St Helens and Knowsley Teaching Hospitals NHS Trust

# Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 27TH FEBRUARY 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 30th January 2019 | | Attached | |
| | | 4.1 | Correct Record & Matters Arising | Verbal | |
| | | 4.2 | Action Log | Attached | |
| **Performance Reports** | | | | | |
| 09:50 | 5. | Integrated Performance Report | | NHST(19) 12 | 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** | | | | | |
| 10.00 | 6. | Committee Report – Executive | | NHST(19) 13 | Ann Marr |
| 10:10 | 7. | Committee Report – Quality | | NHST(19) 14 | Val Davies |
| 10:20 | 8. | Committee Report – Finance & Performance | | NHST(19) 15 | Jeff Kozer |
| 10:30 | 9. | Committee Report – Audit | | NHST(19) 16 | Su Rai |
| 10:40 | 10. | Committee Report – Charitable Funds | | NHST(19) 17 | Paul Growney |
| **BREAK** | | | | | |

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| **Other Board Reports** | | | | |
| 11:00 | 11. | Strategic & Regulatory Report | NHST(19) 18 | Nicola Bunce |
| 11:10 | 12. | NHS Resolution: maternity incentive scheme – briefing and action plan | NHST(19) 19 | Sue Redfern |
| 11:20 | 13. | 7 Day Services Board Assurance Statement | NHST(19) 20 | Kevin Hardy |
| **Closing Business** | | | | |
| 11:30 | 14. | Effectiveness of Meeting | Verbal | Chair |
| | 15. | Any Other Business | | |
| | 16. | Date of Next Meeting – Wednesday 27th March 2019 | | |

St Helens and Knowsley Teaching Hospitals NHS Trust

**Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Board meeting held on Wednesday 30th January 2019 in the Boardroom, Whiston Hospital**

# PUBLIC BOARD

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| **Chair**: | Mr R Fraser | (RF) | Chairman |
| **Members:** | Ms A Marr | (AM) | Chief Executive |
| | Ms S Rai | (SR) | Non-Executive Director |
| | Mrs V Davies | (VD) | Non-Executive Director |
| | Mr J Kozer | (JK) | Non-Executive Director |
| | Mr P Growney | (PG) | 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 H Cain | (HC) | Patient Experience Manager *(for Patient Story only)* |
| | Ms S Whelan | | Patient Experience Manager *(for Patient Story only)* |
| | Dr A Gatignol | | Observer |
| | Dr E Kleidi | | Observer |
| **Apologies:** | Mr D Mahony | (DM) | Non-Executive Director |
| | Mrs J Quinn | (JQ) | Non-Executive Director |

## 1. Employee of the Month

1.1. The Employee of the Month Award for December 2018 was presented to Emma Knowles, Lead Flu Nurse.

1.2. The Employee of the Month Award for January 2019 was presented to Laura Croft, Temporary Workforce Manager.

## 2. Patient Story

2.1. HC introduced the new Patient Experience Manager, Sandra Whelan, who was attending today to gain experience.

2.2. HC presented the story to the Board on behalf of the patient. The story had been brought to HC's attention when the patient's friend used the Trust's Twitter account to express her gratitude for the way the patient had been treated during a

recent visit to A&E. The patient had special needs and found hospital visits overwhelming and became extremely anxious as a result. A&E staff had recognised this immediately and found a side room containing very little clinical equipment in which to conduct the assessment and had provided him with accessible explanations of what was happening and how long it would take, at regular intervals during the attendance. In total the patient was seen and treated in 35 minutes, which relieved his anxiety and made the hospital visit bearable. HC felt that this represented an excellent example of patient centred and individualised care, which was impressive because the patients additional needs had been identified at a very early stage and the staff had adapted their practice to ensure that the patient to meet these needs.

2.3. RF thanked HC for sharing the story and congratulated the A&E team involved. He asked how this exemplary experience could be replicated throughout the Trust.

2.4. HC had spoken to the Emergency Care Manager to understand what had worked well and how the Trust could replicate the experience for all patients with additional needs. SRe confirmed work was also ongoing in relation to pathways and would be a priority for the adult safeguarding team in the coming year. A Band 7 nurse had also been appointed with a special interest in additional needs.

2.5. SR asked if the Trust had a policy for 'fast-tracking' patients with additional needs through A&E. RC confirmed the A&E receptionists were very good at flagging such patients up to Triage nurses to ensure the appropriate care was put in place and this had received some very positive feedback from other patients and their carers. AMS had also received excellent feedback regarding staff in the Sanderson Suite at St Helens Hospital, where patients with additional needs were often invited to visit the ward beforehand to alleviate any fears. She knew that the Radiology department also had a similar scheme in place to help reduce any patient anxiety about their scans.

2.6. NK asked if patients with additional needs had Healthcare passports. HC said that not all patients with additional needs had a passport when they first attended the hospital, as in this case. It was important to raise the awareness of healthcare passports across all areas of the health system so that the use of the system is increased. In fact the Trust itself issued these passports to patients who were identified whilst in the Trust's care.

2.7. AM felt that the level of sensitivity and compassion shown to this patient is the standard the Trust should be aspiring to for all patients.

