Patients are regularly assessed to note any changes in nutrition and hydration status. Trust rolled out the Malnutrition Universal Screening Tool (MUST) for adults to ensure compliance with NICE guidance in 2015 which is now included in the electronic risk assessments introduced in 2017. There has been significant improvement in the recording of MUST scores and implementation of relevant care plans. In addition, electronic fluid balance charts to support appropriate recording of hydration have been rolled out.	Working with the volunteer service to increase the number of trained dining companions to further support patients during meal times.

Appendix 1

7	15 - Premises and equipment	Premises and equipment are clean, secure, suitable, properly used/maintained, appropriately located and able to maintain standards of hygiene. Management of hazardous/clinical waste within current legislation. Security arrangements in place to ensure staff are safe.	**Safe**	Quality	DoCS		The Trust was rated best acute Trust for Patient Led Assessments of the Care Environment (PLACE) programme. The Trust achieved top marks in the country in every area of the inspection, including; • cleanliness • food • privacy and dignity • facilities for patients living with dementia and disabilities • condition, appearance and maintenance of the hospital buildings A comprehensive internal environmental audit is undertaken and reported to the Patient Experience Council. Workplace inspections and COSHH risk assessments in place. Security service provided 24 hours per day.	
8	16 - Receiving and acting on complaints	All staff to know how to respond when receiving a complaint. Effective and accessible system for identifying, receiving, handling and responding to complaints, with full investigation and actions taken. Providers must monitor complaints over time looking for trends and areas of risk.	**Responsive**	Quality	DoNMG		Staff aware of how to manage complaints at a local level, including local resolution where possible, with involvement of PALS. Improvements to the management of complaints remain ongoing, with effective system in place via Datix for recording and monitoring each complaint. Themes identified and reported to Patient Experience Council and the Quality Committee.	Continue to improve response times to complainants, building on the work undertaken in 2017-18.

Appendix 1

9	17 - Good governance	Robust assurance and auditing processes in place to drive improvement in quality and safety, health, safety and welfare of patients and staff. Effective communication system for users/staff/ regulatory bodies/ stakeholders so they know the results of reviews about the quality and safety of services and actions required.	**Well-led,** Responsive	Board	CEO		An annual Board effectiveness review is undertaken, including a review of the Board Committees and the outcomes are considered by the whole Board. Progress in delivering the Trust's objectives is reported to the Board annually and these are then refreshed for the next year. MIAA review the governance arrangements within the Trust including compliance with the CQC processes. External Audit review the annual governance statement. The Trust complies with the NHS Publication scheme, with an internal team briefing system in place to ensure staff are aware of the results of external reviews. Ward accreditation scheme in place (Quality Care Assessment Tool – QCAT) that is aligned to CQC standards. Twelve wards were presented with gold awards in 2017-18 out of the 27 assessed; only one ward remains at bronze.	CQC noted that there was effective staff engagement in the development of the Trust's vision and values, which were widely understood across the organisation.

Appendix 1

10	18 - Staffing	**Sufficient numbers** of suitably qualified, competent, skilled and experienced persons deployed to meet CQC requirements.	**Safe, Effective**	Workforce Council	DoHR		Comprehensive workforce strategy in place supported by a Recruitment and Retention Strategy, including targeting workforce hotspots and proactive international recruitment for both medical and nursing staff. There is an active recruitment programme for the nursing and midwifery workforce, on-going throughout the year, including participating in the international global learner campaign. The Trust delivers apprenticeship programmes, from local health care cadets at further education colleges through to part-time registered nurse degrees and is supporting the implementation of the new nurse associate role. There is a Preceptorship, Mentorship and Leadership (StHK PML) three year foundation programme in place to enhance retention. There is a comprehensive workforce performance dashboard, which enables detailed monitoring and oversight. A safer staffing report is presented every month to the Board, with a 6 monthly detailed staffing review reported to the Board including nurse establishment and patient acuity.	Review of clinical supervision delivery. CQC inspection report noted that the Trust maintains a rolling programme of nurse recruitment that meant vacancies were filled in a timely way and that where there were medical vacancies patients received prompt and appropriate care.

Appendix 1

11	19 - Fit and proper persons employed	Staff to be of good character with appropriate qualifications, competence, skills and experience ie all staff are fit and proper – honest, trustworthy, reliable and respectful	**Well-led**	Workforce Council	DoHR		Effective procedures in place for pre-employment and on-going revalidation of relevant staff. The Trust has range of HR policies and procedures. Staff are aware of the requirement to raise any concerns about patient care and anything that may affect them personally in fulfilling their duties.	Audit of recruitment policies and procedures, with all relevant checks.
No FS maps to this regulation	20 - Duty of candour	Open and transparent with people who use services/people acting lawfully on their behalf. Promote culture of openness, transparency at all levels, with focus on safety to support organisational and personal learning. Actions taken to ensure bullying and harassment is tackled in relation to duty of candour.	**Safe**	Quality Committee	DoNMG		Electronic reporting system, Datix, amended to include mandatory field to confirm compliance with Duty of Candour Compliance included in future Serious Incident Board reports Training is provided to staff within the following training programmes: • Trust's induction. • Mandatory training • Root cause analysis training From June 2015 all line managers trained as speak up safely champions and received a training video, which also includes their responsibilities under duty of candour. Speak in confidence electronic system launched in 2016-17 as a further route for staff to report concerns anonymously. Assistant Director of Patient Safety appointed as Freedom to Speak Up Guardian.	CQC confirmed in their inspection report that the Trust has good systems in place to fulfil its obligations in relation to the Duty of Candour Regulations.

Appendix 1

No FS maps to this regulation	20A - Requirement as to display of performance assessments	Notify via all websites and in each premise where services are provided the latest CQC rating, including principal premises. The information is to include the CQC's website address and where the rating is to be found and for each service/premise the rating for that service/premise.	**Responsive,** Well-led	Executive	DoCS		Ratings available on internet with links to the full reports using the CQC widget. Full list of clinics and sites where services provided collated for staff to display ratings in individual clinics.	

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18) 029
Title of paper: Elimination of Mixed Sex Accommodation - Declaration
Purpose: To provide assurance to the Trust Board that the Trust had complied with the national guidance to eliminate mixed sex accommodation.
Summary: All Trusts are required to make annual declaration confirming compliance with the guidance in relation to elimination of mixed sex accommodation. Failure to comply with the guidance could result in significant financial penalties for breach of contractual standards, unless it would be in the overall best interests of the patient or is their personal choice. The annual declaration must be published on the Trust website. For 2017/18 there have been no mixed sex breaches reported and the Trust is able to make the annual declaration.
Corporate objectives met or risks addressed: Safe and effective care
Financial implications: Financial penalties apply if breaches occur
Stakeholders: All staff and external partners
Recommendation(s): The Board approves the declaration of compliance in relation to the elimination of mixed sex accommodation
Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance
Date of meeting: 20 March 2018

Eliminating Mixed Sex Accommodation Declaration

1. Background

1.1 In November 2010, the Chief Nursing Officer (CNO) and Deputy NHS Chief Executive wrote to all NHS Trusts. The letter (PL/CNO/2010/3) set out the expectations that all NHS organisations 'are expected to eliminate mixed sex accommodation, except where it is in the overall best interests of the patient, or their personal choice'. The CNO letter included detailed guidance on what was meant by 'overall best interests', including situations, for example, when a patient is admitted in a life threatening emergency.

