NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 24TH APRIL 2019
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

AGENDA				Paper	Presenter
09:30	1.	Employee of the Month		Verbal	Chair
09:40	2.	Apologies for Absence		Verbal	
	3.	Declaration of Interests		Verbal	
	4.	Minutes of the Previous Meeting held on 27th March 2019		Attached	
		4.1	Correct Record & Matters Arising	Verbal	
		4.2	Action Log	Attached	
Performance Reports					
09:50	5.	Integrated Performance Report		NHST(19) 30	Nik Khashu
		5.1	Quality Indicators		Sue Redfern
		5.2	Operational Indicators		Rob Cooper
		5.3	Financial Indicators		Nik Khashu
		5.4	Workforce Indicators		Anne-Marie Stretch
Committee Assurance Reports					
10:10	6.	Committee Report – Executive		NHST(19) 31	Ann Marr
10:20	7.	Committee Report – Quality		NHST(19) 32	Val Davies
10:30	8.	Committee Report – Finance & Performance		NHST(19) 33	Jeff Kozer
10:40	9.	Committee Report – Audit		NHST(19) 34	Su Rai
Other Board Reports					
10:50	10.	Strategic and Regulatory Report		NHST(19) 35	Nicola Bunce
BREAK					
11:10	11.	Corporate Risk Register		NHST(19) 36	Nicola Bunce

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<tr><td>11:20</td><td>12.</td><td>Board Assurance Framework</td><td>NHST(19) 37</td><td>Nicola Bunce</td></tr>
<tr><td>11:30</td><td>13.</td><td>Learning from Deaths Quarterly Report</td><td>NHST(19) 38</td><td>Kevin Hardy</td></tr>
<tr><td colspan="5">Closing Business</td></tr>
<tr><td rowspan="3">11:40</td><td>14.</td><td>Effectiveness of Meeting</td><td rowspan="3">Verbal</td><td rowspan="3">Chair</td></tr>
<tr><td>15.</td><td>Any Other Business</td></tr>
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NHS
St Helens and Knowsley
Teaching Hospitals
NHS Trust

Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Board meeting held on Wednesday 27th March 2019 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
	Ms N Bunce	(NB)	Director of Corporate Services
	Mr R Cooper	(RC)	Director of Operations & Performance
	Dr T Hemming	(TH)	Director of Transformation
In Attendance:	Ms J Byrne	(JBy)	Executive Assistant *(Minute Taker)*
	Ms J Crolla	(JC)	Senior Buyer, Procurement, STHK *(Observer)*
	Ms L Edwards	(LE)	Buyer, Procurement, STHK *(Observer)*
	Cllr A Lowe	(AL)	Halton Council *(Co-opted member)*
	Mr M Roscoe	(MR)	Asst Director of Operations for Community & Primary Care *(Observer)*
	Mr M Weights	(MW)	Lay Member, St Helens CCG *(Co-opted member)*
	Ms S Whelan	(SW)	Patient Experience Manager *(for Patient Story only)*
Apologies:	Mr P Growney	(PG)	Non-Executive Director

1. Employee of the Month

1.1. The Employee of the Month Award for February 2019 was presented by RF to Joanne Battensby, Specialist Midwife in Mental Health.

1.2. The Employee of the Month Award for March 2019 was presented by RF to Colin Davidson, Reablement Support Worker, Newton Intermediate Care Service.

2. Patient Story

2.1. SW introduced JS who shared his experience of using Marshalls Cross Medical Centre with Board members.

2.2. JS had been a patient of the practice for a number of years and had initially been concerned when he learnt that the practice was going to be managed by the Trust.

However, he had found the service to be very responsive and had always been able to get an appointment quickly. He had attended the medical centre most recently with a painful shoulder. X-Rays and tests were undertaken at St Helens Hospital and the problem was diagnosed and treatment started, on the same day. He observed that he was sometimes seen by a nurse rather than a GP and felt this was a good arrangement.

2.3. RF thanked JS for sharing the story and assured JS the Trust aspired to provide all patients of the practice with this level of service.

2.4. NK asked what could have been done better when the Trust took over responsibility for the medical centre. JS believed the changes could have been communicated better with patients, but appreciated that this was not always easy. He also felt that the experience for patients could be further enhanced if there was a dispensing pharmacy at St Helens, as this would create a true one stop experience for patients.

2.5. SW and JS left the meeting.

2.6. SRe commented that patient feedback on Marshalls Cross was reported on NHS Choices which was monitored very closely, and the overall ratings had shown a steady improvement. AM noted that Marshalls Cross had adopted a new service delivery model with a multi-disciplinary team delivering patient care, rather than the traditional GP model, this aimed to provide a holistic approach to treating patients, e.g. by GPs, Advanced Practitioners – nurses and therapists. The Trust had also received support and advice from St Helens CCG to develop the service.

2.7. VD asked if there were any plans to have an on-site pharmacy, AM explained that there was currently a hospital pharmacy for patients attending outpatients, but not a pharmacy that could dispense prescriptions. The provision of licences for dispensing chemists was regulated by the CCG and due to the proximity of other commercial pharmacists and the level of demand a licence had not been granted for St Helens when the hospital was being built, but this was currently being reviewed.

2.8. SR queried how patient stories were chosen to be presented at Board meetings. SRe confirmed Patient Experience team were asked to identify both positive and negative stories so Board members received a good understanding of the Trust's services and learning could be shared throughout the Trust.

3. Apologies for Absence

3.1. Apologies were noted as above.

3.2. RF had received a letter of resignation from Dr Jean Quinn as a Non-Executive Director, due to changes in her personal circumstances. He thanked Jean for her contribution and sent her best wishes for the future on behalf of the Board.

4. Declaration of Interests

4.1. There were no declarations of interest.

5. Minutes of the previous meeting held on 27th February 2019

5.1. Correct Record

5.1.1. The minutes were accepted as a correct record, once Cllr Alan Lowe's attendance was recorded.

5.1.2. RF thanked the minute taker for the accuracy of the minutes.

5.2. Action List

All outstanding actions were due for future meetings.

CQC Inspection 2018 Briefing.pptx

6. Extra-ordinary Agenda Item – CQC Briefing

6.1. NB presented a summary of the CQC inspection report to Board members, to explain how the overall 'Outstanding' rating was achieved and the service and domain ratings for the acute and community services that had been inspected. NB also explained some of the changes that had been made as a result of the factual accuracy process and the challenges that had not been accepted.

6.2. SR queried the Whiston Hospital 'requires improvement' rating for urgent and emergency services in the 'responsive' category. SRe confirmed this was largely due to the Trust not meeting the 4-hour A&E waiting time target.

6.3. VD was concerned about the rating of 'requires improvement' for urgent and emergency services in the 'safe' category. SRe explained that some of the national standards in relation to safeguarding training had changed in June 2018, and had not been fully implemented at the time of the service inspection in July. The other issues highlighted in the report had been the initial time to assessment, which the report had acknowledged had improved and also Ambulance turnaround times which had also improved significantly during 2018/19. The data sources used by the CQC had been 2017/18 and it was disappointing that despite the acknowledged improvements the rating had still been requires improvement. SRe informed the Board that action had been taken since the inspection and that she was assured that patients had been and continued to be safe in the department. SRe and RC were supporting the team in ED who had naturally been extremely disappointed.

6.4. Marshalls Cross Medical Centre had also been rated as requires improvement overall and the CQC had asked the trust to take action in relation to three regulations. The CQC had acknowledged that the Trust had only been providing the service for a few months at the time of the inspection and had already made substantial improvements, and as a result the ratings were not aggregated into the overall Trust rating. The Trust had until 23rd April to present its action plan for Marshalls Cross to the CQC; however NB explained that an action plan had been developed immediately following the inspection and the issues identified had already been addressed. SRe commented that this service was likely to be inspected again in the next few months.

6.5. Board members acknowledged the outstanding rating could not have been achieved without the help of the Trust's partner organisations, particularly St Helens, Halton and Knowsley CCGs and thanked them for their support.

6.6. Cllr Lowe commented that the increased flow of patients to the Trust from both Halton and Runcorn were also evidence of the standard of service provided.

7. Integrated Performance Report (IPR) – NHST(19)21

7.1. The key performance indicators (KPIs) for February were reported to the Board, following in-depth scrutiny of the full IPR at Quality Committee and Finance & Performance Committee meetings.

7.2. Quality Indicators

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

7.2.2. There had been no never events in the February and one reported year to date (in July).

7.2.3. There had been no MRSA reported in February and one MRSA positive specimen in the year to date (target = 0) as a result of a contaminant and the patient did not come to any harm.

7.2.4. There were 0 C.Diff positive cases reported in February. Year to date there had been 17 cases. The annual tolerance is 40.

7.2.5. There were no grade 3 or 4 avoidable pressure ulcers reported in month or year to date.

7.2.6. The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for January 2019 was 96.6% and year to date performance was 96.2%.

7.2.7. There had been 1 fall resulting in severe harm in January and 12 in the year to date.

7.2.8. Venous thromboembolism (VTE) assessment performance for January 2019 was 95.37%. Year to date performance was 95.95% against a target of 95%.

7.2.9. Year to date HSMR (April to October) for 2018/19 was 96.5.

7.2.10. SRe also reported that the Trust had achieved the highest rate nationally for the uptake of the flu vaccination by healthcare workers, at 95.4%.

7.3. Operational Indicators

7.3.1. RC presented the update on the operational performance.

7.3.2. All cancer performance is reported a month later due to validation, so the figures relate to January. The 62-day cancer standard was 86.7% against the target of 85%.

7.3.3. The 31-day cancer target was achieved with 98.1% performance against a target of 96%.

7.3.4. The 2-week cancer standard was also achieved with 94.4% against a target of 93% and the year to date position had recovered to 91.4%, continuing the improving trend.

7.3.5. A&E access time performance was 70.2% in February (type 1) and the all types mapped footprint performance was 84.7%. JK confirmed that the Finance and Performance Committee had received a detailed report on the actions being taken by the ED to improve this performance.

7.3.6. Whiston A&E had the highest volume of ambulance attendances in Cheshire & Merseyside and Great Manchester during February. Ambulance notification to handover time was 13:53 minutes on average, against a target of 15 minutes and represented a significant improvement from January.

7.3.7. The average number of Super Stranded patients (patients with a length of stay of greater than 21 days) during February 2019 was 112 compared with 156 in February 2018, which was a 28% reduction year on year. RC thanked partner organisations for their ongoing help in ensuring that patients could leave hospital for an appropriate alternative setting.

7.3.8. The 18-week referral to treatment target (RTT) was achieved in January 2019 with 93.3% (target = 92%). The 6-week diagnostic target was also achieved with 99.8% (target = 99%). There were no patients on the waiting list for over 52 weeks.

7.3.9. VD had attended a recent Sepsis Quality Ward Round and asked whether the data relating to the 'one-hour rule', ie patients displaying signs of life-threatening sepsis had to be seen within one hour by a senior doctor; should be included in the IPR. SRe confirmed the data would be available to report from June 2019, once the new NEWS2 system was embedded in A&E department.

7.3.10. In response to a query from RF, RC confirmed the 'one-hour rule' started when patients triggered the pathway at triage in the ED. He advised that wherever possible, NWAS was now flagging suspected sepsis and administering antibiotics before arrival at hospital. Additionally, chemotherapy patients who could have neutropenic sepsis if they were feeling unwell were advised to notify Reception on arrival at ED, so they could be seen urgently.

7.4. Financial Indicators

7.4.1. NK presented the update on the financial performance.

7.4.2. At the end of month 11, the Trust reported a deficit of £1.9m including Provider Sustainability Fund (PSF) and £7.8m excluding PSF. This was in line with the revised forecast outturn position that the Trust had submitted to NHSI in December.

7.4.3. To achieve the year to date position the Trust had utilised £7.4m of non-recurrent resources, which was offsetting some of the cost pressures from the impact of the changeover to Medway and under-performance in clinical income.

7.4.4. The Trust continued to deliver above the year-to-date CIP target with £13.2m transacted year to date against a plan of £11.7m. It was acknowledged that the £4.6m of CIP relating to STP collaboration was highly unlikely to be delivered by the end of the financial year.

7.4.5. The Trust cash balances at the end of month 11 were £5.7m. The deterioration in the financial position, loss of PSF funding and mitigation of non-payment of lead employer invoices had resulted in the Trust requiring temporary loan support totalling £13.9m to meet payments until the end of the financial year.

7.4.6. The Trust revised forecast position in month 9 as agreed with NHSI and at month 11 NK had been able to reduce that deficit position by £0.250m to report a planned outturn deficit of £5.7m including PSF, which had been welcomed by NHSI. NK thanked colleagues for their hard work in helping the Trust to achieve the improved position.

7.4.7. The financial performance in the month delivered a Use of Resources level of 3.

7.5. Workforce Indicators

7.5.1. AMS presented the update on the workforce indicators.

7.5.2. Absence in February had been 5.3%, which was an improvement but exceeded the Q4 target of 4.68%. AMS reported work was ongoing to support departments to improve performance in March.

7.5.3. Qualified nursing and HCA sickness was 6.3% in February. Qualified Nursing and Midwifery sickness was 5.1%.

7.5.4. Mandatory training compliance for the core skills framework subjects was 95.3% (target = 85%). Appraisal compliance was 89.3% which was above the target of 85%.

7.5.5. VD noted the largest proportion of sickness was long-term and therefore the sickness rate was unlikely to change significantly before the end of the financial year, however AMS was hopeful of an improvement in March.

8. Committee Report – Executive – NHST(19)22

8.1. AM presented the report summarising the key issues considered by the Executive Committee at meetings held during February 2019. The key issues highlighted to the Board from the report were;

8.1.1. Trust Telephony Service - It was recognised that the current switchboard system was nearing the end of its useful life and a replacement was needed, which should take advantage of modern capability to provide a better service for callers. In order to improve performance, short term additional capacity had been approved for the switchboard team. A review of the system replacement options and needs of the organisation was also commissioned to inform a future business case. SR had recently tried to contact another local hospital and it had taken considerable time for her call to be answered; she wondered whether patients experienced the same at the Trust. AM confirmed she had received some feedback on the telephony service via ‘Ask Ann’, which emphasised the need for the review.