2.8. RF thanked HC and SW for attending the meeting and asked HC to pass on the Board's thanks to the patients and his carer for sharing their experience.

## 3. Apologies for Absence

Apologies were noted as above. RF asked for the Board's condolences to be passed on to JQ following a recent family bereavement.

## 4. Declaration of Interests

4.1. KH declared he had been appointed as a Director of the Holy Family Catholic Multi Academy Trust Board in Wirral, which was not remunerated and he did not anticipate would cause any conflict of interest.

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

### 5.1. Correct Record

5.1.1. The minutes were accepted as a correct record.

### 5.2. Action List

5.2.1. Meeting Date 25.07.18 (Minute 11.5) – revision of Learning from Inpatient Deaths policy – **ON AGENDA. ACTION CLOSED.**

5.2.2. Meeting Date 25.07.18 (Minute 12.7) – time taken to resolve employee relations' cases – an electronic tracker was currently being implemented and this information would be included in the next scheduled HR Indicators report for July's Board meeting.

5.2.3. Meeting 31.10.18 (Minute 6.8) – action plan for the introduction into the workforce of new advanced nurse practitioners – to be included as part of the Workforce Strategy that was being presented at the Strategy Board in February.

## 6. Integrated Performance Report (IPR) – NHST(19)001

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

### 6.2. Quality Indicators

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

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

6.2.3. There had been no MRSA reported in month and one MRSA positive specimen in the year to date (target = 0). The RCA had indicated that this was a contaminant and the patient did not come to harm.

6.2.4. There were 4 C.Diff positive cases reported in December 2018. Year to date (month 9) there had been 19 cases. The annual tolerance was 40.

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

6.2.6. The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for December 2018 was 95.5% and year to date performance was 96.2%.

6.2.7. There had been no falls resulting in severe harm in December and 1 in the year to date (November 2018).

6.2.8. Venous thromboembolism (VTE) assessment performance for November was 96.48%. Year to date performance was 96.08% against a target of 95%.

6.3. **Operational Indicators**

6.3.1. RC presented the update on the operational performance.

6.3.2. The 62-day cancer standard was achieved in November at 88.4% against the target of 85%.

6.3.3. The 31-day cancer target was achieved with 96.7% performance against a target of 96%.

6.3.4. The 2-week cancer standard was also achieved with 94% against a target of 93%. The work that had been done to improve the cancer performance was noted by the Board.

6.3.5. A&E access time performance was 68.4% (type 1). The all types mapped footprint performance for December was 84.1%. The work of the Urgent and Emergency Care Improvement Programme was ongoing, and the Finance & Performance Committee had received a detailed presentation giving a progress report on all five of the work streams. This had provided assurance on the level of work that was being undertaken to increase discharges before midday, streaming of patients for assessment and the time to get patients into an appropriate bed if they needed to be admitted and it was disappointing that all this excellent work had not yet translated into an improvement in the Trust's 4-hour performance.

6.3.6. Whiston A&E had the highest volume of ambulances in Cheshire & Merseyside and Great Manchester in December. Ambulance notification to handover time was 16.35 minutes on average for December, against a target of 15 minutes. This was the first time in 8 months that the Trust has not met the target. JK felt it was important to recognise that although the Trust did not achieve the target, the figure was still an improvement on the previous year.

6.3.7. The average number of Super Stranded patients (patients with a length of stay of greater than 21 days) during December 2018 was 111 compared with 143 in December 2017, which was a 29% reduction year on year.

6.3.8. Following the migration of the Trust patient administration system in April, RC confirmed the Trust had resumed reporting Referral to Treatment (RTT) performance in December, as agreed with NHS Improvement. The RTT performance was 93.7% against a target of 92%.

6.3.9. VD asked about the Cancer 62-day waits from urgent GP referral to first treatment by tumour site for the Upper GI and Head & Neck pathways, which were below target. RC confirmed some of the issues were as a result of the complex multi-organisational pathways which sometimes resulted in delays. He also explained that because these were very specialist pathways the numbers of patients were small, so a single breach could result in the target being failed. AM explained there was lots of work in progress across the Cheshire & Merseyside Cancer Alliance and she had recently met with the Lead for the Head & Neck Cancer pathway, Prof Jones, who was going to work with the Trust and Aintree Hospital to revise the referral pathway. If successful, the pathway would be rolled out across the whole Cancer Alliance. The proposed revisions to the pathway may involve boosting the Trust's resilience with the (possibly joint) appointment of an additional ENT surgeon which would ensure the correct tests could be requested at the right time in the patients journey for them to be seen and treated within the target timescales.

6.4. **Financial Indicators**

6.4.1. NK presented the update on the financial performance.

6.4.2. At the end of month 9, the Trust reported a surplus of £1m which was a £2.5m adverse variance to agreed plans. The reason for the variance the removal of the Provider Sustainability Fund relating to A&E performance in the year to date.

6.4.3. 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.

6.4.4. The Trust continued to deliver above the year-to-date CIP target with £9.8m transacted year to date against a plan of £9.4m. Whilst plans and ideas for delivery of the full £19m CIPs had been discussed in detail at the Finance & Performance Committee, a significant proportion remained high risk.

