NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 30TH MAY 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.	May		
09:55	3.	Apologies for Absence			
	4.	Declaration of Interests			
	5.	Minutes of the Previous Meeting held on 25th April 2018		Attached	
		5.1.	Correct Record & Matters Arising		
		5.2.	Action List	Attached	
Performance Reports					
10:05	6.	Integrated Performance Report		NHST(18) 41	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					
10.25	7.	Committee Report – Executive		NHST(18) 42	Ann Marr
10:35	8.	Committee Report – Quality		NHST(18) 43	David Graham

10:40	9.	Committee Report – Finance & Performance		NHST(18) 44	Jeff Kozer
BREAK					
11:10	10.	Committee Report – Audit		NHST(18) 45	Su Rai
		10.1.	Adoption of Annual Accounts	NHST(18) 46	
		10.2.	Approval of Audit Plan	NHST(18) 47	
Other Board Reports					
11:35	11.	Strategic & Regulatory Report *(including Provider Licence Self-Certification 2018)*		NHST(18) 48	Nicola Bunce
11:45	12.	Quarterly Complaints, Claims and Incidents Report		NHST(18) 49	Sue Redfern
11:55	13.	Approval of Quality Account		NHST(18) 50	Sue Redfern
12:05	14.	Board and Committee Effectiveness Review		NHST(18) 51	Nicola Bunce
12:15	15.	Information Governance Annual Report		NHST(18) 52	Francis Andrews
12:25	16.	Trust Objectives and End of Year Review		NHST(18) 53	Ann Marr
Closing Business					
12:35	17.	Any Other Business			Richard Fraser
	18.	Effectiveness of Meeting			
	19.	Date of Next Public Board Meeting – Wednesday 27th June 2018			

St Helens and Knowsley Teaching Hospitals NHS Trust

Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Board meeting held on Wednesday 25th April 2018 in the Boardroom, Whiston Hospital

PUBLIC BOARD

Chair:	Mr R Fraser	(RF)	Chairman
Members:	Ms A Marr	(AM)	Chief Executive
	Mr D Mahony	(DM)	Non-Executive Director
	Ms S Rai	(SR)	Non-Executive Director
	Mrs V Davies	(VD)	Non-Executive Director
	Mr J Kozer	(JK)	Non-Executive Director
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Prof K Hardy	(KH)	Medical Director
	Mrs S Redfern	(SRe)	Director of Nursing, Midwifery & Governance
	Mr N Khashu	(NK)	Director of Finance
	Mrs C Walters	(CW)	Director of Informatics
	Mr P Williams	(PW)	Director of Facilities Management/Estates
	Mr R Cooper	(RC)	Director of Operations & Performance
	Ms N Bunce	(NB)	Director of Corporate Services
	Dr T Hemming	(TH)	Director of Transformation
In Attendance:	Ms J Byrne	(JBy)	Executive Assistant *(Minute Taker)*
	Cllr G Philbin	(GP)	Halton Council *(Co-opted Member)*
	Ms J Marlow	(JM)	Respiratory Registrar *(Observer)*
Apologies:	Prof D Graham	(DG)	Non-Executive Director
	Mr T Foy	(TF)	St Helens CCG *(Co-opted Member)*

1. Patient Feedback

Board members watched a video that had been shown at the Annual Awards Evening, which had included feedback from a number of patients about the care they had received at the Trust. AM had emphasised the importance to using the awards evening to celebrate the excellent care given by Trust staff.

2. Employee of the Month

2.1. The Employee of the Month Award for March 2018 was awarded to Ms Emma Taylor, Sepsis Specialist Nurse.

2.2. The Employee of the Month Award for April 2018 was awarded to Sharon Carpenter, Housekeeper Ward 2B.

3. Apologies for Absence

Apologies were noted as above.

4. Declaration of Interests

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

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

5.1. Correct Record

JK had been omitted from the list of attendees, with this amendment the minutes were accepted as a correct record.

5.2. Matters Arising

None.

5.3. Action List

There were no actions due for completion in April.

6. Integrated Performance Report (IPR) – NHST(18)32

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

6.1. Quality Indicators

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

6.1.2. The Trust had submitted the routine Provider Information Request (PIR) return to CQC by the deadline of 19th April, the Trust had also now received notification of the NHS Improvement Use of Resources Assessment timetable.

6.1.3. There were no never events in March and 2 cases in 2017/18, both related to the incorrect insertion of nasogastric tubing.

6.1.4. There were no MRSA bacteraemia cases in March. Of the 2 cases reported in 2017/18, 1 was still subject to appeal and the other 1 was a contaminated specimen. The appeal was being heard on 25th April. SRe would report on the outcome of the appeal at the next meeting.

6.1.5. There were 2 C.Diff positive cases in March, 23 cases in 2017/18 although 3 cases are subject to appeal, with the hearings scheduled for May.

6.1.6. There had been no grade 3 or 4 avoidable pressure ulcers reported during 2017/18.

6.1.7. The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for February was 93.9%, performance to month 11 was 93.9%.

6.1.8. During the month of February there were 3 inpatient falls resulting in severe harm. Year to date total for all falls is 20

6.1.9. Venous thromboembolism (VTE) performance for February was 95.24%. Year to date performance is 93.67% and although there had been a significant improvement in performance over the later part of the year the recovery would not be sufficient to achieve 95% for the year.

6.1.10. Final Hospital Standardised Mortality Ratio (HSMR) for 2016/17 was 102.4 and the reported figure for 2017/18 is 100.4.

6.2. **Operational Indicators**

6.2.1. RC presented the update on the operational performance.

6.2.2. The Trust continued to achieve the 31 and 62-day cancer access standards.

6.2.3. The Trust was also continuing to deliver the 18 week referral to treatment standard with 94% performance reported for the year.

6.2.4. A&E performance was 67.7% (type 1) and 84.0% (mapped STHK footprint – all types) for March. March 2018 activity was 12% higher than March 2017 (1,056 more patients). The trust continued to experience very high bed occupancy – 98% for the medical wards, and face challenges in filling medical staff positions, which made efficient patients flows difficult to achieve.

6.2.5. In response to a query from RF, RC confirmed staff in A&E were coping very well with the additional pressure. Their hard work and effort had been recognised in the Annual Awards evening, however RC stressed the importance of ensuring that all staff continued to feel supported. It was acknowledged the hospital had been built with a capacity for an average of 250 daily attendances, and ED was now regularly seeing 400+ attendances, particularly on Mondays. A presentation to the Finance & Performance Committee had highlighted an 8% increase in type 1 attendances from the St Helens during 2017/18. Additionally, the Trust was experiencing increased out of area activity, as well as increased paediatric activity from Liverpool in the last few days, as a result of the events at Alder Hey Hospital.

6.2.6. The scheme to extend the ED department would help to improve patient flows, once completed. The Executive Committee were also developing other plans to maximise bed capacity and alternative staffing models ahead of next winter.

6.2.7. NK noted that the good performance on cancer standards and RTT was a significant achievement and the staff in these areas of the Trust should also be recognised for all their good work.

6.3. **Financial Indicators**

6.3.1. NK presented the update on the financial performance.

6.3.2. The Trust submitted to NHSI its provisional outturn position of a £2.9m deficit excluding STF. When including the known STF allocation of £5.1m, this gave a reported surplus of £2.2m. After this draft NHSI submission, on 20th April the Trust received a letter from NHSI saying that due to nationally unallocated STF and in recognition of the winter pressures, the Trust was to receive and account for an additional STF allocation of £2.8m. This meant the Trust year end position would still be a £2.9m deficit without STF. Accounting for all allowable STF of £7.9m meant a new and final reported surplus of £5.0m.

6.3.3. The Trust finished the year with a closing cash balance of £11.7m and capital expenditure of £9.18m, which were in line with the plans for the year.

6.4. **Workforce Indicators**

6.4.1. AMS presented the update on the workforce indicators.

6.4.2. Absence in March was 4.7% and the year-end position was also 4.7% against a target of 4.5%. This is an improvement compared to 2016/17.

6.4.3. Mandatory training compliance was 92.5% and continued to exceed the 85% target. Appraisal compliance was 88.4% which also exceeded the 85% target. AMS thanked all staff for their support in meeting these targets.

7. Committee Report – Executive – NHST(18)33

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

7.2. The planned ward swap between surgery and medicine on Ward 3C had been completed successfully on 19th April.

The Executive Committee had agreed a proposal to support more staff to train to become qualified nurses, via the emerging alternative training routes and to introduce a new role of Nurse Associate, which was being piloted in a number of Trusts nationally. These initiatives would help the Trust to deliver its recruitment and retention strategy.

7.3. The Executive Committee reviewed the monthly activity and assurance report in relation to the Marshalls Cross Medical Centre. In response to a query from RF, TH confirmed the majority of patients were offered an appointment within 48 hours unless they asked to see a particular GP.

7.4. An emergency planning exercise to test the ability to "lock down" the Whiston site had been conducted and a formal report with recommendations to improve the procedures was being prepared. In response to a query from RF, SRe confirmed the lock down had gone well with 23 entrances locked down in a short period of time, and valuable lessons learnt which would allow for the process to be improved.

7.5. The Committee had noted an increase in agency expenditure since month 9, reflecting the operational pressures in Medical Care and increased staff sickness. There had been an increase in off framework and above agency cap spend on mainly nursing and medical staff. The positive impact of the Staff Bank recruitment campaign had been acknowledged.

SR asked about agency expenditure in relation to planned CIP. NK confirmed the Trust was planning expenditure of £7.2m for 2018/19, in line with NHS Improvement's (NHSI) target figure. The plans were based on the Trust being able to recruit more permanent staff to enable agency and locum staffing to be reduced, however due to national staff shortages in some specialities there was a degree of risk. There were medium and long-term solutions in place, for example the Trust was leading on the collaborative bank, and is developing a user-friendly phone app to enable staff to choose bank shifts.

7.6. A business case had been approved to install PCs to ensure ancillary and domestic staff could access electronic payslips, to bring these staff in line with the rest of the Trust.

7.7. The Executive Committee was updated on the hyper acute stroke service that had been in operation for 12 months. The service had performed very well in the recent Sentinel Stroke National Audit Programme (SNNAP), which provided assurance that the service model was delivering improvements across a number of the domains.

North West Boroughs Healthcare NHSFT had provided an update on the work that had been undertaken with the District and Community Nursing Teams since April 2017. The progress made to date in implementing the service specification was noted and the next steps had been discussed, including how different parts of the system, could work more closely together.

7.8. AM also updated the Board on the capacity options that had been developed as a result of the Executive "time-out" day on 12th April.

8. Committee Report – Audit – NHST(18)34

8.1. SR presented the Chairs assurance report from the Audit Committee meeting on 18th April.

8.2. It was noted that the Committee had not been quorate, but no decisions had been made.

8.3. The Director of Finance and Committee chair had responded to questions from the External Auditor and had also considered the "going concern" assessment.

8.4. There were no other issues for escalation to the Board.

8.5. NK reported that the draft annual report and accounts had now been submitted to the External Auditor.

9. Committee Report – Quality – NHST(18)35

9.1. In DG's absence, VD had chaired the meeting and presented the Chair's assurance report to the Board, which summarised key issues arising from the Quality Committee meeting held on 17th April 2018.

9.2. The number of new stage 1 complaints opened in March 2018 was 8.

9.3. The Trust had received 224 complaints in 2017/18, a reduction of 44% (114) compared to 2016/17, which could partly be attributed to greater engagement with families at the informal stage.

9.4. The Trust had responded to 67% of complaints within the agreed timescale which was an improvement on the previous two years' performance (58% in 2016/17 and 61.4% in 2015/16).

9.5. All 57 actions from the CQC Inspection Action Plan had now been formally accepted as fully completed, and the action plan had been closed.

9.6. National Inpatient Survey – the committee had reviewed the Trust's data and would compare these to the national results that would be published in May. The Quality Committee had requested an action plan be developed to address the issues identified.

9.7. GP asked if the survey could be simplified to make it easier to use. Unfortunately as this was a national survey, the questions were set centrally. The Trust was intending to conduct local surveys to understand any interpretation or communication issues in advance of the next national survey.

9.8. AM commented that many of the responses to the national cancer survey actually related to oncology services that were provided by another Trust, so it was important to analyse these survey results carefully as patients could not be expected to distinguish who was providing their care.

9.9. RF queried why a number of the returned responses could not be used. SRe explained the survey provider had classed the responses as 'incomplete'. RF suggested contacting the provider to obtain feedback on these unused responses, as it was a great opportunity for learning, for some of the questions.

10. Committee Report – Finance and Performance – NHST(18)36

10.1. JK presented the Chair's assurance report to the Board, which summarised key issues arising from the Finance and Performance Committee meeting held on 19th April 2018.

10.2. The Committee had reviewed A&E performance compared to peers, both regionally and nationally. The discussion centred on how the Trust can use predictable patterns in attendances to improve resilience next winter.

10.3. GP informed Board members that an additional 250 houses per year over the next 5 years were being built in Widnes alone, which would inevitably impact on demand for the Trust's services.

10.4. Since the meeting the Trust had received notification of the additional STF allocation, which changed the provisional 2017/18 reported outturn position.

10.5. The Finance & Performance Committee had discussed the risks and challenges of delivering the 2018/19 CIP programme and had requested an increase to monthly reporting rather than quarterly., to provide additional monitoring and assurance.

10.6. The Committee had also discussed the role of the PMO in supporting the development and delivery of CIP plans and the importance of ownership by the Care Groups and services.

10.7. There was a Board discussion on how the CIP target for transformational and partnership working would be managed, with agreement that this needed to lead by the Executive who could influence the wider system.

10.8. The Committee would also increase its scrutiny of the Quality Impact Assessment process, throughout the life of the CIP scheme and instigate enhanced post implementation reviews to prevent any adverse impact on quality.

10.9. The communications with staff about the 2018/19 financial plan were being developed to raise understanding of the objectives and alley any concerns.

11. Corporate Risk Register Report – NHST(18)37

11.1. NB presented the Corporate Risk Register report, which provided assurance that the risks management and escalation processes used by the Trust were effective.

11.2. The register reported at total of 770 risks from across the organisation at the end of March 2018, half of which were rated moderate or high risks.

11.3. Thirteen of these risks had been escalated to the Corporate Risk Register, a summary of which was presented in the report.

11.4. In relation to Risk 1955, JK asked whether there should be a separate risk relating to CIP, given the discussions at the Finance and Performance Committee. NB confirmed that the reported risks related to the 2017/18

financial year and all the finance risks were now being reviewed in light of the 2018/19 plans.

11.5. The Board members discussed the CRR and agreed that the risks reported via the escalation process were all issues the Board would recognise and discussed regularly.

12. Board Assurance Framework Report – NHST(18)38

12.1. NB presented highlights from the quarterly Board Assurance Framework (BAF) report which gave assurance to the Board that it had sufficient processes in place to gain assurance on the delivery of its statutory functions and long-term strategic objectives.

12.2. The report had been reviewed at the Executive Committee and changes proposed to ensure the BAF remain up to date. Some minor changes to the wording of the overarching objectives had also been recommended to take account of the Trust's increasing role in working as part of wider health and care systems.

12.3. VD asked how the quality of the Community Services were monitored, and it was confirmed that the activity and performance dashboard for community nursing was now included as part of the full IPR and a similar dashboard was being developed for Marshalls Cross Medical Centre. There was further discussion on how the benefits of delivering these services would be assessed and NB confirmed that in relation to Adult Community Nursing the full service specification required by the CCG was now being delivered, however to achieve the full St Helens Cares vision for integrated care required further transformation across these and other services including primary care, social care, mental health etc.

12.4. The Board discussed the capacity and expertise needed by the Trust to help deliver this level of transformation in St Helens and across other health systems.

12.5. Board members asked that risk 8 include the action to deliver the St Helens Shared Care record and with this change approved the BAF.

13. Learning from Inpatient Deaths – NHST(18)39

13.1. KH presented the second quarterly report, which detailed data to Q3 2017/18, including the methods for sharing and learning lessons, in accordance with the Learning from Inpatient Deaths Policy.

13.2. KH stated that there was now a cohort of 13 reviewers in the process of undertaking formal structured training and that the Trust was likely to switch from the St Helens & Knowsley Teaching Hospitals NHS Trust (STHK) Structured Judgement Review (SJR) to the Royal College of Physicians (RCP) SJR in due course. A sample of 25% of deaths from the non-specified groups were reviewed and all of the deaths from the specified groups.

13.3. Board members noted the number of stroke deaths, a high proportion of which were associated with Atrial Fibrillation (AF). A working group had been set up

to improve best practice management of AF in the community to help prevent strokes caused by AF.

13.4. AM noted the Cheshire Fire Service had recently carried out an experiment in the Halton area, whereby they suggested AF health checks whilst installing fire alarms in residential properties. As a result of carrying out the exercise, the borough's statistics for identifying and treating AF were much better than other local Boroughs, however it was not yet clear if this then impacted on the numbers of AF strokes.

13.5. There had been one 'red' death in the quarter, which was consistent with national returns, but small numbers prevented any solid conclusions on the matter at this time.

13.6. In response to a question from AM, KH confirmed different Trusts had adopted different methodologies for reviewing inpatient deaths and the objective of the national guidance was to support learning rather than to compare different organisations.

13.7. The 2 key learning priorities for the next quarter were agreed. KH explained that 'sharing' was inevitably audited a quarter in arrears and 'learning' following sharing, two quarters in arrears.

13.8. These priorities would be disseminated to all forums and minutes requested from the different clinical and governance forums to ensure they had been reported and discussed.

13.9. In relation to a query from NK, KH did not feel that it was likely that the new process would identify any issues or concerns the Trust was not already detecting via its other processes, eg incident reporting, complaints etc. however the focussed identification of priority lessons and structured dissemination would hopefully contribute to strengthening the learning culture and as a result improve the care provided.

13.10. The Board approved the report.

14. Clinical & Quality Strategy Update – NHST(18)40

14.1. KH presented the paper and explained the Trust had set a series of challenging stretch targets to drive higher quality performance when the strategy had been developed a few years ago.

14.2. The report provided an update on the stretch KPIs and the improvements against them.

14.3. DM noted the Trust's zero tolerance approach to MRSA had been a great achievement.

14.4. KH explained that all of the targets were routinely reported via the Integrated Performance Report but in summary, in 9 of the areas the Trust's performance had improved. The area where performance had not yet improved was sending e-discharge summaries within 24 hours, however the long term solution to this would be delivered as part of the new Medway Patient administration system

which was being implemented and performance should improve in 2018/19.

14.5. KH reported that the Strategy was now due to be refreshed.

14.6. The Board approved the report.

15. Any Other Business

15.1. CW tabled a short paper to support this item. National Cyber Security Audit – in January 2018 the Department of Health and Social Care (DHSC), NHS England and NHS Improvement published 10 data and cyber security standards that apply to all providers of health and care. The Board had previously been briefed on these requirements.

15.2. On 11th April, NHSI issued a survey that all provider Trust were to complete and return by 11th May, detailing whether they are compliant, partially compliant, or not compliant with these Data Security Protection Requirements (DSPR).

15.3. The response to the survey was expected to be Board approved, however due to the deadline for submission the majority of Trusts were not able to review it as part of their normal meeting cycle. The DHSC had therefore agreed that Boards could delegate the Chief Executive or a Board Committee to review and approve the submission. As there were no Trust committees scheduled to meet before 11th May the Board was asked to delegate authority to the Chief Executive.

15.4. The Board approved the delegated authority.

16. Effectiveness of Meeting

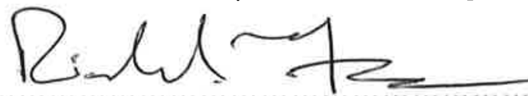
16.1. Jenny Marlow (Observer and Respiratory Registrar) confirmed the meeting had been extremely useful from a training perspective in understanding what happens outside of the clinical area.

16.2. Board members agreed to raise the profile of the Public Board meeting and to make staff aware they could attend. NB to include in the next Team Brief.

16.3. Cara Taylor, Hospital Inspector, CQC (Observer) commented the Board was strong with a good understanding of issues. It had been a wide agenda with good challenge and communication. Overall she felt the meeting was interesting and had been effective, she thanked the Board for allowing her to attend.

17. Date of Next Meeting

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



Chairman: ....

Date: 30th May 2018 ....

NHS
St Helens and Knowsley
Teaching Hospitals
NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 30TH MAY 2018

No	Minute	Trust Public Board Action Log	Lead	Date Due
~~1.~~	~~31.01.18 (13.3)~~ 28.02.18 (4.3)	~~AMS to contact the local Trusts with lower staff turnover to ensure all good practice is being following in relation to retention of staff.~~ Action closed. Follow up action: AMS to undertake further analysis of leavers and pipeline for recruitment initiatives, for review by the Executive Committee and to include a waterfall analysis in the next HR Indicators Board report to come to Board in June.	~~AMS~~ AMS	~~28.02.18~~ 27.06.18
2.	28.02.18 (5.1.2)	Nasogastric Tubing Never Events – ~~SRe to provide feedback on results of RCAs at next Quality Committee~~. Action Closed. Update: 28.03.18: recommendations and action plan to be taken to Quality Committee in May.	SRe	30.05.18
3.	28.02.18 (5.3.6)	SRe to present paper regarding the Maternity Reduction for Clinical Negligence Scheme for Trusts (CNST)	SRe	30.05.18
4.	28.02.18 (8.3)	Quality Committee to develop proposals for a severity rating of complaints.	DG	27.06.18
5.	28.02.18 (13.2)	AMS to undertake further investigation of the issues raised by the WRES survey action plan in relation to disciplinary action.	AMS	27.06.18
6.	25.04.18 (15.3)	National Cyber Security Audit – delegated authority given to the Ann Marr to approve the survey submission.	AM	Complete
7.	25.04.18 16.2	Public Board – NB to include a paragraph in the next Team Brief to ensure staff are aware they can attend public meetings.	NB	June 18

INTEGRATED PERFORMANCE REPORT

Paper No: NHST(18)41
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

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

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

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

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

Patient Safety, Patient Experience and Clinical Effectiveness

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

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

There were no MRSA bacteraemia cases in April 2018.

There were 2 C.Difficile (CDI) positive cases in April 2018. The annual tolerance for CDI for 18-19 is 40.
The Trust originally recorded 28 C-Difficile cases for 2017/18. The Trust subsequently appealed 8 cases, bringing the total down to 20. 1 further case is still pending a decision.

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 March 2018 was 93.9%. YTD performance is 93.9%.

During the month of March 2018 there was 2 inpatient fall resulting in severe harm . YTD total is 22.

Performance for VTE assessment for March 2018 was 93.69%. YTD performance is 93.67% against a target of 95%.

Final HSMR for 2016-17 is 102.4

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 18/19 financial outturn will have implications for the finances of the Trust
Stakeholders: Trust Board, Finance Committee , Commissioners, CQC, TDA, patients.
Recommendation: To note performance for assurance
Presenting Officer: N Khashu
Date of Meeting: 30th May 2018

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (March 2018) at 89.6%. The 31 day target was also achieved with 98.3% performance against a target of 96%. 2 week rule compliance was also achieved with 94.8% performance.

Type 1 A&E performance for April was 72.4%. The main issue affecting performance was related to availability of medical staff. A business case is being prepared proposing conversion of locum/agency spend into substantive posts, which will support effective clinical management of the increased activity.

Bed capacity improved following the bed reconfiguration on 19.4.18, with net 21 additional beds for medicine. This will support the work to cease outlying medical patients into the surgical bed base. Work has also continued to maintain low numbers of 'good to go' patients in the hospital. Ambulance turnaround compliance has also significantly improved from 20% >1 hour in March to 6% in April.

RTT incomplete performance was delivered at 94.3% v target of 92.0%. Specialty level actions to maintain this achievement continue.

Financial Performance

At the end of April (M1) the Trust is reporting an overall deficit of £2m which is in line with agreed plans. Included within the financial position is the full allocation of Provider Sustainability Fund (£0.6m). Failure to recover the A&E position by the end of Q1 could result in the Trust losing 25% of this allocation.

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

The Trust cash balances are above planned levels.

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

Human Resources

Absence in April is 4.1% which is a 0.6% improvement on March (4.7%). This is below the Q1 target of 4.25% by 0.15%. YTD absence is 4.1% against last year outturn of 4.7%.

Mandatory Training compliance exceeds the target by 10.9% at 95.9%. Appraisal compliance is 80.1% and below the target by 4.9%.

The following key applies to the Integrated Performance Report:

▲ = 2018-19 Contract Indicator

▲£ = 2018-19 Contract Indicator with financial penalty

● = 2018-19 CQUIN indicator

T = Trust internal target

Apr-18

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 31-37)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Apr-18	1.9%	1.9%	No Target	2.4%		Overall SHMI and HSMR within control limits. Mortality fluctuates month-to-month, but is stable medium-term. Crude mortality typically increases (nationally) in Winter. Latest NHS evidence supports previous work that patients admitted at weekends and out of hours are sicker. Specific diagnostic groups with raised mortality to intensive investigation.	Patient Safety and Clinical Effectiveness	Trust is implementing an electronic solution to improve capture of comorbidities and to prompt palliative care review in those known to that service. Major initiatives to improve management of AKI and Sepsis are well underway to improve care and reduce mortality.	KH
Mortality: SHMI (Information Centre)	Q	▲	Sep-17	1.03		1.00						
Mortality: HSMR (HED)	Q	▲	Dec-17	88.1		100.0	100.4					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Dec-17	92.1		100.0	96.4					
Readmissions: 30 day Relative Risk Score (HED)	Q	T	Nov-17	100.1		100.0	102.5		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		100.0	91.7		Sustained reductions in NEL LOS are assurance that medical redesign practices continue to successfully embed.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Aug-17	109.7		100.0	99.6					
% Medical Outliers	F&P	T	Apr-18	1.4%	1.4%	1.0%	2.3%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in LoS, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place. Continued focused management of all patients requiring discharge support. A review of the Trust bed model has resulted in plans to reconfigure some surgical beds to medical thus reducing outliers.	RC
Percentage Discharged from ICU within 4 hours	F&P	T				52.5%	48.7%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. Critical care rep now attending all bed meetings to agree plan and to highlight patients who will require transfer over the coming 24 hours.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Mar-18	69.0%		90.0%	69.5%		eDischarge performance poor - there is insufficient trainee doctor resource to hit this target with existing paper-based systems.		Pending ePR, we have devised an automated eDischarge notification which will be computer generated and send within 24 hours. Thereafter a full discharge summary will be sent within 14 days. We're seeking CCG approval at CQPG before implementation.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Mar-18	90.1%		95.0%	89.6%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Mar-18	99.3%		95.0%	99.0%					

Apr-18

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Mar-18	79.4%		83.0%	90.3%		Target is being achieved YTD. With effect from April 2017, STHK is also treating patients from the Warrington Area.	Patient Safety, Quality, Patient Experience and Clinical Effectiveness	Performance has deteriorated in month with plans in place to recover to previous high performance	RC
PATIENT SAFETY (appendices pages 39-42)												
Number of never events	Q	▲ £	Apr-18	0	0	0	2		The National safety standards for invasive procedures will provide further mitigation against future never events.	Quality and patient safety	The RCA and action plans for never events reported has being developed. Immediate and strategic actions have already been implemented including communication to staff, development of training (medical and non-medical) and policy revision. Mitigations and Trust wide development actions are currently ongoing.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Apr-18	98.8%	98.8%	98.9%	98.9%		Achieving standard YTD	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	Apr-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	▲ £	Apr-18	0	0	0	2		Internal RCAs on-going with more recent cases of C. Difficile.	Quality and patient safety	The Infection Control Team continue to support staff to maintain high standards and practices. They also monitor and undertake RCA for any hospital acquired BSI and CDI. CDI and Antibiotic wards rounds continue to be undertaken on appropriate wards.	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲ £	Apr-18	2	2	40	20					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Apr-18	1	1	No Target	22					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Mar-18	0		No Contract target	0		No grade 3 or 4 avoidable pressure ulcers YTD	Quality and patient safety	The Trust provides ongoing tissue viability training for all nursing staff including bank staff . New pressure ulcer reduction actions being implemented.	SR
Number of falls resulting in severe harm or death	Q	▲	Mar-18	2		No Contract target	22		2 severe harm fall reported in March 2018.	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	▲ £	Mar-18	93.69%		95.0%	93.67%		VTE performance remains inconsistent. A recent survey of successful units showed that they all have electronic solutions. The ePrescribing solution implementation has been delayed because of problems with this version of the software.	Quality and patient safety	Every effort is being made to supplement routine reviews with additional activity to improve performance pending an electronic solution.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Apr-18	2	2	No Target	31					
To achieve and maintain CQC registration	Q		Apr-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	Mar-18	93.9%		No Target	93.9%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	The next Shelford audit will be reported to June's Board.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Mar-18	0		No Target	1					

Apr-18

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 43-51)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Mar-18	94.8%		93.0%	95.0%		Two week, 31 and 62 day targets achieved YTD.	Quality and patient experience	A Cheshire and Mersey Cancer Alliance PTL has been established as part of the wider strategy to support system wide issues across patient Cancer pathways. Locally the focus is on accelerating pathway redesign and reducing variation in pathway performance by improved clinical engagement . Tumour specific dashboards are being redesigned to assist with visibility of clinical pathway performance. Increased scrutiny at patient level of open pathways and action planning at the weekly Cancer PTL review meeting. Actions arising from the reviews include working to establish improvements in booking by day 7, inter service transfers ,review of complex pathways requiring multiple MDT access and improved clinical and managerial accountability.	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Mar-18	98.3%		96.0%	97.7%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Mar-18	89.6%		85.0%	87.4%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Apr-18	94.3%	94.3%	92.0%	94.0%		In April 3 specialties are failing the 92% incomplete target; ENT, Plastics and T&O. On going backlog clearance plans continue with good effect but similar issues regarding theatre and bed capacity remain. RMS and more recent MCAS primary care services also have compounded the position. However, RMS and MCAS remains unpredictable with short / no notice diverts back to secondary care	Surgical Beds have now been handed to the Medical Care Group. Bed availability to manage the Surgical demand will potentially risk the backlog increasing, causing more incomplete performance failures. Additional risk also caused by impact of RMS and MCAS	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. A backlog management plan is in place and alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand. Actions to maintain and improve RTT performance reliant on theatre and bed capacity along with staff availability in collaboration with CCG's in ensuring RMS delivers in a sustainable and manageable way	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Mar-18	100.0%		99.0%	100.0%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Apr-18	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Apr-18	0.6%	0.6%	0.8%	0.6%		The cancelled ops targets continue to be achieved in April	Patient experience and operational effectiveness Poor patient experience	The planned increase in elective surgical activity in St Helens has commenced including increasing GA capacity on Saturdays.	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Mar-18	100.0%		100.0%	99.4%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Apr-18	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Apr-18	72.4%	72.4%	95.0%	78.2%		April 2018 Type 1 performance was 72.4% which was a slight improvement on March position of 67.7%. Main issue affecting performance was medical staffing (business case is being prepared to convert locum/agency spend into substantive). Bed capacity improved following bed reallocation on 19.4.18 with net 21 additional beds for medicine. Work has continued to maintain low numbers of 'good to go' patients and no outliers. Ambulance turnaround compliance has also significantly improved from 20% >1 hour in March to 6% in April	Patient experience, quality and patient safety	The urgent and emergency care transformation plan has several interconnected work streams designed to improve overall 4 hour access performance. Emergency Department/Front Door processes in place including 'walk in' streaming, Stretcher Triage streaming and internal departmental efficiencies and exit from ED. GP streaming in place as per NHSE recommendations. Flow through the Hospital Continuation of use of the SAFER Care Bundle to increase hospital discharges before midday to 33% and standardisation of daily Red to Green board rounds and afternoon huddles. Twice weekly discharge tracking meetings to manage medically optimised and DTOC escalation. Monthly Executive Multi-Agency Discharge Events (MADE) continue across the whole system to remove barriers and blocks that prevent patients with complex needs being discharged safely from hospital. Following 6a ECIP event and system resilience planning, commenced daily AMU/ED huddles and Community Matron in reach which is proving beneficial. Frailty in-reach to ED commenced. 1pm Frailty/ED/SpR safety huddle in place.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Mar-18	84.0%		95.0%						
A&E: 12 hour trolley waits	F&P	▲	Apr-18	0	0	0	0					

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Apr-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	Apr-18	9	9	No Target	224		% new (Stage 1) complaints resolved in month within agreed timescales continues to improve overall. The decrease in the number of new complaints received in the last few months has continued for March with 18 received.	Patient experience	The Complaints Team continue to improve the timeliness of responses.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Apr-18	16	16	No Target	270					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Apr-18	93.8%	93.8%	No Target	67.0%					
DTOC: Average number of DTOCs per day (acute and non-acute)		T	Mar-18	9		No Target	20		In February 2018 the average number of DTOCS (patients delayed over 72 hours) was 17. This is lower than the number in February 2017.		Tracking meetings happen with LA/CCG and wards twice weekly to ensure the numbers of DTOCs are maintained below 20.	RC
Friends and Family Test: % recommended - A&E	Q	▲	Mar-18	81.6%		90.0%	87.5%		The YTD recommendation rates remain below target for A&E, maternity (birth, postnatal community) and outpatients, but are above target for in-patients, antenatal, and postnatal ward maternity services. Outpatients saw a decrease in recommendation rates in March 2018.	Patient experience & reputation	Feedback from the FFT responses is fed back to individual areas to enable actions to be taken to address negative feedback, as well as using positive feedback to improve morale. The Patient Experience Manager continues to work with leads in each area where performance is below target, to identify specific themes for improvement, which are then displayed as 'you said, we did' posters.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Mar-18	95.9%		90.0%	95.8%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Mar-18	100.0%		98.1%	98.5%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Mar-18	100.0%		98.1%	97.9%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Mar-18	98.7%		95.1%	96.6%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Mar-18	93.8%		98.6%	98.1%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Mar-18	93.7%		95.0%	94.5%					

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 53-60)												
Sickness: All Staff Sickness Rate	Q F&P	▲	Apr-18	4.1%	4.1%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.7%		Overall absence in April reduced and is below the Q1 target of 4.25% by 0.15%. Qualified & HCA sickness also reduced in month to 4.8% against a target of 5.3%.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	The Absence Support team have supported the HR Advisors with welfare visits and stages to ensure timely action is taken and staff and managers are supported during this very busy period. The Absence Support Team have also been undertaking spot checks of staff absences to ascertain whether triggers have been hit and action subsequently taken by managers in line with the policy.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P	T	Apr-18	4.8%	4.8%	5.3%	5.7%					
Staffing: % Staff received appraisals	Q F&P	T	Apr-18	80.1%	80.1%	85.0%	88.4%		Mandatory Training compliance exceeds the target by 10.9%. Appraisal compliance is below the target by 4.9%.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The Education, Training & Development and Workforce Planning teams continue to work with managers to ensure on-going maintenance of compliance for Mandatory Training & to improve the rate of compliance for Appraisals with non-compliance being reviewed by the Trusts Executive Committee on a monthly basis and also at department level finance & performance meetings.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Apr-18	95.9%	95.9%	85.0%	92.5%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q4	92.0%		No Contract Target			Whilst response rates fluctuate we remain in the top 3 acute Trusts in our region for both response and recommendation rates.	Staff engagement, recruitment and retention.	Findings from the Q4 survey have been shared with Survey Champions in Clinical Support Services and Corporate areas following the publication of the results in April.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q4	76.7%		No Contract Target						
Staffing: Turnover rate	Q F&P	T	Apr-18	0.8%		No Target			Staff turnover remains stable and well below the national average of 14%.		Turnover is monitored across all departments as part of the Trusts Recruitment & Retention Strategy with action plans to address areas where turnover is higher than the trust average. Further action is required by Ward Managers to provide more support to newly qualified nurses.	AMS
FINANCE & EFFICIENCY (appendices pages 61-66)												
UORR - Overall Rating	F&P	T	Apr-18	3.0	3.0	3.0	3.0		At the end of M1 the Trust is currently delivering financial performance in line with agreed plans. The Trust is currently forecasting delivery of the plan but still has a proportion of the Cost Improvement Programme unidentified.	Delivery of Control Total	Weekly update to be provided to DoF on current progress of internal schemes. Divisions to report progress at Finance & Performance Committee. Executives to engage external stakeholders regarding progress of transformational programmes that will assist in delivering the Cost Improvement Programme.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Apr-18	397	397	19,000	12,325					
Reported surplus/(deficit) to plan (000's)	F&P	T	Apr-18	(2,003)	(2,003)	10,993	5,001					
Cash balances - Number of days to cover operating expenses	F&P	T	Apr-18	25	25	2	12					
Capital spend £ YTD (000's)	F&P	T	Apr-18	136	136	9,516	9,180					
Financial forecast outturn & performance against plan	F&P	T	Apr-18	10,993	10,993	10,993	5,001					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Apr-18	87.7%	87.7%	95.0%	91.4%					

APPENDIX A

			Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-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	▲ £	94.4%	100.0%	84.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	97.0%	85.0%		95.2%		
	Total > 62 days		0.5	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.5	0.0	3.5			6.0		
Lower GI	% Within 62 days	▲ £	100.0%	76.9%	100.0%	100.0%	92.3%	84.6%	69.2%	88.9%	82.4%	78.6%	80.0%	91.7%	75.0%	84.0%	85.0%		89.3%		
	Total > 62 days		0.0	1.5	0.0	0.0	0.5	1.0	2.0	0.5	1.5	1.5	2.0	0.5	1.5	12.5			8.0		
Upper GI	% Within 62 days	▲ £	87.5%	100.0%	100.0%	100.0%	33.3%	88.9%	80.0%	100.0%	86.7%	100.0%	100.0%	63.6%	100.0%	87.2%	85.0%		78.7%		
	Total > 62 days		0.5	0.0	0.0	0.0	1.0	0.5	0.5	0.0	1.0	0.0	0.0	2.0	0.0	5.0			10.0		
Urological	% Within 62 days	▲ £	67.6%	92.7%	59.3%	82.1%	83.3%	81.3%	87.5%	77.4%	90.2%	96.6%	60.9%	96.8%	86.2%	82.5%	85.0%		81.4%		
	Total > 62 days		6.0	1.5	5.5	3.5	3.0	4.5	1.5	3.5	2.0	0.5	9.0	0.5	2.0	37.0			36.5		
Head & Neck	% Within 62 days	▲ £	80.0%	66.7%	66.7%	75.0%	75.0%	42.9%	20.0%	100.0%	83.3%	80.0%	33.3%	66.7%	100.0%	64.6%	85.0%		67.3%		
	Total > 62 days		0.5	0.5	0.5	0.5	0.5	2.0	2.0	0.0	0.5	0.5	1.0	0.5	0.0	8.5			8.0		
Sarcoma	% Within 62 days	▲ £	100.0%	66.7%		100.0%		0.0%	100.0%			50.0%	33.3%	100.0%	100.0%	66.7%	85.0%		93.3%		
	Total > 62 days		0.0	0.5		0.0		0.5	0.0			0.5	1.0	0.0	0.0	2.5			0.5		
Gynaecological	% Within 62 days	▲ £	100.0%	70.0%	83.3%	100.0%	68.8%	55.6%	83.3%	100.0%	94.1%	55.6%	90.9%	66.7%	77.8%	78.2%	85.0%		90.1%		
	Total > 62 days		0.0	1.5	1.0	0.0	2.5	2.0	0.5	0.0	0.5	2.0	0.5	0.5	1.0	12.0			5.0		
Lung	% Within 62 days	▲ £	100.0%	100.0%	73.7%	85.0%	100.0%	72.7%	71.4%	87.5%	66.7%	100.0%	80.0%	100.0%	100.0%	84.7%	85.0%		82.7%		
	Total > 62 days		0.0	0.0	2.5	1.5	0.0	1.5	1.0	0.5	3.0	0.0	1.5	0.0	0.0	11.5			13.0		RC
Haematological	% Within 62 days	▲ £	100.0%	100.0%	66.7%	50.0%	71.4%	100.0%	50.0%	100.0%	85.7%	76.9%	100.0%	88.9%	83.3%	80.6%	85.0%		77.6%		
	Total > 62 days		0.0	0.0	1.0	1.0	1.0	0.0	3.0	0.0	0.5	1.5	0.0	0.5	1.0	9.5			8.5		
Skin	% Within 62 days	▲ £	100.0%	92.5%	93.9%	98.1%	93.9%	93.0%	88.9%	95.2%	98.2%	97.7%	100.0%	95.5%	92.5%	95.2%	85.0%		96.5%		
	Total > 62 days		0.0	1.5	1.0	0.5	1.5	1.5	2.0	1.0	0.5	0.5	0.0	1.0	2.0	13.0			9.5		
Unknown	% Within 62 days	▲ £	50.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%		75.0%	78.4%	85.0%		82.6%		
	Total > 62 days		1.0	1.0	0.0	0.0	1.0	0.0	0.0	1.0	0.0	0.0	0.0		1.0	4.0			2.0		
All Tumour Sites	% Within 62 days	▲ £	89.3%	88.2%	81.6%	91.4%	87.1%	84.5%	80.6%	89.5%	90.3%	90.6%	85.2%	89.1%	89.6%	87.4%	85.0%		88.4%		
	Total > 62 days		8.5	8.0	12.5	7.0	11.0	13.5	12.5	6.5	9.5	7.0	15.0	8.0	8.5	119.0			107.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £	100.0%					100.0%		100.0%		100.0%	100.0%			100.0%	85.0%		83.3%		
	Total > 31 days		0.0					0.0		0.0		0.0	0.0			0.0			1.0		
Acute Leukaemia	% Within 31 days	▲ £									100.0%					100.0%	85.0%		100.0%		
	Total > 31 days										0.0					0.0			0.0		
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				

TRUST BOARD

Paper No: NHST(18)42

Title of paper: Executive Committee Chair's Report

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

Summary:

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

There were a total of 3 Executive Committee meetings held during April (the Executive time out took place on the 12th April).

The Executive Committee agreed:

- The development of a feasibility study for robotic surgical equipment.
- An increase in Histopathology staff to cope with increased demand and to reduce cancer diagnostic turnaround times.
- Approval to proceed with the go-live process for the Medway Patient Administration System.

The Executive Committee also received the regular assurance reports covering Marshalls Cross Medical Centre, agency and locum usage, appraisal and mandatory training compliance, the Risk Management Council and Corporate Risk Register and the Board Assurance Framework.

Trust objectives met or risks addressed:

All 2018/19 Trust objectives.

Financial implications:

None arising directly from this report.

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

Recommendation(s): That the report be noted

Presenting officer: Ann Marr, Chief Executive

Date of meeting: 30th May 2018

FEEDBACK FROM THE EXECUTIVE COMMITTEE
April 2018

1. Introduction

There were 3 Executive Committee meetings in April 2018 (due to the Executive Time Out on the 12th April).

2. 5th April 2018

2.1 Update on Tumour site 31 day target improvement plans

The Director of Operations and Performance presented an update on the improvement plans for the Head and Neck, Lower Gastro Intestinal, Haematology and Gynaecological pathways. Where the pathway involved referral to another specialist Trust the aim was for all patients to be seen locally by day 19.