1.2 This was followed by another letter from the Chief Nursing Officer and Deputy NHS Chief Executive in February 2011 (Gateway ref 15552) setting out expectations regarding annual declarations of compliance.

1.3 Trust Boards are required to declare compliance annually. Should they not be in a position to do so, they may declare non-compliance however significant financial penalties may apply under such a circumstance.

1.4 The Trust can continue to declare its compliance for 2017/18.

2. Declaration of Compliance

2.1 The Trust Board of St Helens and Knowsley Teaching Hospitals NHS Trust confirms that mixed sex accommodation has been virtually eliminated within all its hospitals, except where it is in the overall best interest of the patient, or reflects their personal choice.

2.2 We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen by exception based on clinical need. (Example, where patients need specialist equipment such as in critical care areas).

2.3 Sleeping accommodation does not include areas where patients have not been admitted, such as accident and emergency (A&E) cubicles.

2.4 If our care should fall short of the required standard, the Trust will report it. St Helens and Knowsley Teaching Hospitals NHS Trust have assurance mechanisms in place to monitor compliance, the management structure to manage any breaches and the desire to ensure we are communicating to patients and the public that we are delivering our commitment to eliminating mixed sex accommodation.

3. Data collection and performance

3.1 2017/18 year to date there has been zero mixed sex breaches reported via Unify (the national reporting system).

3.2 Financial penalties apply to all non-clinical breaches. This is defined as £250 per person that the breach applies to. (For example 4 bedded bay 1 female and 3 male = 4 breaches).

3.3 On 2nd January 2018,, the National Emergency Pressures Panel (NEPP) chaired by Professor Sir Bruce Keogh made a series of recommendations to help hospitals handle the sustained pressure and activated the NHS's Winter Pressures Protocol. This meant that there was a temporary suspension of the sanctions for mixed sex breaches, to allow Trusts more flexibility to accommodate all patients who needed to be admitted.

3.4 Despite the pressures, the Trust did not have any breaches during this period.

4. Current Situation

4.1 Gender mixing only occurs within critical care units and the emergency department. This is in line with the overall best interests criteria stated by the CNO.

4.2 All adult in-patient wards are either single sex, or where they are mixed sex, areas within the ward are designated as male or female, with separate designated toilets and bathrooms. Where admissions and transfers may potentially cause a mixed sex breach ward teams are able to move patients to prevent this.

4.3 Children, young people and their parents will be asked at time of admission if they wish to be cared for with others of a similar age in a single sex bay or in a single room. This preference is used to determine where to place a child or young person in our children's wards.

4.4 Any changes proposed to the ward environment include a risk assessment to ensure that the requirements for single sex accommodation can continue to be met.

4.5 The Trust Elimination of Mixed Sex Accommodation policy has been reviewed and is available on the Trust website.

5. Patient experience

5.1 Year to date there have been no complaints specifically about breaches of single sex accommodation.

6. Recommendation

The Trust Board is asked to approve the declaration of compliance and for it to be published on Trust website and submitted to NHS England.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD PAPER

Paper No: NHST(18)30
Title of paper: Review of NHS Staff Survey
Purpose: To provide the Trust Board with an overview of the outcomes of the Staff Survey for 2017 and recommended actions.
Summary: This paper highlights the outcome from the 2017 staff survey which is overwhelmingly positive. 27 key finding scores are significantly better than other Acute Trusts, equal to the Trusts performance in 2016. 22 key finding scores are in the best 20% of Acute Trusts, compared to 24 in 2016. There are some areas of concern which will form the basis of the 2018-19 action plan, most notably; The level of violence and aggression from patients, job satisfaction, the quantity of appraisals and communication from senior managers.
Corporate objectives met or risks addressed: Developing Organisational Culture and supporting our workforce, Safety, Communication
Financial implications: No new financial requirements from this paper
Stakeholders: Staff, Staff Side colleagues, Service users, Line Managers, Staff Side, Service users, CCG, CQC.
Recommendation(s): Members are asked to approve: The Board is requested to note the outcomes and accept for progression into a detailed milestone plan interventions to address the proposed actions.
Presenting officer: Anne-Marie Stretch, Director of HR & Deputy CEO
Date of meeting: 28th March 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

2017 NHS Staff Survey Report

1. INTRODUCTION

309 NHS organisations in England took part in the 2017 NHS Staff Survey. Over 1.1 million NHS staff where invited to participate using an online or postal self-completion questionnaire. Responses were received from over 487,227 NHS staff, a response rate of 45% (44% in 2016). All Full-time and part-time staff that were directly employed by an NHS organisation on 1st September 2017 were eligible. The questionnaire used for the 2017 survey was unchanged from that used in 2016.

The survey, administered on our behalf by Quality Health, was completed by a sample of 1250 staff determined by the total number of staff employed on a national sliding scale. The sample was generated at random from all those employed on 1st September 2017 and included those on maternity leave. The official sample size for the Trust was the same as in 2016.

St Helens and Knowsley Teaching Hospitals NHS Trust (STHK/ the Trust) took part in the survey throughout October and November 2017, the results of which were published nationally on 6th March 2018.

The data generated from this sample is used for the purposes of the Care Quality Commission (CQC) monitoring assessments and by other NHS bodies such as the Department of Health.

Postal questionnaires were distributed to staff by hand through the Trusts' network of Staff Survey Champions. Staff responded by using a pre-paid response envelope provided by the contractor. Two reminders were sent; a first reminder letter, and a further mailing which included a repeat questionnaire.

This report provides an overview of all the conclusions arising from the survey into an Executive Summary.

Detailed results will be available on the Trust Intranet Staff Survey pages, with a breakdown of the responses to each question available from the following site:

http://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2017-Results/

2. QUESTIONNAIRE CONTENT

The questionnaire content is agreed nationally after extensive consultation between the CQC, the Department of Health, and the Survey Advice Centre, responsible for coordinating the Staff Survey.

The feedback reports, published by the Survey Advice Centre, map the response to individual questions to "Key Findings".

As in previous years, there are two types of Key Finding (KF):

- **Percentage scores:** i.e. percentage of staff giving a particular response to one, or a series

of survey questions.

- **Scale summary scores:** calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5.

The 2017 survey has been structured thematically so that Key Findings are grouped appropriately into the following nine themes:

• Appraisals & support for development

• Equality & diversity

• Errors & incidents

• Health and wellbeing

• Working patterns

• Job satisfaction

• Managers

• Patient care & experience

• Violence, harassment & bullying

In this report, the results of the questionnaire have been summarised and presented in the form of 32 Key Findings (Appendix 1).

3. RESPONSE RATE

3.1 Local

626 completed questionnaires were returned from this sample. The response rate to the Staff Survey was therefore **51%** (626 usable responses from a final sample of 1,227).

3.2 National

The overall national response rate for Acute Trusts in England was 44%, 7% less than that of St. Helens & Knowsley Teaching Hospitals, which places the Trust in the **highest (best) 20%** nationally.