6.4.5. The Trust cash balances at the end of month 9 were £19.5m, the Trust had a high cash balance as a result of taking a one-month loan of £12m to mitigate non-payment of lead employer invoices over the Christmas and New Year period, because of the earlier than usual payroll deadlines, although NK reported that the support received from NHS Improvement was helping with prompt payments for the Lead Employer contract. The Trust was owed over-performance payments from some of its main commissioners relating to this financial year.

6.4.6. The previously agreed change to the outturn position to a deficit of £5.994m including PSF had now been agreed by NHSI, who had commented on the exemplary manner in which the Trust had applied the change protocol and the Board's consideration of the mitigation actions at the Extraordinary Board meeting that had been held on 13th December. A meeting with Regulators regarding the variance from the plan was to take place with the Chairman, Chief Executive and Director of Finance.

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

6.5. **Workforce Indicators**

6.5.1. AMS presented the update on the workforce indicators.

6.5.2. Absence in December increased to 5.9%, which exceeded the Q3 target of 4.72%. AMS commented on the reasons given for sickness absence and the support that the Trust provided for staff. This included access to a free counselling service provided by Mersey Care NHS Foundation Trust. Not all stress was related to work, but rather to other events that were happening outside work. In recognition of this AMS was also in discussion with a counselling service specialising in financial advice that was already working with a number of other local trusts. This would be discussed further in the Executive Committee meetings.

6.5.3. In response to a query from NK, AMS confirmed the trade unions were an integral partner working with the Trust in regard to sickness absence levels. VD added she had recently attended a Workforce Council meeting where all parties were keen to be involved in an action plan to improve performance.

6.5.4. Qualified nursing and HCA sickness was 7.1% in December. YTD performance was 5.9% against the target of 5.3%. AMS was meeting with health and wellbeing managers and staff representatives to discuss how attendance could be improved. This was a complex issue encompassing policy, culture and staff support.

6.5.5. Mandatory training compliance for the core skills framework subjects was 95.3% (target = 85%). Appraisal compliance was 89.1% which was above the target of 85%.

6.5.6. SR wondered if 100% attendance could be incentivised. AMS confirmed this had been considered but research had shown such initiatives had a short lived impact. NK also believed it could be a risk if people were determined to attend work when they were too ill.

## 7. Committee Report – Executive – NHST(19)002

7.1. AM presented the report summarising the key issues considered by the Executive Committee at meetings held during November and December 2018.

7.1.1. VD asked for a further update in relation to the blood sciences equipment procurement. AM confirmed that the break clause had been agreed and once NHSI had confirmed this met the pathology network development criteria the contract would be awarded.

7.1.2. The Board discussed the issues that made the creation of additional winter bed capacity in the community so challenging. RC confirmed that the reasons were different in the different CCG/LA areas with the main issue being patients awaiting a package of care. The funding issue centred on whether the patients were the Trust's or had transferred back to the CCG or LA. This had been partly mitigated by the growth of the Trust domiciliary care staff team. VD expressed disappointment that the barriers to innovation and creativity to improve patient flow meant that the Trust plans had not come to fruition for this winter.

7.1.3. SR asked why there was an increase in demand for palliative care. KH explained that the principle driver was demography and that the service did not only focus on patients with cancer but many patients with other conditions who were on an end of life pathway. AM commented that it remained challenging to support patients who did not want to die in hospital and this team would help to co-ordinate the necessary care in the community so that patients could die in a place of their choosing. This was a quality decision rather than being income driven.

7.1.4. VD asked how the Trust benchmarked in respect of the MBRRACE audit. SRe confirmed that the Trust's results were comparable with other similar maternity units.

## 8. Committee Report – Quality – NHST(19)003

8.1. VD presented the Chair's report to the Board, which summarised key issues arising from the Quality Committee meeting held on 22nd January and reports from the Patient Safety, Patient Experience and Clinical Effectiveness Councils.

8.2. Issues for note by the Trust Board included improving cancer performance, and that the community nursing services provided by North West Boroughs NHSFT as part of the St Helens Community Services contract had been rated as 'good' in a recent CQC inspection.

8.3. There was a new Clinical Negligence Scheme for Trusts (CNST) Maternity reduction scheme for 2019/20 and the service was working on the action plan to be able to meet all the requirements again this year.

8.4. In response to a request made at the October Trust Board, the Quality Committee had received a report on incidents of violence and aggression to staff over the last 3 years, which demonstrated there had been a reduction in the number of physical assaults against staff (the vast majority of the perpetrators being patients). The majority of the physical assaults at Whiston occurred in A&E and Ward 5B (Care of the Elderly) and actions plans were in place to address this, in line with the national strategy.

8.5. In response to SR's query in relation to resuscitation survivors beyond discharge, KH explained the Trust had higher numbers of patients than the national benchmark going to ICU. The Clinical Effectiveness Committee would continue to monitor the situation but at the moment there was nothing to suggest there was a problem.