8.1.2. Replacement of desktop computers and migration to Windows 10 – a business case to start a rolling programme of replacement for the Trust’s desktop computers as part of the capital programme, had been approved. There was also a national requirement for the NHS to migrate to windows 10 which would require considerable technician input.

8.1.3. Maternity Services Future Plans – the Executive Committee considered future plans for the maternity service including increasing the number of births in the Midwifery Led Unit to 25% by April 2019, implementing the national targets for continuity of carer and achieving the 2019/20 CNST incentive scheme. The committee had also discussed the Cheshire and Merseyside Women’s and Children’s Network plans, including the local bid for a ‘pop up birth centre’. There were also updates on plans for the centralised cardiotocography (CTG) monitoring system, a maternity anaesthetic rota and compliance with K2 training targets.

8.1.4. SR asked why additional information had been requested in relation to the Safer Staffing report and care hours per patient per day (CHPPPD) and AM explained that the committee was keen to fully understand the relationship between these two measures of Staffing. SRe confirmed that the current patient to bed ratio was 1:6.7 which was better than the recommended 1:8.

8.1.5. DM asked if the Executive Committee had reviewed the financial stability of the PFI partners in light of the recent instability within the construction and FM service provider market. AM confirmed that the partner companies operated on a global scale and were financially stable.

9. Committee Report – Quality – NHST(19)23

9.1. VD presented the Chair's report to the Board, which summarised key issues arising from the Quality Committee meeting held on 19th March and reports from the Patient Safety, Patient Experience, Clinical Effectiveness and Workforce Councils.

9.2. Issues for note by the Trust Board included an update on the fasting audit, where 30 planned elective patients had been audited. The audit showed there was compliance with the policy but 63% patients were still fasted longer than recommended, so further work being undertaken and the information given to patients coming to the Trust for an elective procedure had been updated. SR queried why so many patients had fasted for such a length of time. SRe explained that on occasions surgery could not go ahead at the time planned, including when an emergency patient needed to take precedence and in many cases it had been the patient's choice to continue to fast in order to ensure they could still have their procedures on the day.

RF referred to an additional needs patient he had read about in the press, who it was alleged had not been fed for 3 weeks. SRe assured RF that could not happen at the Trust as all patients who were admitted received a nutritional assessment (MUST) within the first 6 hours. This included referral to the dietitian if the MUST score was 2 or above and where appropriate, the patient was started on supplements. Patients would be placed on a diet and fluid chart to monitor input and any patient requiring additional support would have red trays and jugs to highlight the need. Patients requiring supplementary feeds or special regimes were reviewed by the dietician and a plan put in place and reviewed. Additionally, staff were trained to administer enteral feeds via Nasogastric and PEG tubes and Total Parental nutrition via dedicated intravenous lines. For any patients unable to feed, ie Nil by mouth or difficulty with lines, intravenous fluids would be commenced to maintain hydration.

9.3. The Trust currently was awaiting the findings from 3 Healthcare Safety Investigation Branch (HSIB) investigations. The new HSIB's purpose was to improve safety in Maternity services through effective and independent investigations but there was a concern that they would take much longer. The Quality Committee would continue to monitor this.

9.4. The committee had asked for a more robust process around providing evidence of compliance with NICE guidance and had requested a 6-monthly review was to be presented at Quality Committee meetings.

9.5. The committee had noted that a review of the Clinical Effectiveness Council was being undertaken and the membership was being refreshed and a new feedback template introduced to provide clarity on the matters discussed and assurances received.

9.6. The Radiology Department had been recommended for the Imaging Services Accreditation Scheme (ISAS) to UKAS, the first in Cheshire and Merseyside.

9.7. NB informed Board members Quality Committee paper QC(19)47 'CQC compliance and registration' had been written before the inspection report had been published and did not reflect the issues identified in the CQC report of

Marshalls Cross Medical Centre. The paper being reported to the Board had been amended to reflect this and a note would be added to the Quality Committee minutes to reflect these changes.

9.8. Board members noted the report.

10. Committee Report – Finance & Performance – NHST(19)24

10.1. JK presented the Chair's report to the Board which summarised key issues arising from the Finance & Performance Committee meeting held on 21st March.

10.2. The financial outturn had improved compared to the forecast outturn agreed at the December Board meeting due to greater controls around winter expenditure during Q4.

10.3. The 2019/20 financial plans had been reviewed and were being recommended to the Trust Board.

10.4. The committee had received a presentation from the Assistant Director or Operations for Urgent Care, Emergency Department Consultant and Assistant Medical Director. The committee had been assured about the work that was being undertaken by the team to improve ED access time performance, whilst acknowledging that this had not yet yielded positive results.

10.5. DM asked for the reasons behind the poor ED performance on one specific day, and RC explained that on this occasion the Trust had accepted diverts from across the region throughout the night resulting in an exceptionally busy department.

10.6. JK had undertaken a deep dive into one of the CIP schemes to provide additional assurance that the quality impact assessment process was working effectively.

10.7. The committee received an update from the Surgical Care Group that demonstrated the progress on the CIP for 2018/19 and plans for 2019/20. The committee took assurance from the high level of engagement within the care group.

10.8. NK informed Board members the NHSI procurement benchmarking league tables had recently been released and the Trust's procurement team had improved its position from 126th in 2017 to 26th in 2018 and now 7th nationally for 2019, which made StHK 3rd in the North and 1st in Cheshire and Merseyside. NK congratulated the team on this fantastic achievement.

10.9. The Trust had used around 75% of its capital allocation year to date and plans were in place to use the full resource.

10.10. Briefings were received from the CIP Council and the Service Improvement team.

10.11. Board members noted the report.

11. Approval of Opening Budget – NHST(19)25

11.1. NK presented the financial plans for 2019/20 which had been reviewed by the Finance and Performance Committee with the planning assumptions and risks fully explored.

11.2. The plans included within the paper delivered a deficit of £2.6m, which enabled the Trust to accept the control total issued by NHSI and gain access to £6.5m of Provider Sustainability Fund (PSF).

11.3. Providers who accepted their control totals would continue to be exempt from most contractual sanctions, with the exception of those relating to mixed sex accommodation, cancelled operations, Healthcare Association Infections, duty of candour and 52 weeks breaches. The impact of not accepting the control total could mean increased regulatory scrutiny for the Trust as well as the imposition of various fines and sanctions.

11.4. NK summarised the changes in the planning assumptions that had informed the Trusts financial plan. Nationally £1bn had been transferred from the PSF into urgent and emergency care tariffs for 2019/20. This was intended to reduce the gap between the price paid and the cost of delivering non-elective care. The impact to the Trust of this change based on predicted activity was c£7m. In addition 1.25% (half) of CQUIN values had also been transferred into core prices. The remaining 1.25% CCG and 1.0% Specialist Commissioning CQUIN values would still be based on delivery of national key performance indicators and the guidance on those was yet to be released. SRe was to review the guidance for the 5 CQUIN thematic areas which had just been published.

11.5. There was also a new 'blended payment' approach for emergency care activity for 2019/20, however the Trust had offered its qualifying commissioners (over £10m value) a local variation on the proposal which included 'payment by results' up to the Trust's predicted activity levels with a blended payment for activity above this level. This had been agreed with the commissioners in principle.

11.6. The financial plan is underpinned by the delivery of care group activity plans and a 3.8% CIP target that had increased by £2.1m from the draft plan as a result of the RICS guidance change in relation to asset lives. NK would work with commissioners on QIPP costs and delivery of the CIP target. NK was still awaiting final tariffs so there may be further changes before the plan is submitted to NHSI/NHSE on 4th April, but these were not expected to be material.

11.7. NK thanked the Care Groups for their work in delivering the 2018/19 CIP internal targets and also in working up plans for 2019/20, which meant that a significant proportion of the CIP had already been identified.

11.8. DM asked for an analysis of the Trusts income growth over the last 7 years, so the Board could understand how much had been driven by activity growth, by the provision of new services or the acquisition of new contracts. **Action: NK to prepare report for Finance and Performance Committee and share with Board members.**

11.9. TH asked why the Audiology activity had reduced by 5% compared to other areas. NK explained community and high street audiology services were now offering routine testing and treatment out of hospital and less activity was now being referred to the hospital services.

11.10. VD asked if the capacity e.g. additional beds had been included in the plans. VD also queried whether the service development plans in relation to primary care had also been built into the opening budgets. NK explained that the financial modelling was based on the demand for services rather than capacity. The opening budget was based on the services being delivered now, but could be amended throughout the year to reflect service developments and any new contracts that transferred to the Trust during the year, which would result in additional income.

11.11. Cllr Lowe commented on the current Urgent Treatment Centres (UTCs) procurement process currently being undertaken by Halton CCG, and the natural flows of patients from the Widnes and Runcorn UTCs. He also raised an issue with the car parking facilities at the Widnes UTC which was currently being reviewed by the Council. AM agreed with Cllr Lowe; the data showed patients in Widnes initially attended the Walk-In Centre and then came to the Trust for treatment.

11.12. Board members approved the financial plan for submission to NHSI/E and to set the opening budgets for the 2019/20.

12. 2019/20 Trust Objectives – NHST(19)26

12.1. AM presented the 2019/20 proposed Trust objectives which were aligned to support the achievement of the Trust's operational plan and the furtherance of its strategic direction and vision to deliver Five Star Patient Care. The objectives would be launched to the staff at the start of the year conference on 8th April.

12.2. As far as possible progress against each of the objectives was translated into key performance indicators or measurable targets that were reported via the IPR or through the governance structure to provide regular assurance of delivery to the Board.

12.3. VD felt that some of the outcomes /measures of success could be sharper. It was agreed this would be reviewed at the next Executive Committee. **Action: Executives.**

12.4. VD was pleased to see the inpatient survey had been included, but wondered where the commercial strategy fit in with the objectives in terms of numbers and expectations and whether there were any opportunities to create additional income. NK clarified this was considered as part of the CIP programme.

12.5. AM confirmed some things would feature for several years and build on previous years progress, for example, weekend discharges, 7 day services, recruitment and retention initiatives.

12.6. DM asked whether the objectives should contain more about promoting the Trust services. However, it was felt with annual activity growth of 5-6% without

marketing and the amount of new housing being built in Knowsley and other areas in the Trust catchment more patients would automatically flow to the Trust in the coming years.

12.7. Board members approved the 2019/20 Trust objectives.

13. Care Quality Commission (CQC) Compliance and Registration – NHST(19)27

13.1. SRe explained the Trust was required to register with the CQC and had a legal duty to be compliant with the fundamental standards set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

13.2. The Trust was inspected in July/August 2018 and achieved an overall Trust rating of outstanding. The Board reviewed the evidence that demonstrated the acute and community services delivered by the Trust were compliant with the fundamental standards.

13.3. The CQC inspection report identified three breaches of the CQC regulations in relation to primary care services provided at Marshalls Cross Medical Centre and the Trust had until 23rd April to submit its action plans demonstrating how it had or intended to improve this service to meet all the regulations. It was noted that, as previously discussed, action had already been taken to address the CQC concerns. RC gave an update to the Board on the actions taken to secure additional General Practitioners to work in and provide the clinical leadership for Marshalls Cross.

13.4. SRe confirmed that a repeat inspection of Marshalls Cross was likely to be undertaken following the submission of the action plan.

13.5. The CQC charged all providers an annual registration fee to cover its regulatory activities, and for the Trust this had increased to £272,000 for 2019/20.

13.6. Board members noted the report and the actions being taken to ensure compliance with the fundamental standards at Marshalls Cross Medical Centre and ongoing CQC registration requirements.

14. Annual Mixed Sex Declaration – NHST(19)28

14.1. SRe provided Board members with assurance that the Trust had complied with national guidance to eliminate mixed sex accommodation and there had been no breaches in 2018/19, and there had been no complaints from patients specifically in relation to sleeping arrangements.

14.2. In response to a query from SR, SRe explained that a non-clinical breach referred to the reasons for patients being allocated to certain beds in line with clinical guidelines and best interest criteria e.g. critical care units.

14.3. Board members approved the declaration of compliance in relation to the elimination of mixed sex accommodation.

15. 2018 NHS Staff Survey Trust Board Report – NHST(19)29

15.1. AMS provided an overview of the outcomes of the Staff Survey for 2018 and the proposed action plan.

15.2. Under the new reporting scheme, the Trust had recorded best score nationally for 6 out of the 10 themes and second best nationally for 2 out of the 10 themes.

15.3. The five-year look back revealed progress on 8 of the 10 themes, with scores for 2 of the themes significantly higher than 2017.

15.4. There were still some areas for concern which formed the basis of the 2019/20 action plan, most notably: the quality of appraisals, health and wellbeing and violence by patients on staff.

15.5. It was acknowledged that the bullying and harassment score of 11%, even though it was a low score nationally, was still too high and SR asked where this was monitored. VD confirmed that a deep dive had recently been presented at the Quality Committee and was going to be reported on a regular basis going forward.

15.6. RF commented on the importance of effective two-way appraisals processes as an important opportunity for staff to formally record their experience of their role.

15.7. Overall this was a very encouraging set of results, which demonstrated that the previous actions plans had been delivered and had the desired impact on staff experience of working for the Trust.

15.8. The report was noted and the areas for action agreed.

16. Effectiveness of Meeting

16.1. RF asked MW and the observers from the Procurement team for their reflections on the meeting.

16.2. MW felt the tone was welcoming and that it was set at the start of the meeting with the patient story. He had noted the probing questions from the non-executive directors, asking how improvements could be made which demonstrated a desire for continuous improvement.