3.3 Respondent Demographics

The 686 respondents comprised the following groups:

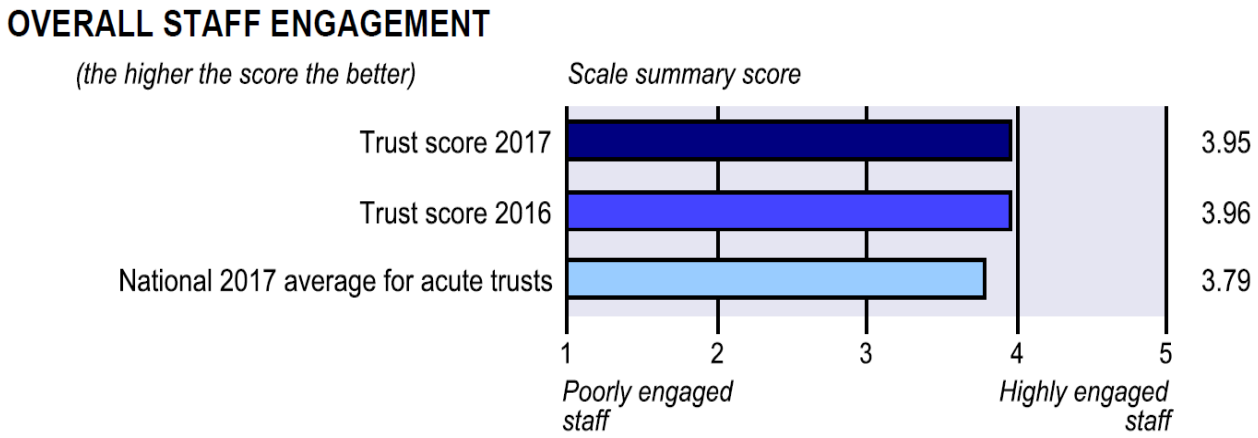
Ethnicity	%	Age	%
White	91	66+	1
Mixed	1	51-65	38
Asian/Asian British	6	41-50	30
Black/ Black British	1	31-40	15
Chinese and other ethnic groups	1	21-30	16
		16-20	0

Length of Service	%	Occupational Group	%
More than 15 years	33	AHP, Scientist, Technical	19
11-15 years	16	Medical & Dental	7
6-10 years	15	Nurses & Midwives	27
3-5 years	15	Healthcare Assistants	12
1-2 years	13	Wider Healthcare Team	29
Less than 1 year	8	General Management	6

4.0 RESULTS

4.1 Overall Staff Engagement

The figure below shows how the Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating poorly engaged staff (with their work, their team and their trust) and 5 indicating a highly engaged workforce. The Trust's score of **3.96** was in the **highest (best) 20%** when compared with trusts of a similar type nationally and places the Trust **best** in the Northwest.



Presented below are the engagement scores for each of the themes that comprise Overall Staff Engagement. Engagement scores from 2016 have also been put in for comparison. The percentage difference between the 2016 and 2017 scores are represented by the coloured gap between the bars. Significant differences between the years have also been indicated.

Theme	Staff Engagement Scores		
Overall Staff Engagement	2016	3.96	-0.01 (Not sig.
	2017	3.95	
Advocacy (KF1)	2016	4.06	+0.07(Not sig.)
	2017	4.12	
Motivation (KF4)	2016	4.02	-0.04(Not sig.)
	2017	3.98	
Involvement (KF7)	2016	3.87	-0.01(Not sig.)
	2017	3.77	

The most notable contributory response to this overall indicator of staff engagement is the 'Staff Friends and Family test question," Staff members' willingness to recommend the Trust as a place to work or receive treatment" (KF1), for which the Trust returned the **best score nationally**.

Other contributory responses to this measure include KF4. 'Staff motivation at work (the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs)' having a score in the **best 20%** of acute hospitals nationally.

4.2 Patient Focus

85% of staff agreed that care of patients / service users is the organisation's top priority.

Responses to this question contribute to the Advocacy key finding (KF1), the score is similar with the 2016 one and well above the national average of 76% for acute trusts, further underlining the Trusts commitment to placing the patient at the centre of all we do.

4.3 Key Findings

The Trusts' results for a significant number of the Key Findings have maintained the improvements made in the previous 2 year's surveys (Appendix 2).

Of the 32 Key Findings, 2 have shown a statistically significant positive change (KF23 - % experiencing physical violence from staff in the last 12 months and KF 13 – quality of non-mandatory training, learning and development.

Twenty two of the 32 Key Findings have a score in the **best 20%** of acute trusts nationally (Appendix 1). Details of the changes for all Key Findings are provided in Appendix 2, with the most notable responses set out in the following tables. In addition, the Trust has obtained the **best** score nationally for 10 key findings, the **best** score in the Northwest for 4 key findings and the overall engagement score, and the **best** score in Cheshire & Merseyside for another 10 key findings plus the response rate.

Key Finding	%		
	STHK	National Average	Best
KF17. % of staff feeling unwell due to work related stress in the last 12 months	28	36	28
KF18. % of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	47	52	42
KF21. % believing the organisation provides equal opportunities for career progression/promotion	93	85	94
KF23. % of staff experiencing physical violence from staff in the last 12 months	1	2	1
KF26. % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	19	25	19
KF29. % of staff reporting errors, near misses or incidents witnessed in the last month .	98	90	98

Key Finding	Scores out of 5		
	STHK	National Average	Best
KF1. Staff recommendation of the organisation as a place to work or receive treatment	4.12	3.75	4.12
KF8. Staff satisfaction with level of responsibility and involvement	4.04	3.91	4.04
KF9. Effective team working	3.85	3.72	3.88
KF13. Quality of non-mandatory training, learning or development	4.22	4.05	4.22
KF14. Staff satisfaction with resourcing and support	3.58	3.31	3.58
KF19. Organisation and management interest in and action on health and wellbeing	3.89	3.62	3.92
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.88	3.73	3.88
KF32. Effective use of patient/service user feedback	3.96	3.71	3.96

Work from the 2016 survey action plan focussing on violence from patients and staff, job satisfaction and appraisals and support for development has led to significant shifts in responses for the following Key Findings, which now place the Trust in the **best 20%** of acute hospitals nationally:

- KF 23. The percentage of staff experiencing physical violence at work from managers and other staff in the last 12 months.
- KF13. Quality of non-mandatory training, learning or development.