## 9. Committee Report – Finance & Performance – NHST(19)004

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

9.2. The Committee was assured that substantial effort was being made across the whole of the Trust to improve patient flow and as a result the 4-hour A&E performance and it was frustrating for everyone that these efforts were not yet resulting in a change in overall performance. RC commented that the right metrics had now been identified and were being tracked which would enable the organisation to understand the complex reasons for blockages and respond. AM felt that it remained important to ensure patients reached assessment areas faster. NK commented that the improvement in the numbers of discharges before midday on some wards was very impressive and it was encouraging to see how so many staff had got behind this campaign. RC confirmed that this was having a significant impact on the number of beds and when they became available.

9.3. The other key issues considered by the Committee had been the annual planning guidance and the financial control total that had been proposed by the Trust by NHSI. The advantages and disadvantages of accepting the control total had been explored alongside the level of CIP that would be necessary to hit the required outturn. The draft operational plan, including the Trust's activity, quality, workforce and financial assumptions for 2019/20 had to be submitted by 12th February and at this point the Trust had to confirm if the control total was being accepted.

9.4. NK had set out the timetable for contract discussions with commissioners and given an update on the challenges and risks.

9.5. Having reviewed and discussed this information, the Committee recommended to the Board that the control total should be accepted subject to a number of caveats that would be detailed in the draft operational plan, pending the final outcome of the contract negotiations. The Board had to approve the final operational plan for 2019/20 at the March meeting, following the conclusion of the contract negotiations.

9.6. NK noted that since the meeting NHS England had clarified that commissioners were required to commission realistic activity levels, which had to be calculated before QIPP schemes were applied.

9.7. Board members agreed that the Trust accept the control total for 2019/20 as part of the draft operational plan submission.

## 10. Corporate Risk Register – NHST(19)005

10.1. NB presented the Corporate Risk Register to provide assurance that the Trust was operating an effective risk management system, and that risks identified and raised by front line services were escalated.

10.2. The report was a snap shot of the risks reported and reviewed in December 2018, rather than a summary of the quarter.

10.3. The total number of risks on the risk register was 778.

10.4. 44% (340) of the Trust's risks are rated as 'moderate' or 'high'.

10.5. There were 12 high/extreme risks that had been escalated to the Corporate Risk Register (CRR).

10.6. NB explained the CRR summary format had been amended following comments made when the report was last presented, to show the date a risk had last been reviewed and where the risk was monitored.

10.7. SR commented that MIAA had suggested that in some organisations the Risk Management Council reported to the Audit Committee rather than the Executive Committee. NB explained the Trust rationale was that it reported to the Executive Committee which had operational responsibility for overseeing the management of risk, but she would investigate what happened in other Trusts.

## 11. Board Assurance Framework (BAF) – NHST(19)006

11.1. NB presented the BAF to Board members and highlighted a number of changes that were being recommended to reflect progress made and changes to national policy.

11.2. VD noted new contracts were scored highly and queried whether the Trust ever considered what would happen if it wasn't awarded the contract. NB explained that an impact assessment was completed in relation to each procurement which evaluated the implications of not winning additional or losing existing business, but because the majority of the Trust's income came through the main commissioner core services contract, the amounts of income covered by these smaller contracts were not material to the overall financial sustainability of the organisation.

11.3. Board Members approved the changes to the BAF.

## 12. Q2 Complaints, Claims and Incidents – NHST(19)007

12.1. SRe presented the key points from the complaints, claims and incidents summary report covering data from Q2 (1st July to 30th September 2018). The report summarised the number and type of incidents, complaints and claims reported during the period and any trends compared to quarter 1 or quarter 2 of the previous year.

12.2. The total number of incidents reported in the quarter was 3793, with a 27% decrease in incidents resulting in patient harms rated moderate or severe, compared to the same quarter in 2017/18.

12.3. There had been 9 incidents that needed to be reported to StEIS during the quarter.

12.4. The number of new first stage formal complaints was 64 and PALS contacts had increased to 723.

12.5. There had been 36 new clinical negligence claims. These claims were being closely monitored.

12.6. SRe reported an increase in the number of incidents being reported, but a downward trend in levels of significant harm resulting from the incidents, indicating a positive culture of safety reporting.

12.7. 5 inquests had occurred during quarter 2, four of these were third party inquests (where the Trust was assisting the coroner) and 1 related a patient who had been cared for by the Trust.

12.8. National quarterly benchmarking data had not yet been published and would be included in the next report.

12.9. NK reported that the annual CNST premium was likely to increase by circa £2m in 2019/20 as a result of historic claims that had been settled in 2017/18. AM felt that it was important for the Trust to ensure that all lessons were learnt from settled claims event when the incidents had occurred many years previously, to ensure that the same thing could not happen again.

12.10. Board members noted the report.

## 13. Safeguarding Annual Reports for Adults and Children – NHST(19)008

13.1. SRe presented the statutory annual reports for 2017/18 in relation to safeguarding adults and children.

13.2. The commissioners had audited the annual reports and had awarded the Trust 'reasonable assurance' for its processes. 'Significant assurance' was achieved in the individual areas of training, policies and partnership working.