Fast track referral for diagnostics will be implemented when the new Medway Patient Administration System (PAS) is embedded. For patients with multiple tumour sites that transferred between different pathways the target could be particularly challenging.

2.2 Agency and Locum Staff

The Deputy CEO/Director of Human Resources presented the report on agency and locum spend for February 2018. The report included the split of expenditure across the Care Groups, the information reported to NHS Improvement and a breakdown between types and grades of staff.

2.3 Gender Pay Gap Information – Annual Publication

The Deputy CEO/Director of HR presented the report in advance of publication on the Trust website. The Trust was not an outlier compared to other NHS bodies; however more analysis was requested to help the Executive understand the breakdown between different groups of staff and if there were any anomalies that should be addressed.

2.4 Marshalls Cross Medical Centre

The Director of Transformation presented the monthly activity and assurance report in relation to the primary care service. Actions were agreed to provide a further update on Practice Nurse/Advanced Nurse Practitioner recruitment and to review the administrative support model.

2.5 Vascular Surgery

The Director of Operations and Performance reported on the discussions with the Royal Liverpool and Broadgreen University Hospitals NHS Trust about the provision of vascular surgery, following an increase in referrals. The service is provided via a Service Level Agreement (SLA) between the two Trusts.

2.6 Trust Board Agenda

The Director of Corporate Services presented the draft Trust Board agenda for April, based on the action log and annual work plan.

2.7 Level 2 Safeguarding Training

The Director of Nursing, Midwifery and Governance presented a report on the safeguarding training improvement plan. Performance had improved to 85.2% of qualifying staff completing the training, but challenges continued in relation to the safeguarding adults training and the Electronic Staff Record (ESR) system being updated to reflect the accurate position, as a result of the system problems experienced nationally.

2.8 Medway Programme

The Director of Informatics presented the Implementation Programme report, which gave an update on the final preparations and timetable for "go live" at the end of April. The number of staff who had received Medway training was being monitored on a daily basis to ensure sufficient numbers would be trained to operationalise the system effectively.

Board approval to go live was being sought on 25th April and the final operational decision would be taken on 26th April.

3. 19th April 2018

3.1. Robotic Surgical Equipment Presentation

The Director of Operations and Performance introduced a presentation that explored the opportunities for introducing robotic surgical equipment and described the safety and efficiency benefits that this could achieve. The adoption of this advanced technology by the Trust was explored and it was agreed that a full feasibility study would be developed.

3.2 Histopathology Turn Around Times

The Director of Operations and Performance presented options for expanding Histopathology capacity in response to the increasing demand and requirements to shorten turnaround times for cancer diagnostic pathways. An increase in the substantive establishment was approved as the most cost effective option. Opportunities for collaborative services across Merseyside, as a longer term solution to maximise capacity were also being explored and developed.

3.3 General Data Protection Regulations (GDPR)

The Director of Informatics presented a report detailing the progress in delivering the Trust's action plan and providing assurance that the Trust would be able to comply with the new regulations when they came into force in May.

3.4 Referral Management Systems (RMS)

The Director of Finance presented the latest capacity and demand modelling information which tracked the impact of the RMS introduced by each of the local Clinical Commissioning Groups since 2016/17. This demonstrated that following the initial reduction in first out patient referrals there was no significant drop in patients being listed for procedures. There was variation between different specialities but overall the on-going impact was less than originally anticipated.

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

The Director of Corporate Services presented the Risk Management Council Chair's report and the risks escalated to the Corporate Risk Register during March 2018. 4 new high level risks have been escalated during the month, and these were to be reviewed by the appropriate Director.

3.6 Board Assurance Framework (BAF)

The Director of Corporate Services presented the quarterly update of the BAF, prior to review by the Trust Board. Progress against the agreed actions was noted and proposed changes to the required controls and actions for the BAF discussed.

3.7 Medway Programme Update

The Director of Informatics presented the weekly report, in the countdown to "go live". Completion of preparation stage 3 of the programme milestones was agreed and stage 4, the countdown to implementation was formally initiated.

4. 26th April 2018

4.1 National Maternity Safety Ambition

The Head of Midwifery presented an update on the implementation of the Saving Babies' Lives Care Bundle and other initiatives to achieve the National Maternity Safety Ambition, which is the long term strategy to improve Maternity Care by 2025 by reducing stillbirths, neonatal deaths, intrapartum brain injuries and pre-term births. The Trust was making progress in line with the planned timescales and the action plan would continue to be monitored on a regular basis.

4.2 Maternity Survey Update

The Head of Midwifery provided a report on the action plan in response to the National Maternity Survey results and in particular the arrangements for a local survey of women who had experienced the new low risk service pathways and had given birth in February 2018. The results of this survey would provide assurance that the action plan was addressing the right issues. The results would be reported to the Executive Committee when they had been collated and analysed.

4.3 Mandatory Training and Appraisals Monthly Report

The Deputy CEO/Director of HR presented the monthly report for March. The Trust had achieved both targets overall for 2017-18, and the hard work of managers, particularly in Operations was recognised. There were some pockets of staff that were not meetings the targets and these would be addressed by the lead Directors for these areas. The national problems with ESR and reporting of uploaded training and appraisal data were also acknowledged.

4.4 7 Day Services

The Medical Director presented a report detailing the Trust's position (based on the audit in September 2017) in relation to each of the 7 day standards against which Trusts were monitored and comparative data with other local Trusts. The opportunities to improve performance on standards 2 (time to first consultant review) and 8 (on-going Consultant directed review) were considered and debated. The next data collection was due imminently and the improvement plans to achieve the standards by 2020 would be reviewed following the release of the new data set.

4.5 Safe Working Environment

The Medical Director presented recent guidance that had been issued to medical staff about their responsibility to highlight deteriorating working conditions. There was a discussion about how this responsibility manifested itself at an organisational level; what the Executive needed to do to support staff when there were exceptional pressures and the difference between the expected workload peaks and sustained pressure.

4.6 Allocate Update

The Deputy CEO/Director of HR presented an update on the implementation of the Allocate system to introduce e-rostering. HealthRoster was now being used for all nursing staff and rolled out to medical staff and staff working in clinical support and corporate services. The SafeCare system was also about to the implemented, to measure patient acuity and the nursing input required. An update on this would be provided later in the year. The Executive Committee acknowledged the national expectation on Trusts to implement electronic rostering, and the support and help required for staff to embed the changes.

4.7 Medway

The Director of Informatics presented the weekly update on the Medway Implementation Programme, confirming that the Programme Board was recommending implementing the "go live" plans for 27th April.

The Committee reviewed the support and contingency plans and the level of staff training that had been achieved. Following Board approval on 25th April, the Executive Committee approved the final request to proceed.

4.8 Use of Resources (UoR) Assessment

The Trust had received notification that the first NHS Improvement Use of Resources Assessment of the organisation would take place in July 2018. The UoR assessment was based on Model Hospital data and the eventual rating would feed into the next CQC rating of the Trust. The UoR self - assessment and information submission was required by 25th May.

4.9 Pathology

Following feedback from the Cheshire and Merseyside Pathology Network and assurance that the Trust's contracts could be aligned to the wider strategic development vision of the network, the Committee approved the procurement to replace equipment when the existing contract expired in December. The expenditure had already been approved as part of the capital programme.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)43
Title of paper: Committee Report – Quality Committee
Purpose: To summarise the Quality Committee meeting held on 22 May 2018 and escalate issues of concern.

Summary: Key items discussed were:

1. Complaints

- There were 9 1st stage complaints received and opened in April 2018; a decrease of 9 from March 2018
- At the end of April 2018, there were 28 open 1st stage complaints, (a decrease of 20%) in comparison to 35 at the end of March 2018
- The Trust responded to 93.8% of 1st stage complaints within agreed timeframes during April 2018; an increase compared to 78.9% in March 2018
- Clinical treatment was the primary cause of complaint in April 2018, which is consistent with previous months
- 1 new case was referred to the PHSO in April 2018
- 8.26% decrease in PALS contacts compared to the previous month
- Communications remains the main reason for enquiries to PALS

2. IPR

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

- The Trust is reporting an overall deficit of £2m in line with agreed plans. The full allocation of Provider Sustainability Fund (£0.6m) is included. (previously known as STF) Failure to recover the A&E position by the end of Q1 could result in the Trust losing 25% of this money
- CIP and Cash balances are in line with plan

3. Safer Staffing

- Overall Trust % staffing fill rates for March were:
  a. RNs on days 93.35%
  b. RNs on nights 95.18%
  c. Care staff on days 110.29%
  d. Care staff on nights 115.28%

- Overall Trust % staffing fill rates for April were:
  e. RNs on days 93.39%
  f. RNs on nights 95.97%
  g. Care staff on days 113.03%
  h. Care staff on nights 112.10%
- 13 of the 32 wards had a % fill rate of less than 90% for registered nurse which is a slight reduction from 15 the previous month
- 5 wards had a % fill rate of less than 90% for care staff. Wards SCBU, 4F (paediatrics) 3E medicine , 4E ICU and Newton ward
- The fill rates are below 90% in spite of Trust procedure being adhered to in order to backfill any staff shortages on shifts due to last minute staff absence and the on-going challenges with recruiting NMC registered staff.

4. Falls Update

- For the year 2017/18, the Trust has sustained and achieved a decrease in the total number of inpatient falls reported. The total number of falls, measured as rate per 1000 bed days, was 8.36.
- Patients experiencing severe harm and deaths due to a fall have shown a slight decrease compared to the previous year, measured as rate per 1000 bed days was 0.135.
- The reduction in total number of falls and harm related incidents is a positive achievement acknowledging the acuity of patients.
- There is no significant change in ward trends
- The Trust has developed strategic falls group to develop and monitor actions to reduce/prevent falls which has increased its frequency from quarterly to monthly to ensure sustained focus.
- An action plan has been developed to support improvement plans, which is being monitored through CQPG.
- GL checked the Model Hospital falls data and confirmed the Trust is performing well.

5. Fasting Audit Update

- All actions are on target
- Inpatient information poster agreed
- Flow chart created for staff use which will be embedded into the policy
- Education sessions arranged in June for staff relating to items identified in the audit
- Completed and signed off by July with re-audit against the policy taking place in August.

6. National Inpatient Survey Action Plan

- It was considered that stronger actions were required for patients to understand operational procedures. Help has been sought from clinical colleagues to assist with the wording to strengthen the actions.
- An inpatient information leaflet is currently being trialled.

7. NG Tube Never Events update

This was wasn't presented and therefore deferred to June.

8. Learning from Inpatient Deaths

- Work is ongoing to improve the quality of reviews, staff are committed to training
- Dual reviews going forwards for mental health and DOLS patients
- To improve feedback to referrers a generic email account has been set up
- Work ongoing with primary care to provide feedback on lessons learnt following reviews
- Improvements in communication and governance issues being led by the Communications department although capacity is very limited. NK suggested educating the staff to remove the burden from the Communications Department.
- NED requested to attend and engage with the Mortality Surveillance Group
- The key priorities for learning and sharing across the Trust are:
    - (1) AF causes stroke. AF strokes are bigger. AF strokes have higher mortality. AF strokes leave more disability. AF strokes are PREVENTABLE. If you find AF, do a CHADS2-VASC score and anticoagulate if indicated; and
    - (2) 'Difficult relatives' are typically frustrated people trying to do the best for their loved ones. Show compassion - it might be you one day.

9. Continuity of Carer

- The paper was deferred to the June meeting.

10. Cancer Work Programme

- The Trust is currently working towards local delivery of the National Cancer Strategy 2015-2020 (Cancer taskforce 2015). The broad aims are: to reduce the incidence of cancer; improve the number of cases that are diagnosed at an early stage; design and build services in collaboration with patients and health partners; improve patient experience of care; provide support to those people living with and beyond cancer and ultimately improve survival.
- The key areas of work for the organisation can be grouped into the following 4 themes:
- Operational standards for delivery, development of robust infrastructure and clinical pathways that support high quality patient care, Patient Experience and the Cancer Workforce.
- YTD performance has been achieved across all standards.

11. Feedback from Councils:

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

- Safety council agreed in principle revision of the Trust Policy for Management of CDs and the SOPs for Controlled Drug (CD) but single nurse administration. The lower class controlled drugs to become single nurse administered CDs are: Codeine, Dihydrocodeine, Tramadol, Morphine sulphate 10mg/5ml liquid (including the Oramorph brand),Temazepam and Phenobarbital.

Patient Experience Council: Summary page noted.

Clinical Effectiveness Council – The summary page was noted by the Committee and the following highlighted:

- Claims were made that there were delays in histopathology reports being sent out by a number of attendees. Concern was expressed that a patient's cancer was delayed as a result. Dr Andrews has subsequently asked Dr Al-Jubouri and Mr Benson to meet to discuss but it was agreed that this was escalated
- Quality Improvement and Clinical Audit have outlined that the number of required national audits is rising very quickly and is putting the department under strain-there is a manpower risk that not all may be deliverable.

CQPG – The summary page was reviewed and noted by the Committee.

Executive Committee – Summary page noted, nothing to escalate.

Workforce Council – Summary page noted, nothing to escalate.

12. Policies/Documents Approved:

- Quality Account

13. AOB - None noted.

Items to be noted by the Board:

- Safer staffing issues continue to be challenging but against this backdrop we are managing it well
- NED required to attend and engage with the Mortality Surveillance Group
- Clinical Effectiveness Council: Quality Improvement and Clinical Audit have outlined that the number of required national audits is rising very quickly and is putting the department under strain; there is a manpower risk that not all may be deliverable.
- Complaints, Learning from Inpatient Deaths and Cancer Work Programme – much good

work ongoing, details in Quality Committee minutes.
Corporate objectives met or risks addressed: Five star patient care and operational performance.
Financial implications: None directly from this report.
Stakeholders: Patients, the public, staff and commissioners
Recommendation(s): It is recommended that the Board note this report.
Presenting officer: Chair of Committee
Date of meeting: 30 May 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)44
Title of paper: Committee Report – Finance & Performance
Purpose: To report to the Trust Board on the Finance and Performance Committee, 24th May 2018

Summary:

Agenda Items

For Information

- Capital Programme 2018/19
  - The paper presented the capital plans for 2018/19 and listed the next steps for future capital planning. Allocation of capital projects funding has been done in conjunction with the Care Groups and reviewed by the Director of Operations.
  - An external bid is also being produced via the STP, the schemes within this fall under 2 key themes:
    - Community Step down/Step up beds
    - A&E/Ambulatory Care capacity
  - Future capital planning will incorporate a 3 to 5 year programme to allow the board to have sight of the future capital needs of the organisation.
- CIP & Procurement Council

  The briefings were accepted

For Assurance

- A&E Update
  - The Committee reviewed current performance within A&E compared to the previous two financial years; this showed a 10% drop in performance against April 2017. The review in attendances by CCG showed an increase in Halton patients arriving both by ambulance and walk in attendances. Patients presenting who had previously been to a walk in centre were also debated as this has increased year on year but the data available doesn't allow us to know which walk in centre they have previously attended to enable us to work with those walk in centres to find solutions.
  - Reporting of ambulance handover times has changed this week to allow Trusts to see the time they have taken to handover the patient as well as for NWAS to leave site, this should give greater clarity in future on where the holdups lie.
  - Discussion also took place around the disparity between the wait times achieved on Monday c. 90% against c.60% the following day. Shift leadership of both medics and nursing were discussed as a contributing factor; a plan is being developed within ED on how to stratify and manage the ED shift lead roles and this will be presented to the committee next month.
  - The committee were not assured by the measures put in place to improve performance and have sought further assurance next month from the whole leadership team within A&E.
- Integrated Performance Report Month 1 was reported
  - Discussion took place around operational performance with specific reference to C-Diff and HSMR figures. The confirmed C-Diff cases for 2017/18 were queried as this had reduced from 23 reported in April to 20. The reduction is due to having three cases appealed, with one case still outstanding.
  - Theatre productivity at both St Helens & Whiston was discussed as the downtime and late start metrics within the IPR have been increasing. Work has already

been completed by the PMO and there is little scope to reduce the time between patients. Work on Anaesthetics scheduling is already underway to reduce the late start times.

- Finance Report Month 12 2017/18 & Month 1 2018/19
  - Final Accounts for 2017/18 were signed off at the Audit Committee yesterday. The only amendment to the figures reported at the last Committee is £2.8m of additional STF funding received by the Trust.
  - Month 1 2018/19 is in line with plan at £2m deficit including all available PSF funding.
  - Non-Elective activity was over the CCG's for April which would trigger the marginal rate penalty. The Trust will be contacting the CCG to confirm this position and to ask where this funding will be invested.
- CIP Programme update
  - An overview of the Trustwide CIP position was presented which showed an improvement of £1.63m in the work in progress from last month. The Trust now has recurrent plans of c.£15m including work in progress of £3.1m. Plans continue to develop within the Care Groups and a number of schemes have been identified with CIP lead officers and indicatives values.
- CIP Programme update – MCG
  - Medical Care Group presented an update on their CIP programme highlighting the work done to date within the Care Group. Formal CIP meetings are in place including the Divisional Medical Direction, ADO, Finance Business Partner and CD's. They have found this approach to be beneficial for generating ideas for CIP.
  - MCG schemes centred on vacancy controls, a 95% challenge to budget holders, medical pay reduction and achievement of activity growth contribution.

Actions Agreed

- Update on the increase Halton Activity and the reasons for this including how this is split between Runcorn and Widnes postcodes.
- Confirmation of management structure for A&E and circulate this through the Trust
- Update on A&E action plan to be brought to the next month by Medical and Nursing leads
- Review of IPR metrics for theatre productivity to ensure they are clear where we are on target
- Review of time to recruit through the Trac process
- Plan for STP CIP target of £4.6m to be brought to the committee

Issues to be raised at Board

- Update on cold decontamination project to go to Board

Corporate objectives met or risks addressed: Finance and Performance duties

Financial implications: None as a direct consequence of this paper

Stakeholders: Trust Board Members, NHSI

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

Presenting officer: Jeff Kozer Non-Executive Director

Date of meeting: 30th May 2018

TRUST BOARD

Paper No: NHST(18)45

Title of paper: Committee Report – Audit

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

Summary:

A meeting of the Audit Committee was held on 23rd May 2018. The following matters were discussed and reviewed:

NHST (18) 46 Annual Accounts, Quality Account and Annual Report

- **The Trust's Annual Governance Statement** – This was presented for information by Nicola Bunce, Director of Corporate Services.

- **Presentation of the audited annual accounts for 2017/18** – The accounts were presented by Dave Brimage, Assistant Director of Finance, to the Audit Committee with a view to approval of the accounts by the Audit Committee on behalf of the Trust Board after consideration of the external auditor's Audit Findings Report (see below).

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

- **Approval of the Trust's accounts** – The Audit Committee approved the Trust's audited financial accounts for 2017/18 on behalf of the Trust Board following consideration of the presentations above.

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

- **Presentation of the Trust's Quality Account for 2017/18** – The Quality Account was presented by Anne Rosbotham-Williams on behalf of Sue Redfern, the Director of Nursing.

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

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

    - It contained at least all the mandatory disclosures required;
    - It reflected what was in the annual accounts where figures were quoted and;

- those figures audited in the annual report by the External Auditor (ie. Remuneration, Pension and Pay Multiplier numbers) were verified to Trust records and calculations.

The Annual Report was approved subject to some minor amendments which have since been actioned in the final report.

NHST(18) 047 – Audit Plan Approval

- The 2018/19 internal audit plan, which is risk-based, was agreed by the Audit Committee at its April 2018 meeting following consultation with the Trust's Board directors. It is recommended therefore that the Trust Board formally approves the plan.

Annual Meeting Effectiveness Reviews of Committees

- Nicola Bunce presented two reports: (i) one covering all the Trust committees and (ii) another specific to the Audit Committee. The recommendations of both were accepted by the Audit Committee and recommended for approval to the Trust Board.

There was no requirement for a meeting of the Trust's Auditor Panel on this occasion.

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

Financial implications: None as a direct consequence of this paper

Stakeholders: The Trust, its staff and all stakeholders

Recommendation(s):

1. To ratify the approval by the Audit Committee of the Trust's;
   - financial accounts for 2017/18
   - the letter of representation
   - annual report
   - 2018/19 audit plan
2. To approve the findings of the annual meeting effectiveness reviews (as accepted by the Audit Committee)

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

Date of meeting: 30th May 2018

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)48
Title of paper: Strategic and Regulatory Update Report – May 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 policy and regulatory developments and the annual self-certificate declarations that the Board is required to make to comply with the NHS Improvement Single Oversight Framework (SOF), including; 1. Operational Planning – update 2. Use of Resources assessment 3. Freedom to Speak Up – guidance for boards 4. Trust Declarations 2018/19
Trust 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 H&SCP, Commissioners, Regulators
Recommendation(s): The Board is asked to approve the self-declarations; • The Board approves the annual declaration of compliance with the Provider Licence condition G6 • The Board approves the annual declaration of compliance with the Provider Licence condition FT4
Presenting officer: Nicola Bunce, Director of Corporate Services
Date of meeting: 30th May 2018

Strategic and Regulatory Update Report – May 2018

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

2. **Use of Resources (UoR) assessments**
   The Trust has been notified that NHSI is to undertake a UoR assessment of the Trust. The Trust has submitted its self-assessment against the UoR key lines of enquiry; clinical services, people, clinical support services, corporate services (including procurement and estates and facilities) and finance, and the on-site visit is scheduled for 5th July.

   The eventual UoR report will be used by the Care Quality Commission (CQC) to determine a new combined rating for the Trust, when the Well-led inspection has been completed.

3. **Freedom to Speak Up**
   In May NHSI and the Freedom to Speak Up (FTSU) National Guardian have issued guidance setting out the expectations of Trust Boards and providing a self-review tool to help identify areas for development.

   FTSU forms part of the CQC well led domain and the new guidance is aligned to the well-led framework and the specific CQC key lines of enquiry.

   The specific expectations are that;

   - Leaders are knowledgeable about FTSU
   - Leaders have a structured approach to FTSU
   - Leaders actively shape the speaking up culture
   - Leaders are clear about their roles and responsibilities
   - Leaders are confident that wider concerns are identified and managed
   - Leaders receive assurance in a variety of forms
   - Leaders engage with all relevant stakeholders
   - Leaders are focused on learning and continuous improvement

   The guidance recommends that the Boards receive a FTSU report at least every six months from the FTSU Guardian or member of the local Guardian network.

   The Trust is reviewing its FTSU arrangements in light of this new guidance to ensure that the Trust continues to be fully compliant with best practice.

4. Single oversight framework – Board declarations

The NHSI single oversight framework requires NHS Trust Boards to make annual declarations in relation to compliance with the NHS Provider Licence; (www.gov.uk/government/Annex_NHS_provider_licence_conditions.pdf)

The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS Trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Conditions G6 and FT4) and must self-certify under these licence provisions.

NHS Trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements.

The requirement is for NHS Trusts Boards to make annual declarations against conditions G6 and FT4 of the Provider Licence conditions (Appendix A). The declaration for condition G6 has to be made by 31st May each year and the declaration for condition FT4 made annually by 30th June. On review it has been assessed that this Trust is in a position to make both declarations at the Board meeting in May alongside the approval of the annual report and accounts and quality account.

4.1 Board declaration – Licence Condition G6

The requirement for this organisation is for the Board to satisfy itself and make a declaration that it has been compliant with all duties and responsibilities assigned to it under the NHS Acts, and that it is operating in a way that meets the 7 principles of the NHS as set out in the Constitution.

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

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

Sources of assurance for the Board that it can make this declaration are;
- Continued CQC registration
- CQC Inspection ratings

- MIAA audit of the Trust Risk Management and Board Assurance Frameworks – with Significant Assurance

Recommendation

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

4.2 Board declaration – Licence condition FT4

Licence condition FT4 relates to the standards of corporate governance in the preceding year. The requirement to conform to best practice standards for corporate governance is a condition that has always been applied to public bodies.

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

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

The Board is satisfied that the Licensee has established and implements:
(a) Effective board and committee structures;
(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
(c) Clear reporting lines and accountabilities throughout its organisation.

The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:
(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) To ensure compliance with all applicable legal requirements.

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

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

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

- CQC Inspection Report (Well led standard)
- Corporate Governance Statement made as part of the annual report and accounts and reviewed by the Trusts auditors
- Annual Board effectiveness review of 2017/18
- Trust accountability framework and annual business cycle
- NHS Improvement segmentation rating – March 2018
- Well led framework self-assessment and action plan

Recommendation

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

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

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:
(a) The Conditions of this Licence,
(b) Any requirements imposed on it under the NHS Acts, and
(c) The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.
2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
(a) The establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
(b) Regular review of whether those processes and systems have been implemented and of their effectiveness.
3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.
4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

Condition FT4 – NHS foundation trust governance arrangements

1. This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
(a) Have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; and
(b) Comply with the following paragraphs of this Condition.
4. The Licensee shall establish and implement:
(a) Effective board and committee structures;
(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
(c) Clear reporting lines and accountabilities throughout its organisation.

5. The Licensee shall establish and effectively implement systems and/or processes:
(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; Section 6 – NHS Foundation Trust Conditions
(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) To ensure compliance with all applicable legal requirements.
6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:
(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
(e) That the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) That there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.
7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.
8. The Licensee shall submit to Monitor within three months of the end of each financial year:

(a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and
(b) If required in writing by Monitor, a statement from its auditors either:
(i) Confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or
(ii) Setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year

ENDS

TRUST BOARD

Paper No: NHST(18)49
Title of paper: Aggregated incidents, complaints & claims report for Quarters 3 and 4 2017-18
Purpose: The purpose of this paper is to present an overview of incidents, complaints, PALS and claims activity and performance during Quarters 3 and 4 (Q3 and Q4) 2017-18 to identify if there are any key themes or trends that need further investigation and to provide the Board with assurance that there are systems and processes in place to report and manage these issues.

Summary for 1st Oct 2017 to 30th March 2018 (Quarter 3 and Quarter 4):

The number of incidents reported has remained fairly steady between Q3 and Q4 and is broadly comparable to the number report in the same quarters in 2016-17.
There was a slight increase in incidents related to moderate harms and above between Q3 and Q4, which is a normal variation in incidents reported; and partially attributable to a seasonal increase in harmful falls in the winter months. However there is a significant decrease in the same period for 2016-17.

Incidents Q3
- 3479 incidents occurred in Q3
  - Decrease of 250 (6.7%) from Q2
  - Increase of 192 (5.5%) increase from Q3 2016-17
- 2899 patient incidents occurred in Q3
  - Decrease of 190 (6.2%) from Q2
  - Increase of 211 (7.8%) from Q3 2016-17
- The rate of patient incidents per 1,000 bed days in Q3 was 47.9
  - Decrease of 7.0% from the Q2 (51.5 per 1000 bed days)
  - Increase of 5.0% increase from Q3 in 2016-17 (45.6 per 1000 bed days)
- 39 moderate/severe and death patient harms in Q3
  - Decrease of 13 (25.0%) from Q2
  - Decrease of 13 (25.0%) from Q3 2016-17
- The rate of incidents affecting patients and resulting in moderate harm or above per 1,000 bed days was 0.6
  - Decrease of 33.3% from the Q2 (0.9 per 1000 bed days)
  - Decrease of 33.3% from Q3 in 2016-17 (0.9 per 1000 bed days)
- 8 incidents in Q3 were StEIS reportable

Incidents Q4
- 3687 incidents occurred in Q4
  - Increase of 208 (5.6%) from Q3
  - Increase of 151 (4.1%) from Q4 2016/17
- 3048 patient incidents occurred in Q4

- Increase of 149 (4.9%) from Q3
    - Increase of 97 (3.2%) from Q4 2016/17
- The rate of patient incidents per 1,000 bed days in Q3 was 47.6
    - Decrease of 1.0% from the Q3 (47.9 per 1000 bed days)
    - Decrease of 4.8% from Q4 in 2016-17 (50.0 per 1000 bed days)
- 49 moderate/severe and death patient harms in Q4
    - Increase of 10 (20.4%) from Q3
    - Decrease of 11 (18.3%) from Q4 2016/17

- The rate of incidents affecting patients and resulting in moderate harm or above per 1,000 bed days was 0.76
    - Increase of 15.8% from the Q3 (0.64 per 1000 bed days)
    - Decrease of 37.3% from Q4 in 2016-17 (1.02 per 1000 bed days)
- 14 incidents in Q4 were StEIS reportable

Complaints and PALS
The number of first stage formal complaints continues to fall with a substantial decrease compared to the same quarters last year, with an increase seen in PALS overall.

Complaints Q3

- 47 1st stage complaints were received and opened in Quarter 3.
- A decrease of 37.3% compared to the previous quarter and 37% compared to 2016-17.
- The Trust closed 25 more 1st stage complaints than it received in Quarter 3.

Complaints Q4
- 51 1st stage complaints were received and opened in Quarter 4.
- An increase of 8.5% compared to the previous quarter, but a 48% decrease from 2016-17.
- The Trust closed 5 less1st stage complaints than it received in Quarter 4.

PALS Q3
- 16% decrease compared to the previous quarter, and 3% decrease compared to the equivalent quarter in 2016-17.

PALS Q4
- 33% increase compared to the previous quarter, and a 31.4% increase compared to the equivalent quarter in 2016-17

Claims
The number of claims received fluctuates each quarter; however, there was a marked increase in Q4 which will be monitored going forward.

Clinical Negligence Claimants (Q3)
- 24 new clinical negligence claims have been received in Q3, a decrease of 1 from the 25 received in Q2 (4%).

Clinical Negligence Claims (Q4)
- 30 new clinical negligence claims have been received in Q4, a 25% increase of 6 from the 24 received in Q3.

Corporate objectives met or risks addressed: Safety – We will embed a learning culture that reduces harm, achieves good outcomes and enhances the patient experience.
Financial implications: There are no direct financial implications arising from this report
Stakeholders: Patients, carers, commissioners, regulators and Trust staff.
Recommendation(s): Members are asked to review the report and consider if there are any issues that need to be referred to the Quality Committee for further investigation.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 30th May 2018

1. Introduction

The Trust uses the same Datix system to record reported incidents, complaints, PALS enquiries and claims. This allows the Trust to link any related occurrences.

This report highlights if there are any trends and the learning derived from incident reporting, complaints, claims and PALS enquiries received by the Trust. The information includes all reported incidents, complaints, PALS and litigation (claims and inquests).

The data included in this report covers **Q3 1st October 2017 to 31st December 2017 and Quarter 4 1st January 2018 – 31st March 2018**.

1.1 Governance of Complaints, Incidents and Claims

The Quality Committee receives a monthly report on complaints management, with a more detailed report submitted monthly to the Patient Experience Council. The Patient Safety Council receives a monthly report on incidents and a quarterly report relating to claims. Each of these Councils provides a chair's report, with escalation of any areas of concern, to the Quality Committee. The Claims Governance Group meets monthly and reviews any potential new claims, high value claims and lessons learnt as a result of claims. A chair's report is submitted monthly to the Risk Management Council, which reports to the Executive Committee.

1.2 Reasons and Themes

The table below compares the reasons for incidents, complaints, PALS contacts and claims for all reported during Q3 and Q4, to identify if there are any common themes that can be identified.

Table 1: Top five themes from reported incidents, complaints, PALS and claims - Q3 & Q4

Incidents	Q3	Q4	Complaints	Q3	Q4	PALS	Q3	Q4	New Clinical Negligence Claim	Q3	Q4
Accident that may result in a personal injury	967	878	Clinical treatment	26	20	Communications	121	161	For all specialities failure to diagnose or delay in diagnosis	7	14
Implementation of Care or ongoing Monitoring	562	588	Values and staff behaviour	4	6	Admission & Discharges (excl. delayed discharged re: care packages)	70	79	Fail/delay treatment	3	2
Medication	379	377	Communications	4	3	Patient Care Nursing Care	66	84	Failure to recognise complications of treatment	3	3
Access, Appointment, Admissions, transfer	355	300	Admission & Discharges (excl. delayed discharged re: care packages)	2	5	Clinical treatment	53	107	Failure to warn (informed Consent)	2	1
Clinical Assessment (Investigations, Images and lab test)	335	410	Patient Care Nursing Care	2	7	Appointments	35	68	Delay in performing an operation	1	0

Note: The charts above should be used as guidance only as the claims received often fall into more than one category, for example there may have been negligent performance of a surgical procedure followed by a fall on the ward, or failure to diagnose a condition with general unhappiness regarding the care received. The categories used for reporting are indicated by external bodies, for example the clinical negligence ones are set by NHS Resolution and the complaints codes are used to report the KO41 via NHS Digital as required by the Department of Health.

Rank	Theme
1st	Clinical care
2nd	Access/admission/discharge issues
3rd	Communication and records
4th	Attitude/behaviour/competence

The top category in each of the 4 areas has been consistent for the last five quarters and the other reasons for each area have also remained in the top five, except for claims, where there is some fluctuation due to the small numbers, for example there were two claims relating to inappropriate treatment in Q1, but not in Q2.

From this analysis it can be seen that the most common theme across all areas is clinical care, followed by access/admission/discharge issues. This analysis will be repeated each quarter to see if the profile changes over time.

2. Incidents

There were 3479 incidents reported by staff during this period in Q3, with 8 incidents reported to StEIS and 39 categorised as moderate, severe harm or death.

There were 3687 incidents reported by staff during this period, with 14 reported to StEIS and 49 categorised as moderate, severe harm and death.

Charts 1 and 2 below show the Trust's incident reporting activity from Q1 2016-17 to Q4 2017-18. This shows an increase in incident reporting but a downward trend in levels of significant harm resulting from the incidents. This indicates an improving culture of reporting.

Chart 1: total incidents reported

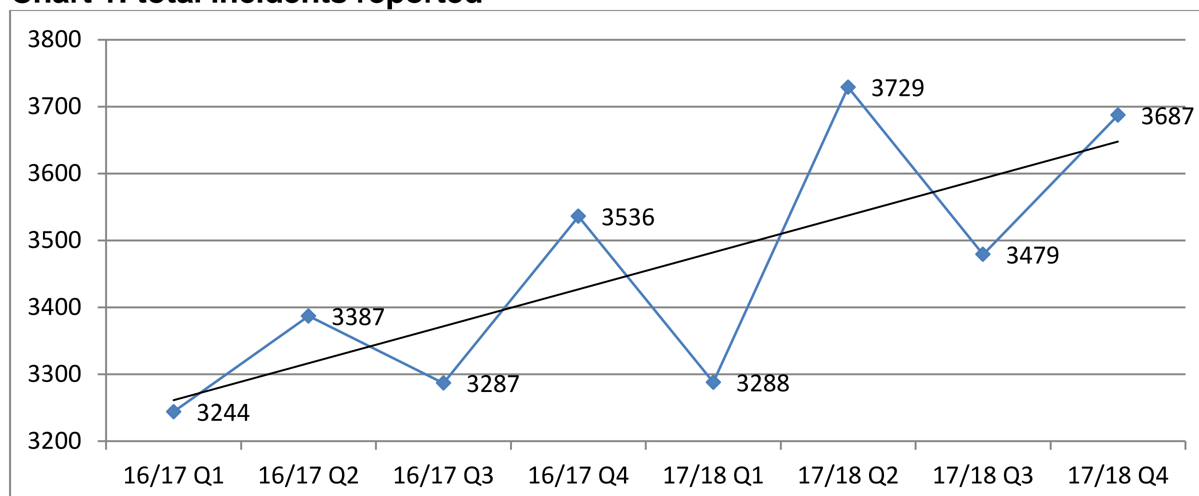
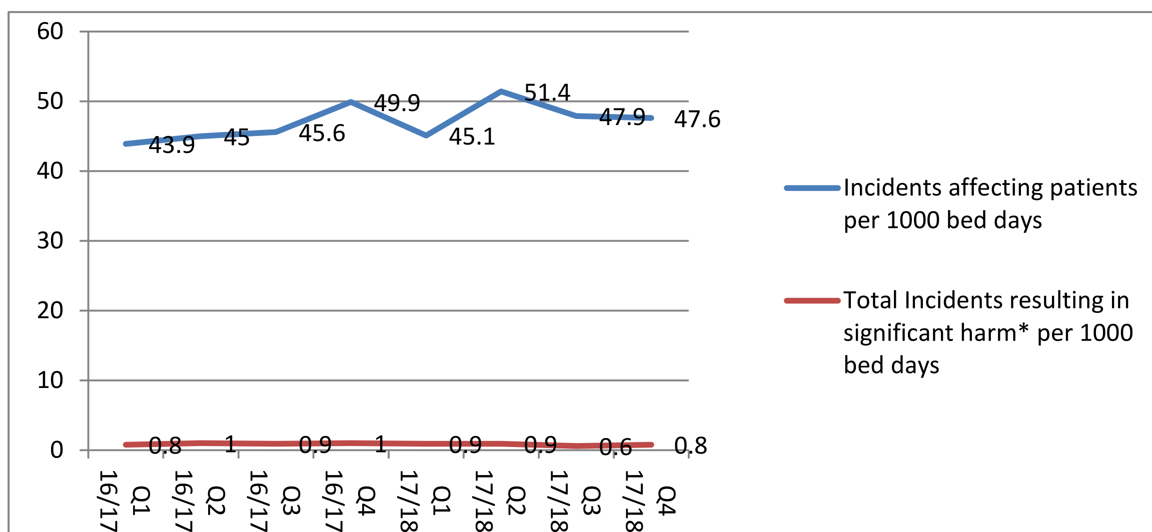


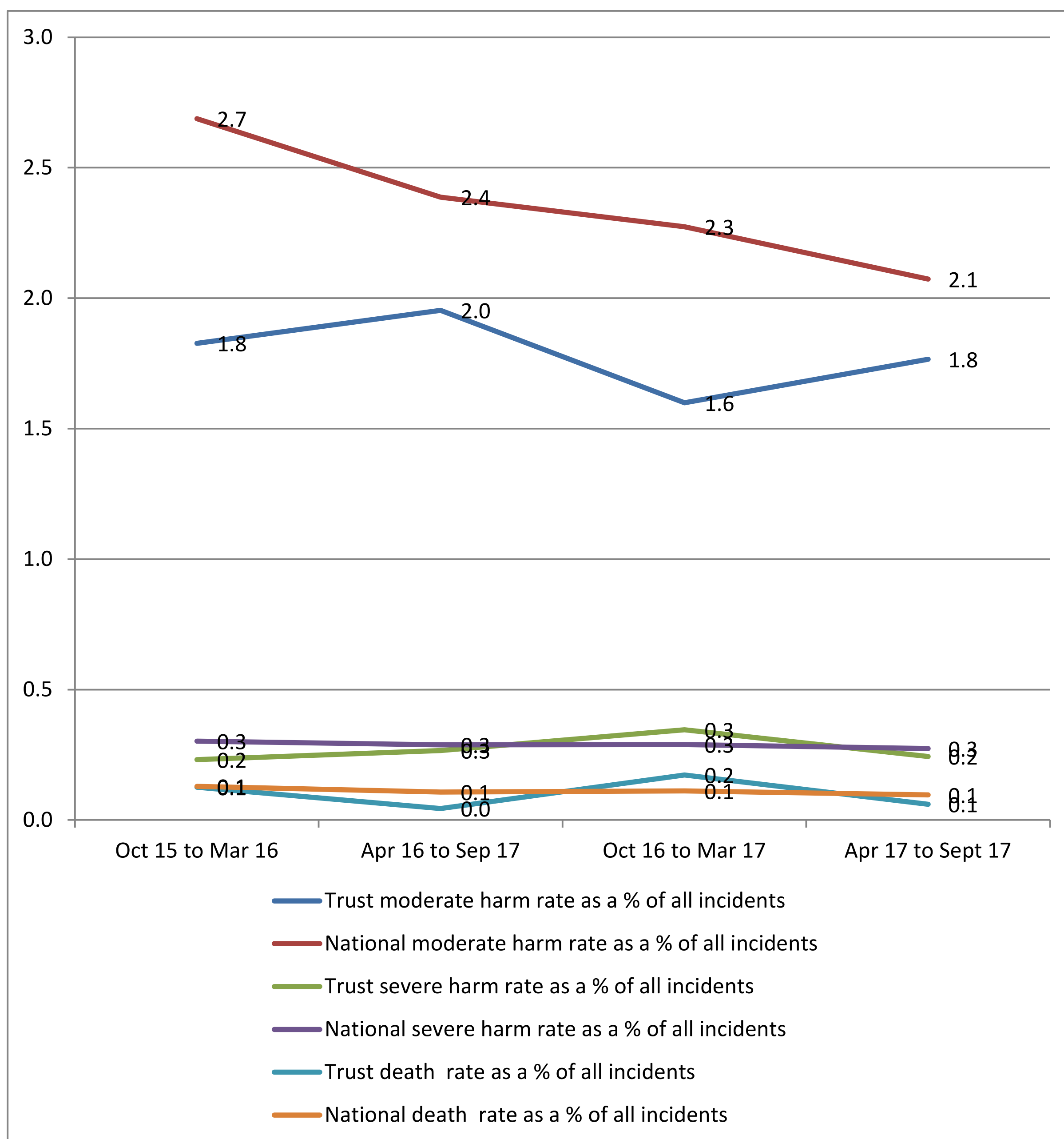
Chart 2: Incidents affecting patients per 1000 bed days



*significant harm = incident resulting in moderate / severe harm or death

Chart 3: Comparison of Trust's rates (as per NRLS data) of moderate harm and above against national rates (October 2015 – September 2017)

Chart 3 shows the most recent data provided by NHS England comparing patient safety incidents reported to the National Reporting and Learning System (NRLS) by the Trust to the national average. The Trust's rates of moderate harm are consistently below the national average, although rates for severe or death vary in comparison due to the relatively small numbers.



2.1. Thematic analysis of incidents reported to StEIS* in Q3 and Q4 2017-18

In Q3 and Q4 the Trust reported 22 incidents to StEIS.

*Only those incidents outlined in the Serious Incident Reporting Framework are reported on StEIS. These include any incident where the Trust causes severe harm or death, IG breaches, allegations of abuse and a number of other categories.

Table 2: incidents reported to StEIS in Q3 2017-18

Incident category	Number
Slips, Trips & Falls	11
Abuse/alleged abuse of adult patient by staff	5
Sub-optimal care of the deteriorating patient	3
Diagnostic incident	1
Surgical/invasive procedure incident (NG Tube Never Events)	2

22 reports were submitted to the CCG in Q3&4 of these 18 were submitted on time (82%).

2.2. Actions taken as a result of serious incidents

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

Examples of the actions taken include:

Nasogastric tube misinterpretation 1
All medical staff inserting NG Tubes on the Critical Care Unit should undergo a competency review to ensure that they have the skills and experience to safely carry out this procedure and undergo Trust NG Training if required.
All clinicians Trust-wide undertaking review of chest X-ray reporting should undergo necessary training and competency review

Growth in oesophagus not identified on OGD leading to a Delayed diagnosis of oesophageal cancer
Implementation of British Society of Gastroenterologists (BSG guidance)

Nasogastric tube misinterpretation 2
Clear policy developed for staff to carry out safety check for nasogastric tube. X-ray interpretation training for medical staff identified and developed. Trust internal training for insertion and care of NG tube developed and rolling out for all staff. Hot radiology reporting facility for NG position check X-ray developed.