4.4 Whilst the overwhelming majority of responses are positive, there are 6 areas for which the results are not as positive as we would wish. Areas of note are:

- KF2. Staff satisfaction with the quality of work and care they are able to deliver – Although we still remain a high scoring organisation (StHK score 4.14, best national score 4.21), the decrease since 2016 (by 0.14) required further investigation. Following a detailed review of the survey data, it has been identified that this result is being negatively impacted by responses of staff from the Corporate Services based at Alex Park and the Medical Care Group at Whiston Hospital. Respondents from the Estates & Ancillary staff group, representing the Trust R.O.E. employees have also shown a lower level of satisfaction compared to the Trust's score.
- KF3. Percentage of staff agreeing that their role makes a difference to patients/service users – This has seen a reduction by 5% to 89%. The best score for acute trusts nationally has also dropped from 94% to 93%. The data analysis carried out shows the majority of respondents that disagree are from the admin & clerical staff group working in Corporate Services. Further investigation indicated a misinterpretation of the question by this particular staff group, as their activity does not have a direct impact on patients and clinical service users. This has led to respondents selecting a negative answer rather than the 'not applicable' option.
- KF11. Percentage of staff appraised in the last 12 months, - The survey shows a decrease of 2% compared to our 2016 score. This places the Trust 2% below the national average of

86% (national average in 2016 was 87%). The best 2017 score for acute trusts was 96%. Work to deliver a revised appraisal process was underway at the time of the 2017 survey field work. The introduction of the new system has delivered an improvement in Appraisal compliance through November and December, however this was too late to influence the 2017 survey responses. Work to embed the new system will continue with a positive impact on the appraisal completion rate is most likely to be noticeable in the 2018 survey results.

- KF16. Percentage of staff working unpaid extra hours – 49% of respondents indicated that they work additional unpaid hours throughout the week, representing an increase by 3% since 2016. This is most evident with respondents from the medical and nursing workforce from the Surgical Care Group. Other areas declaring they routinely work more than 11 unpaid additional hours throughout the week include admin & clerical staff and scientific & technic staff in Corporate Services and Medicines Management respectively.

- KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months – 19% of staff have declared at least one occurrence of this situation, the score placing the Trust in the bottom 20% of acute trusts nationally. The areas with spikes in violent incidents have been identified and interventions are included in the action plan.

- KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months - Although the Trust's score of 19% is the best nationally, we remain committed to further reduce this. Data analysis shows that 9% of respondents, mainly professional scientific & technic staff from Medicines Management, but also allied health professionals and members of the medical and nursing workforce at St Helens and in the Medical Care Group, Whiston. 14% of respondents, mainly in Patient Access, St Helens, stated they had been subjected to this by colleagues.

5.0 CONCLUSIONS AND RECOMMENDATIONS

The Trust has work hard over the last 12 months in the delivery of the 2017-18 staff survey action plan and to engage with, support and develop its workforce and would like to recognise the progress made in what continues to be an extremely challenging operational environment.

Our staff continue to be our most vital resource and we will use the results from the Survey to continuously improve staff experience and service to our patients.

Appendix 4 details the suggested action points, based on those areas where the Trust has responded less favourably to other acute trusts or where performance is not what we would aspire to. The headline areas recommended for the Board to keep under close review throughout the year are highlighted below and progress will be monitored monthly as part of the combined workforce report through the Workforce Council. Whilst some of the areas of focus are consistent with those from the previous survey results, it should be recognised that progress has been made with the Trust improving its position across a wide range of measures and maintaining its excellent performance when compared to 'like' organisations.

5.1 Publicising the results

Results were presented to staff and managers by Quality Health on 19th March 2018, it is important that staff see the benefits of participating in this survey and are aware both of the

outcomes from the Staff Survey and the resultant actions. In support of this, with the support of the Media and Communications team, the results of the staff survey will be publicised through all available channels including:

- Display presentations in appropriate locations on St Helens & Whiston Hospital sites.
- The management and full reports to be uploaded and available on the Intranet.
- Copies to Clinical Governance teams and to Divisional and Departmental Heads.
- Summary of findings at Team Brief.
- Summary with links to full report on Global emails.
- Copies to the local Staff Side representatives.
- Circulation to the Valuing Our People Steering Group.
- Publication in News 'n Views
- Circulation of 'You said/ We did' communications

Reporting to staff on the outcomes of the survey, and telling staff what has been done about key issues arising from it is a major help in maximising response rates at the next survey and significantly improves the credibility of the process.

6.0 ACTION REQUIRED BY THE BOARD

The Trust Board are asked to note the content of this report and to approve and support the recommendations. Actions to address the limited areas of concern will be incorporated into the Combined Workforce Action Plan for 2018-19. This will be monitored by the Workforce Council and assurance of delivery will be provided to the Quality Committee as part of the Board Governance Assurance Framework.