16.3. JC had found the meeting more informal than she was expecting, with a good order to the meeting and clear focus from all members. She felt the discussions had been positive and it had been an excellent learning experience.

16.4. RF thanked the observers for their comments.

17. Any Other Business

17.1. JK highlighted the need for replacement non-executive directors for the Finance and Performance Committee and Mortality Surveillance Group in light

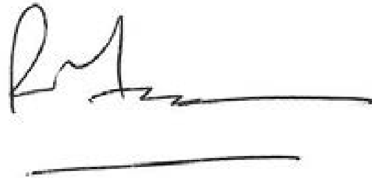
of the resignations from SR and JQ. RF confirmed that he and NB were already working with NHSI on this and the advertisement should be published imminently.

17.2. RF thanked the Communications team for their excellent coverage and promotion of the CQC result.

17.3. RF informed members that the Trust, New Hospitals, VINCI Facilities and Medirest had been awarded 'HSJ Property and Estates Management Service Provider of the Year 2019' for continuing to improve standards and enhancing the patient environment, including internal LED lighting schemes, access to hospital gardens for patient therapy, improved dementia signage, improved seating in accident and emergency, and redesigning maternity services. The Trust, New Hospitals and Vinci Facilities - Combined Heat and Power Plant – had also been shortlisted for the award. He congratulated all involved as this reflected the excellent working relationships between the teams.

18. Date of Next Meeting

18.1. The next meeting will be held on Wednesday 24th April 2019 at 09:30 hrs in the Executive Boardroom, Level 5, Whiston Hospital, L35 5DR.



Chairman: ………………………………………………………………………………

24th April 2019

Date: ………………………………………………………………………………

TRUST PUBLIC BOARD ACTION LOG – 24TH APRIL 2019

No	Date of Meeting (Minute)	Action	Lead	Date Due
1.	25.07.18 (12.7)	AMS to include employee relations' cases time to resolve KPIs in future HR Indicators reports. **To be reported from July 2019.**	AMS	~~30.01.19~~ 31.07.19
2.	30.01.19 (14.9)	AMS/SRe to review the exit interviews process to ensure it is comprehensive and lessons are being learnt to improve retention.	AMS/SRe	31.07.19
	~~27.02.19 (7.7)~~	~~Marshalls Cross performance metrics to be included as part of the Integrated Performance Report from April 2019. DONE~~. **ACTION CLOSED**	~~RC/NK~~	~~24.04.19~~
	~~27.02.19 (7.11)~~	~~Andrew Hill, Lead Stroke Consultant, to be invited to the Quality Committee meeting in July to update members on Q1 performance~~. **DONE. ACTION CLOSED**	~~VD~~	~~For QC~~
3.	27.02.19 (8.3)	Corporate departments to be included in the QWR schedule.	SRe	24.04.19
4.	27.03.19 (11.8)	NK to analyse the reasons for the 40% increase in turnover since 2012 and report back to Finance & Performance Committee and share with Board members.	NK	24.04.19
	~~27.03.19 (12.3)~~	~~Trust objectives to be smarter/more measurable~~. **DONE. ACTION CLOSED.**	~~Exec Comm~~	-

St Helens and Knowsley Teaching Hospitals NHS Trust

INTEGRATED PERFORMANCE REPORT

Paper No: V=ou
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

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

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

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

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

Patient Safety, Patient Experience and Clinical Effectiveness

The CQC rated the Trust as **outstanding** overall following its inspection in July/August 2018. The caring and well-led domains were rated as **outstanding**, with safety, responsive and effective rated as **good.**

There has been 1 never event year to date (target = 0).

MRSA: as a result of a contaminated sample there has been 1 x positive MRSA specimen.

There were 4 C.Difficile (CDI) positive cases reported in march 2019. YTD there have been 21 cases.
In comparison, there were 19 cases for the same period in 2017-18. The annual tolerance for CDI for 18-19 is 40.

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

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for February 2019 was 98.6%. YTD performance is 96.4%

During the month of February 2019 there was 1 fall resulting in severe harm , which occurred in Ward 2C (YTD Severe and above category fall = 14 compared with 22 for the year 2017/18). Falls figure updated to include Newton fall in October 2018.

Performance for VTE assessment for February 2019 was 96.24%. YTD performance is 95.97% against a target of 95%.

YTD HSMR (April to November) for 2018-19 is 94.3

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:

Operational Performance

Performance against the 62 day cancer standard was below the target of 85.0% in month (February 2019) at 82.6%. The 31 day target was achieved with 97.7% performance against a target of 96%. The 2 week rule target was also achieved with 96.0% against a target of 93.0%.

Accident and Emergency Type 1 performance for March 2019 was 72.6%. The all type mapped STHK Trust footprint performance was 85.9%**.** Type 1 attendances for March 2019 were 10,021 compared with 9,186 in February 19. March 2019 was 1.59% higher than March 2018 (9,864).

Five improvement workstreams (streaming, emergency department delivery, assessment areas, inpatient flow and ward daily discharges) are actively working on improving patient flow and are being governed through the Urgent and Emergency Care Council which meets monthly and is chaired by CEO.

Whiston ED had 2927 ambulances conveyances in March 2019. Ambulance notification to handover time was achieved with 12:48 mins/seconds on average (target 15 mins). Whiston achieved this target for 10 months out of 12 in 2018/19 compared with only 5/12 months the previous year.

In line with the national expectation to reduce the number of Super Stranded patients by 25% (patients with a length of stay of greater than 21 days - to achieve a maximum of 94 patients). The average number of super stranded patients during March 2019 was 39 less per day compared with March 18. (154 per day in March 18 v 115 in March 19) which is a 25% reduction year on year. Medical and Surgical clinical /managerial teams and all CCG partners are actively engaged in the achievement of the reduction in superstranded and progress is monitored daily and weekly.

The 18 week referral to treatment target (RTT) was achieved in February 2019 with 93.2% compliance (Target 92%). The 6 week diagnostic target was also achieved with 99.9% (Target 99%). There were no 52 week+ waiters.

Financial Performance

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

Human Resources

In March, overall absence decreased from 5.3% to 5.2%. Although a slight decrease, significant reductions are demonstrated within Qualified & HCA sickness, from 6.3% to 5.6% and Qualified Nursing & Midwifery sickness has reduced from 5.1% to 4.5% thus achieving Q4 2018/19 target (4.68%). In January, it was 7.4%.
Mandatory Training compliance is 95.3% (target = 85%). Appraisal compliance is 89.6% (target = 85%).

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
UOR = Use of Resources

Mar-19

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	Mar-19	2.3%	2.2%	No Target	2.4%		Further improvement in SHMI (governments preferred measure) and HSMR. Weekend admission mortality is a noisy metric.	Patient Safety and Clinical Effectiveness	Continue measures to improve clinical effectiveness and reduce unwarranted variation. Documentation of comorbidities is still below expected - actions to correct this will further improve standardised mortality measures.	KH
Mortality: SHMI (Information Centre)	Q	▲	Sep-18	0.99		1.00						
Mortality: HSMR (HED)	Q	▲	Nov-18	81.7	94.3	100.0	99.1					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Nov-18	87.7	101.2	100.0	95.8					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Oct-18	97.5	100.3	100.0	101.2		The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	The Trust continues to work internally and with healthcare partners to minimise unnecessary readmissions.	KH
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Nov-18	90.3	90.6	100.0	90.6		Sustained reductions in NEL LOS are assurance that Trust patient flow practices continue to successfully embed.	Patient experience and operational effectiveness	Drive to maintain and improve LOS across all specialties. This includes robust management of delayed patients and scrutiny of superstranded patients.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Nov-18	119.6	111.9	100.0	99.2					
% Medical Outliers	F&P	T	Mar-19	0.3%	0.5%	1.0%	2.3%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in LoS, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place. Continued focused management of all patients requiring discharge support. A review of the Trust bed model has resulted in reconfiguration of some surgical beds to medical thus significantly reducing outliers to almost zero through recent months. Medical cover plans are in place ahead of winter increases expected.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Mar-19	52.3%	45.7%	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. Targeted senior manager support to ensure patients are listed and transferred out of ICU in a timely manner	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Feb-19	72.8%	71.1%	90.0%	69.5%		eDischarge performance remains poor. Inpatient performance is stable and is not expected to improve until new (pending) electronic solutions are implemented. Outpatient performance requires investigation is improving as Medway issues are addressed.		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.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Feb-19	89.0%	85.2%	95.0%	89.5%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Feb-19	96.0%	96.4%	95.0%	99.1%					

Mar-19

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

	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-19	87.5%	85.7%	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	Continued achievement.	RC
PATIENT SAFETY (appendices pages 39-42)												
Number of never events	Q	▲ £	Mar-19	0	1	0	2		1 Never event in July 2018 (theatres).	Quality and patient safety	Immediate actions implemented and formal RCA underway. The National safety standards for invasive procedures will provide further mitigation against future never events.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Mar-19	99.3%	99.1%	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	Mar-19	0	0	0	0		The trust continues to have no inpatient prescribing errors which cause serious harm. Trust has moved from being a historic low reporter of prescribing errors to a higher reporter - which is good.	Quality and patient safety	Intensive work on-going to reduce medication errors and maintain no serious harm.	KH
Number of hospital acquired MRSA	Q F&P	▲ £	Mar-19	0	1	0	2		MRSA: as a result of a contaminated sample there has been 1 X positive MRSA specimen (Nov-18). 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	▲ £	Mar-19	4	21	40	19					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Mar-19	3	31	No Target	22					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Jan-19	0	0	No Contract target	0		No grade 3 or 4 avoidable pressure ulcers YTD	Quality and patient safety	The Trust provides ongoing tissue viability training for all nursing staff including bank staff . New pressure ulcer reduction actions being implemented.	SR
Number of falls resulting in severe harm or death	Q	▲	Feb-19	1	14	No Contract target	22		1 severe harm fall reported in February 2019 (Ward 2C)	Quality and patient safety	RCA is currently being undertaken. Falls action plan progressing and monitored through Strategic Falls Group. New initiatives and awareness session programmes planned. Ward falls care assurance review undertaken, standards of care reviewed.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲ £	Feb-19	96.24%	95.97%	95.0%	93.67%		VTE performance monitored since implementation of Medway and newly introduced ePMA. An electronic solution is in the IT pipeline. Performance remains above target.	Quality and patient safety	Every effort is being made to supplement routine reviews with additional activity to improve performance pending electronic solution.	KH
Number of cases of Hospital Associated Thrombosis (HAT)		T	Feb-19	2	23	No Target	31					
To achieve and maintain CQC registration	Q		Mar-19	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards. Trust rated as outstanding following the 2018 inspection.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Feb-19	98.6%	96.4%	No Target	93.9%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	With the implementation and roll out of Safe Care Allocate the data was collected for 20 working days from the 30th Jan 19-27 Feb 19. The late census data is taken 1pm-2pm each day. The final report will indicate care hours excess/care hours short for each area.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Feb-19	0	0	No Target	1					

Mar-19

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	▲ £	Feb-19	96.0%	91.8%	93.0%	95.0%		2 week and 31 day Targets achieved in month. 62 Day target not met due to a combination of factors but Consultant workforce constraints (Radiological capacity in Breast and Dermatology patient rearrangements) contributed to the underperformance	Quality and patient experience	1. All DMs producing speciality level action plans to provide 2 week capacity 2. Capacity demand review on going at speciality level	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Feb-19	97.7%	98.0%	96.0%	97.7%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Feb-19	82.6%	88.2%	85.0%	87.4%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Feb-19	93.2%	93.2%	92.0%	94.0%			Surgical Beds have now been converted to Medical bed capacity. Bed availability to manage the Surgical demand could result in backlog increasing. Additional risk also caused by impact of RMS and MCAS	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. A backlog management plan is in place and alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand. Actions to maintain and improve RTT performance reliant on theatre and bed capacity along with staff availability in collaboration with CCG's in ensuring RMS delivers in a sustainable and manageable way	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Feb-19	99.9%	99.8%	99.0%	100.0%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Feb-19	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Mar-19	0.7%	0.8%	0.8%	0.6%		There was one breach of the 28 day re-list target in January due to difficulties in communicating with the patient.	Patient experience and operational effectiveness Poor patient experience	Proactive system in place to monitor, manage and prevent cancelled operations within the care group. Lessons learned from the 28 day re-list patient in January have been feedback to the relevant departments for learning and reflection.	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Feb-19	100.0%	99.5%	100.0%	99.4%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Mar-19	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Mar-19	72.6%	74.3%	95.0%	78.2%		Accident and Emergency Type 1 performance for March 19 was 72.6%. The all type mapped STHK Trust footprint performance was 84.7%. Type 1 attendances for February 2019 were 10,021 compared with 9,186 in February 19. Five improvement workstreams (streaming, emergency department delivery, assessment areas, inpatient flow and ward daily discharges) are actively working on improving patient flow and are being governed through the Urgent and Emergency Care Council which meets monthly and is chaired by CEO. Whiston ED had the highest volume of ambulances in C+M and GM (3067) in march 2019. Ambulance notification to handover time was achieved with 13:53 mins on average (target 15 mins).	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 New and refreshed workstreams aimed at improving discharges before midday also supported by a media campaign #HomeForLunch. Daily 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. New COPD pilot in place from December.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Mar-19	85.9%	87.1%	95.0%						
A&E: 12 hour trolley waits	F&P	▲	Mar-19	0	0	0	0					