13.3. In relation to Deprivation of Liberty Safeguards (DoLS), NK noted there had been a decrease in applications in 2017/18, which was contradictory to expectation and believed it would be worth the Trust understanding why. He also queried the significant number of discharges prior to assessment. SRe

explained the local authority could not always meet the deadline for completing assessment before patients were discharged; however the Trust completed the DoLS application paperwork correctly.

13.4. KH asked if there was any benchmarking data in relation to DoLS, SRe agreed to see if this information was available and could be included in the reports for next year. **Action: SRe**

13.5. TF commented that the St Helens CCG Governing Body had been impressed by the quality of the Trust safeguarding reports.

13.6. Board members approved the safeguarding annual reports.

## 14. Workforce Strategy and HR Indicators Report – NHST(19)009

14.1. AMS summarised the report which provided Board members with assurance of the workforce indicators that supported the delivery of the Trust's workforce strategy and corporate objectives in relation organisation culture and supporting the workforce.

14.2. AM reported the Trust workforce continued to grow as a result of new services, service development and successful recruitment.

14.3. In relation to EU Exit, the Trust had been asked to pilot the 'settled status scheme'. All the EU nationals working at the Trust had been contacted and supported to make an application to the EU Settlement Scheme. At this stage most of the staff working at the Trust were not planning to leave the UK, following the EU exit, but this situation would be kept under review.

14.4. Successful international recruitment was ongoing, with more nurses scheduled to arrive in February, bringing the total to 56. The Trust had also recruited some international doctors, and although this was low in number they had a high impact in hard-to-fill posts.

14.5. The Trust continued to pursue a range of initiatives to stimulate the supply of registered nurses and other healthcare professionals.

14.6. The Trust continued to actively promote the use of apprenticeships, with 155 staff currently on an apprenticeship programme. Full utilisation of the levy funding continued to present a challenge both for the Trust and NHS in general, but other options continued to be explored.

14.7. PG asked if the Trust's unspent apprenticeship levy could be utilised for the benefit of the wider health economy as many small providers currently had no access to the funds. AMS confirmed that this was being explored.

14.8. The Trust had maintained a high level of volunteer activity with several hundred active volunteers within the Trust. A recent 'ward companion' initiative had been received extremely well and AMS confirmed HR were working closely with staff side to ensure no jobs were being replaced with the use of volunteers. SR queried whether the work of volunteers was recognised. AMS confirmed regular coffee mornings and suppers were organised as a thank you and there was a volunteer awards ceremony held every July but it was important to

continue looking for ways that the contribution of the volunteers could be recognised.

14.9. In relation to recruitment and retention AMS explained that the biggest effort was being focused on retaining that staff that already worked for the Trust to ensure they could develop their whole career in the organisation. VD asked if the Trust made full use of information from exit interviews to improve retention. AMS confirmed there was an exit interview policy in place but felt that more could be done to ensure this was consistently applied and the feedback used to shape future policy. **Action: AMS/SRe**

14.10. NK noted that based on age profiles 950 members of staff could potentially retire from the Trust in the next 12 months. AMS stressed that many staff might choose to retire and return so would not be lost from the workforce, however the Trust, in common with the NHS generally, had an aging workforce.

14.11. RF thanked AMS for a very comprehensive report which gave assurance that the workforce strategy was being implemented.

14.12. The report was noted.

## 15. Learning from Deaths Quarterly Report – NHST(19)010

15.1. KH presented the Q2 learning from deaths report, to provide assurance that all specified groups had been reviewed and key learning had been disseminated throughout the Trust.

15.2. KH highlighted that an internal Trust definition of a 'post-operative' death had now been agreed and this data was included in the report.

15.3. The report demonstrated that the agreed "lessons" had been widely disseminated and discussed across the Trust, but more work was required to demonstrate that practice had changed.

15.4. Work was also on going to produce thematic analysis of the SJRs, which would enable periodic review of the key themes from future deaths, serious incident investigations and litigation, which would improve the opportunities for learning.

15.5. The revised 'Learning from Inpatient Deaths' policy incorporated a new 'Good Practice Guide and Standard Operating Procedure for Care of the Bereaved' reflecting the guidance from the NHS National Quality Board. The policy had been revised to encompass this guidance and to reflect the constructive feedback from CQC during their visit in August 2018.

15.6. The report was noted and the revised policy approved.

## 16. St Helens Cares Collaboration Agreement – NHST(19)011

16.1. NB explained the aim of the proposed arrangements was to bring together the key health and social care commissioners and providers in St Helens to develop and deliver sustainable, quality, health, care and support to the population of St Helens within the context of cost and demand challenges.

16.2. The agreement was being presented to all Boards and Governing Bodies for approval in January.

16.3. In response to a query from RF, NB confirmed the Collaboration Agreement had been drawn up by Hill Dickinson with input from all organisations. It did not subsume any organisation's statutory obligations.

16.4. TF confirmed the agreement had been very well received at the St Helens CCG Governing Body meeting and believed it was the first in a series of steps for St Helens Cares and felt it was important to note the level of collaboration involved in producing the agreement.