APPENDIX 1 – Comparison of all Key Findings for St.Helens and Knowsley NHS Trust

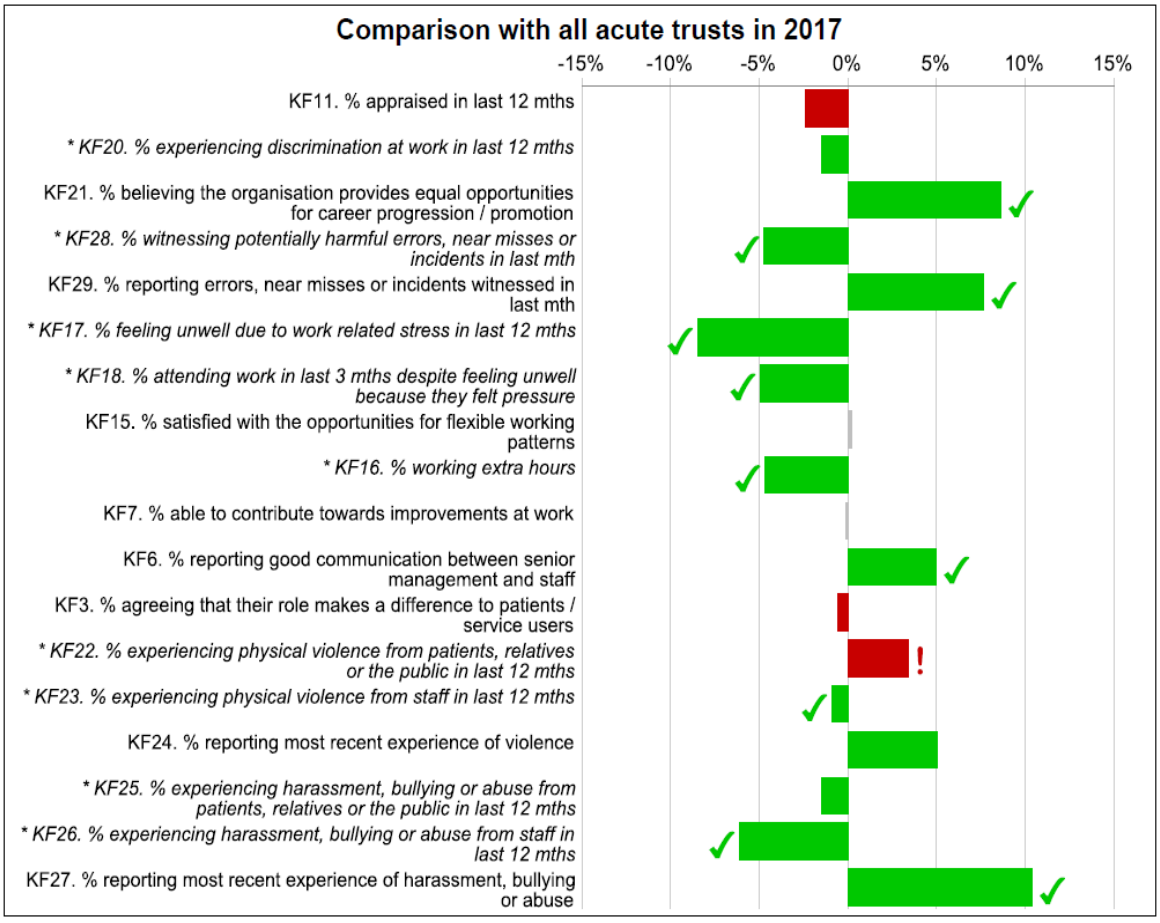
KEY

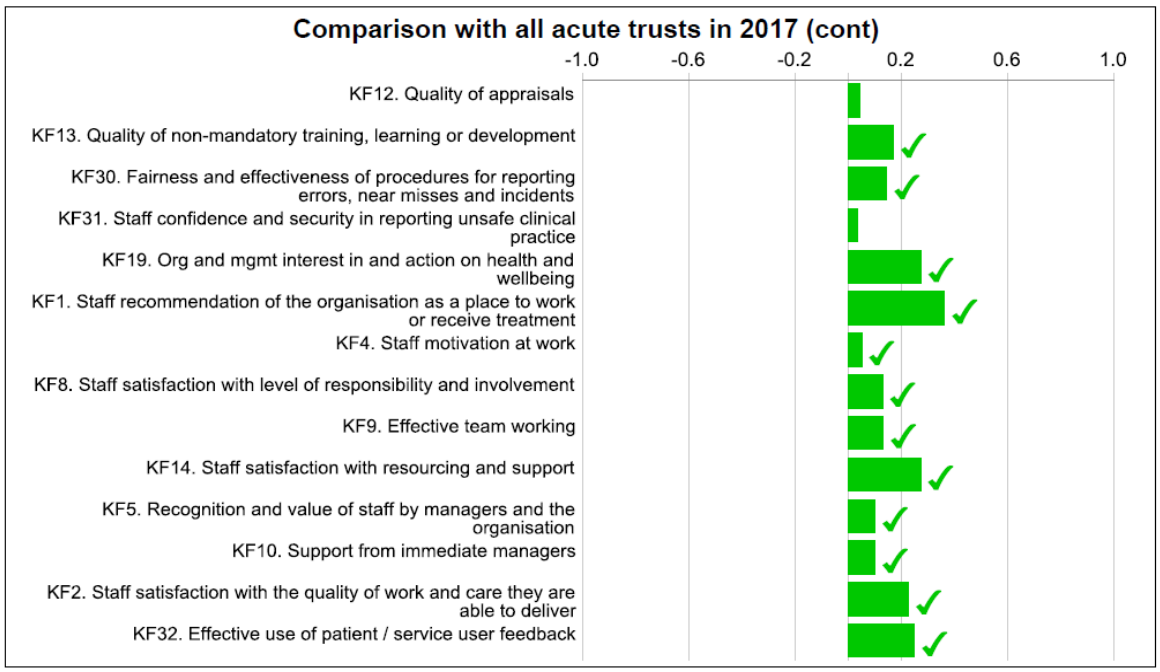
Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, i.e. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.