	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	▲ £	Mar-19	0	0	0	0		Increased demand for IP capacity has a direct bearing on the ability to maintain this quality indicator.	Patient Experience	Maintained focus and awareness of this issue across 24/7.	RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Mar-19	29	267	No Target	224		% new (Stage 1) complaints resolved in month within agreed timescales continues to improve overall and remains above target, with 100% achieved in March 2019.	Patient experience	The Complaints Team continue to work hard to respond to complaints within agreed timescales and to proactively monitor each complaint that is likely to exceed this. The backlog of overdue complaints continues to remain extremely low.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Mar-19	27	242	No Target	270					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Mar-19	100.0%	92.1%	No Target	67.0%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Feb-19	22	19	No Target	20		In February 2019 the average number of DTOCS (patients delayed over 72 hours) was 22.		Tracking meetings happen with LA/CCG and wards twice weekly to ensure the numbers of DTOCs are maintained below 20.	RC
Average number of Stranded patients per day (7+ days LoS)	Q	T	Mar-19	315	311 *Jun-Mar							
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Mar-19	115	116 *Jun-Mar							
Friends and Family Test: % recommended - A&E	Q	▲	Feb-19	86.2%	86.0%	90.0%	87.5%		The YTD recommendation rates remain above target for inpatients, antenatal and postnatal, but slightly below target for A&E, delivery, community postnatal and outpatients, with improvement seen in ED and delivery in February.	Patient experience & reputation	Feedback from the FFT responses continues to be 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 attend team meetings to engage with staff and raise the profile of the FFT programme and to work with staff in each area where performance is below target. At least two members of staff have been identified in each area to take responsibility for production of the 'you said, we did' posters which are used to identify specific areas for improvement. Easy to use guides were issued to each ward to support completion and the posters are now distributed centrally to ensure that each ward has up-to-date posters. Areas continue to review comments to identify any emerging themes or trends, and significantly negative comments are followed up with the contributor if contact details are provided to try and resolve issues.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Feb-19	95.0%	94.6%	90.0%	95.8%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Feb-19	100.0%	98.6%	98.1%	98.5%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Feb-19	100.0%	98.0%	98.1%	97.9%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Feb-19	98.0%	95.5%	95.1%	96.6%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Feb-19	100.0%	97.7%	98.6%	98.1%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Feb-19	94.6%	94.2%	95.0%	94.5%					

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 UOR	▲	Mar-19	5.2%	5.0%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.7%		In March, sickness reduced from 5.3% to 5.2%. Although an improvement, it remains higher than the Q4 target of 4.68% and higher than this time last year. Qualified & HCA sickness decreased from 6.3% to 5.6%, a reduction of 0.7%. YTD absence remains at 6.1%, above the 2018-19 target of 5.3%.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	A large scale review of the current attendance management policy has commenced in line with "Just Culture" with the aim of driving improvements in engagement levels and attendance. A workshop held in March was well attended from all staff groups and a task and finish group has been established with attendees from management, HR, HWWB and staffside. The HR Operational Team & Absence Support Team continue to support managers and staff with regards to absence and implementation of the policy. HR and HWWB are reviewing current reporting mechanisms between the two teams to ensure timely advice and action is taken when required due to the increase in complex cases.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Mar-19	5.6%	6.1%	5.3%	5.7%					
Staffing: % Staff received appraisals	Q F&P	T	Mar-19	89.6%	89.6%	85.0%	88.4%		Mandatory Training compliance exceeds the target by 10.3% and remains unchanged from February. Appraisal compliance is above the target by 4.6%. A slight improvement since February.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	The HRBP's alongside Education, Training & Development and Workforce Planning teams continue to work with managers to ensure on-going maintenance of compliance for Mandatory Training & 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	Mar-19	95.3%	95.3%	85.0%	92.5%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2	92.6%		No Contract Target			For both questions the Trust returned the best scores nationally.	Staff engagement, recruitment and retention.	The Q4 survey within Corporate and Clinical Support Services Directorates has now closed with results expected to be published on 30th April 2019 .	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2	83.6%		No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Mar-19	1.5%	9.2%	No Target	10.0%		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. The Trust is undertaking a project with NHSE regarding retention of Nurses and this is part of our wider retention strategy and action plan for 2018/19 for the Trust.	AMS
FINANCE & EFFICIENCY (appendices pages 61-66)												
UORR - Overall Rating	F&P UOR	T							Finance indicators within the IPR are greyed out subject to final accounts being submitted.	Delivery of Control Total	Weekly update to be provided to DoF on current progress of internal schemes. Divisions to report progress at Finance & Performance Committee. Executives to engage external stakeholders regarding progress of transformational programmes that will assist in delivering the Cost Improvement Programme. The approval of invoices within the Trust is impacting compliance. The Finance department will continue to work with areas of the Trust that need to improve.	NK
Progress on delivery of CIP savings (000's)	F&P	T										
Reported surplus/(deficit) to plan (000's)	F&P UOR	T										
Cash balances - Number of days to cover operating expenses	F&P	T										
Capital spend £ YTD (000's)	F&P	T										
Financial forecast outturn & performance against plan	F&P	T										
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T										

APPENDIX A

			Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	2018-19 YTD	2018-19 Target	FOT	2017-18	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	75.0%	100.0%	100.0%	100.0%	100.0%	95.7%	88.9%	100.0%	100.0%	100.0%	100.0%	96.0%	83.3%	96.2%	85.0%		97.0%		
	Total > 62 days		2.5	0.0	0.0	0.0	0.0	0.5	1.5	0.0	0.0	0.0	0.0	0.5	2.5	5.0			3.5		
Lower GI	% Within 62 days	▲ £	91.7%	75.0%	100.0%	76.5%	100.0%	100.0%	92.3%	100.0%	36.4%	88.9%	100.0%	87.5%	72.7%	87.1%	85.0%		84.0%		
	Total > 62 days		0.5	1.5	0.0	2.0	0.0	0.0	0.5	0.0	3.5	1.0	0.0	1.0	1.5	9.5			12.5		
Upper GI	% Within 62 days	▲ £	63.6%	100.0%	80.0%	77.8%	80.0%	66.7%	62.5%	77.8%	66.7%	33.3%	63.6%	84.6%	88.9%	74.7%	85.0%		87.2%		
	Total > 62 days		2.0	0.0	1.0	1.0	0.5	0.5	1.5	1.0	0.5	1.0	2.0	1.0	0.5	10.5			5.0		
Urological	% Within 62 days	▲ £	96.8%	86.2%	93.8%	90.2%	78.8%	80.7%	97.1%	80.6%	90.3%	75.0%	89.4%	85.2%	87.8%	85.6%	85.0%		82.5%		
	Total > 62 days		0.5	2.0	1.0	2.0	3.5	5.5	0.5	3.0	1.5	3.5	2.5	2.0	2.5	27.5			37.0		
Head & Neck	% Within 62 days	▲ £	66.7%	100.0%	50.0%	66.7%	33.3%	62.5%	42.9%	83.3%	50.0%	80.0%	57.1%	25.0%	0.0%	54.7%	85.0%		64.6%		
	Total > 62 days		0.5	0.0	0.5	0.5	2.0	1.5	2.0	0.5	1.0	0.5	1.5	1.5	0.5	12.0			8.5		
Sarcoma	% Within 62 days	▲ £	100.0%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%			88.0%	85.0%		66.7%		
	Total > 62 days		0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	1.5			2.5		
Gynaecological	% Within 62 days	▲ £	66.7%	77.8%	87.5%	72.7%	75.0%	100.0%	72.7%	50.0%	62.5%	100.0%	81.8%	57.1%	88.9%	77.8%	85.0%		78.2%		
	Total > 62 days		0.5	1.0	0.5	1.5	0.5	0.0	1.5	0.5	1.5	0.0	1.0	1.5	0.5	9.0			12.0		
Lung	% Within 62 days	▲ £	100.0%	100.0%	87.0%	95.8%	88.9%	100.0%	100.0%	81.8%	66.7%	94.1%	100.0%	92.9%	81.8%	90.1%	85.0%		84.7%		
	Total > 62 days		0.0	0.0	1.5	0.5	0.5	0.0	0.0	1.0	2.0	0.5	0.0	0.5	1.0	7.5			11.5		RC
Haematological	% Within 62 days	▲ £	88.9%	83.3%	100.0%	100.0%	100.0%	100.0%	66.7%	90.9%	50.0%	85.7%	66.7%	50.0%	0.0%	75.4%	85.0%		80.6%		
	Total > 62 days		0.5	1.0	0.0	0.0	0.0	0.0	1.0	0.5	1.0	1.0	1.0	2.0	2.0	8.5			9.5		
Skin	% Within 62 days	▲ £	95.5%	92.5%	100.0%	91.2%	97.6%	93.8%	98.1%	93.3%	84.6%	90.2%	98.0%	93.7%	88.1%	93.3%	85.0%		95.2%		
	Total > 62 days		1.0	2.0	0.0	2.5	0.5	1.5	0.5	3.0	4.0	2.5	0.5	2.0	2.5	19.5			13.0		
Unknown	% Within 62 days	▲ £		75.0%	100.0%	100.0%		100.0%	75.0%	100.0%	100.0%	100.0%		100.0%	66.7%	93.8%	85.0%		78.4%		
	Total > 62 days		0.0	1.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.5	1.0			4.0		
All Tumour Sites	% Within 62 days	▲ £	89.1%	89.6%	94.1%	90.1%	90.3%	89.0%	89.1%	90.9%	77.8%	88.4%	89.0%	86.7%	82.6%	88.2%	85.0%		87.4%		
	Total > 62 days		8.0	8.5	4.5	10.0	8.0	9.5	9.5	9.5	16.0	10.0	8.5	12.0	14.0	111.5			119.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £					100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%		90.0%	85.0%		100.0%		
	Total > 31 days						0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0		1.0			0.0		
Acute Leukaemia	% Within 31 days	▲ £				100.0%			0.0%	100.0%						66.7%	85.0%		100.0%		
	Total > 31 days					0.0			1.0	0.0						1.0			0.0		
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)31

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 March 2019.

There were a total of 4 Executive Committee meetings held during this period. The Executive Committee agreed:

- International recruitment team business case
- Quality Matron business case
- Outline plans for the sustainability and transformation capital allocation
- Skin Cancer service business case
- Recruitment and temporary staff team business case
- Halton Urgent Treatment Centre (UTC) bid

The Executive Committee also considered regular assurance reports covering: the Integrated Performance Report, above framework cap agency and locum request Chief Executive approvals, appraisal and mandatory training compliance, the Risk Management Council and Corporate Risk Register, safer staffing monthly report, Information Governance training compliance. There were also progress reports on the actions being taken to resolve the Medway PAS outpatient issues.

There are no specific issues that require escalation to the Board.

Trust objectives met or risks addressed: All 2019/20 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: 24th April 2019

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE
March 2019

1. Introduction

There were 4 Executive Committee meetings in March 2019.

2. 7th March 2019

2.1 Allocate Safe Care Module Implementation

The Director of Nursing, Midwifery and Governance introduced the Corporate Matron leading the process of ensuring that all wards and departments are using the Safe Care module to record the acuity of patients 3 times each day. A 20 day Shelford audit had been undertaken to provide assurance on the reliability and consistency of the data, so that in future Safe Care would be used to inform establishment reviews. The system also linked to the wider Allocate suite of eRostering, bank/agency booking and finance. The system was still in the testing phase and the test data would now be used to inform the next phase of development.

2.2 Marshalls Cross Medical Centre

The Director of Operations and Performance introduced the Assistant Director of Operations for the Primary Care and Community Services Care Group, who gave an overview of the work that had been undertaken during his first three months in post, to strengthen service resilience and clinical leadership at the practice. There was also an update on progress with the wider Primary Care strategy and the work that was being undertaken to develop the proposed delivery model.

2.3 International Recruitment Business Case

The Deputy CEO/Director of HR presented a paper which set out the case for continuing with the programme of international recruitment and funding for the supporting infrastructure to deliver it. The business case was approved.

2.4 Quality Account – Improvement priorities for 2019/20

The Director of Nursing, Midwifery and Governance introduced the paper setting out the longlist of quality improvement objectives for 2019/20. The Committee agreed 3 priorities across the domains of patient safety, patient experience and clinical effectiveness, to form the basis of the public and stakeholder consultation exercise. These priorities would also be incorporated into the Trust Objectives for the new financial year.

2.5 Quality Matron Business Case

The Director of Nursing, Midwifery and Governance made the case for the 12 month appointment of a Quality Matron to lead the quality priority to improve patient information and engagement. The case was approved.

2.6 C-Diff Reporting Changes 2019/20

The Director of Nursing, Midwifery and Governance explained the national changes to recording and reporting cases of C-Diff. From April 2019 the definitions were changing and this would potentially impact on the number of C-Diff cases that had to be attributed as hospital acquired. The nationally allocated tolerance level for Trusts had been adjusted to reflect the changes, but there was concern that this adjustment did not take into account the expected impact for the Trust. It was agreed that the Trust should formally challenge the proposed tolerance and obtain an adjustment. The Committee agreed the process changes to implement and monitor the impact of the new guidance and ensure learning was disseminated following all investigations.

2.7 Trust Board agenda

The Director of Corporate Services presented the draft Trust Board agenda and action log for review.

2.8 Information Governance Training Compliance

The Director of Informatics presented the latest training figures and noted the improvement achieved and the additional progress needed by 31st March.

2.9 Medway

The Director of Informatics gave an update on the Medway programme and testing of the next upgrade. The communications group had also made progress in identifying a solution for patient letters.

2.10 Trust Objectives 2019/20

The Director of Corporate Services set out the timetable and process for drafting the 2019/20 Trust Objectives to be presented to the Trust Board on 27th March.

2.11 Collaboration at Scale Board

Committee members leading various workstreams on behalf of the Cheshire and Merseyside Collaboration at Scale Board had met with management consultants who were working with the STP leadership to clarify the future state vision for corporate services.

3. 14th March 2019

3.1 Agency Usage Report

The Deputy CEO/Director of HR presented the agency usage report for month 10 (January). Agency spend had reduced compared to 2017/18 and staff bank spend had increased. More shifts were now being filled and this was reflected in the positive improvements to the safer staffing levels. The number of agency cap breaches had reduced for nursing staff, and it was recognised that the early agreement of winter plans and significant expansion of the Trust staff bank had both contributed. Further work was now required to analyse the drivers for booking agency/bank shifts and to correlate these trends with sickness absence, holidays and vacancies.