Falls
Additional actions included in strategic action plan to include learning from incidents. Care groups have developed localised falls pledges in specified areas to improve staff commitment and awareness to falls prevention. Falls care plan and actions revised to make it clearer and enhance accountability**.**

Lessons learnt from incidents are shared via the bi-monthly safety bulletin included in Team Brief, via the Ward Manager and Matrons' meetings, Care Group governance meetings and specialist area meetings such as medicine safety group and falls strategy group

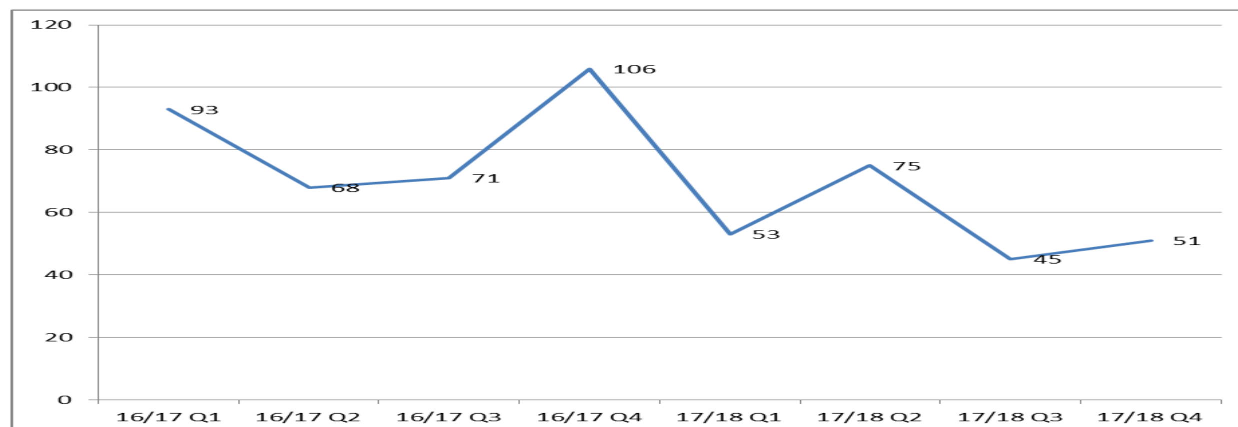
3. Complaints

In Q3, 45 1st stage complaints were received and opened; a decrease of 37.3% compared to the previous quarter. The Trust closed 25 more 1st stage complaints than it received in Quarter 3.

In Q4, 51 1st stage complaints were received and opened; an increase of 8.5% compared to the previous quarter. The Trust closed 5 less 1st stage complaints than it received in Q4. However, the number of overdue complaints fell from 5 at the end of Q3 to 1 at the end of Q4, reflecting the work of the Trust to continue to improve the timeliness of complaints responses.

The chart below contains 1st stage complaints (written and verbal) received by quarter, since April 2016. This shows a continuing, reducing trend in the overall number of complaints received in the last seven quarters.

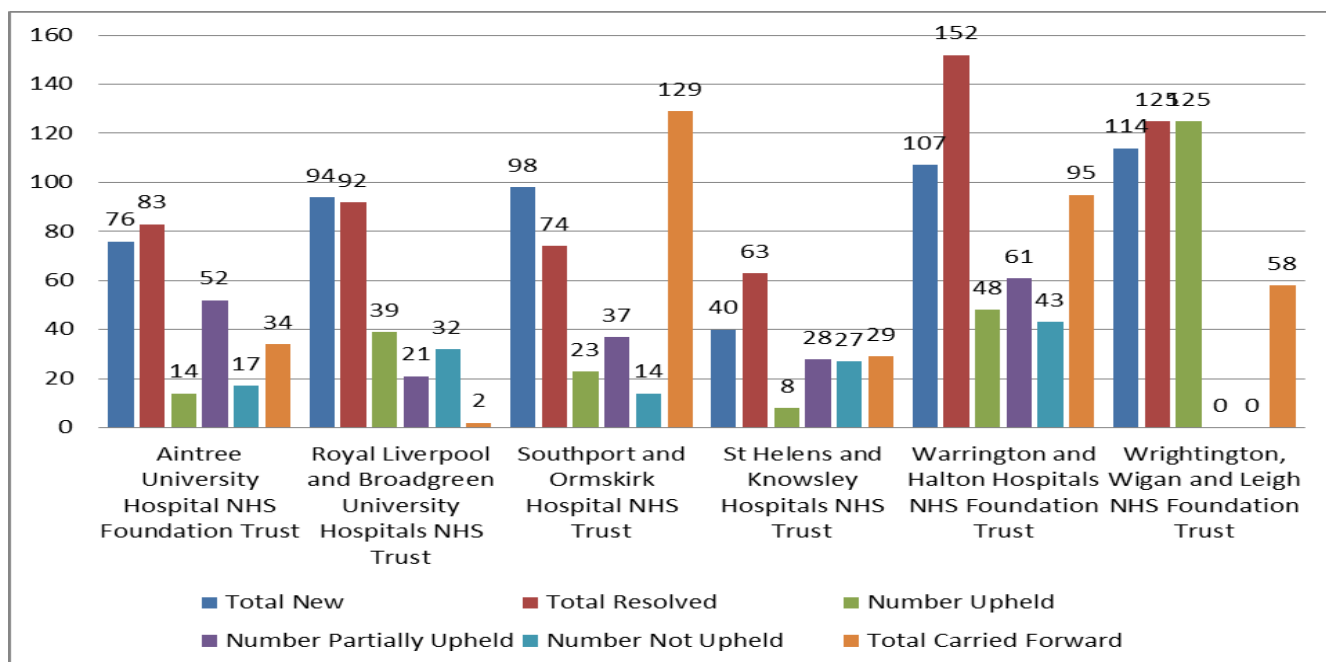
Chart 3: complaints received by each quarter from Q1 2016-17



3.1. Complaints – local and national comparison

NHS Digital collates details of Trust written complaints (which are a sub set of all the complaints received and recorded) via a quarterly return (KO41a). The chart below shows a comparison with neighbouring Trusts.

Chart 4: Comparison of number of written 1st stage complaints received and resolved in quarter 3 2017-18



Note: The resolved complaints will not necessarily have been received in the same quarter. No data for Q3 has been published in respect of Wirral University Teaching Hospital NHS Foundation Trust. Data is not available for Q4.

- The Q3 figures indicate that the Trust has received significantly less written complaints than other local trusts; as well as upholding fewer complaints as a proportion of the total resolved than local other trusts. The Trust has the second

lowest level of complaints carried forward locally.

- Quarterly benchmarking is not available for Q4 yet.

3.2. Actions taken as a result of complaints

Each complaint response includes any learning that has been identified and the necessary actions for each area. A summary of lessons learned and actions taken from incidents and complaints across the Trust is shared at the monthly Matron and Ward Manager meetings for onward cascade to each department/ward. In addition, complaints are a standing agenda item on the Care Group and ward governance meetings' agenda to ensure that lessons are shared and to embed any actions taken to improve the quality of patient care. The following are examples of actions in Q3 & Q4:

- New Liver Nurse Specialist appointed who will be responsible for the referral process for funding for all Hep C patients and follow up and supervision of process.
- Concerns were discussed at the ward meeting and staff were given an ACE behavioural standards leaflet.
- Ward Manager has discussed the importance of ensuring that there is clear communication between staff and the patient as this is vital for the patient to be able to understand their treatment plan and to discuss options available to them;
- Staff were made aware of the communication diary held on the ward for new patients expected to attend the ward following a previous admission or appointment and that this must be kept up to date;
- Manager of ward will now explore the feasibility of adding a further telephone into the unit to support access to this service and to prevent this happening again
- Feedback given to the Prescriber so they can improve the quality of their prescribing and reduce delays caused by queries.
- Pharmacy Staff reminded that transfer lounge prescriptions must be prioritised to allow patients to leave the hospital as soon as possible.
- Very urgent prescriptions are now placed by Pharmacy staff in red trays; highly visible and make sure urgent work is distinguished from other work which are placed in green trays.

4. PALS

There were 489 PALS contacts/enquiries during Quarter 3 2017-18. This represents a 16% decrease compared to the previous quarter, and a 3% decrease compared to the equivalent quarter in 2016-17.

The main themes for PALS contacts are shown in table 1 and remain generally consistent. Other than "access to treatment or drugs" which is not in the top 5, having featured for the first time last quarter. This will be monitored going forward. There was a conversion rate of 7.1% of PALS enquiries becoming complaints (35 of 489 contacts).

In Q4, here were 789 PALS contacts/enquiries during Quarter 4 2017-18. This represents a 33% increase compared to the previous quarter, and a 31.4% increase

compared to the equivalent quarter in 2016-17. There was a conversion rate of 3.16% of PALS enquiries becoming complaints (25 of 789 contacts).

5. Legal Services

5.1. Clinical negligence claims

In Q3, the Trust received 24 new claims, representing a very small decrease compared to the 25 new claims in Q2. Thirteen of the new claims were received by the Surgical Care Group (a 13% decrease on the previous quarter) and nine by the Medical Care Group (a decrease of 1). 2 claims were received that related to Clinical Support Services.

In Q4, the Trust received 30 new claims, representing an increase compared to the 24 new claims in Q3. Nineteen of the new claims were received by the Surgical Care Group (a 31.6% increase on the previous quarter) and nine by the Medical Care Group (similar to Q3). 2 claims were received that related to Clinical Support Services (similar to Q3). As shown in the table below, the amount of new claims received in Q4 is the highest received by quarter in the last 2 years and this will be monitored going forward.

Quarterly Claims Received by Care Group

	2016-17				2017-18				
	Q1	Q2	Q3	Q4	Q1	Q2	17/18 Q3	17/18 Q4	Total
Medical Care Group	8	6	9	11	9	9	9	9	70
Surgical Care Group	16	5	14	13	12	13	13	19	105
Clinical Support Services	0	1	0	0	1	0	2	2	6
Nursing, Governance, Quality & Risk	0	1	0	0	0	0	0	0	1
Total	24	13	23	24	22	22	24	30	182

There was an increase of 4% in active clinical negligence claims (308) in Quarter 3 in comparison to 295 open clinical negligence claims in Quarter 2. The number of clinical negligence claims (with and without damages) that closed fell. More damages were paid in Quarter 3 compared to Quarter 2. During this period, there was a 50% decrease in new insurance claims compared to Quarter 2.

There was an increase of 4.64% in active clinical negligence claims (323) in Quarter 4 in comparison to 308 open clinical negligence claims in Quarter 3. The number of clinical negligence claims (with and without damages) that closed increased. More damages were paid in Quarter 4 compared to Quarter 3. During this period, there was a 75% increase in new insurance claims compared to Quarter 3. Further work is required to analyse the reasons for the increases.

5.2. Actions taken as a result of claims

Learning is identified following each claim and improvements are undertaken to prevent a repeat of the incident. The following are examples of changes made as a result of claims in Q3 & Q4:

- New risk assessment pack introduced by Falls Specialists

- New falls patient care plan introduced
- Pressure pad alarms introduced for patients with high risk of falls
- Urinary incontinence management training provided for junior doctors
- Emphasise importance of timely response to post-operative observations - e-MEWS since introduced in Trust and fully embedded within department of gynaecology.
- Reflection upon clinical diagnosis and management at departmental meeting
- Email to all ENPs to remind them of need to x-ray to exclude foreign body in wound caused by glass
- Ensure on-going education regarding all legal cases

5.3. Benchmarking data for claims

Quarterly benchmarking data is not available for NHS Trusts. However, NHS Resolution does produce annual figures for claims notified in previous financial years. The figures for clinical negligence claims received in 2015-16 and 2016-17 for local trusts were published in the last update. Comparisons for 2017-18 will be included once they are made publicly available via NHS Resolution's Factsheet 5.

5.4. Inquests

The Trust, via the Legal Department, proactively manages non-routine inquests. These inquests are when members of Trust staff are called to give evidence and/or there are novel or contentious issues. In many cases there are lessons to be learned and require a corporate witness to inform the Coroner of these lessons and what action has been subsequently taken to prevent recurrence. The Press and Public Relations Office are also kept informed if there is any potential for media interest and therefore a risk to the organisation's reputation.

Currently there are 18 open inquests that fall within the above criteria. Five inquests were held in Q3&4 with no actions arising for the Trust.

6. Conclusion

Quarter 3

The number of incidents reported has remained steady between Q2 and Q3 and is comparable to the number report in the same quarters in 2016/17. There has been a significant reduction in moderate harms and above between Q2 and Q3 and in the same period for 2016/17.

The number of open complaints decreased significantly to 39 (from 59) and the total number of overdue complaints fell to 5.

PALS decreased compared to Quarter 2 – communications remains the leading reason for enquiries to PALS. The clinical treatment was the primary cause of complaints in Quarter 3.

The number of clinical negligence claims received in Quarter 3 was slightly lower in comparison to 25 in Quarter 2.

Quarter 4
The number of incidents reported has remained steady between Q3 and Q4 and is comparable to the number reported in the same quarters in 2016-17. The increase in incidents related to moderate harms and above between Q3 and Q4 can be partially attributed to a seasonal increase in harmful falls, however there a significant decrease in the same period for 2016-17.

The number of open complaints decreased significantly to 34 (from 39 Q3) and the total number of overdue complaints fell to 5 (Q3) to 1 (Q4).

PALS increased compared to Q3, with communications remaining the leading reason for enquiries to PALS.

The number of clinical negligence claims received in Quarter 4 was slightly higher in comparison to 24 in Quarter 3.

The primary causes for incidents, complaints and clinical negligence claims throughout Q3&4 2017-18 were clinical, in comparison; the primary reason for PALS concerns was communication.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)50
Title of paper: Approval of Quality Account 2017-18
Purpose: To present the final draft of the Quality Account for review and approval by the Board, following its review by the Quality Committee, Audit Committee, external partners and External Auditors.
Summary: The final draft of this year's Quality Account has been completed subject to the outstanding information being inserted, that is, finalisation of the Clostridium difficile figures following the outcome of appeal meeting on 12th June and written comments from Healthwatch. The Director of Nursing and Assistant Director of Governance presented the draft Account to a number of external partners: • Halton CCG and Halton Borough Council (8th May) • St Helens and Knowsley CCGs, Knowsley Local Authority and Healthwatch (18th May) The feedback from these presentations has led to some minor amendments and additional information on the work undertaken by the Trust, which are listed in section 4.3 of the Quality Account. Grant Thornton have reviewed the draft version and undertaken testing of the VTE and patient safety indicators. They presented their limited assurance report to the Audit Committee on 23rd May and have provided a provisional unqualified conclusion, subject to a review of the outstanding feedback. It was reviewed by the Quality Committee at its meeting on 22nd May. The final information will be inserted as soon as it has been received and the Quality Account will be provided to the Communications Team for layout and design purposes. We remain on track to ensure that the final version is ready for uploading to NHS Choices by the national deadline of 30th June 2016. The latest version is attached as Appendix 1.
Corporate objectives met or risks addressed: Care, safety, communication
Financial implications: There are no additional resource requirements arising directly from this report.
Stakeholders: Trust Board, patients, carers, staff, regulators, commissioners, Healthwatch

Note: ***text in green font is mandated***

Recommendation(s): Members are asked to comment on and approve the final draft version of the Quality Account. The Board is asked to delegate final approval of the remaining items for inclusion to the Chief Executive and Director of Nursing, Midwifery and Governance.
Presenting officer: Sue Redfern, Director of Nursing, Midwifery and Governance
Date of meeting: 30th May 2018

NHS
St Helens and Knowsley
Teaching Hospitals
NHS Trust

Quality Account 2017-18

Note: ***text in green font is mandated***

What our patients said about us in 2017-18

Plastic surgery
I just cannot fault this hospital regarding plastic surgery. The staff are so kind and considerate. The surgeon explained exactly what he was going to do as he went along and both he and the theatre staff put me at ease. All in all an excellent service.

Emergency Department, Intensive Care and Respiratory Ward
The Emergency Department doctor reported his findings in a clear and caring manner which helped in putting my wife at ease. From the time of her admission to the intensive care unit through to her time spent on Ward 2c, the care and treatment my wife received was of the highest quality. The doctors, nurses and support staff all responded to her needs in a warm caring and sympathetic manner and at all times, kept her fully briefed with regards to the treatment administered and their expectations of that treatment. They were happy and at all times ready to answer questions we raised which we felt were always answered openly. Given the pressures we were fully aware the hospital was under in terms of high volumes of patients requiring their services, the service provided to my wife could not have been bettered.

Radiology
Visited the X Ray department today for an ultrasound of a lump. The doctor/consultant who performed the ultrasound was amazing. Amazing service & lovely people.

Maternity
All services and teams I have accessed through Maternity at Whiston hospital have been excellent. From scanning and dopplers to Labour ward, Fetal Assessment Unit and Special Care Unit. All staff friendly, helpful. I cannot fault anything from start to finish.

Emergency Department, Radiology and Volunteers
Service was great. Thank you so much. Efficient system. Triaged well. Not waiting long at all considering the numbers in waiting area. Kept informed via TV screen, staff, posters. Pleasant reception staff. Waiting area pleasant, calm, clean. Doctors/nurses helpful, informative, kind. X-rayed quickly, quietly, calmly. Volunteer staff helpful. Good signposting. Toilets clean, no queues. I have no complaints whatsoever.

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1. Section 1

1.1. Summary of quality achievements in 2017-18

Quality of services overall

- Care Quality Commission (CQC) ratings from the latest report (2016) remain in place, with St Helens Hospital, Outpatients and Diagnostic Imaging Services and the caring domain rated as **outstanding** across the Trust, **the best rating possible** and the Trust rated as good overall
- The Trust's Quality Care Accreditation Tool (QCAT), an internal quality assurance measure, has been rolled out across all general inpatient areas, with the highest level gold standard awarded to 12 out of 27 wards assessed

Patient safety

- Michael Lloyd, Research Pharmacist, won the Clinical Pharmacy Congress 2017 award for Excellence in Hospital Pharmacy, for his Trust-sponsored PhD research into the impact of formalised feedback on prescribing errors. He has been shortlisted for the Health Service Journal (HSJ) Patient Safety Awards (Education & Training Category)
- He won the Taking Research into Practice award at the North West Coast Research and Innovations event for implementing this programme of prescribing error feedback in an acute hospital setting
- The Trust was awarded Best Improvement in Patient Safety for electronic modified early warning system (eMEWS) at the Informatics Skills Development conference in Blackpool. It was also shortlisted for the HSJ Awards in the "Using Technology to Improve Efficiency" category
- Patients received 98.9% new harm-free care during 2017-18. This is harm occurring whilst an inpatient in the Trust and reported via the NHS Safety Thermometer
- No patients experienced a hospital acquired grade 3 or 4 pressure ulcer
- Continued to reduce the number of Clostridium Difficile infections, performing significantly better than the threshold
- Reductions in incidents resulting in harm from 2013-14 benchmarks (Sign up to Safety)
    - 31% reduction in theatre-related episodes of moderate/severe harms
    - 59% decrease in prescribing incidents resulting in harm
    - 17% decrease in falls incidents resulting in harm
- 93.9% fill rate for registered nurses/midwives
- 87% of frontline staff received the flu vaccination

Patient experience

- Best acute trust nationally in the Patient Led Assessments of the Care Environment (PLACE) with top marks in the country for every area of the 2017 inspection; cleanliness, food, privacy and dignity, facilities for patients living with dementia and disabilities, condition, appearance and maintenance of the hospital buildings
- The Trust's cancer unit, the Lilac Centre, was awarded the Pride of St Helens, by the readers of the St Helens Star, for the wonderful care provided to patients, during what was the Centre's 25th anniversary year

- 95.8% of inpatients would recommend our services, as recorded by the Friends and Family Test
- Patients rated the Trust 8.9 out of 10 for overall care in cancer, above the national average

Clinical effectiveness
- Trust rated 2nd in the UK overall in the latest Sentinel Stroke National Audit Programme (SSNAP) delivering sustained excellent performance with all domains achieving 'A' (Excellent) or 'B' (Good) ratings
- 99% of electronic E-attendance summaries sent for patients attending the Emergency Department (ED) within 24 hours
- 90.3% of stroke patients spent at least 90% of their hospital stay on a stroke unit
- Sustained achievement of the cancer performance targets against the national cancer waiting times standards
- Louise Delany, Acute Kidney Injury (AKI) Pharmacist, won the best poster presentation at the Renal Pharmacy Group Conference for her presentation of her work to improve care for patients with AKI
- Jo Jones, Liver Nurse was short-listed for the prestigious British Journal of Nursing Liver Nurse of the Year (2018) award
- The Stroke Team's multidisciplinary simulation training, in which the whole multidisciplinary team train together to manage common stroke emergencies, has been accepted for presentation at the European Stroke Organisation in May 2018
- Endoscopy Service was awarded the Joint Advisory Group (JAG) on Gastrointestinal Endoscopy reaccreditation in October 2017 in recognition of the high quality of service provided

Well-led
- Extremely positive national staff survey results, published in March 2018, with the Trust rated as the **best place to work in the NHS**. The Trust scored above the national average in 27 of the 32 indicators and **achieved the highest score for 10 of the 32**, including the following areas:
  - Staff recommendation of the organisation as a place to work or receive treatment
  - Percentage of staff who feel able to report errors, near misses or incidents witnessed in the last month
  - Effective use of patient/service user feedback
  - Fewest number of staff feeling unwell due to work related stress in last 12 months
  - Quality of non-mandatory training, learning and development
- The Trust has retained the Disability Confident Employer accreditation which will last for the next two years
- The Trust achieved the bronze Armed Forces Covenant – Employer Recognition Scheme award and is in the process of applying for the silver award
- The Trust was awarded the Navajo Charter Mark in May 2016 and is currently preparing for reassessment in 2018-19. This is an equality mark signifying good practice, commitment and knowledge of the specific needs, issues and barriers facing lesbian, gay, bisexual and transgender (LGBT)

- Awarded the contract to deliver a number of new services, including primary care services at Marshalls Cross Medical Centre and a number of community services
- Paul Siner (Project Manager) won the NHS Unsung Heroes Awards for Leader of the Year in 2018 at the annual awards ceremony that celebrates the dedication of non-medical staff to the founding principles of the NHS
- Rowan Pritchard-Jones, Chief Clinical Information Officer (CCIO) and Consultant Plastic Surgeon was short-listed for CCIO of the year in the prestigious eHealth Insider Awards
- PatienTrack system was shortlisted for the HSJ Awards in the Using Technology to Improve Efficiency category

The Trust continues to celebrate success internally, hosting our 13th Annual Staff Awards presentation evening in May 2017. The awards celebrate the hard work and achievements of staff in providing excellent patient care every day of the year. The readers of the St Helens Star newspaper awarded the Emergency Department the prestigious People's Choice award, highlighting the appreciation that patients and their families have for the excellent care they receive.

The Trust held its first annual awards ceremony for our volunteers to recognise the invaluable contribution they make across the organisation.

The annual awards, along with the Employee of the Month and the annual Learning and Development Awards are important ways of recognising and rewarding the ongoing dedication and commitment of staff throughout the year. In addition, positive comments received from patients are shared via a weekly 'Thank you Thursday' email sent to all members of staff.

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

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

The Trust's mission continues to be to provide high quality health services and an excellent patient experience. Our vision to provide 5-star patient care remains the Trust's primary objective so that patients and their carers receive services that are safe, patient-centred and responsive, aiming for positive outcomes every time. The mission and vision continue to be embedded in the everyday working practices of staff throughout the Trust.

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

St Helens and Knowsley Teaching Hospitals NHS Trust's (STHK) Vision

St Helens and Knowsley Teaching Hospitals NHS Trust's Values

The Trust's vision is the driving force for our focus on continuous improvement, supported by the Clinical and Quality Strategy, which outlines specific areas for quality improvement to deliver our aspiration to provide the highest standards of care. The Strategy focusses on a small number of clinical and quality improvements that were key

local health economy priorities. The Strategy was refreshed in 2016 and will be rewritten in 2018.

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

The Trust has delivered a comprehensive programme of quality improvement clinical audits throughout the year, with a number of actions taken as a result of the audit findings, which are detailed in section 2.4.2 below. Delivery of the quality improvement and clinical audit programme is reported to the Quality Committee via the Clinical Effectiveness Council.

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

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

We have continued to work with patients and carers during the year to ensure that they are able to influence changes made to our services. Patients are able to present their experiences of the care received, in their own words, as a patient story at the start of our public Trust Board meetings.

We continue to work with our local Healthwatch partners to improve our services, and Healthwatch representatives are key members of the Patient Experience and the Patient Safety Councils, which report to the Trust Board's Quality Committee, ensuring effective representation in the oversight and governance structure of the Trust.

This Quality Account details the progress we have made with delivering our agreed priorities and our achievement of national and local performance indicators, highlighting any challenges and the initiatives undertaken to work towards realising our vision of 5-star patient care. It also includes a summary of our Clinical & Quality and Nursing &

Midwifery Strategies. It outlines our quality improvement priorities for 2018-19, which were subject to consultation with staff, patient representatives and our commissioners.

I am pleased to confirm that the Trust Board of Directors has reviewed the Quality Account for 2017-18 and confirm that it is a true and fair reflection of our performance and that, to the best of our knowledge, the information contained within it is accurate. We hope that it provides you with the confidence that high quality patient care remains our overarching priority and that it clearly demonstrates the progress we have made.

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

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

Note: ***text in green font is mandated***

2. Section 2

2.1. About us

2.1.1. Our services

St Helens and Knowsley Teaching Hospitals NHS Trust provides a range of acute and specialist healthcare services including, inpatient, outpatient, community, and primary care, maternity and emergency services. In addition, the Trust hosts the mid-Mersey Neurological Rehabilitation Unit and the Mersey Regional Burns and Plastic Surgery Unit providing services for around five million people living in the North West of England, North Wales and the Isle of Man.

The Trust has just over 700 inpatient beds, with circa up to 40 additional escalation beds and provides the majority of its services from two main sites at Whiston and St Helens hospitals, both of which are new state-of-the-art, purpose built modern facilities that are well-maintained. Whiston Hospital houses the Emergency Department, the maternity unit, children and young people's service and all acute care beds. St Helens Hospital houses day-case and elective surgery, outpatients, diagnostic facilities, rehabilitation beds, the Lilac Centre (a dedicated cancer unit, linked to Clatterbridge Centre for Oncology) and Marshalls Cross Medical Centre (primary care services). The Trust provides intermediate care services at Newton Hospital, which has 30 inpatient beds. The Trust also provides outpatient and diagnostic services in a small number of other settings.

The Trust Board is committed to continuing to deliver safe and high quality care. The Trust has had an extremely challenging year, set within the financial challenges facing the NHS. There has been a continued increase in demand for services, as the Trust continues to be one of the busiest acute hospital trusts in the North West of England. It has an excellent track record of providing high standards of care to its population of approximately 350,000 people across St Helens, Knowsley, Halton and South Liverpool, as well as further afield. The Trust was extremely disappointed to have two never events and to fail to achieve the target of zero methicillin resistant staphylococcus aureus (MRSA) bacteraemia, outlined in more detail below. The Trust uses incidents as opportunities for learning and, therefore, has detailed action plans in place to address any issues arising from the investigations of these cases.

The Trust has remained busy during 2017-18 and continues to see an increase in activity across most areas, as shown in the table below, particularly in non-elective admissions and ED attendances. The average length of stay for non-elective admissions is 6.7 days.

	Apr 16-Mar 17	Apr 17-Mar 18	% change
Non-elective admissions	51,560	54,398	5.5%
Elective admissions	48,795	49,866	2.2%
Outpatient attendances	455,552	452,974	-0.6%
Births	4,061	4,095	0.8%
Emergency Department attendances	103,315	111,340	7.8%

2.1.2. Our staff and resources

Our staff and resources

The Trust's annual total income for 2017-18 was £384m million. We employ more than 5,600 members of staff and we are the lead employer for the Mersey Deanery and West Midland Deanery responsible for nearly 5,000 trainee specialty doctors based in hospitals and general practice (GP) placements throughout Merseyside, Cheshire, East and West Midlands and the East of England.

The Trust recognises the importance of maintaining high quality patient care in the context of year-on-year increases in demand and on-going recruitment challenges facing the NHS. There are a number of measures in place, which are outlined below, to ensure the right staffing across the Trust, including a focus on recruitment and retention and creation of new roles.

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

The Trust acknowledges the challenges that it faces in maintaining high quality care when delivering the increased activity levels highlighted above and in working to ensure appropriate staffing levels across all areas, within the financial pressures facing the NHS.

The average staff turnover rate in the Trust for 2017-18 was 11.3%, which is slightly lower than the national rate of 13.85%. Significant recruitment challenges remain within specific specialties and for specific roles, in particular: medical, nursing and scientific staff. The Trust is proactive in addressing these challenges and has established the Trust 'brand' via social media as an employer of choice, using online and other media advertisement with open days and nursing campaigns.

In addition, the Trust hosts regular recruitment events and uses international recruitment to ensure vacancies are filled. The Trust has collaborated with Masaryk University, Brno, Czech Republic in the recruitment of twelve newly qualified doctors who trained in Brno using the English syllabus. These new recruits joined the Trust for two years as Clinical Fellows at foundation year one and two to fill vacancies resulting from the reduced numbers of allocated posts from the North West Deanery. This provides the opportunity to reduce agency spend and maintain continuity of care. The doctors have the same opportunities to access further training in the North West, which keeps the talent pool local. They are a valuable asset to the Trust and our delivery of patient care.

The Trust is also exploring all possible opportunities to attract and retain nursing and midwifery staff, including:

- An active recruitment programme for the nursing and midwifery workforce, ongoing throughout the year, both locally and internationally, including participating in the international global learner campaign
- Delivering apprenticeship programmes from local health care cadets at further education colleges through to part-time registered nurse degrees
- Supporting the implementation of the new nurse associate role
- Implementing the St Helens and Knowsley Teaching Hospitals NHS Trust Preceptorship, Mentorship and Leadership (STHK PML) three year foundation programme to enhance retention

Nursing and midwifery safer staffing levels are reported externally, with details of the total planned number of hours of registered and care staff measured against the total number of actual hours worked to produce a monthly fill rate as a % for nights and days on each ward. Agency, bank, overtime, extra time hours, discharge coordinators and ward managers' supernumerary management days are included in the actual hours worked totals in accordance with the guidance. The acceptable monthly fill rate is 90% and over, which the Trust consistently exceeds overall. There is Executive Team scrutiny of the individual areas that fall below 90% each month to review the actions in place to reduce the risk of any recurrence. The safer staffing figure, however, does not analyse skill mix or the impact of temporary staff on a shift-by-shift basis, which can have an impact on the quality of care provided. The Trust has an embedded daily process for reviewing nurse staffing levels across the Trust, with a daily matron huddle, that ensures all areas have appropriate nursing staff to support the delivery of high quality care and to maximise patient safety.

The Trust also reports Care Hours per Patient per Day (CHPPD), which is calculated from the total actual hours worked in a month divided by the monthly total of the midnight count of inpatients in the ward. The National Quality Board adult inpatient ward staffing guidance (January 2018) advises that registered nurse (RN) CHPPD should be 3 hours. The Trust's position is reported monthly as part of the mandated safer staffing report. The wards facing ongoing challenges with recruitment are generally the wards that are unable to meet the safer staffing 90% fill rate consistently and the RN CHPPD recommendation.

2.1.3. Our communities

The local population is generally less healthy than the rest of England, with a higher proportion of people suffering from a long-term illness. Many areas suffer high levels of deprivation, which contributes to significant health inequalities among residents, leading to poorer health and a greater demand for health and social care services. Rates of obesity, smoking, cancer and heart disease, related to poor general health and nutrition, are significantly higher than the national average. In addition, it is anticipated that the elderly population will continue to grow significantly over the next ten years, which is likely to increase the incidence of diseases linked to older age and potentially increase demands on health and social care services in our local area. The local population is growing faster than the national average, with an increasing proportion of people aged over 65 as noted above.

2.1.4. Our partners

The Trust remains actively committed to working with its health and social care partners across Cheshire and Merseyside to create Integrated Care Systems and clinically and financially sustainable secondary care services to deliver the vision of the NHS Five Year Forward View.

The Trust is an active member of the Cheshire and Merseyside Health and Care Partnership, which includes all local NHS organisations providing care, all Clinical Commissioning Groups (CCGs) and all Local Authorities operating in Cheshire and Merseyside. The Trust is supportive of the initiatives to remove barriers between different parts of the health and social care system and to deliver more integrated and personalised care that responds to the needs of individuals.

Collaborative working with local partners has enabled the Trust to deliver a range of community and Primary Care Services, including:

- Provision of primary care at Marshalls Cross Medical Centre, successfully winning the longer term contract following a period as interim provider with St Helens Rota, who provide GP services
- Collaboration with our commissioning, health and social care partners to develop 'St Helens Cares'
- Delivery of the following community services, in partnership with other providers including North West Boroughs Healthcare NHS Foundation Trust:
    - Frailty Service
    - Intermediate Care Assessment Team
    - Inpatient intermediate care at Newton Community Hospital, with GP cover provided by St Helens Rota
    - Community Matrons
    - District Nursing Teams
    - Continence Team
    - Treatment Rooms

The continued close working in delivering adult community and intermediate care nursing services in St Helens listed above has facilitated better integration and management of patient pathways across the acute and community setting and has complemented the vision of St Helens Cares to create an integrated care system for the Borough. St Helens Cares is a partnership between all the major public services in St Helens, including the Local Authority and NHS, who have come together to explore how services could be delivered differently to meet the specific needs of the population in St Helens and achieve further integration and greater efficiency to meet growing demand.

In addition, the Trust is a member of a number of the Cheshire and Merseyside transformation programmes including; clinical support services collaborations, the Women's and Children's Services Partnership, the Cancer Alliance and the Urgent Care Network. The Trust is also part of the Prevention at Scale work programme, which seeks to work with public health to reduce the incidence of some of the common causes of non-elective hospital attendances, such as alcohol misuse and the prevention of high blood

pressure and diabetes, through consistent advice and support for patients across the health system.

The Trust has worked with its commissioners and Warrington and Halton Hospitals NHS Foundation Trust, during 2017-18, to create a single hyper-acute stroke unit at Whiston Hospital, which can deliver more specialist and expert care in the critical period following a stroke.

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

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

The Trust actively participates in the mid-Mersey patient safety and healthcare associated infection collaboratives. This includes working in partnership with primary care, Local Authorities and commissioners to ensure the services we provide meet the needs of our local population and to share lessons learned as widely as possible. Staff also attend the North West intravenous/aseptic non-touch technique (ANTT) forum meetings.

In the last year, the Trust has maintained close working relationships with Healthwatch, NHS Improvement and the Care Quality Commission, as well as local voluntary organisations that work to support patients in their own home, such as the Red Cross.

2.1.5. Technology and information

This year, the Trust has continued to deliver a portfolio of technological advancements to enhance patient safety and care. Every day in the NHS, information has to be collected, managed, used and shared. Excellent patient care depends on this fast and accurate flow of information.

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

Following the national cyber security incident in May 2017, Health Informatics has worked closely with the operational and clinical teams to strengthen and enhance the security of our clinical and operational systems. The following initiatives have taken place:

- All clinical and administrative systems have been amalgamated under a Unified Threat Management solution which has been implemented to further enhance the security of our systems and information
- Enhanced monitoring of all systems is now in place and Health Informatics is working very closely with all Information Asset Owners and Information Asset Administrators in the hospital to ensure systems meet with national requirements
- A dedicated network and security manager has been recruited to support this essential work

The following initiatives have taken place during 2017-18:

- Electronic Prescribing and Medicines Administration (ePMA) went live in two ward areas – Haematology and Stroke Rehabilitation
- A new theatre system, 'Opera' is now live in all theatre areas across both St Helens and Whiston Hospitals
- An Electronic Palliative Care Co-ordination System (EPaCCS) was launched, which allows key professionals across various care settings, including the hospital, to view the needs and wishes of patients with a palliative care diagnosis
- The telephone system in the hospital has been upgraded, allowing improved access for patients
- Within the Electronic Medical Early Warning Scores system (PatienTrack), a combined electronic risk assessment form has been launched, which combines information from five paper nursing assessment forms. This saves a great deal of time for nursing staff and ensures that information is captured in a standardised and clear format, as well as automatically alerting clinical staff to any patients whose condition is deteriorating
- In addition, clinical noting to capture fluid balance was launched across the Trust using the same Patientrack software. This will enhance the information required for early identification of Acute Kidney Injury (AKI) as well as complying with national NICE guidelines
- Upgrades were undertaken to the Electronic Document Management System (EDMS), the Pathology Telepath system and the DOCMAN system which sends letters to GP practices
- Following a successful bid to the Innovation Agency, the Trust commenced a Telehealth project following discharge from hospital for patients who have had a stroke and for patients who have a drain in place following plastics surgery. Telehealth provides the technology for consultants to engage with patients via webcam technology. This means that patients and consultants do not need to be in the same location to conduct consultations. This project went live and responses to the initiative from both patients and clinicians have been extremely positive
- The hospital launched their transformational Electronic Patient Record programme, which will commence in spring 2018 and which will see a replacement of the current Patient Administration System (PAS). The new Medway PAS will also link up key clinical systems including EDMS, PACS, Maternity and ICE discharge
- The IT Service Desk software was replaced with a new tool, which allows users to log and track the progress of their calls on a self-service 'portal'
- Internally, the Health Informatics structure has been reviewed and revised to enhance the technical teams and place equal emphasis on innovation and business

relationship management to ensure that the future plans of every department are known and understood in advance and can be jointly planned with the clinical teams

- The Trust has worked closely with our CCG colleagues and NHS England to deliver national and local initiatives to improve the use of technology and reduce the need for paper whilst improving patient access, experience and quality of care along with the added efficiency, effectiveness and financial benefits. This has included:
  - Electronic referral system (eRS)/paper switch off
  - Provision of advice & guidance via eRS to primary care colleagues
  - Referral Management System (RMS)

2.2. Summary of how we did against our 2017-18 Quality Account priorities

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

Progress in achieving 2017-18 quality goals

Quality Improvement Goal	Outcome delivered	Progress
Maintain the safety of patients in the Emergency Department (ED)	Achieved	High compliance with the monitoring of modified early warning scores for patients in line with the requirements of the Trust policy was confirmed by audits. There were 6 serious incidents in the ED in 2016-17, which reduced to 5 in 2017-18 despite a 7.8% increase in attendances, this represents a reduction from 0.06 serious incidents per 1000 attendances to 0.04 in 2017-18. There are a number of continuous actions to reduce the waiting times and to ensure the safety of all patients, including: • Ongoing review of medical and nursing staffing rotas to manage demand safely across the 24 hour and 7-day period • Front door streaming to a GP • Pre–assessment in stretcher triage designed solely to fast track patients from that area to the most appropriate clinical area according to need • Multi-specialty Consultant ED in reach is provided, according to demand • Community matron and consultant-led frailty in-reach and clinical huddles at 9.30 am and 2 pm each day • Ring-fenced beds for frailty patients, with fast track processes in place • Funding for Health Care Assistants to circulate the walk-in waiting area and repeat observations at peak times • Closely working with North West Ambulance Service (NWAS) to maintain effective ambulance handover times • Opened an additional 21 medical beds to improve flow in ED
Reduce by 50% in the next 3 years avoidable harm from:		
Falls	Partially achieved	• Number of falls resulting in harm reduced by 17% from the 2013-14 baseline

*Note: **text in green font is mandated***

Pressure ulcers Medication incidents	Achieved Achieved	• Trust had no hospital acquired avoidable grade 3 or 4 pressure ulcers in 2017-18 with continued year-on-year reductions in pressure ulcers relating to all categories since 2014-15 • 59% reduction in harms related to prescribing errors from the baseline
Refresh and redesign the process for learning from incidents and complaints	Improved	• Incident reporting through the national reporting and learning system (NLRS) has been maintained at high levels • Improved timeliness of responding to complaints within agreed timescales and improved process for investigating serious incidents within the agreed timeframe to enable earlier identification of lessons • Bi-monthly patient safety newsletter introduced in 2017, with additional newsletters circulated to cascade urgent information • Weekly incident review forum developed to review any significant incidents across the Trust and enable the identification of immediate learning • Care Group sharing of incidents and trends reinforced • Lessons learned from complaints and incidents are shared via the Ward Managers and Matrons meetings A framework for learning from deaths is being implemented which will form the framework for sharing and learning from all incidents and complaints.
Provide respiratory ward based non-invasive ventilation (NIV) supported by appropriate equipment and staffing levels in the next 12 months	Due to commence in summer 2018	• The required equipment is in place and staff have been recruited, with imminent start dates to enable the service to be in place in 2018-19
Increase the percentage of e-discharge summaries sent within 24 hours to 90%	Not achieved	• The Trust is currently implementing a new patient administration system that will help to improve the timely dispatch of e-discharge summaries, which achieved 69.5% for 2017-18

Improve the effectiveness of discharge planning	Achieved	• The Trust has increased the number of morning discharges, resulting in an increase in bed availability • The Trust has reduced delays for patients waiting for take home medication as a result of quality improvements implemented in the transfer lounge • Weekend board rounds take place on many wards to ensure consistent practice seven days a week for patient discharge pathways • Multidisciplinary discharge tracking meetings in place twice weekly reviewing medically optimised patients/longest length of stay escalating to CCG with plan, do, see, act (PDSA) cycles to improve productivity and outcomes • Multi-agency discharge event (MADE) attended monthly by executives from the whole system • Community matron in-reach in place since September supporting earlier discharges daily • Discharge leaflet produced to improve communication with patients. • Implemented electronic processes for referring inpatients to community nursing services

2.3. Quality priorities for improvement for 2018-19

The Trust's quality priorities for 2018-19 are listed below with the reasons why they are important areas for quality improvement. The views of stakeholders and staff were considered prior to the Trust Board's approval of the final list. The consultation included an on-line survey that was circulated to staff, commissioners and patient representatives, as well as placed on the Trust's website for public participation. In addition, Healthwatch members of the Trust's councils and our commissioners were asked for their views on what should be included in the list of priorities.

The consultation was undertaken using SurveyMonkey and a face-to-face survey with 84 responses received. Analysis of the responses has shown overall agreement and support for the proposed quality improvements for 2018-19 with the majority of responses receiving over 94% approval (increase from 90% last year). Patient safety and the continued drive to reduce patient harm scored 99% closely followed by ensuring change is implemented following lessons learned from incidents and complaints, which scored 98%. Ensuring the most effective use of the skills of the nursing workforce through the use of an electronic system, SafeCare, scored the lowest value of 91%. Additional comments submitted have suggested that further information and support is required about the SafeCare system to ensure that staff fully understand the benefits of this work, which will be included in the implementation plans.