APPENDIX 2 – Summary of all Key Findings for St. Helens and Knowsley NHS Trust

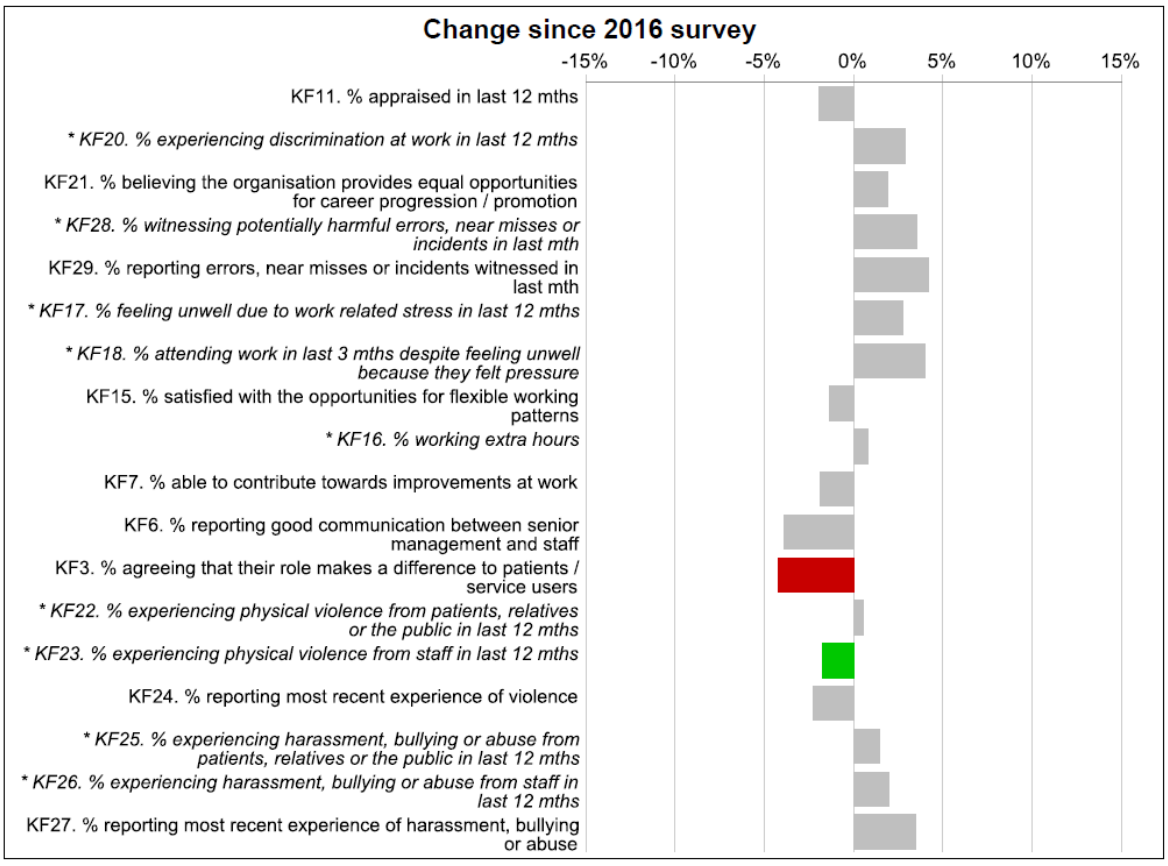
KEY

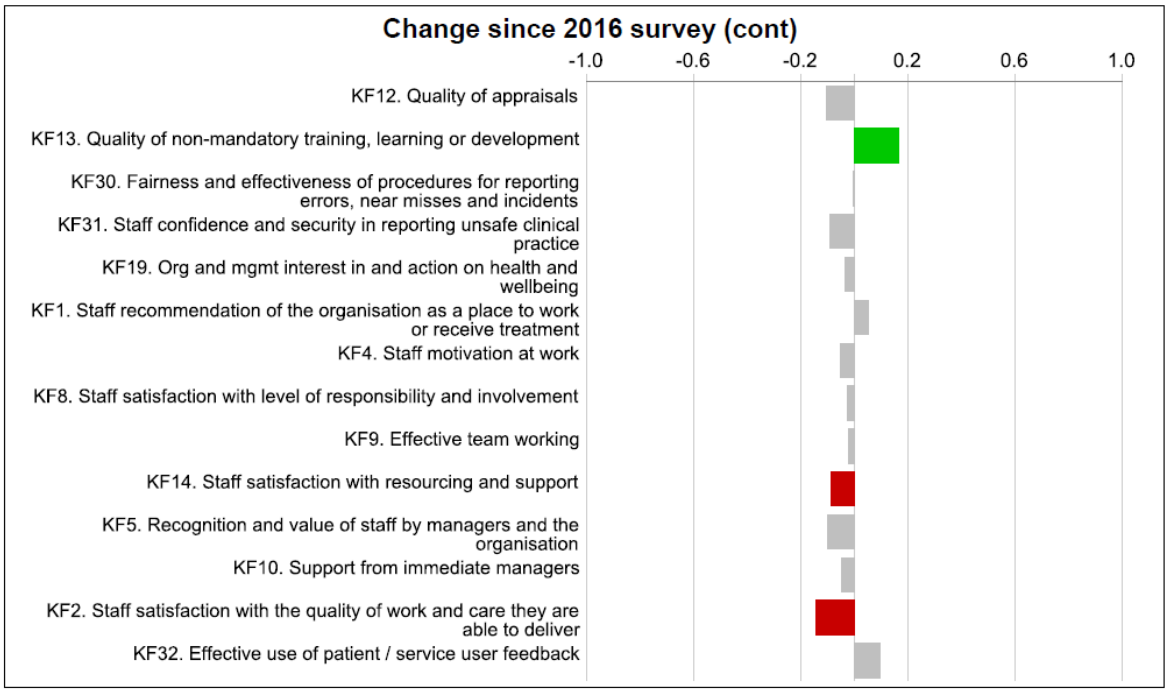
Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2016 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2016 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2016 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.





APPENDIX 3 – Staff Survey recommended actions 2018-2019

Medical Care Group Whiston			
Recommendation	**Intervention**	**Lead**	**Anticipated deadline**
KEY FINDING 22. % of staff experiencing physical violence from patients, relatives or the public in last 12 months KEY FINDING 26. % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	Non-Clinical Risk Management Lead to work with managers in areas where spikes of violent incidents have been identified, in order to understand the causative factors and agree and implement methods or reducing these occurrences. • Focus groups • Analysis of DATIX	Head of Non-Clinical Risk Management	June 2018
KEY FINDING 2. Staff satisfaction with the quality of work and care they are able to deliver	Work with clinical staff and managers in department with poorest staff satisfaction to define the actions necessary to ensure a high quality of care.	Deputy Director of Nursing	May 2018
KEY FINDING 7. % of staff able to contribute towards improvements at work	Work with managers in those areas highlighted in the survey to establish systems that encourage staff to contribute to developments/ improvements at work • Roll out of improvement Techniques Apprenticeships. • Development of Managers in the appreciative leadership approach • Review and re launch of the 'Ideas Bank'	Programme Manager, PMO	September 2018
KEY FINDING 11. % of staff appraised in the last twelve months.	The appraisal lead to work closely with the HR Business Partners in order to maintain the compliance improvement in the Care Groups, registered after the launch of the new appraisal documentation.	Head of Education, Training and Development	June 2018

KEY FINDING 6. % of staff reporting good communication between senior managers and staff.	The Head of Media and Communications to work closely with the Head Education, Training & Development and Directorate managers and HR Business Partners in order to understand what is limiting effective communication from the Board to the 'shop floor' to establish systems leading to an improvement in the Care Group	Head of Education, Training and Development	June 2018

Surgical Care Group Whiston			
Recommendation	**Intervention**	**Lead**	**Anticipated deadline**
KEY FINDING 26. % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	Non-Clinical Risk Management Lead to work with managers in areas where spikes of violent incidents have been identified, in order to understand the causative factors and agree and implement methods or reducing these occurrences. • Focus groups • Analysis of DATIX	Head of Non-Clinical Risk Management	June 2018
KEY FINDING 16. % of staff working unpaid extra hours	HR Business partners to work with leads for medical and dental workforce and nursing workforce to understand this phenomenon and its potential impact on sickness absence rates	Deputy Director of HR	August 2018
KEY FINDING 11. % of staff appraised in the last twelve months.	The appraisal lead to work closely with the HR Business Partners in order to maintain the compliance improvement in the Care Groups, registered after the launch of the new appraisal documentation.	Head of Education, Training and Development	June 2018
KEY FINDING 6. % of staff reporting good communication between senior managers and staff.	The Head of Media and Communications to work closely with the Head Education, Training & Development and Directorate managers and HR Business Partners in order to understand what is limiting effective communication from the Board to the 'shop floor' to establish systems leading to an improvement in the	Head of Education, Training and Development	June 2018

	Care Group		

Clinical Support Services / Corporate Services			
Recommendation	**Intervention**	**Lead**	**Anticipated deadline**
KEY FINDING 3. % of staff agreeing that their role makes a difference to patients/service users	Provide training for survey champions from Corporate Services prior to the 2018 survey field work, in order for them to be able to advise the respondents which questions are not applicable, in order to avoid misinterpretation and skew the data.	Head of Education, Training and Development	June 2018
KEY FINDING 7. % of staff able to contribute towards improvements at work	Work with managers in those areas highlighted in the survey to establish systems that encourage staff to contribute to developments/ improvements at work • Roll out of improvement Techniques Apprenticeships. • Development of Managers in the appreciative leadership approach • Review and re launch of the 'Ideas Bank'	Programme Manager, PMO	September 2018
KEY FINDING 2. Staff satisfaction with the quality of work and care they are able to deliver	Work with staff and managers at Alexandra Park in departments with poorest staff satisfaction, to define the actions necessary to ensure a high quality of work.	Deputy Director of HR	August 2018
KEY FINDING 11. % of staff appraised in the last twelve months.	The appraisal lead to work closely with the HR Business Partners in order to maintain the compliance improvement in the Care Groups, registered after the launch of the new appraisal documentation.	Education, Training and Development Team	June 2018
KEY FINDING 6. % of staff reporting good communication between senior managers and staff.	The Head of Media and Communications to work closely with the Head Education, Training & Development and Directorate managers and HR Business Partners in order to understand what is limiting	Head of Education, Training and Development	June 2018

	effective communication from the Board to the ‘shop floor’ to establish systems leading to an improvement in the Care Group		

END

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(18)31
Title of paper: 2018 -19 Trust Objectives
Purpose: To agree the Trust objectives for 2018-19
Summary: 1. The Trust Board agree objectives each financial year to ensure that the Trust continuously improves its quality and performance and implements new initiatives/national policies and service developments. 2. The objectives are aligned to support the achievement of the Trust's operational plan and the furtherance of its strategic direction and vision to deliver Five Star Patient Care. 3. The objectives have traditionally been split into 9 categories; 5 representing the Trust's Five Star Patient Care criteria of; care, safety, pathways, communication, and systems. There are then 4 categories covering; organisational culture and support for the workforce, operational performance, financial performance, efficiency and productivity and strategic plans 4. A member of the Executive Team takes lead responsibility for each of the objectives and they are built into the individual's personal objectives for the year. 5. As far as possible progress against each of the objectives is translated into key performance indicators or measurable targets that are reported via the Integrated Performance Report (IPR) or through the governance structure, to provide regular assurance of delivery to the Board. 6. There are also two formal reviews of progress incorporated into the Trust Board annual work plans; in November and May each year. 7. Setting and monitoring the delivery of the annual plan and objectives is a key role for the Board and part of the Well Led Framework and CQC assessment.
Trust objective met or risk addressed: Delivery of the annual operational plan.
Financial implications: None directly as a result of approving this report.
Stakeholders: Staff, Regulators and Health System Partners.
Recommendation(s): The Board approves the 2018-19 Trust objectives.
Presenting officer: Ann Marr, Chief Executive.
Date of meeting: 28th March 2018.