3.2 5 Year Capital Plans

The Director of Finance and Information introduced the presentation which modelled the indicative capital requirements of the Trust over the next five years. It was agreed that a detailed rolling five year plan should be maintained.

3.3 Risk Management Council (RMC) and Corporate Risk Register (CRR) Report

The Director of Corporate Services presented the Chair's report from the RMC and briefed committee on those risks that had been escalated to the CRR during February. The Council had received reports from the Information Governance and Claims Governance Groups.

3.4 Sustainability and Transformation Capital

The Director of Operations and Performance presented the proposals to maximise bed and assessment area capacity at Whiston Hospital utilising the £4m STP capital allocation. There were a number of linked schemes that appeared to offer the best options to address both capacity and patient flow. It was agreed that a number of design working groups should be established to develop the detailed specifications for each area. The full business case was scheduled for consideration by the Trust Board and then submission to NHS Improvement at the end of May 2019.

3.5 HIS Budget

The Director of Informatics presented a discussion paper detailing the challenges with the HIS funding model and the perceptions of some partners about the hosting arrangements. It was agreed that more work needed to be undertaken to allow a full understanding of the implications for all parties.

3.6 Information Governance Training Compliance

The Director of Informatics reported a further improvement in the compliance figures and on the development of an action plan to ensure that this improvement continued and was then sustained.

3.7 Integrated Performance Report (IPR)

The Director of Finance and Information presented the February IPR figures for committee review, to agree the commentary and escalate issues if performance had fallen below target.

4. 21st March 2019

4.1 Mandatory Training and Appraisals Report

The Deputy CEO/Director of HR presented the report covering February 2019 and the position of each Director was noted. The process for expanding or adding topics to mandatory training was also discussed to ensure that all changes had Directors' approval.

4.2 Safer Staffing Report and Vacancy Dashboard

The Director of Nursing, Midwifery and Governance presented the report which showed a further improvement in overall fill rate for qualified nurses, with on-going challenges for the fill rate on some wards at night. Care Hours per Patient per Day (CHPPPD) figures were presented against the standard of 3 hours for each patient. The vacancy dashboard was also presented, which showed a continued reduction in nursing vacancies. It was noted that the nurse staffing situation felt better than it had at the same point last year and the recruitment initiatives were beginning to have an impact on front line staffing which was very welcome.

4.3 Halton Urgent Treatment Centre Procurement

The Director of Finance and Information introduced a discussion about the on-going tender and bid development process. There had been a number of updates throughout the process which changed the bid assumptions. The final bids had to be submitted by 5th April and the Committee agreed the further actions that would be taken to develop the bids before the final decision to submit could be taken.

4.4 Cancer Patient Survey Action Plan

The Director of Nursing, Midwifery and Governance introduced a paper which outlined the action plan agreed in response to the Cancer Patient Survey results. The lead Cancer Nurse gave a progress report on the work to improve information available for patients at every stage of their cancer journey. There was further training for staff and a refresh of the information packs that could be tailored to individual patient needs. There were also examples of how the Trust teams worked across the whole pathway to improve transitions from one care setting to another.

4.5 Midwifery Led Unit (MLU)

The Head of Midwifery presented an update on the task and finish group working to ensure the MLU delivery rooms were only used for women delivering full term babies. Staff training is being undertaken to support staff in the alternative locations to care for women who would otherwise have to deliver in the MLU.

4.6 Maternity Service complaints deep dive

The Head of Midwifery presented a summary of the complaints received by the service between October 2017 and February 2019. 23 formal complaints had been received in this period, of which half had been upheld following investigation. There had been no identified trends or common themes across the complaints and although it was a high number compared to other Trust services, it was not disproportionate when compared to other Maternity units.

4.7 K2 Training Update

The K2 training compliance was reviewed and it was noted that some of the new rotation of staff had not yet completed the training. Committee agreed that this was unacceptable and all staff using the CTG monitoring equipment were given 2 weeks to

successfully complete the training (note – by 4th April 97% of Medical staff and 98% of Midwives had completed the K2 training).

4.8 Information Governance Training Compliance

The compliance rates had improved again compared to the previous week.

4.9 NEWS2 Implementation

The Director of Nursing, Midwifery and Governance reported on the roll out of the NEWS2 electronic system for monitoring patients, which was being successfully implemented across the Trust.

5. 28th March 2019

5.1 Skin Cancer Service Business Case

The Director of Operations and Performance introduced the skin cancer team and the business case to expand the cancer nurse specialist and support worker establishment, to respond to increasing demand and improve support for patients. Benchmarking illustrated that the Trust had a smaller team than other comparable units, and the financial analysis demonstrated that more specialist staff would support a reduction in waiting lists and generate additional income. The business case was approved.

5.2 Recruitment and Temporary Staff Team Business case

The Deputy CEO/Director of HR presented a business case to substantively recruit to a number of posts to give the team capacity to respond to the growth in the permanent and temporary workforce. The importance of recruitment to maintaining safer staffing was acknowledged and the improvements in time to recruit were also recognised. The business case was approved.

5.3 Halton Urgent Treatment Centre Procurement

The Director of Finance gave an update on the Halton UTC tender submission. The bid document had been reviewed and the financial modelling revisited in light of the changes to the bid assumptions regarding the estate for the Runcorn UTC. The bid was approved for submission.

5.4 Clinical Quality and Performance Group (CQPG) – Feedback

The Director of Nursing, Midwifery and Governance provided feedback from the CQPG meeting on 19th March 2019. The meeting had included a presentation by the Breast Cancer Service and discussions about the effectiveness of the system winter plans, and how the Trust was assuring patient safety in the A&E department when it was very busy.

5.5 Patient Booking Service Review

The Director of Operations and Performance introduced the paper which detailed the experience of the patient booking service implementing the new Medway PAS and some of the outstanding issues where a solution was still being developed. The HIS, Information and patient booking teams had worked very closely together to respond to the issues and it was recognised that this had been a frustrating and stressful time for everyone concerned. The Committee also discussed the continuing support that would

be required to resolve the remaining issues and the impact on the PAS business case benefits realisation plans.

5.6 Information Governance Training Compliance

There had been a further improvement in the Trust overall compliance rates that could be reported with the action plan as part of the Data Security Protection (DSP) toolkit submission to NHS Digital at the end of March.

5.7 Women's and Children's Network Visit

The Deputy CEO/Director of HR reported on the planned visit of the Cheshire and Merseyside Women's and Children's Network to the Trust and the team that were preparing for the visit.

ENDS

TRUST BOARD

Paper No: NHST(19)32

Title of paper: Committee Report – Quality Committee Chair's Report

Purpose: To summarise the meeting papers from the 16 April 2019 and escalate issues of concern.

Summary:

Proposed Work Plan and Effectiveness Review 2019/20

- Going forwards the meeting will focus on the four key areas of Quality with emphasis on the quality KPIs.
- The review concluded that the purpose and remit of the Committee remains appropriate, but some changes are recommended to improve the effectiveness of the meetings.

QC(19)050 ATAIN Action Plan Update:

- The action plan is currently mainly amber, good progress is being made and the team are confident all will be achieved.

QC(19)051 HSIB Presentation:

- The Trust makes the referral electronically via a portal. Following confirmation of a case HSIB arrange a scoping visit. They engage and interview family and staff and take a human factors approach to evidence gathering and analysis. Any immediate concerns or issues identified are escalated to the Head of Midwifery. The family and Trust are updated regularly. Draft reports are shared with family and the Trust for comments. Trust, staff and families receive the same anonymised report which is also shared with the CCG and RCOG.

QC(19)052 Mandatory & Resus: Defibrillator Issue update: The landlord at Alex Park has confirmed there are first aid facilities in place. A Task & Finish Group is now reviewing facilities across all sites.

QC(19)053 Maternity Survey Action Plan:

- The survey undertaken in April 18 provided information on women's experiences during all aspects of their maternity care. In 2018 the maternity service received 12 recommendations**.** There were a similar number of improvements and declines since the 2017 survey.

- An action plan was developed following the survey feedback.
- In order to evaluate the effectiveness of the 2018 survey action plan the maternity service will undertake a snapshot survey in April 2019 of all women seen by the service on one day.

QC(19)054 Clinically Assisted Nutrition & Hydration:

- In December 2018 new guidance was published for patients who lack capacity to consent in England and Wales. The court judgement removed the requirement to obtain legal sanction for every decision to withdraw clinically assisted nutrition and hydration from patients who lack capacity through 'prolonged disorders of consciousness'. It returns clinical decision making to the clinical team, including families.
- The Trust has a well-established Nutrition Team and a Steering Group. A number of actions have been implemented to review the trust response to the recent CANH guidance which includes education and training and practical and emotional support. Actions are ongoing to embed and ensure this is rolled out Trust-wide.

Midwifery Staffing update: The over recruitment position was discussed. NK to review the details further outside of the meeting.

QC(19)055 IPR:

- The CQC rated the Trust at outstanding overall following the inspection in July/August 2018. The Caring and Well Led domains were rated as outstanding with safety, responsive and effective rated as good.

- 1 never event has been reported year to date against a target of 0.
- There has been 1 MRSA contaminant case reported against a target of 0.
- There were 4 C.Difficile positive cases reported. YTD there have been 21 cases. The annual tolerance is 40 cases.
- No grade 3/4 pressure ulcers reported.
- Safer staffing fill rate was 98.6% for February. YTD performance is 96.4%. The trend is improving.
- There was 1 inpatient fall in February resulting in severe harm with 14 YTD in the severe category; by comparison there were 22 last year. The fall figure has been updated to include a fall at Newton in October 2018.
- VTE assessment performance was 96.24% for February. YTD performance is 95.97% against a target of 95%.
- YTD HMSR is 94.3.

QC(19)056 Draft Quality Account: Comments and suggestions were sought by 23 April for inclusion in the final draft which is due for submission on 30 April.

QC(19)060 Medicines Management Audit Report:

- 69% of locations were fully compliant for all stock being locked away, including I/V store rooms being locked.
- 63% of locations were rated green for overall compliance with the Trusts SOP for Safe Storage & Security of Medicines.
- Recommendations have been made which will be monitored by the Heads of Nursing & Quality within the Care Groups together with the Matrons and Ward Nurse Managers.

QC(19)057 Patient Safety Council

The PSC summary page was noted by the Committee. No issues to escalate.

QC(19)058 Safeguarding Report

- Safeguarding Team Update: A gap analysis has been undertaken which is being shared with the Executive Team for discussion.
- The Trust is complaint against the safeguarding and mental capacity act training targets of 90%, however the Trust is not compliant with PREVENT Level 3 target. This change in compliance was as a result of too few staff being identified as requiring Level 3 training. The Trust has agreed a date for total compliance by March 2020. There is currently a drive to exceed the 38% target by the third week in April to be able to demonstrate actions taken to the CCG by the KPI submission date that will put the Trust back on target, however there will need to be a continued drive to ensure staff undertake the training.
- Policies: Two Safeguarding Adult policies have been updated this quarter to cover e-safety in adults and the changes made in the PREVENT Training Needs Analysis. These changes should ensure the CCG rate this area as green.
- Safeguarding Activity: The Trust reported 9 referrals to the Local Authority in Q3. In Quarter 4, 25 referrals have been made to Local Authority which is a significant increase.
- CQC Action Plan: The CQC highlighted staff in the Emergency Department and Obstetrics were not trained to Level 3.
- Learning disability: Learning disability requirements are included in the 19/20 Quality Schedule.
- Transition: There is ongoing dialogue and meetings with the Alder Hey Transition Lead regarding four highly complex patients who require transfer to adult services. STHK is the nearest Trust for these four patients and they are likely to attend until their presenting condition has been stabilised.

QC(19)059 Infection Prevention & Control Report

- 25 hospital acquired (by date) cases of Clostridium difficile infection (CDI) against an objective of no more than 40. 7 cases have been successfully appealed with 5 cases due for appeal in April. The trust current C.Diff total is 18 cases compared to 19 last year.
- 0 cases of Meticillin Resistant Staphylococcus Aureus (MRSA) and 1 contaminant: no harm to the patient. During 2017-18 there was 1 MRSAb and 1 contaminant.
- 31 cases of Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia of which 7 had no lapses in care.

- HCW vaccination rates noted to be the highest in the country at 95.4%.
- Audits: Hand hygiene rate is 99% and commode cleaning is 100%.

QC(19)061 Patient Experience Council

The PEC summary page was noted by the Committee. The following were highlighted:

- 98% of volunteers responding to the survey would recommend the trust as a place to volunteer.
- Recent senior nurse walkabout received positive feedback from patients who confirmed they were receiving person centred care.

QC(19)062 Complaints, PALs & Claims Report:

- 77 1st stage complaints were received and opened in Q4; 9 more than Q3.
- 96.9% of 1st stage complaints were responded to within the agreed timescales in Q4.
- Clinical treatment was the primary cause of complaint with appointments being the second in the Surgical Care Group indicating there may still be an issue with appointments.
- 15.3% increase in PALS contacts compared to the previous quarter.
- Communications remains the main reason for enquiries to PALS.

QC(19)063 Annual Inpatient Survey Report

- The final response rate for 2018 was 39% compared to 36% for 2017.
- Of the 81 questions, 16 questions related to demographics or information and 65 questions related to patient experience and quality of care.
- The combined responses of all trusts surveyed by Quality Health showed a deterioration in 46 of the questions asked, indicating a national decline in responses.
- Identification of themes indicates similarity with the 2017 Inpatient Survey results. Three key areas identified were information, communication and person centred care. The 2017 action plan has been revised to reflect this.

QC(19)064 Clinical Effectiveness Council

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

- Positive ICNARC report was received.
- Terms of Reference review has been deferred until May when efficacy feedback will be presented.