	Safety		
Priority title	**1. Reduce further the rate of avoidable harm from falls, pressure ulcers and medication incidents**	**2. Implement change as a result of lessons learned from incidents and complaints.**	**3. Maintain effective assessment and monitoring of all patients in the Emergency Department.**
Rationale	Patient safety remains the key priority and the Trust is committed to reducing avoidable harm to patients, with the focus on 'getting it right for every patient, every time'.	Patients sometimes experience unintended harm or a poor experience, despite the hard work of healthcare staff, and when this happens it is important that we learn from these incidents to improve care in the future. The Trust remains committed to improving how these lessons are shared across the whole organisation and embedded in our policies and guidelines for staff.	The Trust is aware that some patients may have to wait longer in the Emergency Department at certain times, for example during the winter months when the number of patients in the department increases. The Trust remains committed to providing the timely assessment and monitoring of all patients to ensure they receive appropriate treatment
Measurement	Reduction in avoidable harm of moderate category or above from pressure ulcers, falls and medication errors from a baseline set in 2017-18.	Audit the new dissemination process to provide evidence that sharing is being learned. Detailed review of repeated incidents or complaints, following the dissemination of learning, to identify why they reoccurred to enable the Trust to take measures that are more effective.	Compliance with the Trust's Policy for Modified Early Warning System
Monitoring	Monthly reports to Patient Safety Council	Quarterly reports to Patient Safety Council and Patient Experience Council	Quarterly reports to Patient Safety Council

	Clinical effectiveness		Patient experience	
Priority title	**4. 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**	**5. Further embed the seven day services clinical standards across the trust**	**6. Improve the effectiveness of discharge planning**	**7. Increase the percentage of e-discharge summaries sent within 24 hours to 85%**
Rationale	SafeCare is a live electronic system that will enable us to meet the individual healthcare needs of patients better by the effective allocation of nursing staff according to their specialist skills. It provides real time information about the healthcare needs of patients and then calculates the number of nursing staff required at ward-level.	The Trust is committed to ensuring that we provide consistently high quality care, with patients admitted in an emergency having access to the same level of in-patient care every day of the week. This includes consultant assessment and review, access to diagnostic tests and consultant-led interventions by 2020.	The Trust has made improvements in the effectiveness of the discharge processes, but recognises that there is further work to do. Commencing discharge planning as soon as patients are admitted should reduce any delays and will improve the patient and carers' overall experience of care	In order to communicate the ongoing treatment plan when patients are discharged it is essential to share the relevant information in a timely and efficient manner. This will ensure that patients' ongoing clinical care is provided effectively and reduce the potential for readmission into hospital. The target has been set to 85% in view of 2017-18 performance.

Note: ***text in green font is mandated***

Measurement	Delivery of SafeCare implementation plan	Delivery of Trust's seven day services action plan assessed by national and local audit.	Delivery of the implementation plans for each discharge transformation scheme	Numerator - % of summaries issued Denominator - % of discharges
Monitoring	Quarterly reports to Workforce Council	Audit results reported to the Executive Committee	Monthly reports to Operational Transformation Executive meeting.	Reported via Integrated Performance Report to the Quality Committee

2.4. Statements relating to the quality of the NHS services provided by the Trust in 2017-18

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

2.4.1. Review of services

During 2017-18, the Trust provided and/or sub-contracted £308m NHS services.

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

The income generated by the NHS services reviewed in 2017-18 represents 100% of the total income generated from the provision of NHS services by the St Helens and Knowsley Teaching Hospitals NHS Trust for 2017-18.

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

2.4.2. Participation in clinical audit

2.4.2.1. Participation in Quality Account audits 2017-18

Annually NHS England publishes a list of national clinical audits and clinical outcome review programmes that it advises trusts to prioritise for participation and inclusion in their Quality Account for that year. This will include projects that are ongoing and new items.

During 2017-18, 35 national clinical audits and 3 national confidential enquiries covered relevant health services that St Helens and Knowsley Teaching Hospitals NHS Trust provides.

During that period, St Helens and Knowsley Teaching Hospitals NHS Trust participated in 95% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The table below shows:

- The national clinical audits and national confidential enquiries that St Helens and Knowsley Teaching Hospitals NHS Trust was eligible to participate in during 2017-18.
- The national clinical audits and national confidential enquiries that St Helens and Knowsley Teaching Hospitals NHS Trust participated in during 2017-18.

- The national clinical audits and national confidential enquires that St Helens and Knowsley Teaching Hospitals NHS Trust participated in, and for which data collection was completed during 2017-18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits and Clinical Outcome Review Programmes	Eligible	Participated	Rate of case ascertainment % submitted
Diabetes (Paediatric): Paediatric National Diabetes Audit (PNDA)	Yes	Yes	100%
CEM Pain in Children (ED)	Yes	Yes	100%
CEM Procedural Sedation in Adults (ED)	Yes	Yes	100%
CEM Fractured Neck of Femur (ED)	Yes	Yes	100%
Diabetes (Adult): * National Diabetes Audit (Adult) (NDA (A)	Yes	Yes	37.5%
UK Parkinson's audit	Yes	Yes	100%
National Dementia Audit Round 3	Yes	Yes	100%
National Blood Transfusion programme:	Yes	Yes	100%
1. Transfusion associated circulatory overload (TACO) 2017 2. Transfusion red cell-&-platelets-re-audit	Yes Yes	Yes	100%
Learning Disability Mortality review (LeDeR)	Yes	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	Yes	>96-100% (Dec16-Dec17)
National Prostate Cancer Audit (NPCA)	Yes	Yes	100%
National Ophthalmology Audit	Yes	Yes	87.8%
National audit-breast cancer in older patients (NABCOP)	Yes	Yes	100%
National Maternity And Perinatal Audit (NMPA)	Yes	Yes	100%
National Audit Of Seizures And Epilepsies In Children And Young People (**EPILEPSY 12**/Round 3)	Yes	Yes	New - study not yet started
Inflammatory Bowel Disease (IBD) Programme (Registry)	Yes	Yes	100%

National Clinical Audits and Clinical Outcome Review Programmes	Eligible	Participated	Rate of case ascertainment % submitted
BAUS: Stress Urinary Incontinence	Yes	No	Not applicable
BAUS: Nephrectomy Audit	Yes	Yes	100%
BAUS: Urethroplasty	Yes	No	Not applicable
BAUS: Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	100%
National Chronic Obstructive Pulmonary Disease Programme (COPD)	Yes	Yes	100%
Adult Critical Care: Case Mix Programme - Intensive Care National Audit & Research Centre (ICNARC)	Yes	Yes	100%
Severe Trauma: Trauma Audit & Research Network (TARN)	Yes	Yes	100%
Acute Coronary Syndrome or Acute Myocardial Infarction: Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	95-100%
National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	>100%
Neonatal Intensive and Special Care (National Neonatal Audit Programme (NNAP)	Yes	Yes	100%
Bowel Cancer: National Bowel Cancer Audit Programme (NBOCAP)	Yes	Yes	103%
Oesophago-Gastric Cancer: National Audit Oesophago-Gastric Cancer (NAOGC)	Yes	Yes	81-90% 2016 report
Lung Cancer: National Lung Cancer Audit (NLCA)	Yes	Yes	72.7%
National Heart Failure (HF)	Yes	Yes	74% Based on latest published figures available – 2015-16
Falls And Fragility Fractures Programme (FFFAP)	Yes	Yes	116.2%
1. National Hip Fracture Database (NHFD)	Yes	Yes	100%

Note: **text in green font is mandated**

National Clinical Audits and Clinical Outcome Review Programmes	Eligible	Participated	Rate of case ascertainment % submitted
2. National Audit Of Inpatient Falls (NAIF): Round 2	Yes		
National Joint Registry (NJR)	Yes	Yes	93.57% Based on latest published figures available – 2015-16
Elective Surgery: national patient-reported outcomes measures (PROMS)	Yes	Yes	71.7% Participation rate – based on latest published figures available – 2016-17
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	Yes	100%

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

National Confidential Enquiries			
2017-18	**Eligible**	**Participated**	**Rate of case ascertainment % submitted**
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Medical & Surgical Clinical Review Outcome Programme			
Peri-operative management of surgical patients with diabetes study	Yes	Yes	100%
Acute heart failure study	Yes	Yes	100%
Cancer in children, teens and young adult (0-25 years)	Yes	Yes	no eligible cases: – organisational questionnaire only
NCEPOD - Child Health Clinical Outcome Review Programme			
Mental health conditions in young people	Yes	Yes	100%
Chronic neuro-disability	Yes	Yes	100%
MBRRACE-UK - Confidential Enquiries across the UK			

Maternal, infant and newborn clinical outcome review programme (mothers and babies - reducing risk through audits)	Yes	Yes	100%

2.4.2.2. Other national audits (not on Quality Account list 2017-18)

National audits	Status
British Thoracic Society (BTS) Bronchoscopy audit 2017	Completed
Royal College of Psychiatrists' feasibility study: national depression audit	Completed
National spotlight audit: delirium screen and delirium assessment	Completed
Royal College of Physicians' asthma audit development project- hospital pilot	Completed
Psoriasis re-audit 2017: British Association Dermatologists (BAD)	Completed
British Association of Parenteral and Enteral Nutrition (BAPEN) national nutritional care audit	Completed
Society for acute medicine benchmark audit (SAMBA): 'Against the clock – time for patients'	Completed
National breast surgery IBRA3 team study therapeutic mammoplasty	Completed
National diabetes inpatient audit 2017	Completed
Saving Babies' Lives Project Impact and Results Evaluation (SPiRE)	Completed
British Thoracic Society (BTS): National Adult Bronchiectasis audit 2017	Active
Get it right first time - surgical site infection (GIRFT – SSI)	Active
National pregnancy in diabetes (NPID) 2017/18 ()	Active
Rapid access chest pain clinic (RACPC) audit programme	Active
National bullous pemphigoid (BAD) audit	Active
Neoadjuvant systemic therapy	Active
Imagine (ileus management) - STARSURG	Active
Breast and cosmetic implant surgery	Active
National 3rd corrective jaw treatment audit	Active
Cystic Fibrosis Registry	Active

The reports of 40 national clinical audits were reviewed by the provider in 2017-18 and St Helens and Knowsley Teaching Hospitals NHS Trust has taken and intends to take the following actions to improve the quality of healthcare provided:

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)/Child Heath Programme	
Completed study reports have been disseminated and reviewed with report recommendations implemented or planned.	
Current active studies: 1. Pulmonary embolism 2. Peri-operative diabetes	**Completed studies – awaiting national report:** 1. Acute heart failure 2. Cancer in children, teens and young adult study 3. Mental health conditions in young people 4. Chronic neuro-disability
Audit title	**Outcome/actions**
NCEPOD: Care of patients with mental health problems in acute general hospitals	Mental health triage documentation has been RAG rated to make explicit the referral to mental health. The referral form for liaison collects the necessary data at the point of referral, including risk to self and others and safeguarding. A comprehensive consultant-led team is in place that provides a rapid response to mental health emergencies, and a 24-hour elective response. The alcohol team is dual diagnosis trained, so covers alcohol and substance misuse 7 days a week from 09:00 to 21:00. An expanded and robust liaison psychiatry team is in place to assist in decision-making providing an emergency response, as well as planned response within 24 hours. Senior ED staff have been trained on RIO system, which holds patient data for our partner mental health trust allowing review of care plans.
NCEPOD: Non-invasive ventilation (NIV)	The development of a new NIV unit is currently underway and the unit should be running by June 2018.
NCEPOD: Sepsis	Major changes have been implemented in the Trust over the last 12 months in the management of sepsis with actions led by Sepsis Consultant lead in ED: Sepsis team has been expanded. A Sepsis Policy and pathway have been completed including a specific maternal sepsis pathway. A ‘Safe management of sepsis e-learning module’ is now available to staff through the Virtual College. Sepsis study days are ongoing and procedures have been updated. Trust Sepsis Patient Information Leaflet produced. A number of specific sepsis trolleys are available for use.
Royal College of Emergency Medicine (RCEM) 2016-17	
Audit title	**Outcome/actions**
Severe sepsis/septic shock	Findings highlighted the Trust achieved a large percentage of patients having lactate measured and blood

*Note: **text in green font is mandated***

	cultures taken (above average) prior to leaving the department. Review of ED sepsis pathway with a view to include further information to assist with management of these patients.
Audit title	**Outcome/actions**
Asthma care in ED	Further staff training undertaken on the importance of peak expiratory flow rate (PEFR), early steroids and oxygen prescribing.
Audit title	**Outcome/actions**
Consultant sign off in ED	Actions taken: identification of the Consultant shift leader, who now wears a red scrub top with 'shift lead' written on to indicate this. Clinical rota has been changed to improve availability of shift lead consultant.
Severe Trauma: Trauma Audit & Research Network (TARN)	
Audit title	**Outcome/actions**
TARN	Reports have been reviewed - no further actions required at this time Planned audit to be undertaken to review 'Time to CT' in ED
National Cardiac Arrest Audit (NCAA)	
Audit title	**Outcome/actions**
NCAA	National Cardiac Arrest Audit reports are circulated to appropriate Trust Groups/Councils and reviewed. Cardiac arrests are reported on the Datix system and reviewed within 72 hours. A further local review is undertaken if any cause for concern is noted.
Sentinel Stroke National Audit Programme (SSNAP)	
Audit title	**Outcome/actions**
SSNAP	**Service developments which have contributed to improvements are listed:** Additional **Speech & Language Therapists (SLT)** in post. **Group Working:** The 7-day SLT service has also made a large impact in assessing patients at a weekend, which allows staff to make better and safer decisions on how to manage our patients. Full allocation of **Physiotherapists**, which has improved the scores. **Consultant working:** Consultant weekend working changed so that the Hyper Acute Stroke Unit (HASU) receives a full ward round every day by a stroke consultant who is present at weekends. All suspected strokes are called through by the North West Ambulance Service (NWAS) as a standby call. This allows ED to alert the stroke team who will meet the

	patient at the door giving them direct access to specialist care. **Staff training:** individualised training for the whole team to recognise the sick stroke patient.
Acute Coronary Syndrome or Acute Myocardial Infarction:	
Audit title	**Outcome/actions**
Myocardial Ischaemia National Audit Project-MINAP	**Better data completeness for risk-adjusted outcomes:** Improvements in data quality have been addressed through implementation of new minimum data standards during 2017.
UK National Haemovigilance Scheme	
Audit title	**Outcome/actions**
Serious Hazards of Transfusion (SHOT)	Implementation of report recommendation that anti-D should be given up to 10 days after sensitising event. Anti-D is most effective within 72 hours: this was disseminated to staff during 'safety huddle' meetings. Transfusion is now covered as part of local maternity induction education.
Falls And Fragility Fractures Programme	
Audit title	**Outcome/actions**
National Audit of Inpatient Falls (NAIF): Round 2	The issues identified from the report have now been incorporated into the Trust Falls Strategy. Key focus: Process for carrying out eye tests has been finalised and the template disseminated for use. Laminated information has been distributed further with education and monitoring of compliance planned to increase number of lying and standing blood pressure recordings.
National Neo-natal Audit Programme (NNAP)	
Audit title	**Outcome/actions**
NNAP audit (2016 data)	Actions: Planned to be completed by January 2019: • Introduction of family integrated care & training to improve breastfeeding • Set up of a dedicated clinic to facilitate a 2-year follow - up of patients.

2.4.2.3. Local clinical audit information

The reports of 182 local clinical audits were reviewed by the provider in 2017-18 and St Helens and Knowsley Teaching Hospitals NHS Trust has taken and intends to take the following actions to improve the quality of healthcare provided:

Acute Medical Unit (AMU)	
Audit title	**Outcome/actions**

Implementation of acute headache pro forma	Re-audit results showed: improved assessment, documentation and an increased number of final diagnoses made. No further actions needed.
Audit title	**Outcome/actions**
Audit of ambulatory admissions of diabetes patients presenting with hyperglycaemia	Developing and implementing an Ambulatory Emergency Care (AEC) hyperglycaemia pathway. Also rapid access clinic appointment for follow-up care. Increased availability of Diabetes Specialist Nurses working for extended hours. Training to be rolled out to ward staff.
Burns & Plastics	
Audit title	**Outcome/actions**
Audit of Adherence to delegated consent policy	To incorporate a consultant-led (or post-certificate of completion of training (CCT)-led) training session on delegated consent for all new starters in the department.
Audit title	**Outcome/actions**
Audit of copying letters to patients	'Opt out' approach has been adopted for sending copies of clinic letters to patients when listed for surgery
Cardiology	
Audit title	**Outcome/actions**
Appropriate use of criteria for inpatient transthoracic echocardiogram	Implement inpatient & outpatient options on the echocardiogram (ECHO) request form in the new electronic patient record (EPR) system. Increase repeat request interval limit from 1 month to 6 months, March 2018.
Critical Care	
Audit title	**Outcome/actions**
Sedation breaks in ICU	A targeted sedation guideline has been developed: including sedation break guidance for how to undertake a sedation break/how to assess a patient 'off sedation'.
Audit title	**Outcome/actions**
Re-audit efficiency of enteral feeding, ICU	Results show there has been some improvement in the amount of enteral feed delivered since 2016 and is in line with published data. No significant actions to be taken.
Dept. of Medicine for Older People (DMOP)	
Audit title	**Outcome/actions**
Drug omissions in geriatric medicine	Training nursing staff undertaken to use electronic access system to find where the medication is available from.
Audit title	**Outcome/actions**
How safe are safe patient observations?	Planned actions include: • Review of current guidelines • Formulate risk assessment tool to standardise assessments for patients who may require 1:1 and trial

	it on key areas and new care plan. • New Policy to be devised • Introduce 'Make Specialing Special' education programme • Nurses to receive training in delivering 1:1 care • Formulate information leaflets for patients, relatives and staff involved in 'Specialing'
Audit title	**Outcome/actions**
Re-Audit of Parkinson's Service (Following on from 2015 national audit)	• Parkinson's UK information packs to be given to patients at initial consultation • New patients to have Mini-Mental State Examination (MMSE) and Geriatric Depression Scale (GDS) prior to consultation • Advance care planning • Social worker referrals - Parkinson's Practitioner has contact numbers for social services & will inform GP, to improve communication and documentation • Leaflet also to be provided on carer support and services • Lee Silverman Voice Treatment (LSVT), a form of speech treatment, will be available
Diabetes	
Audit title	**Outcome/actions**
Audit of the discharge times on diabetes ward	To avoid medications to take out (TTO)/transport delays: prioritise morning discharge; increase number of patients discharged before 10am. Inter-specialty referrals wait time to be reviewed. Discharge time to be recorded accurately on admission, discharge and transfer (ADT) system.
Emergency Dept. (ED)	
Audit title	**Outcome/actions**
Management of pain in adults attending ED	Improvements have been shown in pain score assessment at triage (within 15 minutes) since the introduction of a dementia pain score tool being incorporated into the over 65 years ED Casualty Record Card and the displaying of pain management guideline posters in all triage areas. Patients being offered analgesia at triage and receiving analgesia within 30 minutes has also improved with introduction of Patient Group Directives (PGDs) into the department.
Audit title	**Outcome/actions**
Audit of the "Quick Set" blood test requesting in ED	C-reactive protein test (CRP) added to appropriate quicksets
ENT	

Audit title	Outcome/actions
ENT Rapid Access Clinic (RAC) Referral Pathway	Creation of new referral form and a list of ENT conditions appropriate for the RAC to be distributed among ED, Walk-in Centres, GPs and other specialities.
Audit title	**Outcome/actions**
Surgical management of otitis media with effusion in children	Better management of patient's expectations when offering the options of treatment and a better explanation of physiology and treatment of glue ear. Provide a holistic approach and take into consideration special needs such as patients with Autism, ADHD, etc. Creation of Otitis Media With Effusion (OME) form planned to complete in clinic and facilitate patient information completion, in order to decide on further management.
Gastroenterology	
Audit title	**Outcome/actions**
Rectal biopsies in diarrhoea audit	Decision has been made on the standard regime and types of scope to be used.
Audit title	**Outcome/actions**
Audit of therapeutic upper gastro-intestinal (UGI) endoscopy - percutaneous endoscopic gastrostomy (PEG)	Continue annual audit to ensure safety standards remain high. Use the pre-assessment checklist & audit its use. Assessment & care of PEGs will fall under Nutritional Specialist Nurse's remit
Audit title	**Outcome/actions**
Therapeutic UGI endoscopy dilatation	A standardised post procedure care plan has been agreed. Further audits to be undertaken to review patient visits more closely.
Audit title	**Outcome/actions**
30-Day mortality & 8-day non elective surgery	Avoid throat spray if patient high risk of aspiration. Use carbon dioxide for all procedures. Mortality is monitored every six months. The mortality rates are within the nationally expected limits. Mortality & readmission data will be cumulated going forward to identify further learning.
Audit title	**Outcome/actions**
Quality & safety lower gastro-intestinal endoscopy	Documentation of withdrawal times has improved. Continue to improve documentation on the Unisoft system reports particularly with tattooing.
General Surgery	
Audit title	**Outcome/actions**
Review of waiting times for perianal abscess	Patients will try to be prioritised at the start of each day when clinical condition of other waiting patients allows. All

	patients with perianal abscess will be referred to a colorectal surgeon for follow-up
Audit title	**Outcome/actions**
Venous thromboembolism (VTE) prophylaxis in emergency general surgery patients	1st Cycle Key Actions: of those patients eligible for low molecular weight heparin (LMWH) 100% should receive it within 24-hours of admission; otherwise it should be documented by medical personnel. 100% of patients who undergo general surgery, where mobility is expected to be reduced, should receive LMWH; otherwise, decision should be documented. 2nd Cycle Key Actions: Re-write the VTE guidance - in conjunction with advice from VTE lead
Audit title	**Outcome/actions**
Extended VTE prophylaxis in colorectal cancer patients undergoing major surgery	Planned actions: incorporate extended VTE education in foundation year 1 doctors' induction
Audit title	**Outcome/actions**
Breast Unit documentation audit	The Breast Unit form is to be re-designed and simplified for use by patients and clinical staff. Re-audit planned following implementation of new form.
Neuro-Physiology	
Audit title	**Outcome/actions**
Waveforms audit- nerve conduction studies	Patients asked to wash hands prior to the test to ensure good skin preparation resulting in a better quality reading.
Obstetrics & Gynaecology	
Audit title	**Outcome/actions**
Stillbirth audit	Bereavement Team to encourage uptake of post mortems (PM) with families. Raise awareness with staff in relation to the importance of PM.
Audit title	**Outcome/actions**
Management of endometrial hyperplasia	Implementation of new Trust guideline based on the Royal College of Gynaecologists' guideline for the management of endometrial hyperplasia to provide consistent approach by all clinicians and to clarify doses and suitable regimes.
Audit title	**Outcome/actions**
Audit of the use of Oxytocin (Syntocinon)	The actions recommended were completed on the day it was requested. Dissemination of the requirement for doctors to prescribe the Oxytocin as an infusion. Draft of a potential sticker has been given to the ward manager and shown to the core midwives for comments. To revisit the sticker with the newly appointed ward

	manager and trial the sticker once available. Use of the Oxytocin form has been included on the safety bulletin on Delivery Suite and its use will be monitored.
Paediatrics	
Audit title	**Outcome/actions**
Overnight oxygen study	Amendments to the patient information leaflet and referral form.
Audit title	**Outcome/actions**
Diabetes support for children at nursery and school	New standards have been implemented, which will be reviewed in the coming audit year 2018-19. Extra administration support is needed to support the clinical team
Audit title	**Outcome/actions**
Paediatric sepsis screening tool and pathway audit	All children have a sticker attached to their notes, which is now incorporated into the ED casualty card. All children who 'trigger' must have screening tool attached and completed.
Audit title	**Outcome/actions**
Audit of inpatient management of patients with eating disorders	New Eating Disorders Pathway has been introduced with continued training and a re-audit will be planned for coming year. Children Eating Disorders (CEDs) team (Mid-Mersey) are activity working with lead key workers
Audit title	**Outcome/actions**
Audit of the paediatric epilepsy services	Key Actions: Ensure/encourage better compliance with pro forma filling in epilepsy clinic. Amend existing pro forma to include a tick box at the beginning to document if Epilepsy Nurse present in the clinic. Increase the number of epilepsy clinics. Renaming the existing Paediatric Neurology clinics as Epilepsy Clinic. Individual consultant to review appropriateness of new patient bookings/ referrals to epilepsy clinical 6-8 weeks in advance. Actions: April 2018
Respiratory	
Audit title	**Outcome/actions**
Re-audit of insertion, management and removal of chest drains	Planned actions: develop and implement the use of a specific chest drain checklist pro forma/sticker for clinicians inserting chest drains. Teaching sessions for doctors and nurses to raise awareness of the issues regarding the procedure/further re-audit cycle planned.
Rheumatology	
Audit title	**Outcome/actions**
Rheumatoid arthritis	Planned actions: The rheumatology handbook is to be

and cardiovascular disease	updated with information on hypertension and what to do in clinic. More detailed information to be included in clinic letters with regards to encouraging exercise/weight loss.
Trauma & Orthopaedics	
Audit title	**Outcome/actions**
Upper limb neurovascular assessment: pro forma use	Additional teaching undertaken for junior doctors at the start of each rotation.
Audit title	**Outcome/actions**
Post-op. complications in patients taking Apixaban	Stop Aspirin on admission if on Apixaban
Audit title	**Outcome/actions**
Analgesic management of hip fracture in adults	Re-audit undertaken: significant improvements have been made in overall compliance compared to the audit undertaken in 2015-16. No further actions required.
Safeguarding: Paediatrics	
Audit title	**Outcome/actions**
Safeguarding compliance and assurance audit	A work plan has been compiled in response to the recommendations and relevant changes in processes and documentation are being implemented. A themed audit has also taken place to look specifically at management of 16 and 17 year olds.
Therapies	
Audit title	**Outcome/actions**
Dietetics audit to re-assess compliance with NSPA Guidance: Naso-Gastric (NG) Feeding Tubes	The NG Care Bundle to be rolled out across all wards highlighting the importance of documentation of discussions, NG tube chart use, and using the NG insertion record sticker.
Audit title	**Outcome/actions**
Acquired brain injury: occupational therapists (COT)-Seddon Suite	Planned actions: development of guidelines for commonly identified procedures used on Seddon. Work with Cheshire and Merseyside Rehabilitation Network on agreed format for 'My Rehab' files, and with multidisciplinary team around format/types of family education. Training to be arranged for therapy staff around seizure management. Production of commonly used list of medications and provide training for therapists. Local wheelchair services: Cheshire and Merseyside Network Head /Seddon Suite manager monitoring this issue with the goal of reducing waiting times for wheelchair provision.

Trust-wide	
Audit title	**Outcome/actions**
Record keeping annual audit programme	Improvements have been demonstrated again during the year. The Trust record keeping policy was reviewed; the programme re-designed and streamlined with the introduction of a new electronic record keeping workbook. Staff reported they found the new tool more user-friendly and time-saving. Submission/data process time has drastically been reduced as a result.
Audit title	**Outcome/actions**
Consent documentation - annual audit programme	The programme has continued with two audits cycles undertaken by the individual specialties in the audit year. Plan to look at the feasibility of introducing an electronic data tool going forward to eliminate paper returns (similar to the record keeping workbook).
Research, Development & Innovation	
Audit title	**Outcome/actions**
Compliance with Good Clinical Practice (GCP) for RDI	For Trust-sponsored studies, a robust and regular monitoring system will be introduced as part of a formal standard operating procedure (SOP). Training regarding SOPs will be carried out and a snapshot audit to follow.
Resuscitation Services	
Audit title	**Outcome/actions**
Resuscitation trolley audit 2016	All errors, omissions or problems identified were corrected at time of audit or via email to responsible manager as a safety measure. Re-audit undertaken 2017-18.
Urology	
Audit title	**Outcome/actions**
Audit of 2-week referral pathway for prostate cancer patients	Planned actions: Implement more of a one-stop service with specific magnetic resonance imaging (MRI) slots. Implementing prostate diagnosis clinic and two transrectal ultrasound-guided biopsy lists a week.
Audit title	**Outcome/actions**
Review of active surveillance protocol for patients with low risk prostate cancer	A plan is in place for converting one of the stable prostate cancer clinics to an active surveillance clinic in 2018-19. The unit has procured fusion biopsy software, which is in the process of being trialled under local anaesthetic.
Pathology	
Audit title	**Outcome/actions**
Audit of thyroid cytological diagnosis on thyroid nodules (THY 1)	Due to high incidence of malignancy, patients with Thy3f, where there is a stable prediction of malignancy, should undergo diagnostic lobectomy. This is an ongoing project.

2.4.3. Participation in clinical research

The aim of Clinical Research is to offer patients access to new and emerging treatments. The Trust remains committed to delivering safe and effective high quality patient-centred services, based on the latest evidence and clinical research. Our focus is on improving care, developing better treatments and increasing our understanding of disease by providing an environment that is conducive to the undertaking of quality research and development activities.

The UK Policy Framework for Health and Social Care in Research was introduced in late 2017. It includes principles to protect and promote the interests of patients, service users and the public in health and social care research, by describing ethical conduct and proportionate, assurance-based management of health and social care research, to support and facilitate high-quality research in the UK that has the confidence of patients, service users and the public. We are fully committed to ensuring that the Trust adheres to these principles.

The Trust is a partner organisation in the North West Coast Clinical Research Network (NWC CRN) and works closely with them to ensure a culture of research and innovation is embedded within the Trust. This partnership working helps the Trust to support the National Institute for Health Research (NIHR) commitments, including improving the quality, speed and co-ordination of clinical research by removing the barriers within the NHS, unifying systems, improving collaboration with industry and streamlining administrative processes.

The Trust employs a team of specialist research staff to support clinical research across the organisation and to increase recruitment to high quality clinical trials and other robust research studies. Our reputation for research is another area of growth, with the Trust having again exceeded its target for recruiting patients to studies.

During 2017-18 the Trust was involved in104 active studies and the NIHR supported 88 of these, with the remaining 16 studies being local or student studies.

The number of patients receiving relevant health services provided or sub-contracted by St Helens and Knowsley Teaching Hospitals NHS Trust in 2017-18 that were recruited during that period to participate in research approved by a research ethics committee/Health Research Authority:

- 1005 recruited to NIHR adopted studies.

We were pleased that NIHR recruitment figures have exceeded those forecasted during 2017-18 and that the Trust successfully recruited 1005 participants against the proposed target of 500.

The Trust has impressive research activity across a wide range of clinical specialities. Since 1st April 2017 the RDI department produced RDI permission

(confirmation of capacity & capability) for 46 new studies of which 37 were NIHR portfolio adopted studies. The following table displays the specialties of the new studies:

Speciality	Number of Studies
Burns and Plastics	1
Cancer	8
Cardiology	2
Critical Care	2
Diabetes	2
Emergency Medicine	2
Gastroenterology	2
General Surgery	3
Genetics	1
Haematology	1
Neurology	1
Orthopaedics	4
Paediatrics	4
Rheumatology	4
Sexual Health	1
Stroke	3
Trust Wide	1
Urology	2
Woman & Child Health	2

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

We report quarterly to the Department of Health on the initiation and delivery of research (for clinical trials only).

The Trust has a 70-day benchmark to recruit the first patient into a clinical trial. This is a very challenging target and at present the Trust is running at approximately 62.5% for initiating research (10 of the 16 clinical trials met the target). Only two studies closed within the time period for delivering research. The Trust met the target for one of the studies and the other study closed to recruitment early.

2.4.3.2. Commercially sponsored studies

We have continued to increase our participation in commercially sponsored studies, with 14 commercial studies active within the Trust.

2.4.3.3. Key achievements

- We have encouraged our research staff to work generically across specialties. This has proven to be a really successful initiative as it increased our recruitment

figures and offered the nurses an insight into a range of research specialities, with opportunities to develop their skills further.

- The Trust has been recognised as a top recruiting site in a number of areas of research. In addition the Research Team have been inspirational in the delivery and set up of a number of high recruiting studies including:
    - FUTURE initiative that aims to build up a database of 3,000 healthy volunteers who have been genotyped and are readily available to be recruited for early phase studies;
    - Examining the potential side effects of a particular analgesic called Methoxyflurane (Penthrox®) and of other analgesics routinely given to patients in the Emergency Department to compare its safety with that of the other analgesics
    - Saving Babies' Lives Project Impact and Results Evaluation (SPiRE) to review antenatal care

These have collectively recruited 581 patients since April 2017. The success of this is due to team work including setting a recruitment strategy/goals and clarifying responsibilities for each member of the team.

- The Cancer Research team are committed to providing patients with the opportunity to take part in high quality cancer research studies. At present, there are 17 open studies actively recruiting across different tumour groups. This year 119 patients diagnosed with cancer have participated in a cancer research study. Breast cancer research achieved national recognition in recruiting to a surgical trial and the skin cancer research was highly recognised for its contribution to recruitment into a rare skin cancer trial. These sustained efforts have allowed patients to benefit from access to new treatments and the opportunity to help researchers find better treatments for others in the future.

- The Gastroenterology team at the Trust has successfully expanded its commercial research portfolio. A major achievement has been recruiting the first patient in Europe for one of the studies.

- All of our other research specialties, including Diabetes, Stroke, Cardiology, Paediatrics and Rheumatology have worked extremely hard and, with their input, we are pleased that the annual NIHR recruitment target for 2017-18 was met by quarter 3.

- Michael Lloyd, Medical Education and Training Pharmacist won the "Excellence in Hospital Pharmacy Award" at the Clinical Pharmacy Congress 2017 for his Prescribing Errors research.

- The Trust's Research Practitioner Group (RPG) meets quarterly and plays an important role in the delivery of good quality research. NIHR recruitment is a standing item on the agenda and updates on performance are discussed and plans put in place to achieve compliance.

- The RPG is committed to making sure that our patients have the chance to participate in clinical trials and encourage our patients to discuss research opportunities with their doctors and nurses. The RPG promotes research with our regular research awareness stands, which showcase the NIHR "I am Research" campaign.

- International Clinical Trials Day is celebrated around the world, on or near 20th May each year, to raise awareness of the importance of clinical trials for advances in research and healthcare. In May 2017, the research team celebrated with a stall promoting the campaign. This was a great opportunity to promote clinical research trials and let patients, staff and the public know more about the research trials on offer at our Trust.

- The NIHR wants to understand more about patient experience of clinical research taking placing in the NHS and in October 2017 launched a patient experience survey. The Trust made a significant contribution by contacting patients who have been involved in research.

- The Trust has promoted research and innovation to staff via social media and regularly post good news stories on the Trust's Facebook and Twitter accounts.

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

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

2.4.3.4. Research aims for 2018-19

Our aims for 2018-19 are to maintain:

- A comprehensive performance management system to improve NIHR national targets for RDI approval times and recruiting patients to time and target. Regular performance updates will be disseminated at the Research Team meetings
- Existing strengths and key areas of current research, as well as supporting developments in other health priority areas
- High levels of research conduct within the Trust, providing assurance to the RDI Group and Trust Board through audit and monitoring
- Ongoing and enhanced engagement about clinical research at all levels within the Trust and with the public, in line with CQC requirements. This will be achieved by increasing the number of promotional events, providing speakers at local groups, conducting satisfaction surveys and providing activity reports to the Research Development and Innovation Group
- Engagement with the Research Design Service who provide support to health and social care researchers across England on all aspects of developing a grant application

2.4.4. Clinical Goals agreed with commissioners

A proportion of St Helens and Knowsley Teaching Hospitals NHS Trust income in 2017-18 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017-18 and for the following 12-month period are shown in the tables below:

CQuIN targets 2017-18

Commissioning Organisation	Care Group	Type	Type Ref	Title
Clinical Commissioning Group	Corporate	National	STP	Risk Share - Control Totals
Clinical Commissioning Group	Corporate	National	STP	Risk Share - Participation
Clinical Commissioning Group	Corporate	National	1a	Improvement of health and wellbeing of NHS staff
Clinical Commissioning Group	Corporate	National	1b Part A	Healthy Food For NHS Staff, Visitors & Patients
Clinical	Corporate	National	1b	Healthy Food For NHS Staff,

Commissioning Organisation	Care Group	Type	Type Ref	Title
Commissioning Group			Part B	Visitors & Patients
Clinical Commissioning Group	Corporate	National	1c	Improving The Uptake Of Flu Vaccinations For Front Line Clinical Staff
Clinical Commissioning Group	Medical Care Group	National	2a	Timely identification of sepsis in Emergency Departments (ED)
Clinical Commissioning Group	Medical Care Group	National	2a	Timely identification of sepsis in acute inpatient settings
Clinical Commissioning Group	Medical Care Group	National	2b	Timely treatment of sepsis in emergency departments
Clinical Commissioning Group	Medical Care Group	National	2b	Timely treatment of sepsis in acute inpatient settings
Clinical Commissioning Group	Medical Care Group/Clinical Support Services	National	2c	Assessment of clinical antibiotic review within 72 hours of patients with sepsis who are still inpatients at 72 hours. For the Trust, the local protocol is Modified Early Warning Scores (MEWS) greater than or equal to 5.
Clinical Commissioning Group	Clinical Support Services	National	2d	Appropriateness of antibiotic consumption (agent and duration)
Clinical Commissioning Group	Clinical Support Services	National	2d	Appropriateness of antibiotic consumption (agent and duration)
Clinical Commissioning Group	Clinical Support Services	National	2d	Appropriateness of antibiotic consumption (agent and duration)
Clinical Commissioning Group	Clinical Support Services	National	2d	Appropriateness of antibiotic consumption (agent and duration)
Clinical Commissioning Group	Clinical Support Services	National	2d	Appropriateness of antibiotic consumption (agent and duration)
Clinical Commissioning Group	Clinical Support Services	National	2d	Appropriateness of antibiotic consumption (agent and duration)
Clinical Commissioning Group	Clinical Support Services	National	2d	Appropriateness of antibiotic consumption (agent and duration)
Clinical Commissioning	Medical Care Group	National	4	Improving services for people with mental health needs who

Commissioning Organisation	Care Group	Type	Type Ref	Title
Group				present to A&E
Clinical Commissioning Group	St. Helens	National	6	Offering Advice and Guidance (A&G)
Clinical Commissioning Group	St. Helens	National	7	NHS e-Referrals
Clinical Commissioning Group	Medical Care Group	National	8 Parts A & B	Supporting Proactive and safe discharge
Clinical Commissioning Group	Medical Care Group	National	8 Part C	Supporting Proactive and safe discharge
Specialised Commissioning	Medical Care Group	National	WC5	Neonatal Critical Care Community Outreach
Public Health England	St. Helens	National		Referral Management - Changes needed to deliver the new pathways and to integrate dental services and patient centred care.
Public Health England	St. Helens	National		Managed Clinical Networks (MCNS)
Public Health England	Clinical Support Services	National	1a	Improvement of health and wellbeing of NHS staff Adjusted Specifically To Support Cytology Service Team During Cytology Service Transformation Programme. Development of personalised professional development plans for all staff currently involved in the delivery of the cervical screening programme and who will be affected by the switch from cytology to HPV as the primary screen.
Alder Hey	Medical Care Group	Local		Cystic Fibrosis
Clinical Commissioning Group	Community	National	STP	Risk Share - Control Totals
Clinical Commissioning Group	Community	National	STP	Risk Share - Participation
Clinical Commissioning Group	Community	National	1a	Improvement of health and wellbeing of NHS staff

Note: **text in green font is mandated**

Commissioning Organisation	Care Group	Type	Type Ref	Title
Clinical Commissioning Group	Community	National	1c	Improving the uptake of flu vaccinations for front line clinical staff
Clinical Commissioning Group	Community	National	8b	Supporting Proactive and safe discharge - community providers
Clinical Commissioning Group	Community	National	9	Preventing ill health by risky behaviours - alcohol and tobacco
Clinical Commissioning Group	Community	National	9a	Tobacco screening
Clinical Commissioning Group	Community	National	9b	Tobacco brief advice
Clinical Commissioning Group	Community	National	9c	Tobacco referral
Clinical Commissioning Group	Community	National	9d	Alcohol screening
Clinical Commissioning Group	Community	National	9e	Alcohol brief advice or referral
Clinical Commissioning Group	Community	National	10	Improving the assessment of wounds
Clinical Commissioning Group	Community	National	11	Personalised care and support planning

The proposed CQuIN targets for 2018-19 will be published on the Trust's website at www.sthk.nhs.uk following agreement with commissioners.

2.4.5. Statements from the Care Quality Commission (CQC)

The CQC is the independent regulator for health and adult social care services in England. The CQC monitors the quality of services the NHS provides and takes action where these fall short of the fundamental standards required. The CQC uses a wide range of regularly updated sources of external information and assesses services against five key questions to determine the quality of care a Trust provides, asking if services are:

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

- Well-led

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

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

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

The Care Quality Commission has not taken enforcement action against St Helens and Knowsley Teaching Hospitals NHS Trust during 2017-18.

St Helens and Knowsley Teaching Hospitals NHS Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2017-18:

- Halton Local System Review
- Liverpool Local System Review
- St Helens CCG Safeguarding Children Review
- Merseyside thematic review of Section 136 of the Mental Health Act

St Helens and Knowsley Teaching Hospitals NHS Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

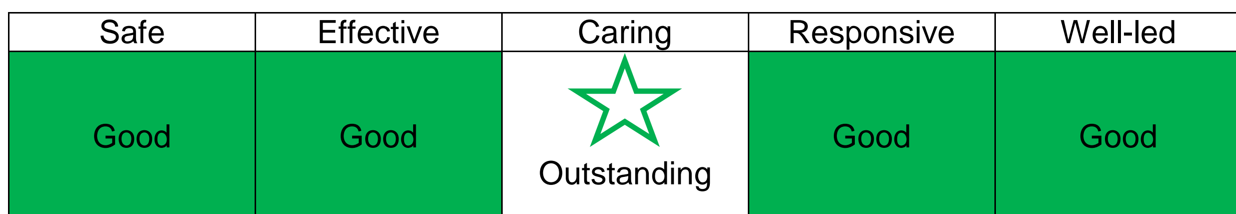
- Consistently apply the Home of Choice Policy
- Proactive ongoing monitoring of delayed transfers of care
- Identify solutions to the community midwifery electronic patient record
- Ensure carer responsibilities of adult attendees to the Emergency Department are identified and documented in order to reduce any risk to dependents resulting from their attendance.

St Helens and Knowsley Teaching Hospitals NHS Trust has made the following progress by 31st March 2018 in taking such action:

- Updated the Home of Choice Policy
- Strengthened the processes for effective discharge, including specific training for ward staff and improved information for patients
- Increased the number of Discharge Co-ordinators to improve patient flow
- Audited compliance with discharge checklists
- Increased levels of safeguarding supervision for community midwives

St Helens and Knowsley Teaching Hospitals NHS Trust is subject to periodic reviews by the Care Quality Commission and the last review was in August/September 2015. The CQC's assessment of the Trust following that review was good. St Helens Hospital was rated as outstanding and the Trust was rated overall as outstanding for the care it provides to patients, with the Outpatients and Diagnostic Service rated as outstanding on both sites. The Trust's Maternity Services were rated as requires improvement for responsive, safe and well-led, with the Emergency Department also rated as requires improvement for the responsive domain. Action plans have supported the delivery of the required improvements, with key actions taken outlined in the section below.