Proposed Trust Objectives 2018/19

Objective	Lead Director	Measurement	Governance Route
1. 5 STAR PATIENT CARE – Care ***We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families***			
1.1 Improve the effectiveness of discharge planning (QA Priority) 1.1.1 Increase the proportion of discharges achieved before midday to at least 33% 1.1.2 Increase discharges at the weekend to be at least 85% of the weekday average 1.1.3 Improve effective communication with patients with regard to discharge planning	DoOps	33% of patients to leave hospital by noon on the day of discharge, including weekends. Reduce the number of complaints associated with discharge processes.	Quality Committee
1.2 Maintain effective assessment and monitoring of all patients in the Emergency Department (QA Priority) 1.2.1 The Emergency Department safety checklist is used and recorded for all patients 1.2.2 Undertake eMEWS or National Early Warning Score (NEWS) - which must be implemented during 2018/19 – assessments for all patients 1.2.3 Effective allocation of appropriate staffing, to be able to undertake the assessments	DoOps	Regular audit, monitoring of patient safety incidents and eRoster compliance	Quality Committee
1.3 Achieve the national seven day services clinical standards across the Trust (QA Priority) 1.3.1 Expand the range of services available 7 days a week 1.3.2 Increase the reported % of patients receiving a senior clinical review each day 1.3.3 Increase the reported % of patients being assessed by a Consultant within 14 hours of admission	DoOps & MD	Increase the provision of 7 day services across Pharmacy, Therapy, Diagnostics and Community Frailty National Target - 90% of patients	Quality Committee
2. 5 STAR PATIENT CARE – Safety ***We will embed a culture of safety improvement that reduces harm, improves outcomes and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care***			
2.1 Reduce further the rate of avoidable harm from falls, pressure ulcers and medication incidents (QA Priority) 2.1.1 Falls – 10% reduction from 2017/18 baseline for moderate and severe harm	DoN	Monthly monitoring and reporting /RCA process and lessons learnt	Quality Committee

Objective	Lead Director	Measurement	Governance Route
2.1.2 Pressure Ulcers – maintain zero tolerance of grade 3 or 4. Deliver a 15% reduction in grade 2 pressure ulcers compared to 2017/18 2.1.3 Medication Incidents – Following the implementation of ePrescribing (in Q3) to identify trends and develop a targeted action plan e.g. Insulin prescribing and administration			
2.2. Implement changes as a result of lessons learned from incidents and complaints (QA Priority) 2.2.1 Annual complaints report to provide better analysis of themes 2.2.2 Monthly publication of lessons learnt and discussion at Ward/Department governance meetings	DoN	Incidents, complaints and claims quarterly reports. Regular audit and improvement cycle Add to Quality Ward Round checklist	Trust Board
2.3. Fully establish the systems for reviewing hospital deaths, identifying and sharing learning and reporting the outcomes, in line with best-practice national guidance. 2.3.1 Quarterly publication of the Trust's screening and review of all deaths 2.3.2 Identification of two learning points 2.3.3 Evidence that the learning points have been disseminated throughout the Trust 2.3.4 Evidence that the learning has changed practice	MD	Publication of mortality reviews each quarter Audit of lessons learnt and changes in practice	Trust Board
3. STAR PATIENT CARE – Pathways ***As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient***			
3.1. Increase the percentage of e-discharge summaries sent within 24 hours to 85% (QA Priority)	DoI	Achieve 85% by Q4 2018/19	IPR
3.2. Maximise the benefits of the adult community nursing services in St Helens 3.2.1 Deliver end to end pathways to reduce duplication and number of handoffs e.g. Adult Continence, Heart Failure and Respiratory	DoOps	Improved patient experience Fewer hospital admissions	Quality Committee
3.3. Implement solutions to increase Car Parking capacity to improve the experience and access for staff, patients and visitors.	DoE&F	Increase car parking spaces by 419 by September 2018	Executive Committee
4. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**			
4.1. We will improve the systems used to investigate and respond to complaints and to respond to 90% of complaints within the agreed timescale.	DoN	Achieve 90% by September 2018	Quality Committee

Objective	Lead Director	Measurement	Governance Route
4.1.1 Improve the learning from complaints to change practice (same process as 2.3) 4.1.2 Reduce the number of 2nd level complaints where the complainant is unsatisfied with the initial response 4.1.3 Produce a quarterly report on complaint satisfaction survey results		Reduction on 2nd level complaints Audit of lessons learnt	
4.2. We will fully implement the action plans developed in response to the results of all national patient surveys, including; 4.2.1 National inpatient survey 4.2.2 National maternity inpatient survey 4.2.3 National cancer survey	DoN	Monitoring of action plans	Quality Committee
4.3. Use patient feedback to shape future service developments – identifying themes from all sources of feedback e.g. F&FT, Healthwatch, patient surveys, ask Ann, complaints, PLACE 4.3.1 Produce a thematic annual report from all patient feedback 4.3.2 Agree 2 -3 priority initiatives in response to the key issues identified 4.3.3 Publicise the changes made and the difference it has made to patients	DoN	Feedback from Healthwatch F&F test responses and approval ratings. Annual PLACE assessment You said we did reports	Quality Committee
5. 5 STAR PATIENT CARE – Systems ***We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes***			
5.1 Implement the new Patient Administration System with minimal disruption to contractual or operational performance.	DoI	Achieve BAU state by August 2018	Executive Committee
5.2 Make the most effective use of the skills of the nursing workforce by implementing an electronic system (SafeCare) to ensure optimal deployment of nursing resources. (QA Priority)	DoN/DoHR	System implementation by September 2018 Safer staffing reports – maintain over 90% fill rates Care Hours Per Patient – maintain 3 hours	Quality Committee
5.3 Implement phase 1 of the Shared Care Record with partners in St Helens.	DoI	Shared care record operational by March 2019	Executive Committee
6. DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE ***We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce that feel valued and supported to care for our patients.***			
6.1 Implement innovative approaches to recruitment and retention	DoHR	HR Indicators Reports	Trust Board