QC(19)065 Safer Staffing Reports:

- M12 demonstrates a 1.51% decrease in the RN overall fill rate from M11 (98.56%); with fill rates still above target. The Care Staff overall fill rate for M12 has increased by 0.11% with fill rates being 114.01%.

Policies/Documents for Approval:

- Annual meeting Effectiveness Review

Items to be brought to the attention of the Board:
None

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: Val Davies, NED and Chair of Committee

Date of meeting: 24th April 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)33

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Board on the Finance & Performance Committee, 18th April 2019

Summary:

Agenda Items

For Information

- Integrated Performance Report
  - The Committee discussed the below target performance for 62 day cancer.
  - RTT performance remains above statutory standards for the year.
  - The Committee noted and discussed the positive HSMR position and further plans to improve this going forward.
- Finance Report
  - Indicative financial figures subjecting to the submission of the annual accounts were presented to the committee.
  - The Trust is reporting a £5.7m deficit in line with forecast and is an improvement to the initial forecast (£6m) discussed at Decembers Board.
  - All capital resources were utilised in year in line with plans (£9.3m).
  - The Trust delivered a UoR of 4 in line with forecasts and reflective of the movement from plan.
  - The financial position does not include any additional potential Provider Sustainability Funding (PSF). If further PSF is offered to the Trust this will improve the financial position.
  - The Committee were informed of the ongoing issue around asset revaluation. The 2018/19 figures currently assume no impact. This issue remains under discussion with Trust auditors.
  - The Committee was updated on the current contractual sign off progress. Contracts are yet to be signed as a result of delays with Commissioners; the committee discussed any potential risks with a delay in signing.
- Briefings were accepted from:
  - Procurement council
  - Capital council
- A&E Performance
  - The Committee reviewed the presentation from the ADO for Urgent Care, Emergency Department Consultant, and Associate Medical Director.
  - The Committee noted the detailed information included within the presentation.
  - There will be additional triage resources to assist in flow to consultants

For Assurance

- CIP Programme update
  - The Committee noted the £14.9m delivery of CIP within the financial year which equated to 3.8% of turnover and 1.8%higher than national planning assumptions.
  - The Committee took assurance from the 2019/20 CIP and the high level of schemes currently rated as green.
  - The Committee also took assurance from the high volume of low-level schemes.
- CIP Programme update – CSS
  - The committee took assurance from the strategic approach the care group was taking to deliver the CIP.
  - It was noted that there has been a significant increase in green rated schemes in comparison to the previous year.

Risks noted/Items to be raised at Board: • 62 day cancer performance is adverse to target • Final I&E position (asset revaluation/additional PSF) • A&E performance • Agreement of final contracts
Corporate objectives met or risks addressed: Finance and Performance duties
Financial implications: None as a direct consequence of this paper
Stakeholders: Trust Board Members
Recommendation(s): Members are asked to note the contents of the report
Presenting officer: Jeff Kozer, Non-Executive Director
Date of meeting: 24th April 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)34

Title of paper: Committee Report – Audit

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

Summary: The Audit Committee met on 17th April 2019. The following matters were discussed and reviewed:

External Audit :
- External audit update report (GT)

Internal Audit:
- Internal audit progress (MIAA) – Several finalised reports were presented in the report with one audit report receiving limited assurance (A&E appraisals review).
- Updates from management – Responding to a request from the Audit Committee, managers were invited to provide updates on progress on recently received limited or moderate assurance reports, namely Newton (Adult Community Services) Locality Review (DoN), Enterprise Mobile Management Review (DDoI) and A&E Appraisals Review (ADoOM).
- Head of Internal Audit Opinion 2018/19 (MIAA). Note that substantial assurance was awarded.
- Internal Audit Charter (MIAA)

Anti-Fraud Services:
- Anti-fraud work plan-final (approved at February meeting) (MIAA)
- Anti-Fraud Annual report 2018/19 (MIAA)

Trust Governance and Assurance:
- The Director of Nursing update including update from Quality Committee and draft Quality Account 2018/19 (DoN)

Standing Items:
- The audit log (report on current status of audit recommendations) (ADoF)
- The losses, compensation and write-offs report for the period 1st April 2018 to 31st March 2018 (ADoF).
- Aged debt analysis as at the end of March 2019 (ADoF). The high level of over 90 day aged debt remained was brought to the Committee's attention.
- Tender and quotation waivers report (ADoF).

Other:
- Trust response re questions from External Auditors to Management (DoF) (agreed)
- Audit Committee Chair's response re questions from External Auditors to Those Charged with Governance (DoF) (agreed)
- Draft Accounting Policies 2018/19 (ADoF) (approved)
- Going Concern re 2018/19 accounts (ADoF) - recommendation that accounts be prepared on a going concern basis (approved) and the indicative wording of the going concern statement to include in the accounts (approved)

NB. There was no meeting of the Auditor Panel required on this occasion.

Key:

GT	= Grant Thornton (external auditor)	MIAA	= Mersey Internal Audit Agency (internal audit & anti-fraud services)
DoF	= Director of Finance	DoN	= Director of Nursing, Midwifery & Governance
DDoI	= Deputy Director of Informatics	ADoOM	= Asst Director of Operations (Medicine)
ADoF	= Asst Director of Finance (Financial Services)		

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/Escalation: For the Board to:

(i) Note the various approvals by the Committee cited in this paper; and to

(ii) Note the high level of over 90 day aged debt.

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

Date of meeting: 24th April 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)35
Title of paper: Strategic and Regulatory Update Report – April 2019
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 including: 1. Operational Planning 2019/20; 2. Workforce Disability Equality Standard (WDES); 3. Clinical review of NHS access standards; 4. Interim Workforce Implementation Plan – emerging priorities and actions; 5. Accounting Manual Guidance – GDPR.
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 note the report.
Presenting officer: Nicola Bunce, Director of Corporate Services
Date of meeting: 24th April 2019

Strategic and Regulatory Update Report – April 2019

1. Operational Planning 2019/20

Following review at the March Board meeting the Trust's operational plans were submitted to NHS Improvement on 4th April, in accordance with the national time table. The submitted version of the narrative plan was circulated to Board members for information, as there were no material changes for the draft discussed at Board.

2. Workforce Disability Equality Standard (WDES)

The NHS Workforce Disability Equality Standard (WDES) is designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the National Health Service (NHS). The WDES follows the NHS Workforce Race Equality Standard (WRES) as a tool and an enabler of change.

The WDES is a series of 10 evidence-based Metrics that will provide NHS organisations with a snapshot of the experiences of their Disabled staff in key areas. By providing comparative data between Disabled and non-disabled staff, this information can be used to understand where key differences lie; and will provide the basis for the development of action plans, enabling organisations to track progress on a year by year basis. The WDES provides a mirror for the organisation to hold up to itself, to see whether it reflects the communities that it serves.

The WDES has been mandated, through the NHS Standard Contract to apply only to NHS Trusts and Foundation Trusts from 2019/20. The intention is that the requirement will be extended to other NHS organisations in the next 2 years. The requirement for the Trust is to:

- Implement the National Workforce Disability Equality Standard; and
- Report to the Co-ordinating Commissioner on its progress.

In the first year, NHS Trusts and Foundation Trusts need to review their data and take any necessary action on key areas that support the implementation of the WDES. A focus will be to increase ESR disability declaration rates and a reduction in the rates of staff in the unknown/'not declared' categories.

WDES reporting will follow the same process as the WRES. The WDES online reporting form must be completed and submitted by 1st August 2019. The Trust must then publish its results and Board approved action plan by 30th September 2019.

3. Clinical review of NHS access standards

In 2018 the prime minister asked Professor Stephen Powis, the NHS National Medical Director to undertake a review of access targets, an interim report was published in March 2019. This report proposed updating several of the current performance measures to help staff improve patient care and remove barriers for Trusts that seek to modernise the delivery of treatment.

These proposals are designed to:

• Establish standards to guarantee short waits for mental health and community health services
• Improving clinical quality and outcomes through earlier diagnosis of cancer and faster assessment and treatment for major emergencies such as heart attacks, stroke and sepsis.
• Help, rather than penalise, hospitals that modernise care. Standards should encourage consultants to work with GPs so that patients are diagnosed without a hospital visit or A&Es to successfully treat a patient in five hours rather than admit them.
• Lock-in short waits for A&E and planned surgery and provide a more complete picture of performance by measuring the whole wait experienced by every patient.

The review worked with an external Oversight Group which includes members from the Academy of Medical Royal Colleges, the Royal College of Surgeons, the Royal College of Physicians, the Royal College of Nursing, Healthwatch and senior members of NHS England and NHS Improvement clinical teams.

The proposals are now being tested in a number of Trusts across the country to assess their real world impact. Whilst this testing is being undertaken and evaluated the existing waiting time targets remain in place.

4. Interim Workforce Implementation Plan – emerging priorities and actions

Following the publication of the NHS Long Term Plan, Baroness Dido Harding, Chair NHS Improvement and Julian Hartley, CEO Leeds Teaching Hospital NHS Trust were tasked by the Prime Minister and Secretary of State for Health and Social Care to develop an interim Workforce Implementation Plan, as part of the overall Implementation Plan for the NHS Long Term Plan (LTP). An update on the development of the plan was published on 6th March 2019, seeking views on the emerging ideas and acknowledging that aspirations and detailed plans beyond 2019/20 would be subject to the conclusion of the Comprehensive Spending Review, later in the year.

A summary of the emerging themes and proposed short term actions is:

Theme 1: We can make a significant difference to our ability to recruit and retain staff by making the NHS a better place to work.

Potential actions for 2019/20

- Consultation on a new deal with staff, building on the NHS Constitution, and setting out what they can expect from the NHS as a world-class and modern employer
- Associated campaign to engage all our people; framework to support Boards on how to engage with their people; good practice case studies of employers that are at the vanguard on this agenda
- Further action to improve health and wellbeing, including implementing the recommendations from the recently published *NHS staff and learners' mental wellbeing commission*
- Next steps on tackling violence and aggression, and bullying and harassment
- Embedding the Workforce Race Equality Standard and consulting on Workforce Disability Standard
- Expanding the NHS Improvement retention programme to all trusts and developing an equivalent program for Primary Care
- Streamlining induction and training processes, and passporting training and qualifications across different employers and settings
- Review of the impact of pensions policy on retention and options to resolve

Theme 2: If our workforce plan is to succeed we must start by making real changes to improve the leadership culture in the NHS.

Potential actions for 2019/20

- Review of the support provided to challenged organisations by NHSI/E to ensure it reflects the inclusive and compassionate leadership we know delivers
- Develop a consistent, whole system approach for identifying, assessing, developing, deploying and supporting our talent to include:
    - rolling out regional talent boards
    - resources to support development of system leadership skills
    - consulting on common job descriptions, competency, values and behaviour frameworks for board level roles and other recommendations from recent reports by Tom Kark QC and Sir Ron Kerr
    - reviewing investment in talent management programs for all our staff
- Co-production of new 'leadership compact' between NHS Improvement/NHS England and Chief Executive Officers/Accountable Officers and Chairs which will set out the, values, behaviours and competencies expected of senior leaders, and the support and development those senior leaders should expect in return
- Review of the national oversight frameworks to ensure they are reflecting the inclusive and compassionate leadership we know delivers, specifically the Care Quality Commission/NHS Improvement well-led framework, NHS Improvement Single Oversight Framework and NHS England Improvement and Assessment Framework to enable measurement of culture, leadership, inclusion and organisational health

Theme 3: Although there are workforce shortages in a number of professions, disciplines and regions, the biggest single challenge we currently face nationally is in the nursing and midwifery profession.

Potential actions for 2019/20

• 5,000 expansion of clinical placements for impact September 2019 intake
• New annual campaign and targeted approaches to school leavers, in particular 15 to 17-year olds (linked to volunteering and work experience programmes to maximise opportunities for exposure to health careers)
• Review of current Return to Practice processes to determine whether these can make a further contribution to increasing supply
• Details of the job guarantee offer, and an approach to preceptorship and early career support as part of an expanded retention programme

Theme 4: To deliver on the vision of 21st century care set out in the LTP will not simply require 'more of the same' but a different skill mix, new types of roles and different ways of working.

Potential actions for 2019/20

• Tools and good practice case studies to support systems to maximise the use of the apprenticeship levy
• 4 new multi-professional credentials and details of the next set for development
• Review of priorities areas for CPD investment
• Establishment of sustainable NHS Digital Academy; plans to ensure new areas such as AI are included in curricula; establishment of a board level leadership development model; and a digital workforce planning exercise

Theme 5: We must look again at respective roles and responsibilities for workforce across the national bodies and their regional teams, ICSs, and local employers, to ensure we are doing the right things at the right level.

Potential actions for 2019/20

- Clarity about the roles and responsibilities of the national bodies and their regional teams, STPs/ICSs and local employers on workforce, with a roadmap for greater devolution of responsibilities and resources to STPs/ICSs and the support offer from regional teams
- Details of the critical path to establish single, real time, workforce dataset available to national, system and local bodies, built up from local systems

5. Accounting Manual Guidance – GDPR

The accounting manual has been updated to include guidance that Trusts should consider the application of GDPR to the publication of personal and remuneration information in NHS annual reports and accounts.

The production of the annual report and accounts is a statutory obligation for all NHS bodies, including disclosures about its directors and remuneration. All the information is auditable.

The information that is published; name, position, remuneration has not changed from previous years.

The Trust legal advisors have confirmed that;

The lawful basis on which the Trust will be processing personal data in this case is defined in Article 6 of the GDPR:

- processing is necessary for compliance with a legal obligation to which the controller is subject (6(1)(c)) – because Trust's are under an obligation to include the remuneration details in the annual report; and

- processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller (6(1)(e)) – this includes processing which is necessary for the exercise of the Trust's statutory functions, which include the publication of an annual report.