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



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

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

- Ongoing focus on maintaining the improvements that the Trust has implemented as outlined below.

St Helens and Knowsley Teaching Hospitals NHS Trust has made the following progress by 31st March 2018 in taking such action:

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

- Improved the ambulance turnaround times within the Emergency Department by putting in place 7 day/week ambulance clinical coordinators to promote the use of alternative destinations for patients as appropriate and providing a 12 hour day coordination service
- Continue to focus on ensuring staff appraisals and mandatory training are up-to-date
- Roll out of advanced care planning for patients at the end of their lives.
- Maintain robust systems for the storage of medications, with regular audits to demonstrate compliance
- Reviewed and improved the systems for managing and responding to serious incidents within Maternity Services, ensuring effective processes for implementing lessons learned. This includes the introduction of daily safety huddles at each shift hand-over, patient safety boards and safety briefings to share lessons learned. In addition, an organisational development plan has been implemented, following a series of staff listening events
- Strengthened the processes and timeliness of risk management within maternity services
- Implemented Maternity Strategy and Midwife-led Unit for low risk births.
- Adaptations to the Maternity Unit bereavement rooms to enhance patient experience
- Firmly embedded processes for reviewing staffing levels across the Trust on a daily basis to ensure safe staffing in all areas, with monthly reporting to the Trust Board
- Installed permanent screen in Coronary Care Unit to ensure the privacy and dignity of patients is maintained at all times

2.4.6. Learning from deaths

2.4.6.1. Number of deaths

During Q1-3 2017-18, 1216 of St Helens and Knowsley Teaching Hospitals NHS Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
386 in the first quarter;
423 in the second quarter;
407 in the third quarter;
Data unavailable for Q4 as data are reported a quarter behind.

By end of Q3, 290 case record reviews and 150 investigations have been carried out in relation to 1216 of the deaths included in item 2.4.6.1
In 37 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
9 in the first quarter;
13 in the second quarter;
14 in the third quarter.
Data unavailable for Q4 as data are reported a quarter behind.

1 representing 0.0008% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of:
0 representing 0% for the first quarter;
1 representing 0.002% for the second quarter;
0 representing 0% for the third quarter;
Data unavailable for Q4 as data are reported a quarter behind.

These numbers have been estimated using the St Helens & Knowsley Teaching Hospitals NHS Trust Structured Judgement Review (SJR) (which uses NCEPOD Quality Score and RAG rating similar to Royal College of Physicians SJR and consistent with Royal College of Physicians and NHS Improvement guidance.

2.4.6.2. Summary of learning from case record reviews and investigations

The Trust has focussed on two key learning priorities for each quarterly report to the Trust Board and is in the process of establishing a database that collates all learning from deaths, incidents, complaints, PALS and litigation into a single repository for quarterly thematic analysis and sharing. Key lessons from quarters 1 and 2 (reported as single report in the first published report) were the need to:

- Monitor (check, action, repeat) blood gases in patients with chronic obstructive pulmonary disease (COPD)
- Escalate to a senior immediately when intravenous (IV) access cannot be obtained

Key lessons from quarter 3 were:

- Atrial fibrillation (AF) causes strokes, which can be more serious, leave more disability and have a higher mortality. They are preventable and, therefore, if a patient is found to have AF, an assessment of the risks and benefits of administering blood thinning medication (anticoagulation) must be completed and anticoagulation provided if indicated
- There are times when some patients' relatives may become distressed and behave out of character, particularly when trying to do their best for their loved ones in difficult situations. Staff are reminded to consider this and that more understanding and compassion is required in these instances

2.4.6.3. Actions taken resulting from learning

Lessons have been shared with the Trust Board, Quality Committee, Finance & Performance Committee, Clinical Effectiveness Council, Patient Safety Council, Patient Experience Council, Grand Rounds, Team Brief, Intranet Home Page, global email, Medical Care Group (Governance), Surgical Care Group (Governance),

Medical Care Group Directorate Meetings, Surgical Care Group Directorate Meetings and Clinical Support Directorate meetings.

2.4.6.4. Impact of actions taken

The effectiveness of learning is assessed by audit of Datix, serious incidents, complaints, PALS, Litigation and Mortality Reviews for evidence of failure to deliver these priorities. Systematic assessment of effectiveness is necessarily two quarters behind priorities (allowing time for sharing and then time to establish that learning has become embedded.

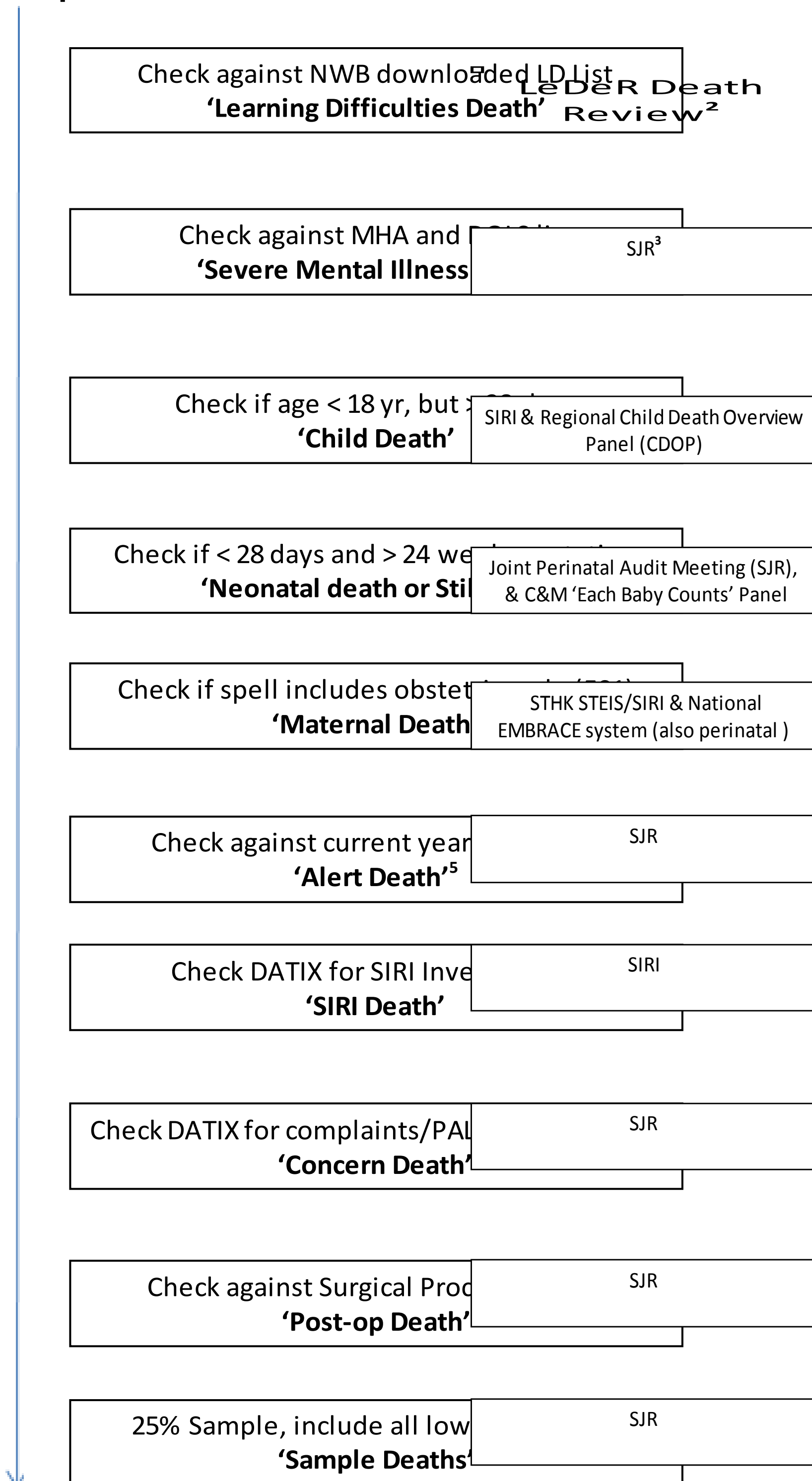
2.4.6.5. Process prior to new nationally mandated system

Like most other organisations, prior to the introduction of the new nationally mandated assessment and reporting system, which was first reported in Q3 (as required), the Trust has for many years undertaken systematic review of deaths, but these systems used different methodologies that are not comparable with the new process. The Trust, therefore, is unable to provide the figures for the number of case record reviews and investigations completed which related to deaths prior to 2017-18.

2.4.6.6. Trust approach to learning from deaths

A summary the Trust approach to learning from deaths is outlined below:

Total Deaths in Scope[1]



1. All inpatient deaths at STHK, transfers to other hospitals or settings not included

Note: text in green font is mandated

2. LeDeR – nationally prescribed process for reviewing LD deaths
3. Structured judgement review, currently STHK tool (see Appendix A)
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

2.4.7. Priority clinical standards for seven day hospital services

The seven-day services clinical standards are designed to ensure patients who are admitted as an emergency, receive high quality consistent care, whatever day they are admitted. Trusts are working towards implementing the four priority standards by 2020, which will mean that patients will:

- Not wait longer than 14 hours to initial consultant review
- Get access to diagnostic tests which are reported within 24 hours for non-urgent requests, 12 hours for urgent and 1 hour for critical patients
- Get access to specialist, consultant-directed interventions
- Receive twice-daily specialist consultant review for those with high-dependency care needs, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds

The Trust has identified a number of actions that will improve delivery of these standards. These include:

- Electronic system for identifying patients who have not had a consultant review and are approaching 14 hours of admission
- Targeted ward rounds in assessment areas to prioritise review of these patients
- Better documentation of consultant assessment and input in ED
- Better documentation of post-take consultant review on the surgical assessment unit and surgical wards
- Plans to develop pathways for patients who do not require daily consultant input

2.4.8. Information governance and toolkit attainment levels

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

The Trust continues to benchmark itself against the Information Governance Toolkit. The toolkit is an online system that allows NHS organisations and partners to assess themselves against NHS Digital Information Governance policies and standards. It also allows members of the public to view our commitment to information governance standards. St Helens and Knowsley Teaching Hospitals NHS Trust Information Governance Assessment Report overall score for 2017-18 was 81% and was graded ‘green’. This represents an increase on last year’s score and means that the Trust is compliant in all sections of the Information Governance Toolkit. This submission was audited by Mersey Internal Audit Agency and once again, the Trust

has maintained its assurance level of "significant" which demonstrates the Trust's commitment to protecting the information it holds and uses.

The Trust has a robust Information Governance Framework in place led by Craig Walker, Head of Information Governance and Quality Assurance. Dr Francis Andrews, Assistant Medical Director, as Caldicott Guardian is the dedicated designated individual within the Trust who is responsible for ensuring confidentiality of personal information. The Trust also has a Senior Information Risk Owner (SIRO), Christine Walters, Director of Informatics, who is responsible for reviewing and reporting on the management of information risk to the Trust Board. These employees are appropriately qualified, trained, registered and accredited.

Work is underway to ensure that the Trust is working towards compliance with the pending General Data Protection Regulations and there is a detailed action plan in place, which is monitored on a monthly basis at the Trust's Information Governance Steering Group.

The Trust has a duty to report any incident regarding the loss of personal data to the Information Commissioner's Office (ICO) and for the financial year 2017-18 there was one such incident. This incident has been closed by the Information Commissioner's Office with no actions taken against the Trust. The reported incident was reviewed by relevant members of staff and members of the Information Governance Team, with actions taken to minimise the likelihood of any reoccurrence.

2.4.9. Clinical coding error rate

St Helens and Knowsley Teaching Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2017-18 by the Audit Commission. The Trust was subject to an audit of clinical coding, based on national standards undertaken by Clinical Classifications Service (CCS) approved clinical coding auditors in line with the Information Governance Toolkit requirement 505 during 2017-18. The error rates reported in the latest published audit for that period of diagnoses and treatment coding (clinical coding) were:-

2017-18 data reported in January 2018				
Measure	Primary diagnosis incorrect	Secondary diagnosis incorrect	Primary procedure incorrect	Secondary procedure incorrect
IG Toolkit audit	4.5%	5.76%	5.76%	7.66%

2.4.10. Data quality

The Trust continues to be committed to ensuring accurate and up-to-date information is available to communicate effectively with GPs and others involved in delivering

care to patients. Good quality information underpins effective delivery of patient care and supports better decision-making, which is essential for delivering improvements.

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

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

Following the implementation of the new Medway Patient Administration System the quality of the data we collect will be improved. Medway functionality allows for National Spine integration, giving users the ability to update patient details from national records using the NHS number as a unique identifier. There will also be a decreased number of referral to treatment related data quality issues as the configurability of Medway means that users will only be presented with suitable referral to treatment outcomes in certain scenarios and settings.

2.4.11. NHS number and general medical practice code validity

St Helens and Knowsley Teaching Hospitals NHS Trust submitted records during 2017-18 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data which:

- Included the patient's valid NHS number was:

Care Setting	StHK result	National Average
Admitted patient care	99.8%	99.4%
Outpatient care	99.9%	99.5%
Accident and Emergency care	98.9%	97.3%

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

Care Setting	StHK result	National Average
Admitted patient care	100%	99.9%
Outpatient care	100%	99.8%
Accident and Emergency care	100%	99.3%

(Source: SUS Data Quality Dashboard latest published report: April 2017 – January 2018)

In all cases, the Trust performed better than the national average, demonstrating the importance the Trust places on data quality.

The Trust will be taking the following actions to improve data quality:

- Data Quality Team continuing to run regular reports to monitor data quality throughout the Trust
- Liaising with line managers and end users to address issues
- Identifying training needs
- Providing data quality awareness sessions about the importance of good quality patient data
- Continuing to identify areas where errors are created, looking for solutions to working practices and/or system configuration to mitigate the issues

2.4.12. Benchmarking information

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

Benchmarking Information
Please note the information below is based on the latest nationally reported data with specified benchmarks from the central data sources.

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
SHMI	NHS IC	Oct-16 to Sep-17	1.030	1.000	0.727	1.247	Next SHMI data (for Oct-16 to Sep-17) due to be published end of March 2018
SHMI	NHS IC	Jul-16 to Jun-17	1.043	1.000	0.726	1.228	
SHMI	NHS IC	Apr-16 to Mar-17	1.028	1.000	0.708	1.212	
SHMI Banding	NHS IC	Oct-16 to Sep-17	2	2	3	1	
SHMI Banding	NHS IC	Jul-16 to Jun-17	2	2	3	1	
SHMI Banding	NHS IC	Apr-16 to Mar-17	2	2	3	1	
% of patient deaths having palliative care coded	NHS IC	Oct-16 to Sep-17	34.6%	31.5%	11.5%	59.8%	
% of patient deaths having palliative care coded	NHS IC	Jul-16 to Jun-17	34.6%	31.1%	11.2%	58.6%	

Note: ***text in green font is mandated***

<table>
<tr><th rowspan="2">Indicator</th><th rowspan="2">Source</th><th rowspan="2">Reporting Period</th><th rowspan="2">StHK</th><th colspan="3">National Performance</th><th></th></tr>
<tr><th>Average</th><th>Lowest Trust</th><th>Highest Trust</th><th></th></tr>
<tr><td>% of patient deaths having palliative care coded</td><td>NHS IC</td><td>Apr-16 to Mar-17</td><td>32.7%</td><td>30.7%</td><td>11.1%</td><td>56.9%</td><td></td></tr>
<tr><td colspan="8">The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:
Information relating to mortality is monitored monthly and used to drive improvements.
The mortality data is provided by an external source (Dr Foster).
The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve the indicator and percentage, and so the quality of its services, by:
Monthly monitoring of available measures of mortality.
Learning from Deaths Policy implemented with continued focus on reviewing deaths to identify required actions for improvement and effective dissemination of lessons learned.</td></tr>
<tr><td>EQ-5D adjusted health gain: Groin Hernia</td><td>NHS IC</td><td>Apr-17 to Sep-17 (provisional)</td><td>*</td><td>0.089</td><td>0.055</td><td>0.140</td><td rowspan="4">Next PROMs data due to be published May-18

* data suppressed due to small numbers</td></tr>
<tr><td>EQ-5D adjusted health gain: Groin Hernia</td><td>NHS IC</td><td>Apr-16 to Dec-16 (final)</td><td>0.051</td><td>0.086</td><td>0.006</td><td>0.135</td></tr>
<tr><td>EQ-5D adjusted health gain: Hip Replacement Primary</td><td>NHS IC</td><td>Apr-17 to Sep-17 (provisional)</td><td>*</td><td>0.465</td><td>0.472</td><td>0.472</td></tr>
<tr><td>EQ-5D adjusted health gain: Hip Replacement Primary</td><td>NHS IC</td><td>Apr-16 to Dec-16 (provisional)</td><td>0.397</td><td>0.445</td><td>0.310</td><td>0.537</td></tr>
</table>

*Note: **text in green font is mandated***

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS IC	Apr-17 to Sep-17 (provisional)	*	0.328	0.289	0.368	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS IC	Apr-16 to Dec-16 (provisional)	0.294	0.324	0.242	0.404	
EQ-5D adjusted health gain: Varicose Vein	NHS IC	Apr-17 to Sep-17 (provisional)	*	0.096	0.068	0.134	
EQ-5D adjusted health gain: Varicose Vein	NHS IC	Apr-16 to Dec-16 (final)	0.010	0.092	0.010	0.155	
The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The questionnaire used for PROMs is a validated tool and administered for the Trust by an independent organisation, Quality Health. The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these outcome scores, and so the quality of its services, by: Delivering a number of actions to improve patient experiences following surgery. Monitoring the PROMs data at the Clinical Effectiveness Council.							
(Indirectly age, sex, method of admission, diagnosis, procedure	NHS IC	Apr-11 to Mar-12	12.73	11.45	0.00	17.15	2011-12 still latest data available. Next version due TBC Lowest and best national

*Note: **text in green font is mandated***

St Helens and Knowsley Teaching Hospitals NHS Trust

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
standardised) % of patients aged 16+ readmitted to the Trust within 28 days of discharge							performance based on acute providers
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 16+ readmitted to the Trust within 28 days of discharge	NHS IC	Apr-10 to Mar-11	12.60	11.43	0.00	17.10	
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 0-15 readmitted to the Trust within 28 days of discharge	NHS IC	Apr-11 to Mar-12	11.39	10.01	0.00	14.94	
(Indirectly age, sex,	NHS IC	Apr-10 to	10.66	10.01	0.00	14.11	

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
method of admission, diagnosis, procedure standardised) % of patients aged 0-15 readmitted to the Trust within 28 days of discharge		Mar-11					
The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The data is consistent with Dr Foster's standardised ratios for re-admissions. The data is monitored monthly by the Trust Board. The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these scores, and so the quality of its services, by: Working to improve discharge information as a patient experience priority. Reviewing and improving the effectiveness of discharge planning.							
Patient experience measured by scoring the results of a selection of questions from the national inpatient survey focussing on the responsiveness to personal needs.	NHS IC	2016-17	68.7	68.1	60.0	85.2	Next version due Aug-18

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Patient experience measured by scoring the results of a selection of questions from the national inpatient survey focussing on the responsiveness to personal needs.	NHS IC	2015-16	70.9	69.6	58.9	86.2	
The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust's vision and drive to provide 5-star patient care ensures that patients are at the centre of all the Trust does. The Trust was rated outstanding overall for caring by the CQC following their inspection in 2015. The survey is conducted by an independent and approved survey provider (Quality Health), with scores taken from the CQC website. The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this data, and so the quality of its services, by: Promoting a culture of patient-centred care. Responding to patient feedback received through national and local surveys, Friends and Family test results, complaints and Patient Advice and Liaison Service (PALS). Working closely with Healthwatch colleagues to address priorities identified by patients, including improving discharge planning.							
Q21d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2017	83.4%	69.8%	46.8%	85.7%	All data is for Acute Providers only

*Note: **text in green font is mandated***

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Q21d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2016	80.8%	69.8%	48.9%	84.8%	
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2017	19%	25%	19%	38%	Low scores are better performing trusts
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2016	17%	25%	16%	36%	
% believing the organisation provides equal opportunities for career progression/ promotion	NHS staff surveys	2017	93%	85%	69%	94%	

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
% believing the organisation provides equal opportunities for career progression/ promotion	NHS staff surveys	2016	91%	86%	69%	95%	
The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons; The Trust provides a positive working environment for staff with a proactive Health, Work and Well-being Service. An independent provider, Quality Health, provides the data. The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these percentages, and so the quality of its services, by: Embedding a positive culture with clear visible leadership, clarity of vision and actively promoting behavioural standards for all staff Engagement of staff at all levels in the development of the vision and values of the Trust. Honest and open culture, with staff supported to raise concerns via Speak Out Safely, Freedom to Speak Up champions and anonymous Speak in Confidence website.							
Friends & Family Test - A&E - Response Rate	NHS England	Mar-18	21.7%	12.8%	0.0%	45.1%	National data for Mar-18 to be published on 10th May 2018
Friends & Family Test - A&E - Response Rate	NHS England	Feb-18	17.3%	13.4%	0.0%	69.7%	
Friends & Family Test - A&E - Response Rate	NHS England	Jan-18	19.1%	12.2%	0.0%	49.1%	
Friends & Family Test - A&E -	NHS England	Dec-17	18.6%	11.6%	0.0%	45.4%	

*Note: **text in green font is mandated***

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Response Rate							
Friends & Family Test - A&E - % recommended	NHS England	Mar-18	81.6%	84.3%	63.9%	100.0%	
Friends & Family Test - A&E - % recommended	NHS England	Feb-18	86.0%	84.7%	67.3%	100.0%	
Friends & Family Test - A&E - % recommended	NHS England	Jan-18	89.3%	86.4%	65.5%	100.0%	
Friends & Family Test - A&E - % recommended	NHS England	Dec-17	88.8%	85.5%	56.8%	100.0%	
Friends & Family Test - Inpatients - Response Rate	NHS England	Mar-18	30.0%	23.2%	0.2%	100.0%	National average includes Independent Sector Providers
Friends & Family Test - Inpatients - Response Rate	NHS England	Feb-18	31.8%	24.5%	3.6%	100.0%	
Friends & Family Test - Inpatients - Response Rate	NHS England	Jan-18	30.4%	23.3%	3.0%	100.0%	
Friends & Family Test - Inpatients - Response Rate	NHS England	Dec-17	29.1%	22.1%	2.6%	100.0%	

Note: ***text in green font is mandated***

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Friends & Family Test - Inpatients - % recommended	NHS England	Mar-18	95.9%	95.6%	81.1%	100.0%	
Friends & Family Test - Inpatients - % recommended	NHS England	Feb-18	96.2%	95.8%	82.1%	100.0%	
Friends & Family Test - Inpatients - % recommended	NHS England	Jan-18	96.2%	95.7%	75.1%	100.0%	
Friends & Family Test - Inpatients - % recommended	NHS England	Dec-17	96.5%	95.6%	64.3%	100.0%	
The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust actively promotes the Friends and Family Test across all areas. The data is submitted monthly to NHS England. The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these percentages, and so the quality of its services, by: Continuing to promote Friends and Family Test (FFT) using a variety of methods, including face-to-face and technology. Actively working with ward staff to improve levels of engagement with the system, to ensure the latest results are shared at local level.							
% of patients admitted to hospital who were risk assessed for VTE	Internal	Quarter 4 2017-18	94.63%.	/	/	/	National VTE data for Q4 2017-18 will be published in June 2018 All data is for Acute Providers only
% of patients admitted to hospital who were risk	NHS England	Quarter 3 2017-18	95.01%	95.30%	76.08%	100.00%	

*Note: **text in green font is mandated***

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
assessed for VTE							
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 2 2017-18	93.21%	95.21%	71.88%	100.00%	
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 1 2017-18	91.75%	95.11%	51.38%	100.00%	
The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: Continued focus on achieving the target of 95% of patients having a VTE risk assessment within 24 hours of admission to ensure that they receive the most appropriate treatment, having achieved 93.67% for 2017-18. Root cause analysis (RCA) undertaken on VTEs recorded on Datix to ensure best practice is followed. During 2017-18 31 patients developed a hospital acquired thrombosis, of which 28 RCAs have been completed to date and 89% were found to have received appropriate care. Data on VTE risk assessments are submitted to NHS England each month. The St Helens and Knowsley Teaching Hospitals NHS Trust is taking the following actions to improve this percentage, and so the quality of its services, by: Maintaining focus on, and closely monitoring, the rate of risk assessments undertaken by the Quality Committee. Undertaking audits on the administration of appropriate medications to prevent blood clots. Completing RCA investigations on all patients who develop a hospital acquired venous thrombosis to ensure that best practice has been followed. Sharing any learning from these reviews and providing ongoing training for clinical staff.							
C Difficile rates per 100,000 bed-days for specimens taken	Internal	April-17 to Mar-18	11.4* This includes 28 cases of which 8 were	/	/	/	Apr-16 to Mar-17 data was published in July 2017 Data for Apr-17 to Mar-18

*Note: **text in green font is mandated***

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
from patients aged 2 years and over (Trust apportioned cases)			successfully appealed due to no lapses in care				due to be published in July 2018
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	GOV.UK	Apr-16 to Mar-17	11.4	13.2	0	82.7	
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	GOV.UK	Apr-15 to Mar-16	16.4	14.9	0	67.2	

The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:
Infection prevention and control remains a priority for the Trust.
All new cases of C. difficile infection are identified by the laboratory and reported to the Infection Prevention and Control Team, who co-ordinate mandatory reporting to Health Protection England.
The Trust is maintaining compliance with the national guidance on testing stool specimens in patients with diarrhoea.
All cases are thoroughly investigated using RCA, which is reported back to a multidisciplinary panel chaired by an Executive Director to ensure appropriate care was provided and lessons learned are disseminated across the Trust.
The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this rate, and so the quality of its

*Note: **text in green font is mandated***

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
services, by: Focus on ensuring staff compliance with mandatory training for infection prevention and control. Actively promoting the use of hand washing and hand gels to those visiting the hospital. Providing a proactive and responsive infection prevention service to increase levels of compliance. Ensuring comprehensive guidance is in place on antibiotic prescribing.							
Incidents per 1,000 bed days	Internal	Oct-17 to Mar-18	47.66	/	/	/	
Incidents per 1,000 bed days	NHS Improvement	Apr-17 to Sep-17	40.48	42.10	23.47	111.69	Next data to be published on 28th September 2018 Based on acute (non-specialist) trusts with complete data (6 months data)
Incidents per 1,000 bed days	nrls.npsa.co.uk	Oct-16 to Mar-17	38.27	40.55	23.13	68.97	
Incidents per 1,000 bed days	nrls.npsa.co.uk	Apr-16 to Sep-16	38.81	39.64	21.15	71.81	
Number of incidents	Internal	Oct-17 to Mar-18	5944	/	/	/	
Number of incidents	NHS Improvement	Apr-17 to Sep-17	4927	5287	1992	15228	
Number of incidents	nrls.npsa.co.uk	Oct-16 to Mar-17	4629	5137	2061	14506	
Number of incidents	nrls.npsa.co.uk	Apr-16 to Sep-16	4504	4985	1485	13485	
Incidents resulting in severe harm or	Internal	Oct-17 to Mar-18	0.12	/	/	/	

*Note: **text in green font is mandated***

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
death per 1,000 bed days							
Incidents resulting in severe harm or death per 1,000 bed days	NHS Improvement	Apr-17 to Sep-17	0.12	0.15	0.00	0.64	
Incidents resulting in severe harm or death per 1,000 bed days	nrls.npsa.co.uk	Oct-16 to Mar-17	0.20	0.15	0.01	0.53	
Incidents resulting in severe harm or death per 1,000 bed days	nrls.npsa.co.uk	Apr-16 to Sep-16	0.12	0.16	0.01	0.60	
Number of incidents resulting in severe harm or death	Internal	Oct-17 to Mar-18	15	/	/	/	
Number of incidents resulting in severe harm or death	NHS Improvement	Apr-17 to Sep-17	15	19	0	121	
Number of incidents resulting in severe harm or death	nrls.npsa.co.uk	Oct-16 to Mar-17	24	19	1	92	
Number of incidents resulting in severe harm or death	nrls.npsa.co.uk	Apr-16 to Sep-16	14	19	1	98	

*Note: **text in green font is mandated***

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Percentage of patient safety incidents that resulted in severe harm or death	Internal	Oct-17 to Mar-18	0.25%	/	/	/	
Percentage of patient safety incidents that resulted in severe harm or death	NHS Improvement	Apr-17 to Sep-17	0.3%	0.4%	0.0%	2.0%	
Percentage of patient safety incidents that resulted in severe harm or death	nrls.npsa.co.uk	Oct-16 to Mar-17	0.5%	0.4%	0.0%	2.1%	
Percentage of patient safety incidents that resulted in severe harm or death	nrls.npsa.co.uk	Apr-16 to Sep-16	0.3%	0.4%	0.0%	1.7%	

The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:
The Trust actively promotes a culture of open and honest reporting within a culture of fair blame.
The data has been validated against National Reporting and Learning System (NRLS) and HSCIC figures. The latest data to be published is up to September 2017. The Trust's overall percentage of incidents that resulted in severe harm or death was 0.28%.
The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this number and rate, and so the quality of its services, by:

*Note: **text in green font is mandated***

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Committing to the Sign up to Safety campaign to reduce avoidable harm by 50% by 2018. Undertaking comprehensive investigations of incidents resulting in moderate or severe harm. Delivering simulation training to enhance team working in clinical areas. Providing staff training in incident reporting and risk management. Monitoring key performance indicators at the Patient Safety Council. Continuing to promote an open and honest reporting culture to ensure incidents are consistently reported.							
Due to reasons of confidentiality, NHS digital has supressed figures for those areas highlighted with an '*' (an asterisk). This is because the underlying data has small numbers (between 1 and 5)							

2.4.13. Performance against national targets and regulatory requirements

The Trust aims to meet all national targets. Performance against the key indicators for 2017-18 is shown in the table below:

Performance Indicator	2016-17 Performance	2017-18 Target	2017-18 Performance	Latest data
Cancelled operations (% of patients treated within 28 days following cancellation)	Achieved	100.0%	99.4%	Apr-17 to Mar-18
Referral to treatment targets (% within 18 weeks and 95th percentile targets) - Admitted	N/A - no target	N/A	81.8%	Apr-17 to Mar-18
Referral to treatment targets (% within 18 weeks and 95th percentile targets) - Non-admitted	N/A - no target	N/A	96.5%	Apr-17 to Mar-18
Referral to treatment targets (% within 18 weeks and 95th percentile targets) – Incomplete pathways	Achieved	92%	94.0%	Apr-17 to Mar-18

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Cancer: 31-day wait from diagnosis to first treatment	Achieved	96%	97.7%	Apr-17 to Mar-18
Cancer: 31-day wait for second or subsequent treatment:				
- surgery	Achieved	94%	98.0%	Apr-17 to Mar-18
- anti-cancer drug treatments	Achieved	98%	100.0%	Apr-17 to Mar-18
Cancer: 62-day wait for first treatment:				
- from urgent GP referral	Achieved	85%	87.4%	Apr-17 to Mar-18
- from consultant upgrade	Achieved	85%	89.9%	Apr-17 to Mar-18
- from urgent screening referral	Achieved	90%	97.7%	Apr-17 to Mar-18
Cancer: 2 week wait from referral to date first seen:				
- urgent GP suspected cancer referrals	Achieved	93%	95.0%	Apr-17 to Mar-18
-	Achieved	93%	95.6%	Apr-17 to

symptomatic breast patients				Mar-18
Emergency Department waiting times within 4 hours - Type 1 only	Not achieved	95%	78.2%	Apr-17 to Mar-18
Percentage of patients admitted with stroke spending at least 90% of their stay on a stroke unit	Achieved	83%	90.3%	Apr-17 to Mar-18
Clostridium Difficile	Achieved	41	20* *28 in total with 8 successfully appealed, with one appeal outstanding	Apr-17 to Mar-18
MRSA bacteraemia	Not achieved	0	2** ** 1 of which was a contaminant	Apr-17 to Mar-18
Maximum 6-week wait for diagnostic procedures: % of Diagnostic Waits who waited <6 weeks	Achieved	99%	100.0%	Apr-17 to Mar-18

3. Section 3

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

3.1. Summary of how we did in achieving our strategies

3.1.1. Clinical and Quality Strategy 2016-20

The Trust's vision to provide 5-star patient care encapsulates the Trust's approach to quality in striving to achieve the best possible care for patients. The Trust performs very strongly against national, regional and local targets and, therefore, when the Clinical and Quality Strategy was refreshed in 2016, the Trust Board chose to narrow its focus to ten difficult and challenging goals.

Details of plans to address these targets are discussed at Quality Committee or Finance and Performance Committee and summarised below:

1. 4-hour performance is the only major national standard that the Trust has consistently failed to achieve. An improvement trajectory for 2018-19 has been agreed with NHS Improvement and intensive work is underway to achieve this trajectory.
2. Weekend mortality has fallen significantly and recent (published) evidence suggests that most of the variance nationally can be explained by patient factors rather than workforce factors.
3. Overall 62-day cancer performance is consistently strong. Several pathways, typically involving other hospitals and teams are less consistent and are subject to intensive improvement work, scrutinised by Quality Committee.
4. VTE assessment has been subject to intensive support and is of late performing above the required standard of above 95%. The implementation of an electronic solution has been delayed by factors outside the Trust's control.
5. eDischarge targets are not possible with the present system, but implementation of a new Patient Administration System (PAS), which goes live in April 2018, and the ePrescribing solution will improve performance in this area. An interim solution with truncated discharges has gone live (March 2018) for backlog reports, which will then be used for real-time reports.
6. All falls fell slightly in the last 12 months and year to date, falls causing moderate or severe harm also reduced, but not by the ambitious 50% stretch target the Trust set itself. The Quality Committee continues to scrutinise this target.
7. Timeliness of complaints performance has substantially improved with new systems, processes, and leadership.
8. Investment in the Sepsis Team has resulted in very strong performance, not only for ED patients (reported) but also for ward inpatients.
9. Time to theatre for fractured neck of femur patients is improving but not yet at the 95% standard. Improvement work is ongoing. A second tier anaesthetic on call rota has been approved by the Executive Team to strengthen timely emergency surgery.
10. Critical care mortality has remained within national control limits, but was higher than the English average, although this continues to improve.

The Trust is in the process of revising the strategy to reflect ongoing changes in the local health and social care environment.

3.1.2. Nursing and Midwifery Strategy 2014-18

The Strategy's aim is to embed the Chief Nursing Officer's '6Cs' through strong clinical leadership. Progress has been made in all areas and consultation has commenced on the new strategy, which will embrace the Chief Nursing Officer's ten commitments. The completion of the new strategy is planned for spring 2018.

Key achievements this year include:

Care

- Continued improvements in patient safety outlined in the section below
- Implementation of the red bag scheme to improve the care for patients during transfer between care homes and hospital

Communication

- Reduced number of complaints relating to communication and staff attitude
- Introduced individual placemats for ward areas with information for patients and their visitors on safety, staff uniforms, mealtimes and discharge information
- Improved template for written patient information leaflets

Compassion

- Trust-wide Compassion in Care Conference where keynote speaker, Dr David Hamilton provided the scientific evidence of the physiological benefits of receiving compassionate care, including lowering blood pressure and increasing immunity
- Implementation of the blue butterfly symbol to denote patients at the end of their lives to all staff

Courage

- Increased number of wards from 6 to 12 being awarded the gold standard in the Quality Care Assessment Tool (QCAT) ward accreditation scheme
- Raised awareness of the confidential routes for staff to raise concerns, including electronic Speak in Confidence reporting system that enables feedback on actions taken to be provided to the anonymous reporter, via a web-based cloud

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Commitment

- Review of wards' funded staffing establishments provided assurance that the registered nurse to care staff ratios and registered nurse to patient ratios continued to meet or exceed national guidance
- Reviewed all student placement opportunities and increased the annual capacity from 300 to 345 nursing and cadet students

Competence

- In-house development and implementation of a combined nursing e-risk assessment tool, which simplifies five of the existing required patient risk assessments, releasing time to care by reducing the time taken to complete paper records
- Low attrition rate of newly qualified nurses due to the comprehensive 12 month preceptorship programme

3.1.3. Equality, Diversity and Inclusion Strategy

The Trust is committed to ensuring that its staff and service users enjoy the benefits of a healthcare organisation that respects and upholds individuals' rights and freedom. Equality and human rights are at the core of our beliefs and the Trust strives to ensure that people with protected characteristics as defined by the Equality Act 2010 are not disadvantaged when accessing services and that all our patients receive the same quality services.

During 2017-18, the Trust developed an Equality and Human Rights Policy, which provided additional support in delivering the vision of 5-star patient care. The Trust's corporate objectives also reflect the rights and values detailed in the NHS Constitution and the policy promotes the Trust's commitment to equality, diversity and human rights in all its activities, whether as a service provider or an employer. Patients remain the Trust's number one priority and involving them in decisions about their care and treating them with dignity and respect at all times is paramount.

Our Diversity and Inclusion Steering Group meets bimonthly to ensure all external standards are fully complied with, including those statutory requirements conferred on the Trust by the Equality Act 2010. The membership of the steering group is drawn from a wide range of staff from all disciplines, clinical, non-clinical, trade union representatives, Healthwatch representatives and independent service users.

The functions provided by the Trust are subject to an Equality Analysis to ensure that the Trust is not either directly or indirectly discriminating against members of one or more protected groups. There is a policy for carrying out an Equality Analysis on:

- The development of Trust policies and procedures
- Service redesign or development
- Strategic or business planning
- Organisational changes affecting patients, employees or both
- Cost improvement programmes
- Commissioning or decommissioning of services

These analyses enable the Trust to meet both the general and specific equality duties by carrying out a robust, systematic assessment of all the Trust's activities in order to eliminate actual or potential discrimination at the earliest stage, before there is an adverse impact on patients, employees or visitors to the Trust. They also provide an opportunity to identify any positive impacts on protected groups. The toolkit to support the implementation of the policy is being revised.

The Equality Delivery System 2 (EDS2) is a toolkit designed to support NHS organisations to deliver better outcomes for patients and better working environments for staff. The Trust embarked on a collaborative approach to progressing the EDS2 outcomes with other local trusts and the Merseyside and Cheshire Clinical Support Unit in 2017. Evidence of health inequalities and barriers to accessing healthcare will be presented to a panel comprising members of local Healthwatch groups, community groups and senior leaders in the Trust during 2018 in order that new equality objectives can be set and an action plan to progress EDS2 outcomes developed.

The Trust provides interpreting services for patients whose first language is not English and those who communicate using British Sign Language (BSL). There was a change in the most popular languages requested in 2017-18, with significant increases in the number of Kurdish, Arabic and Hungarian interpreters, which reflects our changing local communities.

The number of requests received for BSL interpreters is increasing gradually year on year and we are working closely with St Helens Deafness Resource Centre to provide awareness training for staff using BSL interpreters to ensure that both patients and staff are getting the best from BSL interpreting sessions.

The Trust was awarded the Navajo Charter Mark in 2016 and is due for reaccreditation in 2018. This Chartermark is supported by lesbian, gay, bisexual and transgender (LGBT) community networks across Merseyside. It is a signifier of good practice, commitment and knowledge of the specific needs, issues and barriers facing LGBT people in Merseyside. Recent progress includes surveying LGBT staff regarding a staff network, the introduction of a 'virtual' LGBT network and the development of a Care of Transgender Patients Policy. This policy is now in use in the Trust and feedback from ward staff indicates that this policy is supportive for both patients and staff and has recently helped to support staff caring for patients and to improve the patients' experience of care in the Trust.

The Accessible Information Standard (AIS) directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. The Trust has been partially compliant with this standard due to restrictions within the current electronic patient administration system (PAS), but work has been carried out with the Medway project team to ensure that the new PAS will enable us to be compliant with the standard when it goes live in April 2018.

3.1.4. Human Resources and Workforce Strategy 2014-19

The Human Resources (HR) and Workforce Strategy has been in existence since 2014 and continues to positively contribute to the provision of 5-star patient care throughout the Trust, specifically in developing organisational culture and supporting our workforce. There are a number of key HR Directorate strategies that underpin the Human Resources & Workforce Strategy, including Health, Work & Well-being, Recruitment & Retention, Learning & Development, Talent Management Strategy and the Education Strategy.

In September 2016, the Trust became the host for the Merseyside Career Engagement Hub. This involves working collaboratively with local schools, colleges and Job Centre Plus to improve access to structured work placements for a range of local people including, students, the long term unemployed and disadvantaged people from the local community to provide them with the skills and experience to gain employment in the NHS.

The Trust has also signed up to the 'Step into Health' programme, which supports military veterans to gain employment in the NHS. The Trust officially pledged to champion the Step into Health campaign and to value the contribution made by military service leavers and their families. The Trust continues to work closely with the Armed Forces Community to provide career and development opportunities and Trust achieved the bronze Armed Forces Covenant – Employer Recognition Scheme award in 2017-18.

3.1.4.1. Staff survey key questions

The national staff survey provides a key measure of the experiences of the Trust's staff, with the findings used to reinforce good practice and to identify any areas for improvement. The Trust's response rate for the 2017 survey was 51%, which places the Trust in the highest (best) 20% nationally and best response rate in the North West.

The Trust's results for a significant number of the Key Findings have maintained the improvements made in the previous 2 years' surveys.

The Trust was best nationally for staff recommending the organisation as a place to work or receive treatment, with an overall score of 4.12 out of 5. In addition, 85% of staff agreed that care of patients/service users is the organisation's top priority, an increase from 83% last year and well above the national average of 76%.

The Trust received the highest score for 10 areas and scored in the best 20% of acute trusts nationally for 22 of the 32 Key Findings and was above the national average for 84% of the areas, with the most notable responses set out in the following tables.

Key Finding	Scores out of 5		
	Trust	National Average	Best
KF1. Staff recommendation of the organisation as a place to work or receive treatment	4.12	3.75	4.12

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KF4. Staff motivation at work	3.97	3.92	4.07
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
KF14. Staff satisfaction with resourcing and support	3.58	3.31	3.58
KF5. Recognition and value of staff by managers and the organisation	3.55	3.45	3.71
KF10. Support from immediate managers	3.84	3.74	3.94
KF2. Staff satisfaction with the quality of work and care they are able to deliver	4.14	3.91	4.21
KF32. Effective use of patient/service user feedback	3.96	3.71	3.96
KF13. Quality of non-mandatory training, learning or development	4.22	4.05	4.22
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.88	3.73	3.88
KF19. Organisation and management interest in and action on health and wellbeing	3.89	3.62	3.92

Key Finding	%		
	Trust	National Average	Best
KF21. % believing the organisation provides equal opportunities for career progression/promotion	93	85	94
KF29. % reporting errors, near misses or incidents witnessed in last month	98	90	98
KF3. % agreeing that their role makes a difference to patients/service users	89	90	93
KF22. % experiencing physical violence from patients, relatives or the public in the last 12 months	18	15	22
KF27. % reporting most recent experience of harassment, bullying or abuse	55	45	59

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 3.95 was in the highest (best) 20% when compared with trusts of a similar type nationally and places the Trust best in the North West.