Objective	Lead Director	Measurement	Governance Route
6.1.1 Recruit 80 permanent new nurses to the Trust 6.1.2 Recruit 50 nurses via international recruitment/global learners programme 6.1.3 Increase the number of staff who retire and return and promote flexible working 6.1.4 Provide development opportunities including rotational programmes 6.1.5 Expand the Trust preceptorship and whole career development to more staff groups			
6.2 Make further improvements to the Trust so it is increasingly recognised as an employer of choice. 6.2.1 Act on feedback from staff survey to include an increase in rate of appraisals, staff satisfaction in care they provide and reduction in staff experiencing physical violence from patients 6.2.2 Conduct local impact assessment surveys, prior to the 2018 staff survey	DoHR	Quarterly Reports NHS Staff Survey Action Plan	Workforce Council
6.3 Optimise the apprenticeship levy to support staff in realising their potential. 6.3.1 Offer a broad range of apprenticeship schemes to staff to develop skills and aid retention 6.3.2 Utilise the levy to support new roles such as c12 nursing associates, c20 apprenticeship nurse degrees and physician associates when frameworks are in place. 6.3.3 Support the development of new roles e.g. advanced care practitioners to address staff shortages	DoHR	E-rostering Programme Board reports	Executive Committee
6.4 Expand the implementation of e-rostering to allied health professionals to support effective use of resources across all staff groups 6.4.1 Implement e rostering for AHPs by end of Q3 2018/19 6.4.2 Optimise the benefits of e rostering for doctors in training to ensure effective deployment of staff.	DoHR	Improve rota fill rates for AHP and medical Staff	Executive Committee
7. OPERATIONAL PERFORMANCE ***We will meet and sustain national and local performance standards***			
7.1 Plan to achieve national performance access standards including: 7.1.1. The agreed trajectory for emergency access standards 7.1.2. Cancer treatment standards 7.1.3. 18 week access to treatment for planned care 7.1.4. Diagnostic tests completed within 6 weeks	DoOps	IPR	Finance and Performance Committee

Objective	Lead Director	Measurement	Governance Route
7.1.5. Ambulance handover times			
7.2 **Plan to achieve local performance indicators including**: 7.2.1 CQUINS 7.2.2 Contract performance indicators and compliance 7.2.3 Activity levels to meet Trust operational plans.	DoOps	Contract Monitoring	Finance and Performance Committee
7.3 Use of benchmarking and comparative data e.g. GIRFT and Model Hospital to increase productivity	DoOps	Improve comparative GIRFT performance Improve WAU comparators to peer group in the Model Hospital	
8. FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY ***We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money***			
8.1 We will use benchmarking and reference costs to achieve best practice; 8.1.1 Maintain reference cost index of less than 100 8.1.2 Improve performance against all three of the procurement efficiency standards	DoF	Annual Reference Costs NHSI Annual Benchmarking review Annual procurement performance score Model Hospital	Finance and Performance Committee
8.2 We will continue to work with partners across Cheshire and Merseyside and in local Integrated care systems to provide non-clinical back-office services, where cost improvement opportunities can be demonstrated; 8.2.1 Pathology Network 8.2.2 HR Services 8.2.3 Business Information 8.2.4 Informatics and IT 8.2.5 Financial Services	DoF	Annual Reference Costs NHSI Annual Benchmarking review Annual procurement performance score Model Hospital	Finance and Performance Committee
9. STRATEGIC PLANS ***We will work closely with NHS Improvement, and commissioning, local authority and provider partners to develop proposals to improve the clinical and financial sustainability of services***			
9.1 Transform community services by working closely with community, primary and social care to support; 9.1.1 Integrated out of hospital pathways	DoT	IPR & Corporate Activity Reports	Executive Committee

Objective	Lead Director	Measurement	Governance Route
9.1.2 Admission avoidance			
9.2 Collaborate with partners in the development and implementation of integrated care partnerships in order to benefit patient experience through the provision of integrated high quality, safe, efficient and effective services.	DoT		Executive Committee
9.3 We will meet all the compliance requirements set by NHSI in the Single Oversight Framework to maintain the long-term sustainability of clinical services for local people, collaboratively with partners where appropriate. 9.3.1 Commission an independent Well Led Review 9.3.2 Participate fully in the Cheshire and Merseyside Health and Care Partnership	DoCS	Meet all reporting and compliance requirements and deadlines Maintain segmentation rating	Executive Committee

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18) AOB 1
Title of paper: Adverse Changes to Forecast Protocol – Assurance Statement
Purpose: To ensure the Trust Board has complied with all regulatory requirements in changing its 2017/18 forecast outturn.
Summary: 1. The Board has been fully briefed on the increasing financial risks in responding to winter pressures and the potential loss of STF, since November. 2. Based on month 11 (February) performance the forecast outturn position reported to NHS Improvement (NHSI) on 15th March changed from £8.5m to £2.5m 3. The month 11 position has been reported and discussed in detail at the Finance and Performance Committee on 22nd March. 4. To comply with the NHSI regulatory requirements for changing the forecast outturn, the Board is required to approve the attached assurance statement. 5. The Director of Finance has formally spoken to an NHSI representative explaining the reasons for the change in outturn.
Trust objective met or risk addressed: Assurance of robust financial reporting and governance in relation to financial risks
Financial implications: Loss of STF for Q4, as reported in the finance report
Stakeholders: Staff, patients and the public, regulators
Recommendation(s): To approve the assurance statement.
Presenting officer: Nik Khashu, Director of Finance and Information
Date of meeting: 28th March 2018

Adverse Changes to Forecast Protocol - Board Assurance Statement

Trust Name St Helens & Knowsley NHS Trust

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (notes below)

Board Response

Where a provider plans to make an adverse change to an in-year forecast it must be reported through the national reporting process and accompanied with this Board Assurance Statement which has been signed by the Trust Chair, Chief Executive and Director of Finance

For finance:

The Board has been fully briefed on the planned adverse change to forecast and has adhered to the NHS Improvement protocol for ***'Adverse Changes to the In-Year Forecasts'*** prior to requesting the change	Confirmed
All reporting revisions are accompanied with detailed actions and the trust will continue to explore all options to recover the position and achieve delivery of the original financial plan.	Confirmed
The Board is fully committed to the delivery of the Trust recovery plan and will actively monitor the recovery plan milestones	Confirmed
In advance of formally reporting a forecast outturn variance from plan the Trust has discussed the financial deterioration and remedial actions with the NHS Improvement Regional Managing Director and Regional Director of Finance	Not Confirmed

For governance:

Relevant commissioners have been informed of the position and all opportunities for support have been explored and the recovery actions agreed	Confirmed
The senior clinical decision making body within the Trust has been engaged with and are party to the identification and delivery of the recovery actions	Confirmed
The Trust Executive Committee, Finance Committee and Board have considered and agree the proposed financial forecast revision and recovery actions	Confirmed

Board Declaration

I can confirm that in my capacity as a member of the Trust Board, I understand the financial forecast, its key drivers and where there has been a variance signalled, I can confirm that we will continue to explore all options to recover the position and deliver the original plan that was signed off by this Trust Board and that these actions have been and will be considered in full by Clinical Decision Making Groups the Finance Committee and the Board as a minimum.

Signed on behalf of the board of directors

Signature		Signature	
Name	Ann Marr	Name	Richard Fraser
Capacity	Chief Executive	Capacity	Chair
Date	3/28/2018	Date	3/28/2018
Signature		Signature	
Name	Nik Khashu	Name	Su Rai
Capacity	Finance Director	Capacity	Audit Committee Chair
Date	3/28/2018	Date	3/28/2018