16.5. KH observed that in earlier iterations of the agreement the focus had been on creating a single lead provider but this had now shifted considerably to organisations working together. It made the Trust the leader of the Provider Board, but not in terms of holding all the contracts. NB confirmed that the current proposals were at the limit of the current legislative opportunity without a full re-procurement of all services. This was a move in the agreed direction of travel for all parties, and would evolve as national policy developed and potentially legislation was changed to support the development of Integrated Care Systems (ICS) as set out in the NHS Long Term Plan.

16.6. It was noted that several of the Provider organisations could potentially be part of other collaboration or partnership agreements in other "Places" where they provided services.

16.7. The Board approved the Collaboration Agreement.

## 17. Effectiveness of Meeting

17.1. RF asked both observers for their reflections on the meeting. They were in agreement that patient safety and patient satisfaction were core priorities for the Board. They had expected to hear more about cost effectiveness, and had been pleasantly surprised that this had not dominated the discussions.

## 18. Any Other Business

18.1. Working Capital – NK asked for board approval for a £3.8m cash loan to cover working capital in February. JK confirmed that the reasons for this had been fully discussed at the Finance & Performance Committee. The loan would be repaid in the new financial year.

18.2. The Board approved the £3.8m short-term loan.

18.3. RF thanked Board members for their kindness, generosity and thoughtfulness during his absence.

## 19. Date of Next Meeting

19.1. The next meeting will be held on Wednesday 27th February 2019 at 09:30 hrs in the Executive Boardroom, Level 5, Whiston Hospital, L35 5DR.

Chairman: ……

Date: 27th February 2019 ……

# TRUST PUBLIC BOARD ACTION LOG – 27TH FEBRUARY 2019

| No | Date of Meeting (Minute) | Action | Lead | Date Due |
|---|---|---|---|---|
| | ~~25.07.18 (11.5)~~ | ~~KH to review Learning from Deaths policy in light of the Working with Families Guidance and consider the appropriate controls to provide assurance and update the Trust Policy~~. **DONE. ACTION CLOSED** | ~~KH~~ | ~~30.11.18 Revised to 30.01.19~~ |
| 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.** | AMS | ~~30.01.19~~ 31.07.19 |
| | ~~31.10.18 (6.8)~~ | ~~AMS to present action plan of how new advanced nurse practitioners will be introduced into the workforce to the February Strategy Board~~. **ON AGENDA. ACTION CLOSED.** | ~~AMS~~ | ~~27.02.19~~ |
| | ~~30.01.19 (13.4)~~ | ~~SRe to include DoLs benchmarking data in next year's Safeguarding Annual Report~~. **ACTION CLOSED.** | ~~SRe~~ | ~~27.02.19~~ |
| 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 |

St Helens and Knowsley Teaching Hospitals NHS Trust

**Paper No**: NHST(19)12
**Title of Paper:** Integrated Performance Report
**Purpose:** To summarise the Trusts performance against corporate objectives and key national & local priorities.


**Summary**

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

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

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

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


**Patient Safety, Patient Experience and Clinical Effectiveness**

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

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

There has been 1 MRSA positive specimen year to date (target = 0). RCA indicated this was a contaminant and patient did not come to harm.

There was 1 C.Difficile (CDI) positive case in January 2019. YTD there have been 20 cases . In comparison, there were 19 cases for the same period in 2017-18. The annual tolerance for CDI for 18-19 is 40. 3 further cases will be appealed on 5th March 2019.

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 December 2018 was 95.5%. YTD performance is 96.2%

During the month of December 2018 there were 2 falls resulting in severe harm , which occurred in inpatient areas
(YTD Severe and above category fall = 11)

Performance for VTE assessment for December 2018 was 95.47%. YTD performance is 96.01% against a target of 95%.

YTD HSMR (April to September) for 2018-19 is 97.6

**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: 27th February 2019**

**Operational Performance**

Performance against the 62 day cancer standard was above the target of 85.0% in month (December 2018) at 89.0%. The 31 day target was achieved with 97.9% performance against a target of 96%. The 2 week rule target was also achieved with 93.9% against a target of 93.0%.

Accident and Emergency Type 1 performance for January was 67.3%. The all type mapped STHK Trust footprint performance was 83.4%. Type 1 attendances for January 2019 were 10,020 compared with 9,514 in December 18. January 19 was 8% higher than January 18 (9281) .

An Executive led urgent and emergency care summit took place on September 12th, which brought together senior clinical and managerial leaders from across the organisation, with the purpose of formulating a plan to improve 4 hour performance. Five improvement workstreams were established; they 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 (3133) in January 19. Ambulance notification to handover time was 16.39 mins on average (target 15 mins). Although the target was missed by 1 minute and 39 seconds, this year was 8 minutes better than last January.

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 January 2019 was 49 less per day compared with January 18. (111 in Jan 19 v 163 in Jan 19) which is a 28% reduction year on year, so although the NHSE 25% challenge was not quite achieved there was still a significant improvement compared with the previous 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 December 2018 with 92.4% compliance (Target 92%). The 6 week diagnostic target was also achieved with 99.8% (Target 99%). There were no 52 week+ waiters.