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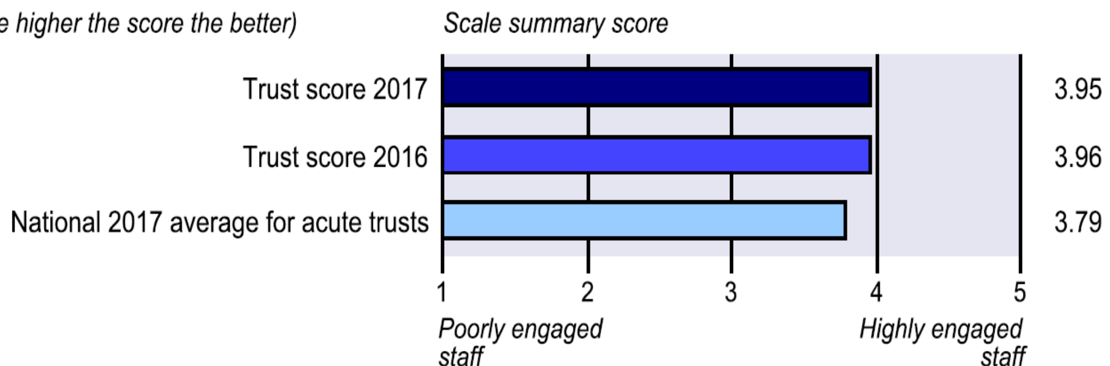

Whilst the overwhelming majority of responses are positive, three areas were identified for improvement:

- The number of staff experiencing physical violence from patients, relatives or the public in last 12 months (18% compared to the national average of 15%)
- Staff not feeling that their role makes a difference to patients/service users (89% compared to the national average of 90%)
- Number of appraisals (84% compared to national average of 86%)

In order to address these concerns, the Trust is reviewing the detail of the responses to get a better understanding of which service areas are affected. This detailed analysis will enable the Trust to deliver appropriate corrective actions during 2018-19.

3.1.4.2. Health, Work and Well-being

The Trust has a Health, Work and Well-being Strategy 2016-2021 in place, which is delivered by the Work and Well Being Service. The service is nurse led and includes many different specialists who work together collaboratively to provide the service, including occupational health physicians, occupational health advisors, an occupational psychologist, counsellors and a physiotherapist who are fully supported by an administrative team.

The main aim of the service is to ensure that employees are both physically and mentally healthy, as a healthy motivated workforce is integral to achieving better care for patients. Research shows that supporting the well-being of the workforce is paramount to achieving higher levels of performance (Boorman Review, 2009).

Every year, the influenza vaccination is offered to NHS staff as a way of reducing the risk of staff contracting the seasonal flu virus and transmitting it to patients or their family members. This year 87.1% of frontline staff at the Trust were vaccinated.

The service successfully underwent the Safe Effective Quality Occupational Health Services (SEQOHS) reaccreditation process in December 2017. The assessment looks at the following aspects of Occupational Health; business probity, information governance, people, facilities and equipment, relationships with purchasers and workers.

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There were numerous well-being events throughout 2017-18, including the annual Open Day, Know your Numbers…Blood Pressure Monitoring, Sun Awareness and Dry January, as well as stop smoking support services. All of these events were well attended by the staff. In July 2017, the Trust entered the NHS games, which are open to all staff of any grade. The Trust entered teams in the football, netball, rounders and badminton, as well as the golf competition.

3.1.4.3. Clinical education and training

The provision of in-situ simulation training has continued to expand throughout 2017-18. The simulation team has successfully implemented teaching in the Maternity Unit Delivery Suite; this will now link with the simulation education provided in the Special Care Baby Unit.

The simulation team have been instrumental in the redesign of core medical trainees and acute care common stem education, following feedback from postgraduate medical trainees. The comments from the trainees has been positive and its success noted by the North West Training Programme Director.

Most recently, with collaboration of the Stroke Team, the design of a simulation course to support the recognition and management of an acute stroke has been created. This educational programme has been accepted at the fourth European Stroke Organisation Conference, Gothenburg, Sweden and will be presented by the Simulation Team.

The education programme designed to support internationally recruited nurses has continued to excel during the year, with 100% pass rate for nurses sitting their objective structured clinical examinations (OSCE). The OSCE is part of the Nursing and Midwifery Council (NMC) registration process for nurses and midwives trained outside of the European Union. The excellent work by the team has been recognised nationally and, from this, opportunities have arisen to work with Health Education England on the Global Engagement Directorate. There has also been recognition from the NMC for the technology enhanced learning materials in place to support overseas learning, with local practices now used nationally.

3.2. Patient safety

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

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

1. **Put Safety First -** Commit to reducing avoidable harm by 50% from 2015 to 2018 and make public our goals and plans developed locally, benchmarked against 2013-14 incident rates. Avoidable harm is harm that can be prevented. The pledges and progress to end of 2017-18:

- Maintain a 50% reduction in **theatre-related episodes of avoidable harm**. The following figures are compared to the project benchmark data 2013-14:
  - 26% increase in incidents resulting in all harms, with a 45% increase in low harm incidents; this is likely to be due to an increase in incident reporting, highlighting a better reporting culture.
  - The Trust have a shown a 31% decrease in incident resulting in moderate, severe harm or death.
- Reduce the incidence of **Clostridium Difficile and avoidable MRSA infections**. There were two incidents of MRSA bacteraemia in 2017-18 (one of which was a contaminant); which remains the same as the 2013-14 baseline. There has been a 12% reduction of cases of Clostridium Difficile measured against 2013-14 with 28 confirmed cases (of which 8 were successfully appealed and one currently in the appeal process) in 2017-18 significantly below the threshold of 41.
- Reduce **prescribing error rates** through the implementation of an error response and re-education system.
  - 59% decrease in incidents resulting in harm from 2013-14 baseline.
  - 74% decrease in low harm incidents from the project benchmark data from 2013-14.
  - An increase in incidents recorded as moderate category from two in 2013-14 to six in 2017-18. The increase in moderate harm is likely to be related to improved scrutiny by the newly appointed Medicines Safety Officer ensuring the correct grading of medication incidents.
- Implement an **Electronic Modified Early Warning Score** (eMEWS) System to increase the efficiencies in the identification of the deteriorating patient, ensuring appropriate escalation and timely intervention.
  - The roll out of the Electronic Modified Early Warning Score (eMEWS) System to all inpatient wards and Emergency Department has been completed.
- Reduce to zero the number of **never events** reported in the organisation.
  - There have been two never events related to nasogastric tubes recorded in 2017-18. Actions from these events, included the following:
    - Immediate Trust-wide communication regarding guidance around safety with nasogastric tube insertion and position checking
    - Completed a review and update of Trust policy for insertion and care of nasogastric tube
    - Shared lessons learned locally, with key safety messages shared across the organisation
    - Developed a comprehensive learning module with a robust assessment to support skill development for clinicians who interpret X-ray to confirm the correct placement of nasogastric tube
    - Strengthened guidance that all medical staff who interpret x-rays for nasogastric tube placement undergo competency training for confirming nasogastric tube position
    - Implemented ‘hot reporting’ facility for x-ray reporting. Hot reporting has been made available during regular x-ray working

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hours (9-5pm, Monday to Friday and 9-3pm Saturday, Sunday and Bank Holidays)
- Developed unified documentation for recording nasogastric tube checks carried out and care offered

- The Trust will have zero tolerance on **hospital acquired grade 4 pressure ulcers** and will continue to seek to reduce harm from pressure ulcers of all grades by 50% from the 2013-14 benchmark.
    - No grade 4 pressure ulcers for the last 5 years
    - Avoidable grade 3 pressure ulcers have decreased from 4 in 2013-14 to 0 in 2017-18
    - 54% decrease in avoidable grade 2 pressure ulcers
    - 74% decrease in avoidable grade 1 pressure ulcers
    - 62% decrease in all pressure ulcers since 2013-14

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

- The Trust will continue to seek a reduction in harm from **inpatient falls**.
    - 17% decrease in incidents resulting in harm from inpatient falls.
    - 17% decrease in low harm incidents from the project benchmark data from 2013-14.
    - 8% decrease in incidents resulting in moderate, severe harm or death, down from 36 in 2013-14 to 33 in 2017-18.

The Trust re-launched the falls strategy in Q2 of 2017-18. A number of wards introduced staff falls pledges to reiterate their commitment to reducing falls.

- Introduce patient safety briefings to increase staff awareness of risk.
    - Patient safety briefings have been successfully implemented across the organisation. The Safety briefing is included in Team Brief on a bi-monthly basis.
    - A number a new initiatives have been implemented to review incidents and complaints, where it is thought harm has occurred, including the implementation a rapid review process for any incidents which may be reportable to the Strategic Executive Information System (StEIS) as per the serious incident reporting framework 2016.

2. **Continually learn** - Make our organisation more resilient to risks by acting on the feedback from patients and staff, by constantly measuring and monitoring how safe our services are.
    - Undertake a programme of safety walks throughout the organisation, which will involve patients, staff and key stakeholders, discussing, identifying and addressing issues/areas for improvement.
        - The programme of Quality Ward Rounds has continued with a team including an Executive and Non-Executive Director visiting each clinical area annually to meet with staff to discuss any issues and areas for improvement.
        - As well as quality ward rounds, a programme of falls safety walk rounds and venous thromboembolism (VTE) prevention walk rounds has been implemented.
    - Continue to develop information systems to support quality and safety dashboards, improving access to clinical outcome data and acting on these to improve.

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    - Standardised quality and safety dashboards have been implemented across all wards in the form of electronic Qlikview dashboards, which display patient safety data. Each ward has also implemented a public ward display board, which utilises safety crosses to display patient safety data.
    - The Patient Safety Team has been working closely with managers to develop Datix dashboards for each area. These dashboards are developed with managers and are intended to provide an overview of incidents that have been reported in respective areas. This has been implemented for Quality and Safety teams, with a plan to roll out to clinical areas across the organisation.
- Make improvements to the monitoring and completion of action plans following patient safety incidents, clinical claims, complaints and clinical audit.
    - Action planning functionally in the Trust incident reporting system, Datix, has been utilised to monitor progress against actions resulting from investigations of serious incidents reported on Strategic Executive Information System (StEIS).
- Seek opportunities to both share our successes and learn from others' success to increase the efficiency of regional, national and local safety improvement.
    - The Trust works closely with the NHS England and regional safety groups to ensure shared learning from patient safety incidents.
    - Staff from the Trust actively participate in regional Quality and Safety forums.
- The Trust had previously faced a number of challenges in terms of investigating serious incidents in a timely fashion. The Trust has reviewed the process for investigating and responding to serious incidents, with input from commissioning colleagues and has developed streamlined processes to improve the management of investigations, supported by redesigned standard operating procedures. This has resulted in a significant reduction of submission breaches from 21 breaches in June 2017 to one submission breach in March 2018.
- The rapid review process, which is now fully embedded, allows the Trust to ensure that any immediate learning from incidents is acted upon in a timely manner. All incidents recorded as a serious incident in Datix have a rapid review undertaken.

3. **Honesty -** Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
    - Always tell our patients and their families/carers if appropriate, if there has been an error or omission resulting in harm. The duty of candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have, or could have, led to significant harm (categorised as moderate harm or greater in severity).
        - The Trust promotes a culture of openness, honesty and transparency and its statutory duty of candour is delivered under the Trust's Being Open - A Duty to be Candid Policy, which sets out our commitment to being open when communicating with patients, their relatives and carers about any failure in care or treatment. This includes an apology

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and a full explanation of what happened with all the available facts. The Trust operates an open learning culture, within which all staff feel confident to raise concerns when risks are identified and then to contribute fully to the investigation process in the knowledge that learning from harm and the prevention of future harm are the organisation's key priorities.
    - The Trust's incident reporting system has a mandatory section to record Duty of Candour.
    - Weekly incident review meetings are now held, where Duty of Candour requirements are agreed on a case-by-case basis allowing timely action.
- Implementation of new serious incident review processes and harm review processes have allowed the organisation to raise the profile of Duty of Candour. Duty of Candour is discussed on a case-by-case basis and this allows the Trust to ensure that it meets its obligations under the Duty of Candour legislation.
- Duty of Candour training is now part of Root Cause Analysis training for staff.
- The Trust publishes annual reviews and patient safety information, both internally and externally. Internal reporting structures are in place in regard to all aspects of patient safety and the Trust reports information via annual quality accounts. In addition, the Trust publishes monthly safety thermometer figures via participation in the national Safety Thermometer programme.

4. **Collaborate** - Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
    - Work with partners to share best practice and improve clinical pathways for patients.
        - The Trust actively participates in the mid-Mersey patient safety and healthcare associated infection collaboratives. This includes working in partnership with primary care, local authority and commissioners to ensure the services we provide meet the needs of our local population and to share lessons learned as widely as possible. Staff also attend the North West intravenous/aseptic non-touch technique (ANTT) forum meetings.
        - The Trust actively participates in the North West Tissue Viability collaborative.
        - The Trust has expanded its internal training on prevention of pressure ulcers to care home staff and domiciliary care staff. The Trust offers a number of complimentary places for primary care to enrich clinical skills of community-based teams. Similarly, the Falls Service offers training to care providers in the community on falls prevention strategies.

    - Ensure good practice and lessons learned are shared and embedded throughout our hospitals.
        - Good practice and lessons are shared through the bi-monthly patient safety briefings, root cause analysis reports, weekly incident review meetings and the Trust-wide governance structures.
    - Roll out and share outcomes from our research and pilot programmes to ensure improvements are implemented across the organisation.

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- The Trust participates in a wide-ranging clinical research programme, with details in the research section above.

5. **Support -** Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the good practice.
   - Continue the Trust programme of six audit half days per year. These days focus on learning from experience and audit and celebrating good practice.
     - The Trust continues with the programme of audit sessions, which are highly valued by staff.
   - Continue the Trust Human Factors and Root Cause Analysis (RCA) training programmes to develop a reactive and adaptive workforce capable of recognising and effectively reducing avoidable harm.
     - The Trust continues with its programme of human factors in the form of supportive clinical simulation exercises and root cause analysis training which is well attended by all staff groups.
   - The Trust has established Freedom to Speak up Guardians to support staff who want to raise any safety concerns. The Guardians have a role in being independent and impartial, and ensure the safety issue that has been raised, is investigated and addressed if found to be true. The Guardians also ensure that there are no repercussions for the individual who raised the concern.
   - The Trust has also subscribed to an anonymous electronic concern raising system, Speak in Confidence, to ensure that all staff irrespective of position feel confident that they can raise concerns anonymously.

3.2.2. Infection control

The Health and Social Care Act 2008 requires all Trusts to have clear arrangements for the effective prevention, detection and control of healthcare associated infection (HCAI). The Trust's Director of Infection Prevention and Control (DIPC) is the Director of Nursing, Midwifery and Governance who has Trust Board level responsibility and chairs the Hospital Infection Control Group.

The infection control team undertakes a rolling programme of infection control audits of each ward and department, with individual reports discussed with ward managers and teams for action. Infection control indicators are included within the Quality Ward Accreditation tool (QCAT).

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

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

During the reporting period April 2017 to March 2018 the Trust reported the following:

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- MRSA bacteraemia (MRSAb): two positive blood samples, including one contaminant against a threshold of zero
- Clostridium Difficile infections (CDI): 20 cases against a limit of 41 cases including one case to be appealed in June 2018. The current CDI rate of infection has remained the same of the 2016-17reporting period.
- Methicillin Sensitive Staphylococcus Aureus bacteraemia (MSSAb): The Trust has 22 cases of (MSSAb), of which nine were unavoidable with no lapses in care identified
- The latest surgical site infection rates related to elective hip and knee procedures from April 2017 to February 2018 are well below national averages as shown below:
  - Hips 0.7% against a national average of 1%
  - Knees 0.5% against a national average of 1.4%.

All staff are aware of the lessons learnt from post-infection reviews (PIRs) of MRSAb and CDI cases, via effective communication of information regarding infection alerts between different wards, clinical teams and members within a team.

In May 2016, the Government announced its ambition to halve healthcare associated (HCAI) Gram-negative bloodstream infections (GNBSIs) by 2021. As approximately three-quarters of E. coli BSIs occur before people are admitted to hospital, reduction requires a whole health economy approach. The Trust in collaboration with CCGs and partners has developed a health economy action plan particularly focusing on a 10% in-year reduction in urinary tract infections and to learn and share lessons. The group meets on a quarterly basis. The Trust continues to work closely with the infection prevention and control, patient safety and quality teams in the wider health economy, attending collaborative meetings across the region in order to improve infection prevention and control practices and monitoring.

The Trust vaccinated over 87% of front-line staff, exceeding the national flu CQuIN target of 75%. In addition, the Trust promoted the flu vaccination with pregnant women and patients in long stay rehabilitation wards. During quarter 4, at the peak of the flu session, the Trust implemented an innovative flu ward round supported by the DIPC and respiratory clinician.

The Trust has 27 Consultant infection control champions and over 70 link nurses who attend education and training and complete local audits to monitor compliance.

Key achievements for 2017-18 were:
- PLACE assessments achieved 100% for Cleanliness for Whiston and St Helens sites
- Compliance with the prescribed CDI target and was under trajectory for 3rd consecutive year
- Continued SSI surveillance within elective Hip and knee
- Achieved aseptic non-touch technique (ANTT) competency for clinical staff
- 100% compliance with carbapenemase-producing Enterobacteriaceae (CPE) and MRSA screening

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- Ensured that there was infection control input into environmental monitoring systems and implementation of national standards for cleanliness and validation of standards

3.2.3. Safety Thermometer

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

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

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

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

- Ensuring education and training is available for all ward staff to enable them to complete and submit the NHS safety thermometer as required
- Forming weekly harm review meeting to look at all incidents across the Trust, including falls
- Monthly Strategic Falls Group to oversee the implementation of the revised falls strategy and performance manage the associated action plans
- Convening a task and finish group to review the bedrail policy
- Ensuring, when possible, a one-to-one staffing ratio is implemented when indicated by the risk assessment for falls
- Providing non-slip anti-embolic stockings
- Continuing to provide education for all clinical staff on VTE, resulting in increased compliance with the prescribing and administration of anticoagulants to prevent these occurring
- Nursing staff attending one hour tissue viability training every three years
- Staff access to a full day wound management training session
- Providing each ward with a comprehensive tissue viability folder as a staff resource

3.2.4. Safeguarding

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

The Trust has a dedicated Safeguarding Team comprising of:

- Named Professional Safeguarding Adults

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

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

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

The Trust's Safeguarding Assurance Framework has separate safeguarding children and adults steering groups, which meet quarterly to discuss required actions, activity and updates on current practice. These steering groups report directly to Quality Committee quarterly and annual reports are taken to the Trust Board for both Safeguarding Children and Safeguarding Adults. These reports are subsequently shared with Local Safeguarding Adult and Children's Multi-Agency Boards and inform their annual reports accordingly.

3.2.4.1. Safeguarding Children

The Trust continues to work pro-actively with St Helens, Knowsley and Halton Local Safeguarding Children Boards (LSCB) as either a board or committee member. Changes to the LSCB structures and statutory function following the Wood Review are ongoing and due to be finalised in 2018, however, the Trust will ensure that safeguarding continues to be a priority and will maintain partnership working across the footprint.

The Safeguarding Team contribute, as required, to multi-agency reviews including serious case reviews, practice learning or management reviews. Any identified learning points are shared across the Trust and any necessary actions implemented to improve practice.

The Trust was reviewed recently as part of a local CCG Safeguarding and Looked after Children Review carried out by the CQC. This was very positive with only a small number of recommendations for the Trust, which are being implemented.

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

The Trust has a dedicated Safeguarding Children Steering Group, which drives the safeguarding children's agenda. Reports are submitted regularly to the Trust's

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Quality Committee in order to provided assurance to the Trust Board and external Commissioners.

3.2.4.2. Safeguarding Adults

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

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

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

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

3.2.4.3. Mental Capacity Act and Deprivation of Liberty Safeguards

The Trust's Mental Capacity Act Policy and Procedure is embedded in clinical practice. Applications for Deprivation of Liberty Safeguards have increased in line with local and national trends. The Trust meets regularly with relevant agencies to share best practice and to ensure our practice follows current legislation.

3.2.5. Domestic Abuse

The Trust actively contributes to the local domestic abuse agenda with active participation at both St Helens and Knowsley Multi-Agency Risk Assessment Conferences (MARAC), together with reports by exception to Halton and Warrington.

The Trust Domestic Abuse Policy ensures support is offered to both patients and staff members who may be affected by domestic violence and or abuse. Training is embedded in all levels of both safeguarding children and adult sessions to ensure that the workforce is competent in the identification and support of domestic abuse victims and children.

Contribution to Domestic Homicide Reviews assists the Safeguarding Team in identifying areas of good practice as well as areas for improvement.

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3.2.6. Learning Disability

Guidance has been implemented for patients with a learning disability attending any department within the Trust on how to meet their individual needs. This is supported by a toolkit to ensure that staff are able to provide the highest standards of care. The Trust works with partner agencies to support the patient journey and to share best practice.

3.3. Clinical effectiveness

The purpose of the Clinical Effectiveness Council is to ensure that the Trust has a robust process for managing and monitoring clinical effectiveness, as well as investigating any potential issues and providing assurance regarding clinical services.

The Council meets monthly and monitors key outcome and effectiveness indicators, such as mortality, nationally bench-marked cardiac arrest data, critical care performance, hip fracture performance, readmissions, clinical audit and application of NICE guidance.

3.3.1. Acute kidney injury (AKI)

Acute Kidney Injury (AKI) affects an estimated 10% of all patients at St Helens and Knowsley Teaching Hospitals NHS Trust, with patients with AKI spending 4.7 days longer in hospital according to NICE. NCEPOD states that appropriate intervention in the identification and management of AKI patients will have a positive impact on their care reducing length of stay, the burden to critical care units and readmissions within 30 days.

The Trust implemented a multidisciplinary AKI Team comprising three Advanced Nurse Practitioners and a specialist Pharmacist which is led by an Acute Medicine Consultant. This team was tasked with modernising the quality of care and, therefore, outcomes of patients with AKI. The team has achieved:

- Reduction in length of stay for AKI patients (17.4 days in 2014-15 to 15.2 days in 2017-18)
- Pharmacist-led medicine optimisation within 24 hours of AKI alert, with over 80% compliance, which is now a Pharmacy Department key performance indicator
- National AKI Nurse Event organised and hosted at Whiston, opened by the Chief Executive, Ann Marr and Dr Richard Fluck, Chair of the 'Think Kidneys' Programme Board and past National Clinical Director for Renal as the key note speaker
- Selected by 'Think Kidneys' (NHS England and Renal Registry Support Programme) to lead on establishing AKI Nurse Education days
- Electronic fluid balance monitoring software implemented
    - Contributed to a 23% reduction in the Hospital Standardised Mortality Ratio for fluid and electrolyte disorder indicator
    - 30% improved compliance of input/output documentation
    - 90% improved correct calculations of cumulative balances and running totals

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- Staff reporting that it is "*easy to use*", "*training received was good*" *and* "*liked the pictures in the fluid input*"

- Content developed for the Cheshire & Mersey version of AKI Care app, winner of the Best Healthcare App at the Building Better Healthcare awards 2016. This app enables region-wide improvement in management of AKI
- AKI Team awarded prize for poster presentation at North West AKI event
- AKI Team awarded prize for poster presentation at Renal Pharmacy Group Conference
- Health promotion on World Kidney Day and patient focus groups

3.3.2. Promoting health

The Trust actively promotes the health and well-being of patients by undertaking a holistic assessment on admission that looks at physical, social, emotional and spiritual needs. Patients are referred or signposted to relevant services, for example; dieticians, stop smoking services and substance misuse. The initial review of patients includes a number of risk assessments that are used to highlight specific concerns that are acted upon, including nutrition and hydration and falls. The Trust has a Smokefree Policy in place that ensures a healthy environment for staff, patients and visitors, with measures in place to support staff and patients to give up smoking. In addition, the Maternity Service actively promotes breast feeding.

The Trust works in partnership with other agencies to provide holistic services throughout the patient's journey to ensure a seamless service, supported by integrated pathways across the hospital and community settings. Examples of this include the work of our Community Falls Team, who work collaboratively with primary and community care and our Infection Prevention and Control Team who liaise closely with community teams and GP services.

The Trust has an effective volunteering service and has about 350 volunteers currently working across the organisation, with recruitment events held every other month. The Trust's Volunteer Department has continued to work with the Department for Working & Pensions to support people back into employment, through building confidence, learning new skills and improving both mental and physical well-being through becoming a volunteer at the Trust. Current volunteers are offered a variety of training opportunities that will be advantageous should they wish to apply for Trust jobs or employment outside of the organisation.

In addition, the Trust has just signed the Step into Health Pledge to champion and assist the transition of ex-military staff into NHS employment. NHS Employers and the Royal Foundation support the pledge.

3.4. Patient experience

Patient experience is at the heart of the Trust's vision to deliver 5-star patient care and we are keen to learn from all our patient and carer experiences so that we can continuously make improvements and share good practice.

Patient stories are a very valuable part of our learning and are shared via various reporting routes, including the Trust Board, Patient Experience Council and Care

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Group meetings. Staff and partner agencies are always keen to support and welcome the patients and their families to present their experiences in their own words.

Patient stories this year have focused on reminding staff of the importance of introducing themselves via the "Hello my name is" campaign. Surgical care patients have come to present their experiences and future plans around structured education programmes to prepare patients for major bowel surgery and breast reconstruction. Other patients have come to discuss how the kindness and compassion from staff at the Trust has touched their lives.

Areas for improvement identified through patient stories included the need to give patients realistic timescales for follow up appointments, more time to consider and discuss treatment options and revisions to documentation to record pain scores.

The Patient Experience Manager engages with at least five patients or carers each day in a range of settings, including wards and outpatients. This gives real-time information about how patients are travelling through their journey and provides an additional opportunity to resolve issues as soon as they arise.

The Dignity Champions and Patient Experience Champions groups merged into one group, now titled Patient Experience and Dignity Champions, to allow a platform for staff, partner agencies and patient representatives to attend. Monthly meetings are held at a time that is in line with nursing handover periods to facilitate attendance. The topics discussed are informed by senior leadership, actions from the Patient Experience Council and the attendees themselves. Agenda items include the Friends and Family Test to ensure staff are supported at a local level to both celebrate positive feedback and to look at any actions we may need to take to improve across all area. Other topics that have been covered include care of patients with learning disabilities, safeguarding children and adults, dementia care and how to raise concerns through the Freedom to Speak up Guardians.

3.4.1. Friends and Family Test

The Friends and Family Test (FFT) asks patients if they would recommend the ward or department where they recently received healthcare to their friends or family if they needed similar care or treatment. It is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback in real-time about their experience.

The FFT has produced well over 30 million pieces of feedback so far across the country, making it the biggest source of patient opinion in the world. The feedback gathered is used to stimulate local improvement and empower staff to carry out the sorts of changes that make a difference to patients and their care.

St Helens and Knowsley Teaching Hospitals NHS Trust uses a variety of survey options, with the majority of feedback captured by sending a text message to our outpatients and Emergency Department attendees on discharge, with over 57,000 text responses received in a year. Postcards and on-line methods are also used for inpatients and maternity services.

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FFT: The Trust's response rate at the end of March is 30.0%, compared to the national average of 23.2%, with the Trust ranked 58th nationally out of 172 (based on March 2018 inpatient national data and including independent sector providers)

Each ward or department within the Trust monitors the patient feedback and creates 'you said, we did' posters for display. These posters reflect what we did as a result of patient comments and are invaluable in maintaining staff motivation and influencing change. Some examples include:

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You said…We did…

You said
Seen quite promptly initially, then kept waiting a hour to be seen by consultant, then kept waiting again whilst consultant saw someone else before my further treatment

We did
We appreciate your comments and feedback relating to your recent visit to our clinic. We are sorry to hear that there was a long wait between consultations. We provide a pager service to allow patients to leave the department and be contacted when you are next to see the doctor. For more information please ask a member of staff.

You said
Although my appointment was at 2:30 and I was seen about 2:45 the service you provided was excellent as all the staff were friendly and helpful. The only improvement I would suggest is that you tell the patient their appointment will be a little late.

We did
We do apologise that you were seen 15 minutes after your appointment time. The nursing staff are encouraged to make announcements for clinic delays of over 30 minutes. We are pleased to hear that the service you received was excellent.

You said
The Labour ward was absolutely amazing. Every member of staff was attentive to mine and my baby's needs. I had complete trust in every person and everything I experienced was thoroughly explained. I can't thank them enough.

We did
We shared these lovely comments with staff in our meetings and displayed them on staff boards. Staff were pleased you had such a positive experience of our care.

You said
No vending machines local to paediatric waiting area, didn't want to leave child to go to adult waiting area

We did
Vending machines were put in along the corridor by paediatric AED entrance.

3.4.2. Complaints

The Trust takes patients' complaints extremely seriously. Staff work hard to ensure that patients and carers concerns are acted on as soon as they are identified and that there is a timely response to rectify any issues that are raised at a local level, through the Trust's PALS team, or through the AskAnn email. Ward and departmental managers and Matrons are available for patients and their carers to discuss their care and to provide timely resolution to ensure patients receive the highest standards of care. At times, however, patients and their carers may wish to raise a formal complaint and these are thoroughly investigated so that patients are provided with a comprehensive written response.

In 2017-18, the Trust received 224 new complaints that were opened for investigation. This represents a decrease of 44% in comparison to 2016-17, when the trust received 338 new complaints. However, there was a slight increase in the number of complainants that were dissatisfied with the initial response; 44 in 2017-18 compared to 42 in 2016-17. The total number of PALS contacts increased by 15% to 2333 in 2017-18, which reflects the decrease in formal complaints in part.

Work remains ongoing to improve the timeliness of responses to those who made the effort to highlight concerns about their care. The average time to respond to new complaints within the agreed timescale has improved from 58% in 2016-17 to 67% in 2017-18.

The Trust has continued to conduct the Complaints Satisfaction Surveys throughout 2017-18, with a copy of the survey sent out with all response letters. There were 29 responses in total received in 2017-18. Overall, the majority of respondents to the survey were satisfied with how easy it was to make a complaint (92.5%) and were provided with a contact number for the complaints team (85%). The majority of respondents (69%) reported that they were either fairly satisfied or very satisfied with the way in which their complaint was handled, which is 1% lower with the previous year's figure

A number of actions were taken as a result of complaints made in 2017-18. The issues highlighted through a complaint relating to enhanced rapid discharge for end-of-life care was shared at a multi-agency discharge-planning workshop. District nurses, palliative care, therapists, nurses, discharge co-ordinators and social services attended the workshop and identified areas for collective improvement, including making more timely referrals and enhancing communication between services and the patient's family. Work is underway to ensure better understanding of the different terminology used across partners and the roles and responsibilities of all those involved in supporting discharges.

Other actions taken include:

- Ensuring that all patients who attend the Emergency Department have their level of pain recorded
- Amendment of documentation to improve pain management for patients with dementia in the Emergency Department
- Provision of additional dermatology clinics

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- Revisions and reinforcement of standard operating procedures and protocols relating to endoscopy and laboratories
- Development of a new ambulatory care pathway to improve the care of children who do not require inpatient treatment
- Documentation training for nursing staff
- Reiteration of best practice in relation to communications
- Staff undertaking reflective practice
- Dissemination of lessons learned through team meetings

3.5. Service developments

3.5.1. Acute Medical Unit (AMU)

The Acute Medical Unit is a dedicated care facility that acts as the focus of care for acute medical care of patients that have presented as medical emergencies to the hospital. This unit delivers 5-star care to over 13,000 patients a year, a 50% increase from four years ago. Over the past year, the AMU has developed a dedicated Enhanced Care Area with four beds that care for patients requiring Level 1 Enhanced Care with a 1:4 nurse ratio. A successful bid to the Trust's charitable funds provided equipment for continuous physiological (including cardiac) monitoring of patients in this area.

Staff have developed additional Ambulatory Emergency Care pathways, including pathways for iron deficiency anaemia and headache amongst others to increase the ability to manage patients with investigations and treatments being provided without an overnight admission to hospital. We have developed enhanced processes to increase the number of patients being offered medical ambulatory care when attending via the Emergency Department. This has increased patient choice and experience.

The assessment area within the Acute Medical Unit has had facilities modernised to enhance patient experience with more seating that is comfortable, television and vending facilities as well as two Dyson pure purifier fans from charitable funds, that automatically remove 99.95% of allergens and pollutants from the air.

There are plans to develop the AMU Assessment further to enhance flow in the Medical Care Group that will improve care further by reducing time from arrival to senior/consultant review.

3.5.2. Therapy Services

Our forward-thinking Therapy Services have achieved the following in 2017-18:

- Participation in trailblazer for apprenticeship development for physiotherapy
- Excellent Sentinel Stroke Audit National Programme (SSNAP) results in stroke therapy
- Introduced satellite stores for equipment to improve safe discharge
- Improved patient experience and reduced missed appointments through the introduction of opt in appointments in musculoskeletal (MSK) services and obstetrics and gynaecology
- Invested in equipment to improve patient experience and dignity so that patients can be assessed in therapy areas on wards rather than in outpatients

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Our rheumatology therapists are:

- Involved in a gloves research project this is a joint venture between Salford and Lancaster University & Health.
- Conducting a survey of rheumatology patients' levels of exercise and what barriers they face in relation to starting and regularly attending exercise. The service is hoping to set up a form of exercise class to try and promote exercise to our patients and hopefully keep them exercising in the community, using the outcomes of the survey to more effectively develop the service, working with St Helens Council (Healthy Living Scheme) and/or Reeve Court

Our musculoskeletal therapy service has:

- Introduced an ear, nose and throat (ENT) pathway and audit system to triage referrals
- Introduced e-triage for MSK and obstetric, gynaecology and urology (OGU) referrals to allow quicker triaging and reduce delays in appointments being made
- Introduced shoulder school to better prepare patients for surgery
- Introduced a well-being session (pain talk) to meet NICE guidelines on the management of pain
- Created an anterior cruciate ligament database, looking at end stage rehabilitation/return to sport utilising outcomes measures to prevent osteoarthritis and re-rupture
- Introduced a functional stability (Pilates) class
- Collaborated with the Royal Liverpool and Broadgreen University Hospitals NHS Trust to create integrated second opinion pathways for complex shoulder instability patients.
- Utilised more OGU classes prior to 1:1 physio.
- Started OGU 'did not attend' (DNA) audit in Feb 2018
- Ratified all orthopaedic protocols (both upper and lower limb)
- Maintained ongoing discussions around using texts to reduce DNA rates and streamline orthopaedic services

Our Dietetics Service has:

- Completed an audit to re-assess compliance with national guidance for patients with nasogastric feeding tubes
- Introduced a telephone clinic to help with efficiency of paediatric outpatient appointments.
- Worked with pharmacy to implement a standard structure for prescribing infant formula milks for Cow's Milk Protein Allergy with potential cost savings
- Introduced adapted cutlery onto Stroke Rehabilitation Unit based on feedback from patient story to Trust Board
- Provided training to ward staff in the use of the Malnutrition Universal Screening Tool (MUST)
- Developed a dietetic page for the Trust's intranet to include referral forms, referral criteria and starter feeding regimes for enteral feeding
- Benchmarked hospital food and drink provision against national catering guidelines
- Developed FODMAP pathway and associated guideline. FODMAPs are Fermentable Oligosaccharides, Disaccharides, Monosaccharides and Polyols,

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which are poorly absorbed simple and complex sugars that are found in a variety of fruits and vegetables and also in milk and wheat
- Review of oral nutritional supplements used within the Trust to reduce costs and be clinically effective
- Involved in upper gastrointestinal (UGI) cancer patient event to establish what the Trust does well and where improvements can be made
- In-service training programme for all grades of Dietitians and Dietetic Assistants to ensure our knowledge is up-to-date and evidence-based for a wide variety of clinical conditions

Our Speech and Language Therapists have:
- Developed a training package for undergraduate students in the management of Dysphagia, in collaboration with Manchester University; this will better prepare graduates for the workplace and improve patient care.
- Introduced seven day working to ensure high risk patients have timely assessments

3.5.3. Cancer Services

There have been a number of developments within our cancer services during 2017-18 and these are summarised below:

- Start of a lymphoma alert system to flag up scans with enlarged lymph glands to ensure patients are directed to the right investigation pathway and given a quicker diagnosis.
- Lilac Centre achieved and maintained the Macmillan Quality Environment award
- First Cancer Clinical Nurse Specialist (CNS) annual education day held, "Curious about cancer" which was funded by Macmillan with over 80 delegates from secondary and primary care attending
- Recognised at the Lyndale Cancer Support Group Annual Business meeting for its contribution to patient care and the collaborative work it has done with the Lyndale over the years.
- Lilac Centre awarded the outstanding achievement award 2017 at the Trust's annual staff award ceremony
- Hairdressing salon opened at the Lilac Centre offering a unique service to all patients undergoing chemotherapy treatment at the Trust, providing a wig service in a pleasant environment close to home
- Number of CNS staff presented and displayed posters at conferences throughout the UK, including acute oncology, experiences of implementing aspects of the recovery package for patients with primary melanoma and skin cancer
- Contributions to an article published in the International Journal of Clinical Practice, entitled "Patient Perception of Telephone Follow-up after Resection for Colorectal Cancer: Is it time for an end to the outpatient clinic?"
- Facilitation by the Upper Gastrointestinal Team of an informal patient world café event, whereby patients and carers were able to come and have discussions with other patients/carers and staff. The event had excellent patient and clinical engagement and provided useful feedback. The event was also attended by the Macmillan sponsors from Scotland and locally who were keen to see how the concept works.

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3.5.4. Diabetes

The Diabetes Team were successful in winning a bid for transformation funding from NHS England, which has been invested in the following:

- Inpatient care – six new inpatient Diabetes Specialist Nurses (DSN) have been employed to deliver inpatient diabetes specialist care seven days a week to allow a greater focus on key areas such as reducing emergency admissions in people with diabetes, driving up standards and the quality of diabetes care across the Trust and reducing the length of stay in people with diabetes
- Improved foot service – increased capacity in the diabetes foot clinics for patients with active diabetic foot disease. Regular multidisciplinary team meetings are held, encompassing Diabetes Consultant, DSN, podiatry, orthopaedics, microbiology, radiology & vascular input. Expansion of the existing foot clinic service will allow greater capacity to support a reduction in outpatient waits for assessment, with an anticipated reduction in risk around the deterioration of foot conditions, overall providing an enhanced positive patient experience
- The Specialist Diabetes Team at the Trust has a strong reputation for developing and delivering diabetes structured education programmes and has won national awards for this work. This structured education programme for people with type 2 diabetes has now been improved, with evening and weekend education sessions offered, including input from the newly employed specialist diabetes dietitian. During the last two years the provision of structured education in St Helens has changed and the current offer has been successful at improving attendance amongst newly diagnosed
- The ‘Cloud’ service is improving collaborative working between primary and secondary care, which will include a telephone line for specialist advice for professionals, patients and carers for diabetes advice and support. This will run seven days 8am – 10pm. A new Community Diabetes Specialist Nurse has been employed to drive this collaborative working, providing support to Practice Nurses, care homes, District Nurses and other community services and to improve achievement of the NICE recommended treatment targets for cholesterol, blood pressure and blood sugar monitoring
- The Diabetes Team internet page will also be updated to include frequently asked questions (FAQs) for professionals and patients and to include up-to-date guidelines

3.5.5. Stroke telemedicine service

The Trust has introduced telemedicine for the 6-month reviews for stroke patients, which has been a great success so far in improving patient experience and increasing the effectiveness of the service, by reducing inconvenience and travel times for patients.

3.5.6. Liver Team

The Trust has a dedicated team of Liver Nurses and two health care assistants who are trained to undertake FibroScans (non-invasive assessments of the extent of liver

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fibrosis (scarring)), which releases the Liver Nurses to do more complex work. The service has procured a new portable device to offer this service at our St Helens site, with plans to roll this out into the community in the future.

The gastroenterology ward, 3D has opened a new Treatment Unit, providing day-case management of recurrent ascites (build-up of fluid in the abdomen) for our patients with known cirrhosis of the liver, so that they do not need an overnight stay.

The Trust is the first district general hospital in Merseyside to register with the Royal College of Physicians improving quality in liver services (IQILS) scheme, with plans to secure level one accreditation by 2019-20. The service has referred over 50 patients for liver transplants in the last 5-years with approximately 90% being listed.

3.5.6.1. Maternity

The last 12 months have seen the leadership strengthened with key appointments made including the Named Midwife for Safeguarding Children. The Trust's safeguarding children arrangements were audited in November 2017, which included maternity services, with excellent feedback received, no required actions and three recommendations. The Specialist Midwives for Safeguarding now conduct a daily ward round and use the opportunity to support staff managing safeguarding issues on the ward and Delivery Suite areas. All staff carrying caseloads of women with safeguarding concerns are provided with safeguarding supervision on the spot and given appropriate support and advice.

A rota for a senior midwife 'helicopter' bleep holder has been implemented. The bleep holder is supernumerary and takes the safety helicopter view of the whole maternity unit, taking any actions needed. Safeguarding alerts are carried by the bleep holder ensuring that high-risk women are identified on admission. The bleep holder report is escalated to the senior management team three times per day. In addition, the senior management team formally check for any breach of the maternity red flags, which may indicate that there are staffing issues, at least three times a day and remedial action is taken immediately

The Delivery Suite now has a supernumerary coordinator on duty on all shifts. All coordinators will soon have access to the Child Protection - Information Sharing system to enable identification of safeguarding concerns for women who have not booked in at Whiston but attend the maternity unit.

The maternity, neonatal and maternity theatre teams have developed an action plan following national guidance on keeping mothers and babies together and are particularly proud that there is now the introduction of skin-to-skin contact in theatre for women having an elective caesarean section.

The introduction of a newly formed Quality and Safety Team has supported a philosophy of shared handling and investigation of risk across the service.

The 'Quality Bus' has been introduced to roll out key messages quickly to clinical staff without them needing to leave the clinical area. Key messages include changes

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to a guideline or a change in practice. Any member of the team can use the 'bus' if they have key messages to deliver quickly.

The ward manager or the in-patient matron meets every women on the antenatal and postnatal wards daily, to ask what is important to them and is there anything that can be done to improve their experience, which is then actioned, resulting in 'you said …we did'.

In August 2017, the Maternity Voices Partnership was introduced in association with midwives from Bridgewater Community Healthcare NHS Foundation Trust, which is hosted at Whiston Hospital. In addition, the service receives a high number of positive comments on the Facebook page from service users. The two initiatives of 'Facebook the Matron' and 'Facebook the Specialist Infant Feeding Midwife' generated thousands of 'hits' and questions which were responded to, with real-time reassurance provided.