If there are questions about the information that will be disclosed about directors in the annual report and accounts, these should be directed in the first instance to the Director of Corporate Services.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)36
Title of paper: Corporate Risk Register
Purpose: To inform the Board of the risks that have currently been escalated to the Corporate Risk Register (CRR) from the Care Groups via the Trust's risk management systems.
Summary: The CRR is reported to the Board to provide assurance that the Trust is operating an effective risk management system, and that risks identified and raised by front line services can be escalated to the Executive. The risk management process is overseen by the Risk Management Council (RMC), which reports to the Executive Committee providing assurance , that all risks: • Have been identified and reported; • Have been scored in accordance with the Trusts risk grading matrix; • Any risks initially rated as high or extreme have been reviewed by a Director; • Have an identified target risk score, which captures the level of risk appetite and has a mitigation plan that will realistically bring the risk to the target level. This report covers the risks reported and reviewed in March 2019 and is a snap shot, rather than a summary of the quarter. The report shows (Appendix 1): • The total number of risks on the risk register is 741; • 45% (336) of the Trusts risks are rated as Moderate or High; • 10 risks that scored 15 or above had been escalated to the CRR. The spread of CRR risks (Appendix 2) across the organisation is: • 2 in the Medical Care Group; • 1 in the Surgical Care Group; • 0 in Clinical Support Care Group; • 7 in Corporate Services; • 0 in Primary Care and Community Services Care Group. The risk categories of the CRR risks are: • 4 x Patient Care; • 3 x Money; • 1 x Governance; • 2 x Staff. Risk 2385 (Plastics Trauma Unit accommodation) has subsequently been mitigated and is now graded as a moderate risk.
Corporate objectives met or risks addressed: The Trust has in place effective systems and processes to identify manage and escalate risks to the delivery of high quality patient care.
Financial implications: None directly from this report.
Stakeholders: Staff, Patients, Commissioners, Regulators.
Recommendation(s): The Trust Board notes the risk profile of the Trust and the risks that have been escalated to the CRR.
Presenting officer: Nicola Bunce, Director of Corporate Services
Date of meeting: 24th April 2019

Appendix 1

CORPORATE RISK REGISTER REPORT – APRIL 2019

1. Risk Register Summary for the Reporting Period

RISK REGISTER	Current Reporting Period 01/04/2019	Previous Reporting Period 05/03/2019	Previous Reporting Period 01/02/2019
Number of new risks reported	56	19	19
Number of risks closed or removed	90	14	25
Number of increased risk scores	2	2	1
Number of decreased risk scores	7	7	12
Total Number of Datix risks	**741**	**775**	**770**

2. Trust Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
54	**59**	**23**	**109**	**12**	**148**	**63**	**113**	**36**	**114**	**1**	**7**	**2**	**0**
136 = 18.35%			**269 = 36.30%**			**326 = 43.99%**				**10 = 1.35%**			

2.1. Surgical Care Group (210 risks reported 28.34% of the Trust total)

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
4	**17**	**9**	**30**	**4**	**43**	**19**	**47**	**8**	**28**	**1**	**0**	**0**	**0**
30 = 14.29%			**77 = 36.67%**			**102 = 48.57%**				**1 = 0.48%**			

2.2. Medical Care Group (179 risks reported 24.16% of the Trust total)

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
28	**24**	**1**	**28**	**0**	**33**	**7**	**18**	**13**	**25**	**0**	**1**	**1**	**0**
53 = 29.61%			**61 = 34.08%**			**63 = 35.20%**				**2 = 1.12%**			

2.3. Clinical Support Care Group (92 risks reported 12.41%% of the Trust total)

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
9	**6**	**1**	**7**	**0**	**13**	**10**	**15**	**9**	**21**	**0**	**1**	**0**	**0**
16 = 17.39%			**20 = 21.74%**			**55 = 59.78%**				**1 = 1.09%**			

2.4. Community Services (40 risks reported 5.4% of the Trust total)

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
0	**2**	**0**	**11**	**1**	**4**	**2**	**4**	**6**	**10**	**0**	**0**	**0**	**0**
2 = 5%			**16 = 40%**			**22 = 55%**				**0**			

2.5. Corporate (Finance, Health Informatics/Health Records, Facilities, Nursing/ Governance/Quality & Risk, HR and Medicine Management) (220 risks reported 29.69% of the Trust total)

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
13	**10**	**12**	**33**	**7**	**55**	**25**	**29**	**0**	**30**	**0**	**5**	**1**	**0**
35 = 15.91%			**95 = 43.18%**			**84 = 38.18%**				**6 = 2.73%**			

The split of the risks across the corporate departments is:

	High	Moderate	Low	Very low	**Total**
Health Informatics/ Health Records	1	20	2	0	**23**
Facilities (Medirest/TWFM)	0	3	12	7	**22**
Nursing, Governance, Quality & Risk	0	17	10	6	**33**
Finance	2	5	15	11	**33**
Medicines Management	0	17	44	8	**69**
Human Resource	3	21	12	3	**39**
Information Governance	0	1	0	0	**1**
Total	**6**	**84**	**95**	**35**	**220**

Appendix 2

Corporate Risk Register – April 2019

KEY	Medicine		Surgical		Clinical Support		Corporate		Community	

Risk Category	Datix Ref	Risk	Current Risk Score I x L	Date of last review and Executive Lead	Target Risk Score I x L	Action plan in place	Monitoring and Governance
Governance	1772	Risk of Malicious Cyber Attack	4 x 4 = 16	31/03/2019 Christine Walters	4 x 3 = 12	Action plan in place	Executive Committee
Money	1555	Risk of not receiving apprenticeship levy payments for Lead Employer Doctors in Training.	4 x 5 = 20	10/01/2019 Anne-Marie Stretch	3 x 4 = 12	Action plan in place	Finance and Performance Committee
Money	1152	Risk to the quality of care, contract delivery and finance due to increased use of bank and agency	4 x 4 = 16	10/01/2019 Anne-Marie Stretch	4 x 3 = 8	Action plan in place	Quality Committee
Patient Care	1080	Risk to patient safety risk and operational effectiveness if staffing levels are below establishment on wards 2B &2C	4 x 5 = 20	28/12/2018 Sue Redfern	2 x 2 = 4	Action plan in place	Quality Committee
Staff	762	Risk that if the Trust cannot recruit sufficient staff to fill approved vacancies then there is a risk to being able to provide safe care and agreed of staffing	4 x 4 = 16	10/01/2019 Anne-Marie Stretch	4 x 2 = 8	Action plan in place	Quality Committee
Staff	2370	Risk to safe levels of medical cover, if consultant medical staff cannot be recruited to critical care vacancies	4 x 4 = 16	29/03/2019 Kevin Hardy	3 x 2 = 6	Action plan in place	Executive Committee
Patient Care	2502	The potential impact of Brexit No Deal on the supply of medical consumables and devices	4 x 4 = 16	18/03/2019 Nik Khashu	3 x2 = 6	Action plan in place	Finance and Performance Committee
Money	2521	If the Trust cannot deliver its agreed activity and CIP then there is a risk to the forecast outturn and the achievement of PSF funding	4 x 4 =16	11/03/2019 Nik Khashu	4 x 3 = 12	Action plan in place	Finance and Performance Committee
Patient Care	2334	Medway migration issues in Patient Booking Services impacting on service delivery across the Trust	4 x 4 =16	20/03/2019 Rob Cooper	4 x 2 = 8	Action plan in place	Executive Committee
Patient Care*	2385	Temporary relocation of the Plastics Trauma Unit due to winter pressures is not fit for purpose	3 x 5 = 15	27/03/2019 Rob Cooper	3 x 2 = 6	Action plan in place	Executive Committee

*New risks escalated to the CRR since the last Board report

Risks that have been de-escalated from the CRR since the last Board report are:

Risk Category	Datix Ref	Risk
Governance	222	Risk of failure to ensure delivery of national performance targets
Patient Care	1569	Risk to consultant recruitment for Clinical Support Services, due to national staff shortages
Money	2518	Risk to cash flow if other Trusts do not pay for their lead employer junior medical staff
Patient Care	767	If ED are unable to recruit to nursing vacancies and maintain nursing establishment then there is a risk to patient safety

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)37
Title of paper: Review of the Board Assurance Framework (BAF) – April 2019
Purpose: For the Trust Board to review the BAF and agree any changes.
Summary: The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to its statutory duties, strategic plans and long term objectives. In line with governance best practice the BAF is reviewed by the Board four times a year. The last review was in January 2019. For this version the BAF risks have also been realigned to the agreed 2019/20 Trust Objectives – Blue = new and Grey = removed. The Executive Committee review the BAF in advance of its presentation to the Trust Board and propose changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the planned actions and additional controls are sufficient to mitigate the risks being managed by the Board, in accordance with the agreed risk appetite. **Key to proposed changes:** ~~Score through~~ = proposed deletions/completed Blue Text = proposed additions Red = overdue actions **Recommended changes** The following changes should be considered: • Reduce score of risk 1 as a result of the recent CQC Inspection rating • Reduce the score of risk 2 as a result of the new financial year and approved plan • Reduce the score of risk 3 as a result of outturn performance against national access targets (except ED 4 hour target) in 2018/19. • Reduce score of risk 4 to 8 as a result of PLACE/Staff Survey/CQC • Reduce score of risk 6 as a result of reduced vacancies, success of international recruitment and growth of staff bank
Corporate Objective met or risk addressed: To ensure that the Trust has put in place sufficient controls to assure the delivery of its strategic objectives.
Financial implications: None arising directly from this report.
Stakeholders: NHSI, CQC, Commissioners.
Recommendation(s): To review and approve the proposed changes to the BAF.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 24th April 2019

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

Alignment of Trust 2019/20 Objectives and Long Term Strategic Aims

2019/20 Trust Objectives	Strategic Aims					
	We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes for the population	We will provide the services of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will work in partnership to create sustainable and efficient health systems
Five star patient care – Care						
Five star patient care – Safety						
Five star patient care – Pathways						
Five star patient care – Communication						
Five star patient care – Systems						
Organisational culture and supporting our workforce						
Operational performance						
Financial performance, efficiency and productivity						
Strategic Plans						

Risk Scoring Matrix

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

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

Risk 1 – Systemic failures in the quality of care	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause: • Failure to deliver the Clinical and Quality standards and targets • Failure to deliver CQUIN element of contracts • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting • Failure in the supply of critical goods or services Effects: • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage Impact: • Harm to patients • Loss of reputation • Loss of contracts/market share	5 x 4= 20	• Quality metrics and clinical outcomes data • Safety thermometer • Quality Ward Rounds • Complaints and claims • Incident reporting and investigation • Quality Governance structure • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings with lead CCG • NHSI Single Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • CQC routine annual PIR return • Medicines Optimisation Strategy • Learning from deaths policy	To Board; • IPR • Patient Stories • Quality Board Rounds • Quality Committee and its Councils • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Staff Survey • Friends and Family scores • Nursing Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • National Patient Surveys Other; • National clinical audits • Annual CQUIN Delivery • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Reports • Learning Lessons League • IG Toolkit results • Model Hospital benchmarking	~~5 x 2 = 10~~ 5x1 = 5	Routine reporting of quality and performance of community and primary care services delivered by the Trust	Routinely achieve 30% of discharges by midday 7 days a week ~~Delivery of the improvement plans for Falls, Infection Control and Pressure Ulcers in 2018/19~~ Delivery of the Falls Strategy Action plan to achieve a 10% reduction in falls resulting in moderate or severe harm. Demonstrating changes in behaviour a reduction in similar incidents as a result of sharing lessons learnt from never events, inquests and mortality reviews	Implementation plans for the four key 7-day service standards by 2020 ~~Implementation of Stroke Service integration with WHH – phase 2 planned completion in 2018/19~~ Transfer of acute stroke services from WHH as phase 2 of the HASU development (June 2019) ~~Targeted improvement work to increase FFT response rates (March 2019)~~ ~~Implementation of NEWS2 (March 2019)~~ Risk assessment of critical suppliers and development of contingency plans for EU exit. Undertake a review of patient communication and information to improve accessibility and understanding (September 2019)	5 x 1 = 5	KH/ SR

Risk 2 –-Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to deliver strategic financial plans two year operational plans and the agreed control total • Failure to control costs or deliver CIP • Failure to implement transformational change at sufficient pace • Failure to continue to secure national PFI support • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • Failure to respond to new models of care (FYFV) • Failure to secure sufficient capital to support additional equipment/bed capacity Effects; • Failure to meet statutory duties • NHSI Segmentation Status increases Impact; • Unable to deliver viable services • Loss of market share • External intervention	4 x 5 = 20	• Operational Plan and STP financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 5 year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSI annual provider Licence Declarations • PMO capacity to support delivery of CIP and service transformation • Signed Contracts with all Commissioners • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Declaration of interests • Benchmarking and reference cost group	To Board; • Finance and Performance Committee • Annual financial plan • Monthly finance report • IPR • Statement of Internal Control • Annual Accounts • Audit Committee • External Audit Reports Inc. VFM assessment • SLM/R Reporting and commercial assessment matrix • Agency and locum spend approvals and reporting process • Benchmarking and market share reports • Annual audit programme • PSF Targets and Control Total • CQUIN monitoring Other; • NHSI monthly reporting • Contract Monitoring Board • NHSI Review Meetings • Use of Resources reviews • Contract Review Boards with Commissioners • St Helens Cares Peoples Board	~~4 x 5 = 20~~ 4x3=12	Develop 2019 -20 detailed CIP plans and strengthen QIA monitoring to mitigate additional risk Continue collaboration across C&M to deliver transformational CIP contribution ~~to the organisations overall CIP target~~ Management plans to deliver GiRFT recommendations	Develop capacity and demand modelling and a consistent approach to service development proposals approval Foster positive working relationships with health economy partners to help create a joint vision for the future of health services Cash flow and prompt payment of invoices from other NHS providers	Develop a 5 year plan with the local Place based systems to deliver the NHS long term plan with C&M partners for submission in July 2019 Secure maximum PSF funding in 2019/20 to achieve revised forecast outturn ~~Agree acceptable funding flows across St Helens health and social care economy and its partners (April 2019)~~ Via the St Helens Cares Finance and Contract group develop proposals for financial allocations and funding flows for the system (September 2019) Seek all possible sources of capital funding including national bids to support capacity planning	4 x 2= 8	NK