**Financial Performance**

At the end of M10 StHK has reported a surplus of £1.1m including PSF; this equates to a deficit of £4.7m excluding PSF. The Trust was instructed by NHSI to remove Q1, Q2 & Q3 PSF relating to A&E performance and the Trust hasn't achieved the finance related PSF in month 10.

Within the YTD position the Trust has utilised £7.4m non-recurrent resources, this is offsetting some of the cost pressures and impacts from Medway as well as under performance in Clinical Income. The non-recurrent nature of this benefit will need to be considered when agreeing future year plans as these benefits will not be available going forward.

The Trust continues to deliver above the YTD CIP target with £11.7m delivered against a plan of £11.0m. Whilst there are plans and ideas for delivery of the full £19m CIPs, the schemes relating to STP delivery (£4.6m) are now highly unlikely to deliver in year but will be kept within the CIP tracker to ensure the schemes remain visible to the organisation and wider stakeholders.

The Trust cash balances at the end of M10 were £8.4m. The Trust is yet to receive over performance payments from some of its main commissioners relating to this financial year. The Trust now employs 9,000 trainee Doctors for 5 HEE areas across the country as part of its Carter at scale innovations. If provider organisations fail to pay their invoices in time this puts significant strain on the Trust cash balances. The Trust now shares the non-compliant organisations with regulators to assist in obtaining payment. The Trust has requested £14.6m of loans over the final two months of the year (£3.8m in February and £10.8m in March, the £3.8m having been received in February and the other being reviewed by NHSI).

In line with the forecast agreed by Board in December and as reported at month 9, the Trust is reporting a deficit position of £5.9m including PSF (£11.8m excluding PSF). The financial performance in the month delivers a Use of Resources level of 3 (YTD) and 4 (FOT).

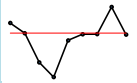
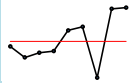
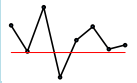
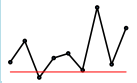
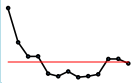
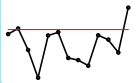
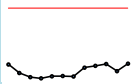
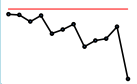
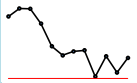
**Human Resources**

In January overall absence deteriorated from 5.9% to 6.1%. This exceeds the Q4 target of 4.68% and is higher than this time last year. The year to date absence is also higher at 4.9% compared to 4.7% in 2017-18. Qualified & HCA sickness has risen slightly from 7.1% to 7.4%. YTD absence has increased to 6.1% against the target of 5.3%. Mandatory Training compliance is 95% (target = 85%). Appraisal compliance is 89.3% (target = 85%).

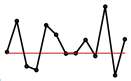
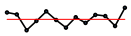
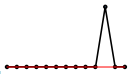
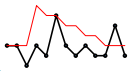
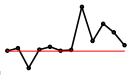
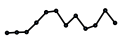
The following key applies to the Integrated Performance Report:

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

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 | Jan-19 | 2.6% | 2.1% | No Target | 2.4% |  | Further improvement in SHMI (governments preferred measure). HSMR YTD higher than in recent months, but still better than England. Weekend mortality is a noisy metric. | Patient Safety and Clinical Effectiveness | Continue measures to improve clinical effectiveness and reduce unwarranted variation. | KH |
| Mortality: SHMI (Information Centre) | Q | ▲ | Jun-18 | 1.00 | | 1.00 | | | | | | |
| Mortality: HSMR (HED) | Q | ▲ | Sep-18 | 99.4 | 97.6 | 100.0 | 99.1 |  | | | | |
| Mortality: HSMR Weekend Admissions (emergency) (HED) | Q | T | Sep-18 | 117.3 | 101.4 | 100.0 | 95.8 |  | | | | |
| Readmissions: 30 day Relative Risk Score (HED) | Q UOR | T | Aug-18 | 101.9 | 101.3 | 100.0 | 101.2 |  | The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms. Overall year to date performance remains stable. | 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 | Sep-18 | 89.4 | 91.2 | 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 | Sep-18 | 117.5 | 109.9 | 100.0 | 99.2 |  | | | | |
| % Medical Outliers | F&P | T | Jan-19 | 0.9% | 0.6% | 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 | Jan-19 | 64.9% | 43.6% | 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 | ▲ | Dec-18 | 73.1% | 70.8% | 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 if it persists after MEDWAY stabilisation. | | Pending ePR, we have devised an automated eDischarge notification which will be computer generated and send within 24 hours. Thereafter a full discharge summary will be sent within 14 days. We have been advised by CCGs to stagger release of historic discharge summaries which is delaying performance catch-up. | KH |
| E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL | Q | ▲ | Dec-18 | 67.7% | 84.4% | 95.0% | 89.5% |  | | | | |
| E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E ) - TOTAL | Q | ▲ | Dec-18 | 96.3% | 96.5% | 95.0% | 99.1% |  | | | | |