A 24/7 Maternity Triage department was implemented in October 2017.   It is staffed by a dedicated midwife and health care assistant and is located within Delivery Suite, consisting of a three-bedded bay with an additional two side-rooms available.

Pregnant women who have any concerns during their pregnancy can contact triage via telephone at any time of day or night. Our dedicated triage midwife is on hand to obtain a thorough history and provide sound evidence-based advice. Many different issues are often dealt with by maternity triage including, bleeding, waters breaking, contractions /possible labour and concerns about babies' movements. The triage midwife will often provide re-assurance to women and their families over the telephone, as sometimes women are not required to attend. If the midwife feels that the woman requires further assessment they will then direct the woman to the appropriate service depending upon her needs and history, for example, Delivery Suite triage, community midwife, GP, Fetal-Maternal Assessment Unit.

The Trust opened its new Midwife-led Unit in the autumn, with an additional two birthing pools. Work continues to adapt the environment to resemble a 'spa like' experience in order to promote oxytocin production and lead to less intervention at birth.

The service introduced the enhanced recovery pathway for women having an elective caesarean section in the last year, which results in a quicker recovery period and a reduced length of stay. Follow up telephone calls to these women have found a high level of satisfaction with the process.

3.5.7. Mohs Service

The continued partnership between Plastic Surgery and Dermatology has enabled the development of a 'gold standard' Mohs Service. This is a one-stop service for a majority of patients whose facial skin cancer is managed and treated under a local anaesthetic, which can include complex reconstruction and tissue-saving surgery. Our commissioners are now using the model as the benchmark for other services to mirror.

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3.5.8. Age-related Macular Degeneration (AMD)

The Trust's ADM service has been moved into a specifically designed area within the Ophthalmology Outpatients and is now a consultant-led, nurse-delivered service. This has enabled us to increase the numbers of patients treated and to enhance the patient experience.

3.6. Summary of national patient surveys

The full results for all the Care Quality Commission's national patient surveys can be found on their website at http://www.cqc.org.uk/

3.6.1. National inpatient survey

The Trust participated in the annual National Inpatient Survey 2016 coordinated by the Care Quality Commission. The results were published in June 2017 and the Trust's response rate was 36% compared to the national response rate of 44%.

The Trust was included in the best performing trusts nationally for one indicator relating to cleanliness of the bathrooms and toilets and was rated about the same as other trusts for the remaining indicators. The Trust has taken a number of actions to improve patient care including:

- Enhancing the discharge process to reduce the length of time patients arriving at the hospital need to wait for a bed
- Improving the quality of written information provided to patients, including information about medications on discharge
- Reiterating the importance of staff introducing themselves
- Working with volunteers to support patient mealtimes

3.6.2. National Emergency Department survey

The Care Quality Commission published the results of the 2016 Emergency Department survey in October 2017. The national response rate was 26% and the Trust's response rate was 23%.

The Trust was rated better than other trusts in the following two areas:

- Being given the right amount of information about their condition or treatment
- Those prescribed new medication, being told about possible side effects

The Trust was rated as about the same as other trusts for all other areas, with no scores rated lower. The following actions are being taken to improve the services we provide:

- Continue to provide information about waiting times for patients to be examined
- Trial new ways of working to allow an earlier first point of contact to reduce the time waiting to be examined
- Increased training and development for nursing staff and implementation of patient group directives to allow nursing staff to provide simple pain relief prior to patients being seen by medical staff

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3.6.3. National children and young people survey

The Care Quality Commission published the results of the 2016 children and young people survey in November 2017. The national response rate was 26% and the Trust's response rate was 15%.

For the experiences of children aged 8-15 years, the Trust scored 'much better than expected' and was only one of five trusts in the country to achieve this maximum score.

The Trust scored about the same as others for children aged 0-7 years.
There were 15 areas in which the Trust was rated better than other trusts including:

- Children and young people feeling they had enough privacy during their care and treatment
- Children and young people saying staff spoke with them about how they were going to care for them
- Children and young people saying they were able to ask staff questions
- Children and young people saying that hospital staff spoke with them when they were worried
- Parents and carers saying they had confidence and trust in staff treating their child
- Parents and carers saying they received enough information about their child's new medication
- Children and young people saying they were told who to contact if they were worried about anything when they got home
- Children and young people saying they were told what would happen next after they left hospital

The Trust was rated about the same as other trusts for all other scores, with no lower scores.

An action plan is in place to continue to improve the services provided to children and young people, with a number of changes already implemented, including:

- Increased awareness of play facilities available to babies, children and young people:
    - Posters are now displayed clearly on the wards stating the working hours of the play specialists and encouraging utilisation of their services and reminding patients that toys and activities can be taken out of the playroom to bed spaces if required
    - Play specialists undertake daily visits to each patient on their ward
    - Utilisation of volunteer services to support play specialists and further encourage and maximise opportunities for play and activities

- Ensuring consistency of communication regarding care plans with parents, carers and patients to avoid any conflicting information being given:
    - Nurse attendance at doctors' ward round on a daily basis supported by nurse in charge, Advanced Paediatric Nurse Practitioners and supernumerary members of staff to attend during times of high occupancy/dependency.

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- Medical staff formally reminded of the importance of sticking to a care plan via local induction, handover, Junior Doctors' Forum, Weekly Grand Rounds, Clinical Governance and team meetings

- Improving food satisfaction rates for children in the 0-7 years age group:
    - Ward managers to liaise with Trust catering suppliers to consider engagement sessions with parents and children; eg food tasting and menu suggestions

3.6.4. National maternity survey

The Care Quality Commission published the results of the 2017 maternity survey in January 2018. The national response rate was 37.4% and St Helens and Knowsley Teaching Hospitals NHS Trust's response rate was 21%.

The survey provides information on women's experiences during all aspects of their maternity care, including antenatal care, postnatal care, the care received during labour and birth. The Trust was rated as about the same as other trusts, other than for 'being able to move around and choose the most comfortable position during labour', which was worse than other trusts.

The Maternity Service has recently opened a Midwife-led Unit supported by midwife-led pathways of care. The Unit has two birthing pools, birthing balls and specialised couches for low risk births. Women who are assessed as high risk can use the birthing pool on the Delivery Suite with telemetry monitoring in place, if they choose to do so.

An action plan has been developed with particular focus on the other areas where improvements can be made; including ensuring women know they can have skin-to-skin contact after the birth, as well as providing additional support for emotional well-being at home after the birth. In addition, the Maternity Service's community midwives are delivering team continuity of care, which will also enhance the care provided.

3.6.5. National cancer patient experience survey (NCPES)

The NHS England National Cancer Patient Experience Survey (NCPES) has been developed and run by Quality Health for the Department of Health since 2010. It is the largest and most comprehensive survey of cancer patients in the world. The results of the 2016 survey were published in July 2017, with a national response rate of 66% and a Trust response rate of 55%.

There is a robust governance structure in place to ensure that the results are shared with all our partners including CCG, local GPs, the Trust Board and clinical teams. The results are also available on line for public viewing.

NCPES is designed to monitor national progress on cancer care, to drive forward quality improvement and to inform the work of groups supporting patients. Organisations are rated as being 'lower', 'within' or 'higher' than an expected range.

DRAFT

Patients treated for cancer within the Trust have highly rated the level of care they received, scoring their overall care as 8.9 out of 10, placing us above the national average rating of 8.7.

The Trust performed above the expected national level across a range of key indicators covering patients' involvement in decisions about their care, their treatment and in-patient experience and the level of advice and support offered to themselves and their families:

- 80% were involved as much as they wanted to be in decisions about their care
- 92% were given the name of a clinical nurse specialist
- 91% said it was easy to contact their clinical nurse specialist
- 91% were always treated with dignity and respect
- 97% were told who to contact if they were worried after leaving hospital

A comprehensive action plan has been put into place by the clinical teams to address issues raised where the scores were below average for individual tumour sites, for example, to improve collaborative work across all parts of the patient pathway, in colorectal services.

The breast cancer service in particular had excellent results and was rated well above the national average. This is credit to the hard work and dedication of the team. The full results can be found at http://www.ncpes.co.uk.

The analysis of results is supported by a patient comments report, which gives valuable insight into what patients feel is positive about the care they receive. Below are some examples:

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You cannot fault the St Helens or Whiston Hospital for treatment and advice, they were marvellous. I would recommend them to anybody
(Breast Patient)

I felt they fully cared for me and my feelings. They fully explained everything so I understood and the timescale in which I was dealt with was fantastic
(Skin Patient)

Once I was diagnosed, I was seen and was fast tracked because of my age, which I was so grateful for, with positive treatment and acting quickly. I am just having follow-up appointments with no treatment i.e. radiotherapy and chemotherapy (Gynaecology Patient)

Excellent, seeing the consultant very quick and all the treatment explained to me.
(Other)

I was looked after in the best possible way. I was explained everything from the start until the end of my treatment
(Lung Patient)

From Ward 2A to Jane and the Lilac Centre I have been given excellent care. And not forgetting the other departments such as radiology department and biopsy team who saw me as a matter of urgency. Plus the consultants who have been fabulous and helped me beat cancer
(Haematology Patient)

I was well informed throughout my treatment for prostate cancer. And still having follow up appointments. I was treated with dignity and respect
(Urology Patient)

The care I received from every hospital, St Helens, Whiston, Clatterbridge and Aintree has all been amazing. My experience has been nothing but positive from scans, chemotherapy, radiotherapy, surgery, Herceptin injections and every other test. Staff have all been wonderful, showing kindness care and compassion.
We are extremely lucky to have the NHS, both my husband and myself have had the unfortunate news that we have cancer but have been lucky to come out the other side and without the NHS that wouldn't be possible, so a big thank you !

4. Annex

4.1. Statement of Directors' responsibilities in respect of the Quality Account

The Trust Board of Directors is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2012) to prepare a Quality Account for each financial year.

The Department of Health issues guidance on the form and content of the annual Quality Account, which has been included in this Quality Account.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered 2017-18
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with Department of Health guidance.

The Trust Board of Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Trust Board

Richard Fraser
Chairman

Ann Marr
Chief Executive

DRAFT

4.2. Written statements by other bodies

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

DRAFT

4.2.2. Halton Borough Council

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

Our Ref	DD/STHK
If you telephone please ask for	Debbie Downer
Your ref	
Date	14th May 2018
E-mail address	Debbie.downer @halton.gov.uk

Dear Ann,

Quality Accounts 2017 - 2018

Further to receiving a copy of your draft Quality Accounts and the Joint Quality Accounts event held on 10th May that your colleagues Sue Redfern and Anne Rosbotham-Williams attended to present a summary of your Quality Accounts, I am writing with the Health Policy and Performance Board comments. The Health Policy and Performance Board particularly noted the following key areas:

During the year 2017/18 the Board were pleased to note that the Trust made progress against the following priorities;

- Reduce by 50% in the next three years, avoidable harm from medication incidents and working towards achievement relating to falls prevention.
- The redesign of the process for learning from incidents and complaints.
- Improvement in the effectiveness of discharge planning.

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

- There were no hospital acquired grade three and four pressure ulcers.
- Patients received 98.9% harm-free care during 2017-18.
- Continued reduction in the number of Clostridium Difficile infections, performing significantly better than the threshold.

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

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

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Communities Directorate
Runcorn Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD
Tel: 0151 907 8300
www.halton.gov.uk

The Board are pleased to note the following Improvement Priorities for 2018 – 2019:

- Reduce further the rate of avoidable harm from falls, pressure ulcers and medication incident.
- Implement change as a result of lessons learned from incidents and complaints.
- Implementation of an electronic system (SafeCare) to ensure optimal deployment of nursing resources.
- Improve the effectiveness of discharge planning.

The Board were interested to hear about how stroke patients are being offered telemedicine and how the service will expand in future.

The Board would like to thank St Helens and Knowsley Teaching Hospitals NHS Trust for the opportunity to comment on these Quality Accounts.

Yours sincerely,

Councillor Joan Lowe
Chair, Health Policy and Performance Board

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Communities Directorate
Runcorn Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD
Tel: 0151 907 8300
www.halton.gov.uk

4.2.3. St Helens Clinical Commissioning Group and Knowsley Clinical Commissioning Group

Nutgrove Villa
Westmorland Road
Huyton
Liverpool
Merseyside
L36 6GA

0151 244 4126

21st May 2018

Ann Marr
Chief Executive
St Helens and Knowsley Teaching Hospitals NHS Trust
Warrington Road
Prescot. L35 5DR

Dear Ann

NHS Knowsley Clinical Commissioning Group and NHS St Helens Clinical Commissioning Group welcome the opportunity to comment on the St Helens and Knowsley Teaching Hospitals NHS Trust Quality Account for 2017/18.

The CCGs commend the Trust on its achievements in 2017/18 including:

a) Best score nationally for staff recommending the Trust as a place to receive treatment and work.
b) Best acute Trust nationally in the Patient Led Assessments of the Care Environment (PLACE) with top marks in the country for every area of the 2017 inspection.
c) 98.9% harm free care.
d) No grade 3 or 4 pressure ulcers.
e) Reduced number of harms from falls.
f) Reduced number of complaints and improved response times.
g) Clostridium difficile infections significantly below threshold.

This Account indicates the Trust's commitment to improve the quality of the services it provides and supports the key priorities for improvement of quality during 2017/18. Commissioners note the 2018/19 priorities of which some are carried over from 2017/18 are:

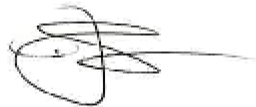
Priority 1: Reduce further the rate of avoidable harm from falls, pressure ulcers and medications incidents.
Priority 2: Implement changes as a result of lessons learned from incidents and complaints.
Priority 3: Make the most effective use of the skills of the nursing workforce.
Priority 3: Improve the effectiveness of discharge planning

The Care Quality Commission (CQC) rating of Good from the latest report (2016) is to be commended and Commissioners recognise the work undertaken by the Trust to address those areas identified as requires improvement. The Quality Account would benefit if this work was emphasised at the beginning of the report alongside the areas of outstanding work.

The CCGs acknowledge progress by the Trust in relation to Learning from Deaths and look forward to strengthened reporting in 2018/19 in-line with the National Quality Board guidance to demonstrate this learning and improvements in practice.

NHS Knowsley Clinical Commissioning Group and NHS St Helens Clinical Commissioning Group will continue to monitor St Helens and Knowsley Teaching Hospitals NHS Foundation Trust through the Clinical Quality and Performance Group meetings to gain assurance that the quality and safety of services delivered to patients continues to improve and that effective governance processes are in place and embedded throughout the organisation.

Yours sincerely



DIANNE JOHNSON
CHIEF EXECUTIVE
NHS KNOWSLEY
CLINICAL COMMISSIONING GROUP

SARAH O'BRIEN
CLINICAL ACCOUNTABLE OFFICER
NHS ST HELENS CLINICAL
COMMISSIONING GROUP

4.2.4. Halton Clinical Commissioning Group

Halton Clinical Commissioning Group

First Floor
Runcorn Town Hall
Health Road
Runcorn
WA7 5TD

Tel: 01928 593479
www.haltonccg.nhs.uk

Mrs A Marr
Chief Executive
St Helens & Knowsley Hospitals NHS Trust
Warrington Road
Prescot
Merseyside
L35 5DR

21st May 2018

Dear Ann,

Quality Accounts 2017 - 2018

I am writing to express my thanks for the submission of St Helens and Knowsley Teaching Hospitals NHS Trust Quality Report for 2017-2018 and for the presentation given by Sue Redfern, Chief Nurse to local stakeholders on 8th May 2017. This letter provides the response from NHS Halton Clinical Commissioning Group.

The Quality Account accurately reflects the performance of the trust during 2017/18 and clearly sets out the priority areas for 2018/19, with rationale and monitoring for each priority for the coming year; it is good to see that the Trust have set ambitious targets for quality improvement. There is evidence of progress and achievements since the 2017/18 quality account and quality targets were exceeded. Examples of patient safety were seen:

- The Trust was awarded Best Improvement in Patient Safety for electronic modified early warning system (eMEWS) at the Informatics Skills Development conference in Blackpool. It was also shortlisted for the HSJ Awards in the "Using Technology to Improve Efficiency" category
- Patients received 98.9% new harm-free care during 2017-18. This is harm occurring whilst an inpatient in the Trust and reported via the NHS Safety Thermometer
- No patients experienced a hospital acquired grade 3 or 4 pressure ulcer
- Continued to reduce the number of Clostridium Difficile infections, performing significantly better than the threshold
- Reductions in incidents resulting in harm from 2013-14 benchmarks (Sign up to Safety)
- 31% reduction in theatre-related episodes of moderate/severe harms
- 59% decrease in prescribing incidents resulting in harm
- 17% decrease in falls incidents resulting in harm
- 93.9% fill rate for registered nurses/midwives [Feb 2018]
- 87% of frontline staff received the flu vaccination

There is strong evidence in this year's account regarding the involvement, engagement and commitment of staff in developing the priority areas for the 2018/19 and it is clear that front line staff have been pivotal to the previous year's success and this should be commended

and there is strong evidence of patient engagement and involvement some examples noted were:

- Best acute trust nationally in the Patient Led Assessments of the Care Environment (PLACE) with top marks in the country for every area of the 2017 inspection; cleanliness, food, privacy and dignity, facilities for patients living with dementia and disabilities, condition, appearance and maintenance of the hospital buildings
- 95.8% of inpatients would recommend our services, as recorded by the Friends and Family Test [at end of February 2018)
- Patients rated the Trust 8.9 out of 10 for overall care in cancer, above the national average

There is an open and honest reporting culture and a robust governance structure surrounding quality within the organisation. Commissioners recognise the Trusts commitment to patient and carer involvement and engagement to ensure continual improvement in quality care and patient experience and the Volunteer support was a particular area of praise from stakeholders.

The annual staff awards and annual Learning and Development Awards demonstrated recognition of the hard work and commitment of frontline staff and the staff feedback is testament to a positive organisational culture with examples seen:

- Extremely positive national staff survey results, published in March 2018, with the Trust rated as the best place to work in the NHS. The Trust scored above the national average in 27 of the 32 indicators and achieved the highest score for 10 of the 32, including the following areas:
  - Staff recommendation of the organisation as a place to work or receive treatment
  - Percentage of staff who feel able to report errors, near misses or incidents witnessed in the last month
  - Effective use of patient/service user feedback
  - Fewest number of staff feeling unwell due to work related stress in last 12 months
  - Quality of non-mandatory training, learning and development

Involvement in both National and local audit is evident, as is learning and embedding new practice as a result of audit with some examples noted:

- Trust rated 2nd in the UK overall in the latest Sentinel Stroke National Audit Programme (SSNAP) delivering sustained excellent performance with all domains achieving 'A' (Excellent) or 'B' (Good) ratings
- 99% of electronic E-attendance summaries sent for patients attending the Emergency Department (ED) within 24 hours [at February 2018)
- 90.3% of stroke patients spent at least 90% of their hospital stay on a stroke unit

NHS Halton CCG noted the Trusts Improvement Priorities for 2018 – 2019:

1. Patient Safety
   - Reduce further the rate of avoidable harm from falls, pressure ulcers and medication incidents
   - Implement change as a result of lessons learned from incidents and complaints
   - Maintain effective assessment and monitoring of all patients in the Emergency Department

2. Clinical Effectiveness
   - 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
   - Further embed the seven day services clinical standards across the trust

3. Patient Experience
    - Improve the effectiveness of discharge planning
    - Increase the percentage of e-discharge summaries sent within 24 hours to 85%

NHS Halton CCG recognises the challenges for providers in the coming year but we look forward to working with the Trust during 2018-2019 to deliver continued improvement in service quality, safety and patient experience and also on the partnership work as we move forward with our One Halton model of service delivery.

NHS Halton CCG would like to congratulate the trust on the hard work of its staff and their commitment to the care of the people of Halton thanking local staff and managers for their on-going commitment locally and for the opportunity to comment on the draft Quality Account for 2017/2018.

Yours sincerely,

Michelle Creed
Chief Nurse

4.2.5. Independent Auditor

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4.3. Amendments made to the Quality Account following feedback and written statements from other bodies

Section	Amendment
2.1.1	Included average length of stay for non-elective admissions
2.1.2	Expanded the section regarding maintaining high quality care in the context of increased demand and recruitment challenges
2.2	Included the rate of serious incidents reported in the Emergency Department
	% of e-discharge summaries sent within 24 hours added
2.3	Included rationale for setting target for e-discharge summaries at 85%
3.4.2	Expanded the complaints section to clarify that staff will attempt to rectify concerns at a local level prior to a complaint being made and that the number of PALS contacts in 2017-18 has significantly increased, whereas formal complaints has fallen
2.4.12	Number of thromboses included in section on VTE risk assessments

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4.4. Abbreviations

AMU	Acute Medical Unit
AKI	Acute kidney injury
ANTT	Aseptic Non-Touch Technique
AQ	Advancing Quality
AQuA	Advancing Quality Alliance
BAPEN	British Association of Parenteral and Enteral Nutrition
BONE	British Orthopaedic Network Environment
BOTA	British Orthopaedic Trainees Association
BSI	Blood stream infection
BSR	British Society for Rheumatology
BTS	British Thoracic Society
CEM	College of Emergency Medicine
CAMHS	Child and adolescent mental health services
CCGs	Clinical Commissioning Groups
COPD	Chronic Obstructive Airways Disease
CPE	Carbapenemase-producing Enterobacteriaceae
CQC	Care Quality Commission
CQuIN	Commissioning for Quality and Innovation
CRN	Clinical Research Network
DATIX	Integrated Risk Management, Incident Reporting, Complaints Management System
DMOP	Department of Medicine for Older People
ED	Emergency Department
EDMS	Electronic Document Management System
EDS or EDS2	Equality Delivery System
eMEWS	Electronic Modified Early Warning Score
eRS	Electronic referral system
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends & Family Test
GNBSIs	Gram-negative bloodstream infections
GP	General Practitioner
GI	Gastro-intestinal
GIRFT	Get it right first time
HCAI	Healthcare associated infections
HES	Hospital Episode Statistics
HF	Heart Failure
HSCIC	Health and Social Care Information Centre
HSMR	Hospital standardised mortality ratio
HWWB	Health, Work and Well-being
IBD	Inflammatory Bowel Disease
iBRA	Implant Breast Reconstruction Audit
ICD	International Classification of Diseases
ICNARC	Intensive Care National Audit & Research Centre
ICO	Information Commissioner's Office
IGT	Information Governance Toolkit

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IQILS	Improving quality in liver services
ISS	Injury severity score
LGBT	Lesbian, gay, bisexual, transgender
LTC	Long-term condition
MARAC	Multi-Agency Risk Assessment Conferences
MBRRACE-UK	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK
MDS	Myelodysplastic Syndromes
MET	Medical Emergency Team
MINAP	Myocardial Ischaemia National Audit Project
MODSS	Multidisciplinary Obstetric Drills, Skills, and Simulation
MRSA	Methicillin-resistant staphylococcus aureus
NAOGC	National Audit Oesophago-Gastric Cancer
NBOCAP	National Bowel Cancer Audit Programme
NCAA	National Cardiac Arrest Audit
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCPES	National Cancer Patient Experience Survey
NDA(A)	National Diabetes Audit Adult
NDFA	National Diabetes Foot Care Audit
NELA	National Emergency Laparotomy Audit
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NIV	Non-invasive ventilation
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NNAP	National Neonatal Audit Programme
NPCA	National Prostate Cancer Audit
NPID	National Pregnancy in Diabetes
NPSA	National Patient Safety Agency
NRLS	National Reporting Learning System
OCS	Order Comms System
OGU	Obstetric, gynaecology and urology
PALS	Patient Advice and Liaison Service
PbR	Payment by Results
PEG	Percutaneous Endoscopic Gastrostomy
PLACE	Patient-Led Assessments of the Care Environment
PNDA	Paediatric National Diabetes Audit
PPE	Personal protective equipment
PROMs	Patient Reported Outcome Measures
PU	Pressure ulcer
RACPC	Rapid Access Chest Pain Clinic
RCA	Root Cause Analysis
RCEM	Royal College of Emergency Medicine
RDI	Research Development and Innovation
ReDEFINe	Rotational Delivery at Full Dilatation
RMS	Referral Management System
RPG	Research Practitioner Group
SAMBA	Society for Acute Medicine (SAM) Benchmarking Audit

SAH	Subarachnoid haemorrhage
SEQOHS	Safe Effective Quality Occupational Health Services
SHMI	Summary Hospital-level Mortality Indicator
SIRO	Senior Information Risk Owner
SPiRE	Saving Babies' Lives Project Impact and Results Evaluation
SSI	Surgical site infections
SSNAP	Sentinel Stroke National Audit Programme
STP	Sustainability and Transformation Plan
SUS	Secondary Uses Service
TARN	Trauma Audit & Research Network
TDA	Trust Development Authority
TIA	Transient Ischaemic Attack
VTE	Venous Thromboembolism

DRAFT

TRUST BOARD

Paper No: NHST(18)51
Title of paper: Board and Committee Effectiveness Review – Revised Terms of Reference (ToR)
Purpose: To provide the Board with a pack of revised Board and Committee ToR that reflect the outcomes of the 2017-18 meeting effectiveness review process.
Summary: 1. The annual effectiveness review of the Board and its Committees has been undertaken in the last 3 months, reflecting the meetings that took place in 2017-18. 2. The detailed review of each committee has or will be reported at its next scheduled meeting, and a summary of the findings of each review has been reported to the Audit Committee. 3. The conclusion of the reviews is that the purpose, remit and organisation of the Trust Board and its Committees remain fit for purpose and provides the assurance that the Trust is effectively and appropriately managed. This evidence supports the development of the Annual Governance Statement. 4. The final part of this review is the issuing of revised ToR for each forum incorporating any agreed changes. 5. The changes ensure that as a whole the Board governance structure remains comprehensive and there are clear lines of accountability.
Trust objective met or risk addressed: Supports the Trust to maintain effective systems of governance to meet best practice and regulatory requirements
Financial implications: None directly from this report.
Stakeholders: Directors, Staff, Patients, Regulators and other stakeholders.
Recommendation(s): To approve the updated ToR which reflect the outcomes of the Board effectiveness review.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 30th May 2018.

GOVERNANCE STRUCTURE 2018-19

MEETING GOVERNANCE STRUCTURE

(May 2018)

- **TRUST BOARD**
  - Audit Committee
  - Executive Committee
    - Care Group Team to Team
    - Clinical Directors Forum
    - Management Info. & Technology Group
    - Specific Care Group project meetings
    - Risk Management Council
      - Claims Governance Group
      - Information Governance Group
      - Major Incident Planning Group
  - Clinical Commissioning Groups
  - Clinical Quality Performance Group
  - Health Information Strategy Board
  - PFI Liaison Committee
  - NHSI Progress Review Meeting
  - Premium Payment Scrutiny Council
  - Finance & Performance Committee
    - Procurement Council
    - Cost Improvement Programme Council
  - Remuneration Committee
  - Quality Committee
    - Clinical Effectiveness Council
      - Cancer Group
      - Clinical Audit Group
      - Clinical Outcomes Group
      - Drug & Therapeutic Group
      - Improving Outcomes Group
      - MET Group
      - Mortality Surveillance Group
      - Organ Donation Group
      - Pathology Quality Group
      - Research & Development Group
      - Resuscitation Group
      - Thrombolysis-Group
      - Trauma Audit & Research Network Group
    - Patient Experience Council
      - Chaplaincy Group
      - End of Life Steering Group
      - Learning Disability Pathway Group
      - Mental Capacity Act Implementation Group
      - Supported Discharge Steering Group
      - Volunteers Group
    - Workforce Council
      - AHP etc Professional Standards Group
      - Clinical Education Group
      - Equality & Diversity Steering Group
      - Health & Safety-Group
      - HR Policy Sub-Group
      - Joint Negotiation & Consultative Group
      - L&D Steering Group
      - Lead Employer Local Consultative Group
      - Local Trust Negotiating Group
      - Medical & Dental Professional Standards Group
      - Medical Revalidation Steering Group
      - Nursing Professional Standards Group
      - Valuing our People Steering Group
    - Patient Safety Council
      - Blood Transfusion Group
      - Decontamination Group
      - Hospital Infection Prevention Group
      - Medical Devices Group
      - Safeguarding Adults Steering Group
      - Safeguarding Childrens Steering Group
      - Strategic Falls Group
      - Tracheostomy Steering Group
  - Charitable Funds Committee

-

TERMS OF REFERENCE 2018-19

TRUST BOARD – Terms of Reference (2018-19)	
Authority	St Helens and Knowsley Teaching Hospitals NHS Trust (the Trust) is a body corporate which was established under the St Helens and Knowsley Hospital Services National Health Service Trust (Establishment) Order 1990 (SI 2446) amended by 1999 (No 632) (the Establishment Order). The principal place of business of the Trust is the address as per the establishment order. The terms under which the Trust Board operates are described in the Standing Orders section of the Corporate Governance Manual (section 7.3).
Delegated **Authority**	The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, and their specific executive powers shall be approved by the Board, and appended within the Corporate Governance Manual. The Board has delegated authority to the following Committees of the Board i) Audit Committee ii) Remuneration Committee iii) Quality Committee iv) Finance & Performance Committee v) Charitable Funds Committee vi) Executive Committee
Agendas	The Board will have a forward work programme for the ensuing year that provides an outline plan for reporting throughout the year. This will include items on quality, performance and statutory compliance as well as reports from the Trust's Committees where more in-depth scrutiny of items has occurred in the presence of both Non-Executive and Executive Directors. This does not prevent agenda items being added as required and may result in items being deferred to another month if the agenda becomes too congested. A Board member desiring a matter to be included on an agenda shall make their request to the Chairman 10 days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman. Where a petition has been received by the Trust the Chairman of the Board shall include the petition as an item for the agenda of the next Board meeting.
Accountability and reporting	All ordinary meetings of the Board are open meetings which members of the public can attend to observe the decision-making process of the Trust. They are

	not open meetings where the public have a right to contribute to the debate, however, contributions from the public at such meetings can be considered at the discretion of the Chairman. Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked ‘In Confidence’ or minutes headed ‘Items Taken in Private’ outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers. Exceptionally, there may be items of a confidential nature on the agenda of these ordinary meetings from which the public may be excluded. Such items will be business that: i) relate to a member of staff, ii) relate to a patient, iii) would commercially disadvantage the Trust if discussed in public, iv) would be detrimental to the operation of the Trust.
Review	In March each year the Board will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the ToR.
Membership	**Core Members (voting)** Non-Executive Chairman (chair) 5 Non-executive Directors (one of which will be appointed Vice Chair, and one appointed Senior Independent Director) Chief Executive 4 Executive Directors (to include Director of Finance, Medical Director, Nursing Director plus one other. One to be the nominated Deputy Chief Executive) Collective Responsibility - Legally there is no distinction between the Board duties of Executive and Non-Executive Directors; both share responsibility for the direction and control of the organisation. All Directors are required to act in the best interest of the NHS. There are also statutory obligations such as quality assurance, health and safety and financial oversight that Board members need to meet. Each Board member has a role in ensuring the probity of the organisation’s activities and contributing to the achievement of its objectives in the best interest of patients and the wider public. <u>In attendance</u> The Board shall be able to require the attendance of any other Director or member of staff.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year.

Quorum	50% of the core membership must be present including at least one Executive Director and one Non-Executive Director.
Meeting Frequency	The Trust Board will meet monthly (with the exception of August and December). All meetings will have public and private elements.
Agenda Setting and papers	Minute production and distribution is via the office of the Director of Corporate Services. Documents submitted to the Trust Board should be in line with the corporate standard.

REMUNERATION COMMITTEE – Terms of Reference (2018/19)	
Delegated Authority	The Trust shall establish a Committee to be known as the Remuneration Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee is authorised to make recommendations to the Trust Board on the appropriate remuneration and terms of service for the Chief Executive and Executive Trust Directors and Associate Directors with due regard to market rates, NHS wide guidance, affordability and equal value.
Terms of Reference	The Committee will undertake the following duties: 1. To receive and consider information and advice from the Chief Executive on the levels of remuneration for individual Directors taking into account internal relativities, the particular contribution and value of individual Directors and affordability. 2. To consider the level of remuneration for the Chief Executive taking into account the above factors. 3. To receive and consider external information on the wider pay scene including: - Guidance on Executive remuneration from the Department of Health. - The levels of Executive remuneration offered by similar NHS organisations. - Consideration of the environment in which the organisation is operating. 4. To advise and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate including the approval process for: - Redundancy payments made to Chief Executives and Directors. - Redundancy payments in excess of £50,000 made to all other staff. - Special payments, i.e. any severance payments exceeding contractual obligations (or exceeding 3-months pay in lieu of notice). 5. Ratify the appointment of new Directors and approve the remuneration and terms of service if outside the parameters agreed for previous appointments to the role.
Review	In March each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	Core Members Membership will comprise the Chairman and all Non-Executive Directors. In attendance

	The Chief Executive (except during discussions about his /her remuneration or terms of service) shall normally attend meetings. The Director of Human Resources shall be Secretary to the Committee and shall attend to take minutes of the meeting. The Chairman may co-opt other members, such as the Director of Finance, as appropriate, in order to assist the Committee in meeting its objectives.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible, - Contribute fully to discussion and decision-making, - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	The Remuneration Committee would be considered quorate when the Trust Chair or Vice Chair plus 3 Non-Executive Directors are in attendance.
Accountability & Reporting	The Remuneration Committee is a Non-Executive function and its decisions must be agreed by a majority of the Non-Executive Directors and reported in accordance with the Trust's publication scheme, via the annual report and accounts.
Meeting Frequency	The Committee will meet at least once a year. Meetings may be convened with the agreement of all members at any time.
Agenda Setting and papers	The Director of Human Resources will be responsible for all administrative arrangements.

AUDIT COMMITTEE – Terms of Reference (2018-19)	
Delegated Authority	The Trust shall establish a Committee to be known as the Audit Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Board may request the Committee to review specific issues where the Board requires additional scrutiny and assurance.
Role	The Committee shall review the establishment and maintenance of an effective system of integrated governance internal control and risk management across the whole of the organisations clinical and non-clinical activities, that support the achievement of the Trust's objectives.
Duties	The Committee will undertake the following duties: <u>Internal Control and Risk Management</u> 1. In particular the Committee will review the adequacy of: - All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board. - The structures, processes and responsibilities for identifying and

	managing key risks facing the organisation. - The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any other reporting and self-certification requirements. - The operational effectiveness of policies and procedures - The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Directorate of Counter Fraud Services. 2. The Committee will: - Provide an overview of the effectiveness of the assurance framework; - Provide an oversight role in respect of the governance structure and the linkages with other committees; - Consider the findings of other significant assurance functions (e.g. regulators, professional bodies, external reviews); - Review the arrangements and their effectiveness for which staff may raise, in confidence, any concerns; - Ensure there is a clear policy for the engagement of internal and external auditors to supply non-audit services, to ensure auditor independence and objectivity; - Review the work of other Trust Committees whose work will provide relevant assurance to the Audit Committee's own areas of responsibility; - Request and review reports, evidence and assurances from Directors and managers on the overall arrangements for governance, risk management and external control. <u>Internal Audit</u> 3. To consider the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal. 4. To review the internal audit programme, consider the major findings of internal audit investigations (and management's response), and ensure coordination between the Internal and External Auditors. 5. To ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation. <u>External Audit</u> 6. Establish an auditor panel with formal terms of reference to consider the appointment of the External Auditor and to ensure the on-going independence of the Auditor, making recommendations to the Trust Board. (See Appendix A.) (The Audit Committee should assess a prospective auditor panel member's independence by considering whether his or her circumstances could affect his or her judgement and by a number of factors – for example, recent employment with the Trust, close family ties to its directors, members, advisors or senior employees or a material business relationship with the Trust.) 7. Consider the audit fee, as far as the rules governing the appointment permit, and make recommendation to the Board when appropriate. 8. Discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with other External Auditors in the local health community. 9. Review External Audit reports, including value for money reports and annual audit letters, together with the management response. 10. Review the adequacy and effectiveness of statements within the quality account together with the external audit assurance.

	11. Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-statutory audit work including the pre-approval by the Audit Committee's Auditor Panel for this work. Financial Reporting and Governance 12. Review the annual report and financial statements before submission to the Board, focusing particularly on: - The Annual Governance Statement; - Changes in, and compliance with, accounting policies and practices; - Unadjusted mis-statements in the Financial Statements; - Letters of representation; - Major judgemental areas, and; - Significant adjustments resulting from the audit. 13. Consider any proposed changes to Standing Orders and Standing Financial Instructions and to the Scheme of Reservation and Delegation of Powers including delegated limits and make recommendations to the Trust Board. (NB. All of these are incorporated within the Trust's Corporate Governance Manual.) 14. Consider any proposed changes to the Trust's Standards of Business Conduct Policy and Anti-Fraud, Bribery and Corruption Policy and make recommendations to the Trust Board. 15. Review responsibilities in respect of the appropriate processes and compliance with Standing Orders for the use of the seal (delegated from the Board), tender waivers, losses and special payments, and aged debt, gifts and declarations of interests.
Review	Terms of reference and effectiveness of the Committee will be reviewed annually each February and included in the report to the Board.
Membership	Core Members The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than 3 members. In attendance The Director of Finance, the Head of Internal Audit and a representative of the External Auditors shall normally attend meetings. However at least once a year the Committee may wish to meet with the External and Internal Auditors without any Executive Board Director present. The Committee shall be able to require the attendance of any other Director or member of staff. Specifically, the Committee should consider inviting the Chief Executive to attend the Audit Committee to discuss the Annual Governance Statement and Internal Audit Plan.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible, - Contribute fully to discussion and decision-making, - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	A quorum shall be 2 members.
Accountability & Reporting	The council reports to the Trust Board and a written summary of the latest meeting is presented to the next Board meeting by the Audit Committee Chair.

Meeting Frequency	Meetings shall be held not less than three times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Director of Finance and Information. Documents submitted to the Committee should be in line with the corporate standard.

QUALITY COMMITTEE – Terms of Reference (2018-19)	
Delegated Authority	The Trust shall establish a Committee to be known as the Quality Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to quality of services and subsequent risk to patients. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported to the Board for approval before action. The Board may request the committee to review specific aspects of quality performance where the Board requires additional scrutiny and assurance.
Role	To enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to: 1. Promote safety and excellence in patient care 2. Identify, prioritise and manage risk arising from clinical care 3. Ensure the effective and efficient use of resources through evidence-based clinical practice 4. Protect the health and safety of Trust employees 5. Ensure compliance with legal, regulatory and other obligations.
Duties	The Committee will undertake the following duties:- 1. To provide assurance to the Board on the delivery of the Trust's Clinical and Quality Strategy, based on the Trust's vision for 5-star patient care, through scrutiny of relevant quality indicators in the IPR 2. To monitor the Trust's performance against other internal and external quality targets via the IPR and to advise the Board of relevant actions if performance varies from agreed tolerances 3. To take appropriate action to address any under-performance, initiating and monitoring quality improvement programmes, and where necessary escalating issues to the Board 4. To oversee the production of the Annual Quality Account and review the final draft prior to submission to the Board for approval 5. To provide assurance on the delivery of the agreed Annual Quality Account priorities through Council reports 6. To approve policies and procedures in respect of quality and if necessary make recommendation to the Board 7. To set the ToR including the annual work programme for the reporting Councils, ensuring that the governance of all relevant aspects of quality is delegated appropriately 8. To receive assurance reports from the Council chairs following each

	meeting of the Councils and to request in-depth reviews or commission independent audits where necessary. In addition, to receive annual reports prior to submission to the Board, e.g. complaints, infection control, safeguarding, medicines management, mixed-sex declaration, clinical audit programme, and medical revalidation 9. To undertake any reasonable quality related reviews as directed by the Board or initiated from work of the Committee or its Councils. 10. To provide assurance that appropriate governance structures, processes and controls are in place through reviewing relevant internal and external reports (including CQC recommendations and compliance, national patient surveys) and assessing the Trust's performance against each.
Review	In February of each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	**Core Members** Non-Executive Director (chair) Non-Executive Directors x 2 Chief Executive Director of Human Resources /Deputy CEO Director of Finance Medical Director Director of Nursing & Midwifery Director of Operations & Performance Divisional Medical Directors The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. In attendance- In addition to formal members the Care Group Heads of Nursing and Quality, Deputy Medical Director, Assistant Director of Clinical Improvement, Deputy Director of Nursing & Quality, Deputy Director of Human Resources and any Assistant Director of Operations, may be in attendance. The Committee shall be able to require the attendance of any other Director or member of staff. Members are selected for their specific role or because they are representative of a professional group or Department. As a result members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making, and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and one Non-Executive Director.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet monthly each year with the exception of August and December.
Agenda	Agendas agreed by the Chair will be in the accordance with the annual reporting

Setting and papers	schedule of the Committee. Minute production and distribution is via the office of the Director of Nursing, Midwifery and Governance. Documents submitted to the Committee should be in line with the corporate standard.

FINANCE & PERFORMANCE COMMITTEE – Terms of Reference (2018 -19)	
Delegated Authority	The Trust shall establish a Committee to be known as the Finance and Performance Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to financial and operational performance and subsequent risk of the Trust. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported for approval before action. The Board may request the Committee to review specific aspects of financial or operational performance where the Board requires additional scrutiny and assurance.
Role	To enable the Board to obtain assurance that the Trust has robust activity and financial plans in place to meet both short and long-term sustainability objectives, and maintain the Trust as a going concern. To contribute to the overall governance framework, and support the development and maintenance of effective financial and performance governance arrangements throughout the Trust to promote the efficient and effective use of resources and identify, prioritise and manage risk from Trust activities.
Duties	The Committee will undertake the following duties:- 1. To review and make recommendations to the Board on the annual financial and business plan and the assumptions which underpin it, and the Trust's longer-term financial and operational strategies 2. To review the performance of the Trust against all elements of the Trust finance and activity objectives via the monthly Finance and Performance Report. To make recommendations to the Board on key risks, and actions to ensure the Trust performs to the optimum level and operates within the resources available 3. To oversee the Trust's commercial strategy and oversee the further development of Service Line Management to contribute towards effective decision making underpinning service developments and market strategy 4. To review proposed cost improvement programme and to monitor implementation and report, to the Board, proposals for corrective actions considered if required 5. To monitor the financial and non-financial benefits realisation from approved business cases to provide assurance of a return on investment 6. To approve policies and procedures in respect of finance and performance and if necessary make recommendation to the Board 7. Based on forecast resources available, to review the capital programme and to monitor progress against it 8. To review and monitor progress with annual contract negotiations and the impact on Trust sustainability; escalating any concerns to the Board 9. To consider relevant central guidance, benchmarking reports, reference costs or consultations and where appropriate make recommendations to the Board 10. To set the ToR including the annual work programme for the reporting

	Councils, ensuring that the governance of all relevant aspects of finance and performance is delegated appropriately 11. To receive assurance reports from the Council chairs following each meeting of the councils and to request in-depth reviews or commission independent audits where necessary. In addition, to receive annual reports prior to submission to the Board, e.g. Annual Accounts, and Strategic Plans 12. To undertake any reasonable finance and performance related reviews as directed by the Board or initiated from work of the Committee or its Councils 13. To provide assurance that appropriate governance structures, processes and controls are in place through reviewing relevant internal and external reports (including Lord Carter and GIRFT report recommendations) and assessing the Trust's performance against each
Review	In February each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	**Core Members** Non-Executive Director (chair) Non-executive Director x 2 Director of Finance Medical Director Director of Operations & Performance The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. In attendance- In addition to formal members the Deputy Director of Finance, Assistant Director(s) of Finance and nominated deputy to the Director of Ops may be in attendance. The Committee shall be able to require the attendance of any other Director or member of staff. Members are selected for their specific role or because they are representative of a professional group or Department. As a result members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making, and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and one Non-Executive Director.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet monthly each year with the exception of August and December.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Director of Finance and Information. Documents submitted to the Committee should be in line with the corporate standard.