Risk 3 - Sustained failure to maintain operational performance/deliver contracts	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories • Failure to reduce LoS • Failure to meet activity targets • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand Effects; • Reduced patient experience • Poor quality and timeliness of care leading to poorer outcomes • Failure of KPIs and self-certification returns • Increases in staff workload/stress Impact; • Potential patient harm • Loss of reputation • Loss of market share/contracts • External intervention • Loss of PSF funding • Increases in staff sickness rates	4 x 4 = 16	• NHS Constitutional Standards • Care group activity profiles and work plans • System Winter Plan • Care Group Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events re DTOC patients • Bed occupancy rates	To Board; • Finance and Performance Committee • IPR • System winter Resilience Plan • Annual Operational Plan • Data Quality audits Other; • Contract review meetings/CQPG • Community services contract review meetings • NHSI monitoring and escalation returns/sit reps including delivery of PSF quarterly targets • CCG CEO Meetings • CQC System Reviews e.g. Halton, Liverpool	~~4 x 5= 20~~ 4 x 3 = 12	Implementation of routine capacity and demand modelling	Achievement of targets to reduce DTOC and super stranded patients, by working effectively with health system partners Review the effectiveness of the 2018/19 health economy winter plans and learn lessons to inform the plans for 2019/20 ~~Achieve target to reduce bed occupancy to 92% in 2018/19~~ Resolve residual Medway and operational issues with OP patient booking systems	Urgent and Emergency Care Summit improvement programme ~~– March 2019~~ – September 2019 ~~Delivery of the ECIP concordat 5 key targets for 2018/19~~ Work with Halton CCG to achieve implementation of the agreed frailty pathway model following the allocation of STP transition funding (May 2019) Reduce the RTT waiting list to below the 2018/19 outturn level (March 2020)	4 x 3 = 12	RC

Risk 4 - Failure to protect the reputation of the Trust	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information Effect; • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff • Increased external scrutiny/review Impact; • Reduced financial viability and sustainability • Reduced service safety and sustainability • Reduced operational performance • Increased intervention	4 x 4 = 16	• Communication and Engagement Strategy • Communications and Engagement Action Plan • Workforce, Recruitment and Retention Strategy • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR	To Board; • Quality Committee • Workforce Council • Audit Committee • Charitable funds committee • Communications and Engagement Strategy • IPR • Staff Survey • Complaints reports • Friends and Family • Staff F&F Test • PLACE Survey • National Cancer Survey • Referral Analysis Reports • Market Share Reports • CQC national patient surveys • CQC Inspection ratings • Annual assessment of compliance against the CQC fundamental standards • Compliance review against the NHS Constitution Other; • Health Watch • CQC • NHSI Segmentation Rating	~~4 x 3 = 12~~ 4 x 2 = 8	Regular media activity reports , including social media, to the Executive Committee ~~Development of a new Patient Experience Strategy (March 2019)~~	Action plan to improve understanding of patients and carers' views (Revised to September 2019)	Update Trust internet site Review and improve patient information and communication (September 2019)	4 x 2 = 8	AMS

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

Risk 6 – Failure to attract and retain staff with the skills required to deliver high quality services	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff Effect; • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff Impact; • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	5 x 4 = 20	• Team Brief • Staff Newsletter • Mandatory training • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCC/Workforce Council • Francis Report Action Plan • Education and Development Plan • HR Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews • Workforce KPIs • Recruitment and Retention Strategy action plan • Nurse development programmes • Agency caps and usage reporting • LWEG/LETB membership • Speak out safely policy • ACE Behavioural standards	To Board; • Quality Committee • Workforce Council • Finance and Performance Committee • Premium Payments Scrutiny Council • IPR – HR Indicators • Staff Survey • Monthly Nurse safer staffing reports • Workforce plans aligned to strategic plan • Monitoring of bank, agency and locum spending • Monthly monitoring of vacancy rates and staff turnover • Staff F&FT snapshots • WRES report and action plan • Quality Ward Rounds • FTSU Self-Assessment and action plan Other • Annual workforce plans • HR benchmarking • Nurse staffing benchmarking • C&M HR Work Stream	~~5 x 4 = 20~~ 5 x 3 = 15		Specific strategies to overcome recruitment hotspots e.g. International recruitment and working closely with HEE's Monitoring of take up of the UK Settlement Scheme by EU staff ~~Plans to optimise opportunities from the apprenticeship levy to create new roles and qualifications to address skills and capacity gaps (March 2019)~~	Development of a C&M collaborative staff bank – Revised to June 2019 ~~Implementation of the NHSI Recruitment and Retention Framework and evaluation of the return on investment (March 2019)~~ Develop workforce strategy in relation to new roles e.g. Nurse Associates to maximise potential – September 2019 Revise the Workforce Strategy to align to the workforce objectives in the NHS Long Term Plan (July 2019)	5 x 2 = 10	AMS

Risk 7 – Major and sustained failure of essential assets or infrastructure	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire Effect; • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric or equipment • Increase in complaints Impact; • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 4 = 16	• New Hospitals / Vinci Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5 year Capital programme • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M STP Strategic Estates work programme	To Board; • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • I.P.R. Other; • Major Incident Plan • Business Continuity Plans • ERIC Returns • PLACE Audits • Model Hospital • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee, to capture: ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance	4 x 2 = 8	Development of a 10 year strategic estates development plan to support the Trusts service development and integration strategies.	~~Maximise the potential from the GP Streaming investment to improve the A&E department flows.~~	NHSI approval of Ambulatory care /bed capacity business case (July 2019) Revise Estates and accommodation strategy – addressing car parking and office accommodation on both sites (September 2019) Operational plans to accommodate 10 year lifecycle works with minimal service disruption (May 2019)	4 x 2 = 8	NB

Risk 8 – Major and sustained failure of essential IT systems	Initial Risk Score (IxP)	Key Controls	Sources of Assurance	Residual Risk Score (IxP)	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)	Target Risk Score (IxP)	Exec Lead
Cause; • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure. Effect; • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity. • Loss of data or patient related information Impact; • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	4 x 5= 20	• HIS Management Board and Accountability Framework • Procurement Framework • Health Informatics Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plan • Disaster Recovery Policy • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Information asset owner/administrator register	To Board; • Board Reports • IM&T Strategy delivery and benefits realisation plan reports (5YFV) • Audit Committee • Executive committee • Risk Management Council • Information Security Assurance Group • Health Informatics Service Operations Board • Health Informatics Strategy Board • Programme/Project Boards • Information Governance Steering Group Other; • Annual financial plan agreed with partners • Internal/External Audit Programme • Data security protection Toolkit Submissions • Information asset owner framework • Information Security Dashboard • CareCert, Cyber Essentials, External Penetration Test • Medway benefits realisation programme monitoring	4 x 4= 16	Annual Cyber Security Business Case approval ~~Annual Infrastructure Replacement Programme to be agreed~~ Annual Corporate Governance Structure review Staff Development Plan Technical Development Annual programme of audit ~~IT Assurance Dashboard – Cyber Controls~~ NHS Digital Unified Cyber Risk Framework	ISO27001 Cyber Essentials Plus Service Improvement Plans Communications Strategy Digital Maturity Assessment Complete investigation and review of controls and business continuity resilience following IT outage in January	ISO27001 (August 2020) Cyber Essentials Plus (revised to August 2019) Approval of draft Cyber Security Strategy (July 2019) Medway benefits realisation programme delivery (Revised to August 2019) Delivery of Penetration Test Action Plan (August 2019) ~~Information asset owner/administrator work programme (Tier 1 systems) (revised to March 2019)~~ Information security management framework (revised to August 2019) Capital Investment Action Plan (Revised to April 2019) ~~Maintaining and enhancing essential IT Systems (March 2019)~~	4 x 2 = 8	CW

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)38
Title of paper: Learning from Deaths Quarterly Report 2018/19 Q3
Purpose: To describe mortality reviews that have taken place in both specified and non-specified groups; to provide assurance that all specified groups have been reviewed for deaths, and key learning has been disseminated throughout the Trust.
Summary: Data is given for Quarter 3 2018/19 and key learning described
Corporate objectives met or risks addressed: 5 star patient care: Care, Safety, Communication
Financial implications: None
Stakeholders: Trust patients and relatives, clinicians, Trust Board, Commissioners
Recommendation(s): To approve the report, policy and good practice guide
Presenting officer: Prof Kevin Hardy, Medical Director
Date of meeting: 24th April 2019

STHK Learning From Deaths Board Report

		Specified Groups										
	Deaths in Scope [1]	Learning Difficulties Death	Severe Mental Illness Death [2]	Child Death	Neonatal Death or Stillbirth	Maternal Death	CQC Alert Death	Diagnosis Group Death [3]	Post-Op Death	SIRI Death	Concern Death [4]	Total [5]
Apr-18	114	2	1	0	2	0	0	4	10	0	5	24
May-18	133	3	0	0	0	0	0	5	5	0	2	15
Jun-18	118	1	0	0	0	0	0	2	6	0	5	14
Jul-18	119	4	0	0	0	0	0	3	12	0	5	21
Aug-18	136	3	2	0	0	0	0	4	10	0	10	27
Sep-18	119	2	3	0	0	0	0	3	10	1	4	21
Oct-18	118	2	1	0	0	0	0	4	8	1	4	17
Nov-18	114	1	1	0	0	0	0	2	13	0	4	20
Dec-18	175	3	1	0	0	0	0	2	7	0	4	17
Grand Total	1,146	21	9	0	2	0	0	29	81	2	43	176

	Specified Groups			Non-Specified Groups		
	Total [5]	Reviewed	% Reviewed	Total	Reviewed	% Reviewed (Target 25%)
Apr-18	24	24	100.0%	90	23	25.6%
May-18	15	15	100.0%	118	30	25.4%
Jun-18	14	14	100.0%	104	28	26.9%
Jul-18	21	21	100.0%	98	24	24.5%
Aug-18	27	27	100.0%	109	28	25.7%
Sep-18	21	21	100.0%	98	25	25.5%
Oct-18	17	17	100.0%	101	27	26.7%
Nov-18	20	20	100.0%	94	25	26.6%
Dec-18	17	17	100.0%	158	45	28.5%
Grand Total	176	176	100.0%	970	255	26.3%

	% of Reviews with RAG Rating [6]		
	Total RAG Reviewed	Total Reviewed	% RAG Reviewed
Apr-18	42	47	89.4%
May-18	42	45	93.3%
Jun-18	41	42	97.6%
Jul-18	43	45	95.6%
Aug-18	50	55	90.9%
Sep-18	42	46	91.3%
Oct-18	40	44	90.9%
Nov-18	43	45	95.6%
Dec-18	58	62	93.5%
Grand Total	401	431	93.0%

	Outcome of RAG Reviewed Deaths			
	where no concerns	where significant doubt about whether or not, problems in care delivery/service provision contributed to death - refer to multi professional review	where balance of probability is that death may have resulted from problems in care delivery/service provision - refer to SIRI investigation	Grand Total
Apr-18	40	0	2	42
May-18	42	0	0	42
Jun-18	40	1	0	41
Jul-18	39	2	2	43
Aug-18	48	2	0	50
Sep-18	40	2	0	42
Oct-18	39	1	0	40
Nov-18	41	2	0	43
Dec-18	56	2	0	58
Grand Total	385	12	4	401

	Outcome % of RAG Reviewed Deaths		
	where no concerns	where significant doubt about whether or not, problems in care delivery/service provision contributed to death - refer to multi professional review	where balance of probability is that death may have resulted from problems in care delivery/service provision - refer to SIRI investigation
Apr-18	95.2%	0.0%	4.8%
May-18	100.0%	0.0%	0.0%
Jun-18	97.6%	2.4%	0.0%
Jul-18	90.7%	4.7%	4.7%
Aug-18	96.0%	4.0%	0.0%
Sep-18	95.2%	4.8%	0.0%
Oct-18	97.5%	2.5%	0.0%
Nov-18	95.3%	4.7%	0.0%
Dec-18	96.6%	3.4%	0.0%
Grand Total	96.0%	3.0%	1.0%

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

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

[3] Diagnosis groups under internal monitoring

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

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

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

Learning & Sharing

Key Learning from Q3 2018/19

(1) Some hospital patients face an uncertain recovery and are sick enough to die despite active treatment. Please ensure that DNA-CPR and ceilings of treatment are proactively discussed with the patient, their family and people important to them. Symptoms control treatments MUST be provided in parallel with active treatment. Please also consider referral to the specialist palliative care team and note that active and palliative treatments are not mutually exclusive.

(2) When patients present with swallowing difficulties and they are frail or approaching the end of life, do not make them NBM as a "reflex". Open discussions with the patient and their relatives about the risks and benefits of continuing oral feeding, and involve the SALT Team.

Assurance from Q2 2018/19

Sharing: (Current Q2) Board (mins) ■, Quality Committee (mins) ■, F&P (mins) ■, CEC (mins) ■, PSC (mins) ■, PEC (mins) ■, MCG Governance (mins) ■, SCG Governance (mins) ■, Grand Rounds (mins) ■, ED Teaching (record) ■, FY Teaching (record) ■, Team Brief (record) ■, Intranet Message Board (record) ■, Global Email (record) ■, Directorate meetings (mins) ■. List any policies/procedures or guidelines changed: ____

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Effectiveness: (Current Q3) Audit of DATIX □, SIRIs □, Complaints □, PALS □, Litigation □, Mortality Reviews for evidence of failure to deliver these priorities □.