CHARITABLE FUNDS COMMITTEE – Terms of Reference (2018-19)	
Delegated Authority	The Trust shall establish a Committee to be known as the Charitable Funds Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee has no executive powers other than those specifically delegated in these terms of reference.
Terms of Reference	The Committee will oversee the administration of charitable funds in line with the Charities Commission requirements and relevant legislation. The Committee will undertake the following duties: • To manage the affairs of the St Helens and Knowsley Hospitals Charitable Fund within the terms of its declaration of Trust. • Develop policies in respect of the management of charitable funds including investments, donated income, spending, fundraising, use of reserves and other relevant matters. • Appoint an investment advisor to advise on investment arrangements for Charitable Funds. • Approval of expenditure requests in accordance with charitable funds expenditure approval procedures reviewing the financial position of charitable funds on at least a four monthly basis. • To ensure funding decisions are appropriate and are consistent with the St Helens and Knowsley Hospitals Charitable Fund objectives, to ensure such funding provides added value and benefit to the patients and staff of the trust, above those afforded by the Exchequer funds. • To implement as appropriate, procedures and policies to ensure that accounting systems are robust, donations received and coded as instructed and that all expenditure is reasonable, clinically and ethically appropriate. • To approve the annual accounts and report and to ensure that all relevant information is disclosed.
Review	Each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	Core Membership Core membership will comprise a Non-Executive Director who will chair meetings of the Committee; the Director of Finance or his nominated officer, two Trust senior officers (preferably clinical). In attendance The Charitable Funds Financial Accountant and Charitable Funds Officer will be in attendance. The Chairman and Chief Executive are invited to attend the Charitable Funds Committee at any time. Representatives of Internal and External Audit and other Trust Senior Managers may be invited to attend meetings in an ex-officio capacity. In addition, the Committee may establish appropriate working groups to consider specific issues on a project basis. The terms of reference of such groups will be agreed by the Committee with minutes of such groups presented to the Committee.
Attendance	Core Members are expected to attend a minimum of 60% of meetings per year. Members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible, - Contribute fully to discussion and decision-making,

	- If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	The Committee would be considered quorate with 50% attendance.
Accountability & Reporting	The Committee reports to the Trust Board and will provide a written report setting out the basis of recommendations made.
Meeting Frequency	The Committee will meet at least three times per year. Meetings may be convened with the agreement of all members at any time.
Agenda Setting and papers	The Director of Finance will be responsible for all administrative arrangements.

EXECUTIVE COMMITTEE – Terms of Reference (2018-19)	
Delegated Authority	The Trust shall establish a Committee to be known as the Executive Committee which will formally be constituted as a Committee of the Board.
Role	The Executive Committee meeting is established as the most senior executive forum within the Trust. This forum will be the final arbiter on all operational issues. The prime role of meetings is to consider the operational issues within the Trust along with the coordination of work programmes required to deliver the annual and strategic objectives of the organisation.
Duties	Duties of the Committee will include: 1. To review and approve business cases for the appointment of consultants and key Trust staff, or the creation of such posts 2. To review and approve business cases for new service developments, material expansion or reduction of existing services including capital developments (within the approved budgets or delegated authority of the Chief Executive), arising within year that cannot be accommodated within the annual planning process 3. To monitor the delivery and benefits realisation of approved business cases and service developments 4. To review and approve significant Tender documents submitted by the Trust 5. The management of issues with reputational and relationship management significance 6. The monitoring of Trust performance against all objectives, standards and targets including the development of any remedial actions 7. Receiving and considering the Chair's report from the Risk Management Council and other appropriate supporting groups 8. Governance matters including preparation and arrangements for regulatory review 9. Brief the Trust's senior managers on the business and decisions made at the Executive Committee
Review	In February each year the Committee will undertake an Annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	Core membership of the meeting will comprise: - Chief Executive (chair) - Deputy CEO/Director of Human Resources (vice chair)

	- Medical Director - Director of Nursing, Midwifery and Governance - Director of Finance and Information - Director of Operations & Performance - Director of Corporate Services - Director of Informatics. - Director of Transformation - Director of Estates and Facilities The attendance of deputies will not routinely be permitted, however attendance by Trust staff and stakeholders is envisaged for specific agenda items.
Attendance	Members are expected to attend a minimum of 70% of meetings. Members are expected to: - Ensure that they read papers prior to meetings - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress - Contribute fully to discussion and decision-making.
Quorum	A quorum will be 50% attendance. Where a decision is to be taken with financial consequences, the delegated authority for expenditure as contained in the Trust's Standing Financial Instructions must be adhered to.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	Meetings will be scheduled weekly on a Thursday.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the Trust office secretariat under the direction of the EA to the Chief Executive. Documents submitted to the Committee should be in line with the corporate standard.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(18)52
Title of paper: Information Governance Annual Report (inc Freedom of Information Annual Report)
Purpose: To provide the Trust Board with assurance that St Helens & Knowsley Teaching Hospitals Trust operates within the parameters defined in the Information Governance Toolkit and have completed the annual submission to demonstrate such compliance.
Summary: Every year the Trust must demonstrate compliance with Information Governance requirements by completing the NHS Digital 'Information Governance Toolkit'. There is a requirement for all NHS organisations to meet the minimum of Level 2 across all requirements within the Toolkit. This Report summarises the Trust's Information Governance Toolkit submission for 2017/18 and looks ahead to 2018/19.
Corporate objectives met or risks addressed: Communications, Systems and Safety, Risk Management, Efficiency and Performance
Financial implications: None directly from this report.
Stakeholders: Staff, Patients, Executive Committee, Trust Board, Commissioners.
Recommendation(s): • The board to note and approve the content of this paper; • Be assured that robust arrangements are in place to effectively manage the Information Governance Agenda within the Trust.
Presenting officer: Dr Francis Andrews, Assistant Medical Director/Caldicott Guardian
Date of meeting: 30th May 2018

Introduction

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

St Helens & Knowsley Teaching Hospitals NHS Trust submits a yearly self-assessment to NHS Digital. Version 14.1 of the Information Governance Toolkit was released in June 2017. The Trust assesses itself against 45 criteria and evidence expectations have again risen considerably making it more difficult to achieve compliance.

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

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

Executive summary

An initial baseline assessment against all 45 requirements was submitted as required at the end of July 2017, with an action plan developed through to March 2018.

Mersey Internal Audit Agency (MIAA) has completed an audit of the Trust's Toolkit submission (as required of larger NHS organisations) during two visits in October 2017 and January 2018 to assess the Trust's compliance against these requirements. MIAA audited 15 of the 45 requirements. The audited requirements covered elements of; IG Management, Training, Information Sharing, Subject Access Requests, Information Flow Mapping, Information Risk Management, Information Security, Data Quality and Staff Awareness.

The Trust has subsequently received the audit report from MIAA – the Trust has maintained their rating of 'Significant Assurance', from the previous 5 year's submissions. This assurance rating once again demonstrates the Trust's commitment to the ever evolving Information Governance Agenda.

Significant Assurance

A final submission of the IG Toolkit was made in March 2018. Our submission shows the Trust score has increased slightly from 2016 - 2017. This is due to the Trust being able to increase its score in 1 requirement this year. This requirement relates to the work we have been doing to improve the security of our information flows (Req 308).

Version 14 2016 - 2017	Version 14.1 2017 – 2018
80%	81%

Senior Information Risk Owner Update (SIRO)

This section of the paper is designed to inform and give assurance to the Board of progress made against the Information Governance work programme for 2017/2018 and with the support of the Caldicott Guardian will outline the key priorities and associated work programmes for 2018/2019.

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

- Have a sufficient structure in place to ensure compliance with all elements of the Information Governance Agenda;

- Have an active and effective Information Governance Steering Group forum, meeting monthly;

- Manage and investigate any Information Governance / Confidentiality incidents and issues.

Role of the SIRO

Christine Walters, Director of Informatics is the Trust's registered SIRO. The role of SIRO at all NHS Trust's has been mandated since 2007, following significant data losses in the public sector.

The SIRO is required to be an Executive Director, Chief Information Officer or a Senior Manager with access to the Trust Board. Broadly; the SIRO's duties include; being accountable for information at the Trust, fostering a culture for protecting and using data, providing a focal point for managing information incidents, and being concerned with the management of all information assets.

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

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

Information Governance Aims

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

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

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

Information Governance Steering Group

The Information Governance Steering Group (IGSG) is a standing committee accountable to the Trust Risk Management Council and, ultimately, the Trust Board. The group which has been operational since January 2008, oversees the implementation of the IG Agenda throughout the organisation.

Its main purpose is to support and drive the broader Information Governance agenda and provide the Trust Board with the assurance that effective Information Governance best practice mechanisms are in place within the Trust.

The IGSG is chaired by the Trust Caldicott Guardian, with the Trust SIRO as Deputy. Core membership includes; Trust Directors and Assistant Directors, Heads of Quality, Heads of Service and Senior Managers.

This year's topics have been in relation to:

- IG Toolkit submission & Action Plans
- IG Issues
- Data Loss
- Data Protection Impact Assessments
- Cyber Security
- Staff Awareness
- Risk Register updates (standing Agenda item)
- Caldicott Issues Log Report (standing Agenda item)
- Data Quality
- Records Management
- Information Security
- Freedom of Information
- General Data Protection Regulation

Reportable Incidents

The Trust has a duty to internally report any incident regarding personal data, however minor. For the financial year 2017/2018 we reported one incident to the Information Commissioner's Office (ICO). The ICO returned to the Trust with the decision that the incident warranted no further action from them in their role as the regulatory body for data protection. This was due to the Trust's comprehensive response to the incident. Steps were also taken to minimise the chance of similar incidents occurring in the future.

March 31st 2018 IG Toolkit Submission

Version 14.1 of the IG Toolkit consists of 45 sequenced standards divided between six initiatives. Each of the questions is scored at a level ranging from 0 to 3 with 0 and 1 indicating non-compliance, 2 satisfactory compliance and 3 representing total compliance.

The overall percentage attainment level achieved by the Trust is based on the level of compliance with the sequenced standards in each of these initiatives between 1st April 2017 and 31st March 2018.

Overall Position

The Trust increased its IG Toolkit score to 81% from 2016-2017. Within the IG Toolkit, there are only 3 possible ratings; Satisfactory, Satisfactory with Improvement Plan, or Unsatisfactory. As with 2016-2017; the Trust once again received a 'Satisfactory' (Pass) rating for the IG Toolkit. This meant that the Trust had achieved at least Level 2 for all 45 requirements.

	31st March 2016 Annual Submission V.13	**31st March 2017 Annual Submission V.14**	**31st March 2018 Annual Submission V.14.1**
Overall Results	80% (Green)	80% (Green)	81% (Green)
	(45 out of 45 answered)	(45 out of 45 answered)	(45 out of 45 answered)

Submission

The Information Governance Steering Group was asked to approve and sign off the 31st March 2018 attainment levels in version 14.1 of the IG Toolkit prior to formal submission.

Progress Reporting

Progress against the IG Toolkit is monitored by the Head of Information Governance & Quality Assurance – Data Protection Officer (DPO) and the IG Steering Group.

A report on progress, prior to each submission, is presented by the Head of Information Governance & Quality Assurance – (DPO) to the IG Steering Group and subsequently to the Risk Management Council then ultimately to the Trust Board by the Senior Information Risk Owner and Caldicott Guardian.

Where standards were not being met action plans were prepared and were monitored to ensure improvement and compliance. As the Trust has declared that it is compliant with all of the requirements the RAG status for this report shows as Green ('Satisfactory').

Caldicott Guardian

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

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

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

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

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

The Caldicott Guardian is a vital source of guidance and expertise for the Head of Information Governance & Quality Assurance (DPO) and Team.

Issues for the coming year

However; there will be two main priorities for the Caldicott Guardian and the Information Governance Steering Group, going forward into 2018/2019:

The Information Governance Toolkit

The IG Toolkit has now been replaced by the new Data Security and Protection (DSP) Toolkit. The DSP Toolkit provides a new mechanism for organisations to assess themselves against the NDG 10 data security standards, through confirming assertions, and providing supporting evidence.

The requirements for the DSP Toolkit differ from those within the old IG Toolkit. An overview of the differences is provided below:

- The requirements of the DSP Toolkit are designed to encompass the 10 NDG Data Standards;

- The requirements of the Data Security and Protection Toolkit support key requirements under the General Data Protection Regulation (GDPR), identified in the NHS GDPR Checklist. This will assist the Trust with its progression towards GDPR compliance;

- The IG Toolkit assessed performance against three levels 1, 2 and 3. Organisations were required to evidence compliance with (at least) level 2 for all elements of their assessment. The DSP Toolkit does not include levels, and instead requires compliance with assertions and (mandatory) evidence items;

- The Assertions and Evidence items within the DSP Toolkit are designed to be concise and unambiguous. Documentary evidence is only requested where this adds value.

General Data Protection Regulation (GDPR)

The General Data Protection Regulation (GDPR) comes into force as UK law on 25th May 2018. It will replace the Directive that is the basis for the UK Data Protection Act 1998, which will be repealed or amended. It has been confirmed that the provisions of the GDPR will remain in force post-Brexit, and for the foreseeable future. Although in general the principles of data protection remain similar, there is a greater focus on evidence-based compliance with specified requirements for transparency, more extensive rights for data subjects and considerably harsher penalties for non-compliance.

It is equally important that organisations and senior management understand that this is not a change that can be managed solely within IG or IT. This is organisational-wide change which will potentially affect every facet of the Trust and will require buy-in and contributions from all teams and departments.

Great strides are being made against the Trust's Plan to ensure that the Trust is working towards compliance and a summary of the key actions completed are as follows:

1. The appointment of a suitably experienced and appropriately resourced Data Protection Officer (DPO).

    Response – The DPO is an essential role in facilitating 'accountability' and the organisation's ability to demonstrate compliance with the GDPR. The organisation must appoint a DPO whose job description is compliant with GDPR requirements.

    The Trust's Caldicott Guardian and Senior Information Risk Officer recommended that the Head of Information Governance be appointed into this role this appointment was approved at the April Executive Committee Meeting.

2. The recording of all data processing activities with their legal bases and data retention periods.

    Response – This is being addressed as part of the Trust's annual Information Flow Mapping exercise which will be completed alongside the Trust's IG Toolkit Submission for 2018/19.

3. Continue to build on existing good practice.

    Response – The Trust has just submitted its Information Governance Toolkit, which shows the Trust to be fully compliant in all areas and once again achieving a rating of "significant assurance" when audited by Mersey Internal Audit Agency. Work is underway to ensure that the Trust is suitably prepared for the release of the new Data Security and Protection Toolkit which as explained above replaces the outdated IG Toolkit in May 2018. A Gap Analysis has been presented to the IGSG and plans are in place to address areas that need to be strengthened.

4. Ensuring demonstrable compliance with enhanced requirements for transparency and fair processing, including notification of rights.

    Response – New fair processing notices have been devised and they were approved at the March IGSG. The fair processing notices are designed to explain to patients in clear language how the Trust uses their information and who it is shared with.

5. Provision of copies of personal data with accompanying supporting information free of charge.

    Response - Policies are being reviewed to ensure that we are able to meet our obligations in relation to requests for access to information.

6. Notification of personal data breaches within 72 hours to the Information Commissioner – unless the breach is unlikely to result in a risk to the rights and freedoms of the individual(s) in question.

    Response – The Trust has a robust process in place for assessing and reporting any data breaches that meet the reporting criteria to the Information Commissioners Office. This process is reviewed annually and involves the Deputy Chief Executive, Caldicott Guardian, SIRO and Head of IG/DPO.

7. Communication of a personal data breach to the data subject where it is likely to result in a high risk to their rights and freedoms.

    Response – The Trust has a robust process in place which was created by the Caldicott Guardian and has been reviewed in line with the new guidance issued. This process aligns itself to our new responsibilities under GDPR.

8. Provide more detailed information to key staff - Information Asset Owners, staff responsible for SARS, staff who deal with contracts, those likely to design and implement new ways of using data and Communications staff.

   Response – Meetings and training sessions have commenced with relevant workstream leads and the work around Information Asset Owner development is well underway.

9. Ensure that the Trust is able to demonstrate that it is working towards compliance and accountability.

   Response – The Trust has a detailed plan which shows how it is going to measure the journey through to transition. Management briefings are provided to help ensure that the Trust Board are equipped with the relevant information to understand the changes and implications for the organisation.

The message we want to give is that we are working towards compliance. GDPR isn't a world apart from existing data protection regulation. We are currently compliant with the law, and remain committed to the journey which will end in GDPR compliance but there are some additional things we must do.

Requirement Status

The below table provides a visual indication of the Trust's level of attainment for each requirement. The toolkit is made up of four levels of attainment as indicated below:

Attainment Level 0 = No controls in place
Attainment Level 1 = Limited controls in place
Attainment Level 2 = Satisfactory controls in place
Attainment Level 3 = Robust controls in place

- The Trust attained level 2 in 22 of the 45 requirements and level 3 in the remaining requirements.

- This places the Trust in the top quartile of performing Acute Trusts across Cheshire and Merseyside.

Requirement Status

Version 14.1 (2017/2018) Assessment	Description	Version 14 March 2017	Version 14.1 March 2018
Information Governance Management			
14-101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	3	3
14-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	3	3
14-110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	2	2
14-111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	2	2
14-112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	2	2
Confidentiality and Data Protection Assurance			
14-200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	3	3
14-201	The organisation ensures that arrangements are in place to support and promote information sharing for coordinated and integrated care, and staff are provided with clear guidance on sharing information for care in an effective, secure and safe manner	3	3
14-202	Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use of this information are appropriately respected	2	2
14-203	Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use	3	3

Version 14.1 (2017/2018) Assessment		Version 14 March 2017	Version 14.1 March 2018
	Description		
14-205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	2	2
14-206	Staff access to confidential personal information is monitored and audited. Where care records are held electronically, audit trail details about access to a record can be made available to the individual concerned on request	2	2
14-207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	2	2
14-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	2	2
14-210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	2	2
Information Security Assurance			
14-300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	3	3
14-301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	2	2
14-302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	3	3
14-303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	3	3
14-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	3	3
14-305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	2	2
14-307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	3	3

Version 14.1 (2017/2018) Assessment		Version 14 March 2017	Version 14.1 March 2018
	Description		
14-308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	2	3
14-309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	3	3
14-310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	3	3
14-311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	3	3
14-313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	3	3
14-314	Policy and procedures ensure that mobile computing and teleworking are secure	2	2
14-323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	2	2
14-324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	2	2
Clinical Information Assurance			
14-400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	2	2
14-401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	2	2
14-402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	2	2
14-404	A multi-professional audit of clinical records across all specialties has been undertaken	3	3
14-406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	3	3

Version 14.1 (2017/2018) Assessment		Version 14 March 2017	Version 14.1 March 2018
	Description		
Secondary Use Assurance			
14-501	National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop	3	3
14-502	External data quality reports are used for monitoring and improving data quality	2	2
14-504	Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	3	3
14-505	An audit of clinical coding, based on national standards, has been undertaken by a NHS Classifications Service approved clinical coding auditor within the last 12 months	3	3
14-506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	3	3
14-507	The secondary uses data quality assurance checks have been completed	2	2
14-508	Clinical/care staff are involved in validating information derived from the recording of clinical/care activity	2	2
14-510	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards	3	3
Corporate Information Assurance			
14-601	Documented and implemented procedures are in place for the effective management of corporate records	2	2
14-603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	3	3
14-604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	2	2

Freedom of Information Annual Report 2017/2018
(Full Report attached)

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

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

- the number of requests received between 1st April 2017 to 31st March 2018;
- source of request;
- type of request;
- monthly breakdown;
- year on year comparison.

The Trust continues to work towards compliance with the Freedom of Information Act 2000.

Conclusion

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

St Helens and Knowsley Teaching Hospitals NHS Trust

INFORMATION GOVERNANCE STEERING GROUP

Paper No: IGSG
Title of paper: Freedom of Information Annual Report
Purpose: To provide assurance that St Helens and Knowsley Teaching Hospitals NHS Trust strives to comply with the Freedom of Information Act.
Summary: This report is designed to give the Trust Board assurances that the Trust is compliant with Freedom of Information legislation. Statistical analysis of the requests and responses will be shown, comparing the year of the report (2017/2018) to previous years, where relevant.
Corporate objectives met or risks addressed: Systems, Communications
Financial implications: None directly from this report.
Stakeholders: Staff, Patients, Executive Committee, Trust Board, Commissioners.
Recommendation(s): The Group to note and approve the content of this report
Presenting officer: Dr Francis Andrews, Assistant Medical Director/Caldicott Guardian
Date of meeting: 30th May 2018

Introduction

This report is designed to give the Trust Board assurances that the Trust works towards compliance with Freedom of Information legislation. Statistical analysis of the requests and responses will be shown here, comparing the year of the report (2017/2018) to previous years where relevant.

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

	Total	Press	Public	Staff	Commercial	Students/ Research	MPs	Not Given	Other
Annual Total 15-16	479	77	86	1	212	34	11	7	21
Annual Total 16-17	663	122	94	1	354	48	12	2	30
Annual Total 17-18	673	172	93	2	344	24	16	3	19

This table shows that the number of requests received has increased slightly from the 2016-2017 figures (2% increase).

Chart 1 - Categories of Request for 17/18

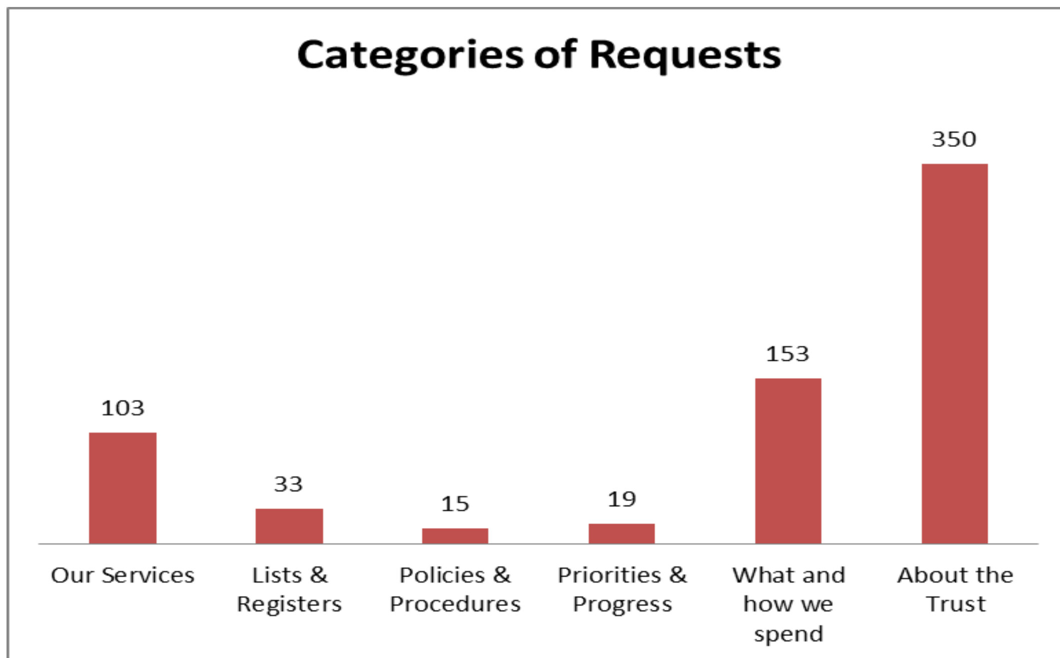


Table 2 - Examples of Category Request

Category	Example of Request
About the Trust	1. Overseas Visitors 2. New Systems Implemented
Decision Making	1. Maternity Closures 2. A&E Diversions
Lists & Registers	1. Software Systems 2. Asbestos
Our Services	1. Accident and Emergency 2. Human Resources
Policies & Procedures	1. Energy Efficiency 2. Compromise Agreement
What & How we spend	1. Monies owed for treatments 2. Locum Staff Spend

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

Chart 2 – Requests by Applicant Type

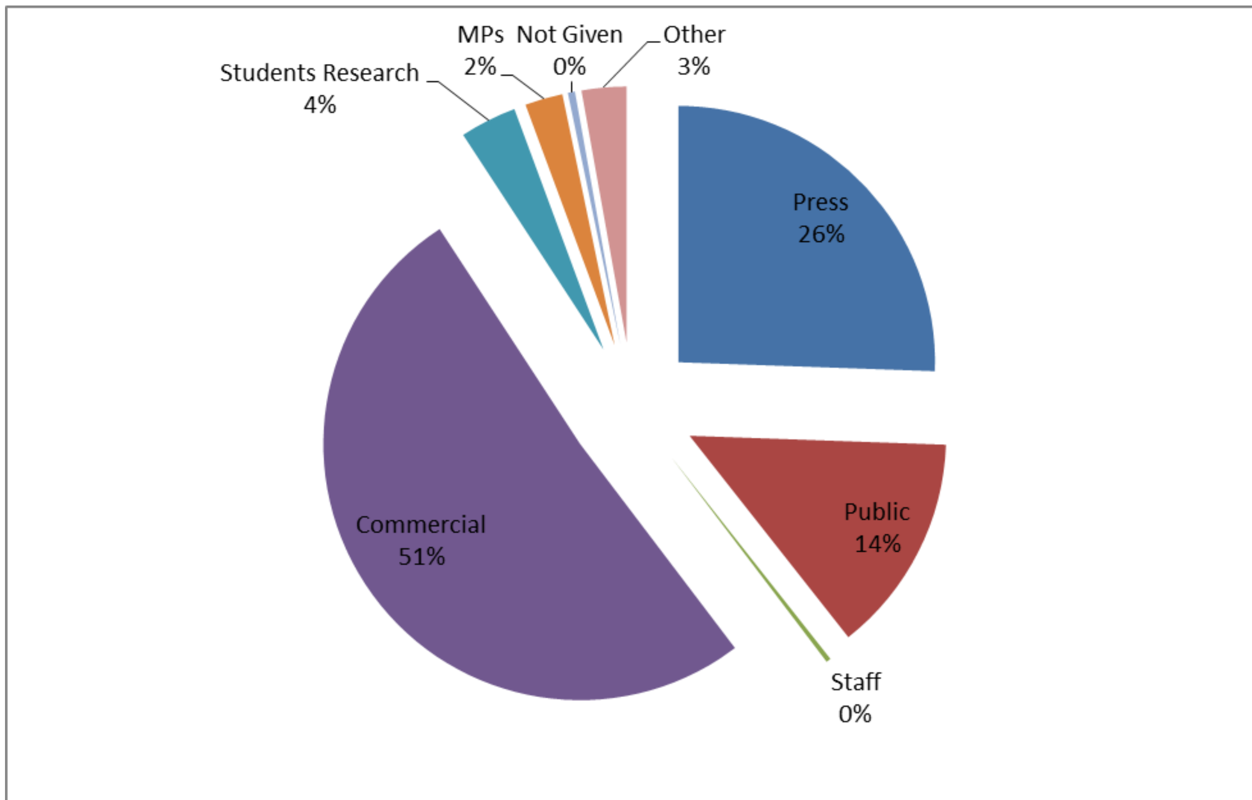
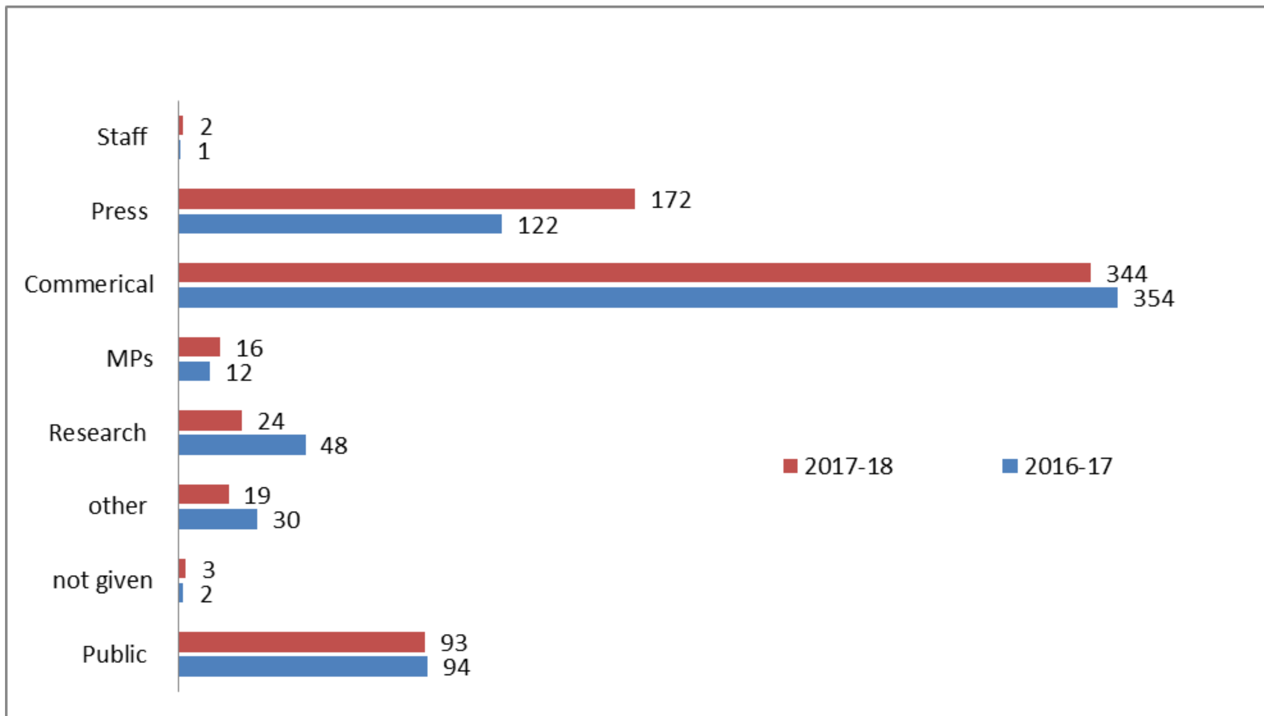


Chart 3 – Comparison of 2016-17 and 2017/2018 Applicant Type



Continuing from the trend of the previous year the applicant type continues to come from commercial organisations requesting information about the Trust. These requests make up 51% of the total received. FOIA also still remains an avenue that both local and national journalists use. This year we have seen a marked increase in the number of requests received into the Trust from the press.

Performance

The Trust received 673 FOIA requests for 2017/2018. The Trust strives to respond to all requests in accordance with the 20 working days timeframe that the legislation dictates. Out of the 673 requests received the Trust responded to 52% within 20 working days with 48% of responses being released after the deadline. The Trust is committed to continuing to improve our performance.

Appeals

The Trust has received no requests for appeals this year.

Conclusion

The number of Freedom of Information requests received by the Trust has increased slightly this year and the team have seen an increase in the level of complex requests we are now receiving from requestors that have an increased awareness of Freedom of Information legislation.

NHS
St Helens and Knowsley
Teaching Hospitals
NHS Trust

TRUST BOARD

Paper No: NHST(18)053
Title of paper: Review of Trust Objectives 2017-18
Purpose: To present the final review and status of the 2017-18 Trust objectives.

Summary:

1. The Trust Board agreed twenty-seven objectives for 2017-18 and progress in achieving these was reviewed at the mid-year point in November.
2. The objectives are 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.
3. In November 18 of the objectives were judged to have been completed or be on track for completion by 31st March, 9 objectives were felt to be behind schedule and recovery plans were put in place. There were no objectives judged to be unachievable, by the end of the year.
4. This paper summarises the final position against each of the objectives at the end of the financial year, using the following coding system;

Colour	Status
Green	Objective achieved
Amber	Objective partially achieved
Red	Objective not achieved

5. This analysis shows that:
   a. 23 objectives are rated green (85%)
   b. 4 objectives are rated amber (15%)
   c. No objectives are rated red (0%)

Trust objective met or risk addressed: provides assurance to the Board that the Trust has achieved the operational plan and improvement objectives.

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff, its regulators and all stakeholders.

Recommendation(s): The Board is asked to note the achievement against the 2017-18 objectives.

Presenting officer: Ann Marr, Chief Executive.

Date of meeting: 30th May 2018.

Trust Objectives 2017-18 – Year End Review

(green)	Objective achieved	(amber)	Objective partially achieved	(red)	Objective not achieved

Objective	Lead Director	Progress to date	Rating (RAG)
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 Through improved planning we will bring forward the time of patient discharges so that at least a third leave hospital by midday with the appropriate medication and care packages in place.	DoOps	More patients are now being discharged before noon with appropriate medication and care packages in place, including some individual wards that consistently achieve above 30%. Although the position has improved significantly across the Trust the target is not yet being universally achieved.	Amber
1.2 In support of "John's Campaign" we will ensure that carers of people with dementia are welcomed to spend as much time with patients as they want to and be involved in their care.	DoN	John's Campaign implemented piloted on DMOP and Orthopaedic ward and then rolled out to the rest of the Trust during 2017-18.	Green
1.3 We will actively seek suggestions to improve patient experience and where appropriate standardise care throughout the week.	DoOps /MD	The Trust is required to meet the 7DS Standards by 2020 and a recent review by the NHSI National 7DS Team confirmed that the Trust has actions in place and is on track to achieve required standards by the national deadline.	Green
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 We will take active measures to improve safety and clinical outcomes particularly in the areas of infection control (MRSA); falls; and pressure ulcers ensuring that lessons are learned and appropriate actions implemented throughout the Trust.	DoN	There have been improvements in the majority of safety indicators during 2017 -18, despite record levels of activity and numbers of Non-Elective admissions over the winter period; • There were no grade 3 or 4 pressure ulcers in the year. • 2 MRSA cases (including 1 contaminant) • 22 falls resulting in harm • 20 C-Diff cases (1 still subject to appeal)	Green

Objective	Lead Director	Progress to date	Rating (RAG)
2.2. We will ensure that incidents are reviewed within 72-hours of their occurrence and clear action plans are in place to prevent recurrence and are widely shared.	DoN	The 72 hour rapid review process has been implemented and embedded into Trust practice.	
2.3. We will implement a new system for learning from hospital deaths, using best-practice national guidance.	MD	System implemented and evolving and Q1-3 data published on time as planned.	
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. We will increase the scope of emergency ambulatory care pathways to reduce non-elective admissions ensuring they are embedded and appropriately accessed.	DoOps	Ambulatory care pathways implemented for medicine, surgery and emergency care. A generic pathway has also been developed to maximise the number of patients identified for ambulatory care. A health system review of ambulatory care pathways has commenced so that primary care can also identify patients before they present at A&E and make direct referrals – this review is on-going	
3.2. We will implement a new midwifery-led care pathway for women having low risk births.	DoN	All capital works have been completed to create a Midwifery Led Unit and the new low risk birth pathways were implemented in November 2017 and are now fully operational.	
3.3. We will achieve the planned benefits from taking over the management of adult community nursing services in St Helens.	DoOps	Safe transfer of the services and implementation of the service specification; • Increased clinical leadership • Integration of the community Intermediate Care Service • Increase in bed occupancy and decrease in LoS for Newton • Community nursing teams aligned to the agreed localities • Frailty team established • IASH (single point of contact) now coordinating referrals • Community nurse in-reach to A&E Overarching service objectives to increase the quality of community nursing, reduce duplication across the system to improve patient experience and reduce reliance on acute hospital care are being demonstrated	

Objective	Lead Director	Progress to date	Rating (RAG)
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 pursue improvements in the systems used to investigate and respond to complaints and strive to respond to 90% within the agreed timescale. We will ensure that lessons are learned and shared.	DoN	The Trust responded to 67% of complaints within the agreed timescale, an improvement on the previous two years' performance (58% in 2016-17 and 61.4% in 2015-16).	
4.2. We will review and improve patient information and communications ensuring that we are delivering concise, clear messages regarding all aspects of the individual patient's care.	DoN	Standard template for patient information booklets has been updated and re- launched, including the electronic versions via the internet site. There is a reader panel that reviews all leaflets before they are published All patient information leaflets are reviewed on a rolling basis, every 12 months to ensure they remain fit for purpose.	
4.3. We will continue to work with patient focus groups to enable a fuller understanding of patients' and carers' views and experiences in order to respond appropriately.	DoN	Positive relationship with and feedback from Healthwatch F&F test responses are over 95% favourable. In the recent PLACE assessment the Trust achieved the highest scores nationally for privacy and dignity in the care environment.	
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 We will manage the smooth transition to the new Patient Administration System with minimal disruption to contractual or operational performance.	DoI	Medway was successfully implemented in April 2018 (following an agreed re-scheduling of the go-live dates to avoid Easter).	
5.2 We will undertake benefit realisation exercises following the introduction of each new system to ensure that the planned benefits have been realised, or highlight where additional opportunities for efficiencies exist.	DoI	There is a benefits realisation workstream with executive leadership, whose responsibility is to ensure that the maximum amount of benefits are realised .	
5.3 We will finalise the 3-year IM&T Strategy to support clinical transformation across a wider footprint.	DoI	Complete and approved by the Trust Board	
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 We will identify creative approaches to recruitment and retention to ensure the Trust remains an employer of choice.	DoHR	The Trust continues to work in collaboration with education institutions to maximise available volunteer and student recruitment and offer development incentives. The Trust has been running a successful international recruitment campaign (22 international recruited nurses have joined the organisation to date. An additional 86 offers of employment are in progress, with dedicated pastoral support in place to support the individuals through the process). The Trust	

Objective	Lead Director	Progress to date	Rating (RAG)
		continues to explore other international opportunities for the recruitment of medical and other shortage occupation staff, drawing on the successes of the Brno and BAPIO cohorts of medics. Retention workstreams are developing specific medical, nursing and AHP strategies to improve the Trust's overall attrition rates.	
6.2 We will optimise the opportunities offered by the Apprenticeship Levy with innovative approaches to new roles and higher level qualifications.	DoHR	Process developed to offer staff apprenticeship opportunities at all levels, aligned to organisational need and the qualifications required. Cohorts of Nursing Associate and Operating Department Assistant apprenticeships will be enrolled through Bolton University in September 2018.	
6.3 We will explore opportunities for innovative ways of staff training and working to address skill shortages such as nurse and pharmacist prescribing to help overcome junior doctor shortages.	DoHR	Assistant Practitioners are being supported to undertake nurse apprenticeships through the Open University. The first cohort commenced in October 2017. An additional cohort of 10 nurse apprenticeships commenced at Edge Hill university in March 2018 with further cohorts planned. Funding has been secured from HEE to support pharmacists and nurses to complete non-medical prescribing qualifications and also for the development of Advanced Nurse Practitioner roles in the Emergency Department and Frailty Service. A second cohort of Physicians Associates is being trained and the entire initial cohort has been offered substantive roles when they qualify. Biomedical Scientists are being supported to complete their degrees funded through the apprenticeship levy	
7. OPERATIONAL PERFORMANCE ***We will meet and sustain national and local performance standards***			
7.1 We will achieve national performance indicators including: a. The agreed trajectory for emergency access standards b. Cancer treatment standards c. 18 week access to treatment for planned care d. Diagnostic tests completed within 6 weeks e. Ambulance handover	DoOps	a. Winter pressures resulted in deterioration in performance that continued through March. b. Cancer access performance is above target c. 18 weeks targets achieved d. Diagnostic targets achieved e. Ambulance handover performance has improved throughout the year and the Trust continues to work closely with NWAS	

Objective	Lead Director	Progress to date	Rating (RAG)
7.2 We will achieve local performance indicators including: a. CQUINS b. Contract performance indicators and compliance c. Activity levels to meet Trust operational plans.	DoOps	a. CQUINS have been achieved b. Contract indicators being delivered and no concerns raised by commissioners c. Overall the Trust achieved the activity and operational plans for the year (some speciality activity plans were impacted by the national escalation plans in response to winter pressures)	
7.3 We will use benchmarking and comparative data to highlight areas for improvement and seek to learn from best practice.	DoF	The Trust uses a range of different benchmarking sources including the Model Hospital, GIRFT, PLICS, NHSI corporate services benchmarking (Carter), national audit comparators etc. that drive the identification of areas for improvement	
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 establish a benchmarking and reference cost group to learn from the multitude of comparative performance information and improve data shared.	DoF	A costing group (which covers reference costs, CTP and SLR) within finance is now established to review cost allocation for both internal and external reporting. A Trust wide group to develop SLM (Service Line Management) has also been established, with the Assistant Medical Director as clinical champion.	
8.2 We will develop capacity and demand modelling capability at divisional level and ensure a consistent approach to service development proposals using regular source information	DoF	Demand and capacity modelling capability has been developed and the system used to inform the winter plan bed modelling and proposals to change the distribution of beds between medicine and surgery. The same principles have also been used to model the impact of RMS on elective care and are now incorporating the NHSI iMAS tool.	
8.3 We will continue to review the opportunities for running non-clinical back-office functions and other services across a wider footprint where economies of scale can be demonstrated	DoF	DoF continues to be involved in the C&M Carter at scale work programme e.g. staff bank, payroll, procurement, pathology, and also the St Helens Cares opportunities for “Place Based” corporate services such as Estates Management and Business Intelligence.	
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 We will foster positive working relationships with health economy partners and help create the joint 5-year strategic vision for health services across wider footprints	All	Working with St Helens, Knowsley and Halton to support the development of “Place Based” integrated care systems as a 2 – 5 year strategy depending on the pace in each Borough	

Objective	Lead Director	Progress to date	Rating (RAG)
9.2 We will collaborate with partners in reviewing integrated patient pathways which offer alternative ways of working to the benefit of patient care, safety and efficiency of services.	DoT	Membership of the St Helens Cares Executive, People's Board and Programme Board in support of the integrated care plans. Tissue Viability, Frailty, Adult Continence, Healthy Heart and Respiratory pathways are all being reviewed to improve the end to end service. A review of Therapy services is in progress. Falls services across St Helens, Halton and Knowsley are working together to increase referrals from ED. Also, membership of the One Halton ICS programme board and the Halton out of hospital care steering group.	
9.3 We will meet all the compliance requirements set by NHSI for long-term sustainability of the Trust's clinical services, collaboratively with partners where appropriate	DoCS	Adoption of Well Led framework and Use of Resources ratings, also preparation for the new style CQC Inspection process. Maintained a NHSI Segmentation rating of 2	

ENDS