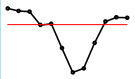
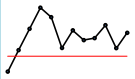
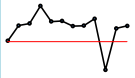
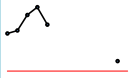
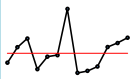
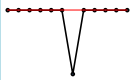
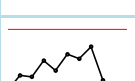
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

| | Committee | | Latest Month | Latest month | 2018-19 YTD | 2018-19 Target | 2017-18 | Trend | Issue/Comment | Risk | Management Action | Exec Lead |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **CLINICAL EFFECTIVENESS (continued)** | | | | | | | | | | | | |
| Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit | Q F&P | ▲ | Jan-19 | 86.8% | 85.4% | 83.0% | 90.3% |  | Target is being achieved YTD. With effect from April 2017, STHK is also treating patients from the Warrington Area. | Patient Safety, Quality, Patient Experience and Clinical Effectiveness | Continued achievement. | RC |
| **PATIENT SAFETY (appendices pages 39-42)** | | | | | | | | | | | | |
| Number of never events | Q | ▲£ | Jan-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 | Jan-19 | 99.9% | 99.0% | 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 | Jan-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 | ▲£ | Jan-19 | 0 | 1 | 0 | 2 |  | RCA conducted on MRSA positive specimen (Nov 18), indicated this was a contaminant and patient did not come to harm. 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 | ▲£ | Jan-19 | 1 | 20 | 40 | 19 |  | | | | |
| Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections | Q F&P | | Jan-19 | 2 | 26 | No Target | 22 |  | | | | |
| Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4) | Q | ▲ | Dec-18 | 0 | 0 | No Contract target | 0 |  | No grade 3 or 4 avoidable pressure ulcers YTD | Quality and patient safety | The Trust provides ongoing tissue viability training for all nursing staff including bank staff . New pressure ulcer reduction actions being implemented. | SR |
| Number of falls resulting in severe harm or death | Q | ▲ | Dec-18 | 2 | 11 | No Contract target | 22 |  | 2 severe harm fall reported in December 2018 ( Ward 1A and 3C) | 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 | ▲£ | Dec-18 | 95.47% | 96.01% | 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 | Jan-19 | 2 | 21 | No Target | 31 |  | | | | |
| To achieve and maintain CQC registration | Q | | Jan-19 | Achieved | Achieved | Achieved | Achieved | | Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards. | Quality and patient safety | | SR |
| Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate | Q | T | Dec-18 | 95.5% | 96.2% | 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 is currently being collected for 20 working days from the 30th Jan19-27 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 | Dec-18 | 0 | 0 | No Target | 1 |  | | | | |

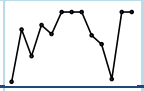
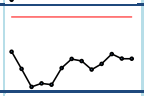
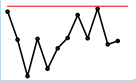
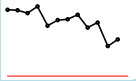
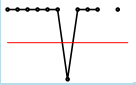
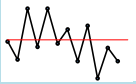
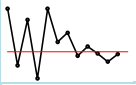
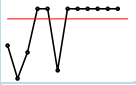
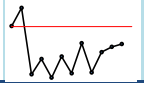
**Jan-19**

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 | ▲ £ | Dec-18 | 93.9% | 91.1% | 93.0% | 95.0% |  | Targets achieved in month | Quality and patient experience | 1. All DMs producing speciality level action plans to provide 2 week capacity<br>2. Capacity demand review on going at speciality level | RC |
| Cancer: 31 day wait for diagnosis to first treatment - all cancers | F&P | ▲ £ | Dec-18 | 97.9% | 98.0% | 96.0% | 97.7% |  | | | | |
| Cancer: 62 day wait for first treatment from urgent GP referral to treatment | F&P | ▲ ● | Dec-18 | 89.0% | 88.9% | 85.0% | 87.4% |  | | | | |
| 18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period | F&P | ▲ | Dec-18 | 92.4% | 92.4% | 92.0% | 94.0% |  | The level of scrutiny and validation of PTL reports required post go live with Medway, has lead to an inability to accurately report RTT performance within the required timescales to report the monthly position. On going backlog clearance plans continue with good effect but similar issues regarding theatre and bed capacity remain. RMS and more recent MCAS primary care services also have compounded the position. However, RMS and MCAS remains unpredictable with short / no notice diverts back to secondary care | Surgical Beds have now been 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 | ▲ | Dec-18 | 99.8% | 99.8% | 99.0% | 100.0% |  | | | | |
| 18 weeks: Number of RTT waits over 52 weeks (incomplete pathways) | F&P | ▲ | Dec-18 | 0 | 0 | 0 | 0 |  | | | | |
| Cancelled operations: % of patients whose operation was cancelled | F&P | T | Jan-19 | 1.0% | 0.8% | 0.8% | 0.6% |  | Under achievement of cancelled ops target for January due to an IT failure resulting in 20 on the day cancellations. One patient breached the 28 day re-list target in July due to the procedure being deemed to be more complex than anticipated. | Patient experience and operational effectiveness<br>Poor patient experience | The planned increase in elective surgical activity in St Helens has commenced including increasing GA capacity on Saturdays. | RC |
| Cancelled operations: % of patients treated within 28 days after cancellation | F&P | ▲ £ | Dec-18 | 100.0% | 99.7% | 100.0% | 99.4% |  | | | | |
| Cancelled operations: number of urgent operations cancelled for a second time | F&P | ▲ £ | Jan-19 | 0 | 0 | 0 | 0 |  | | | | |
| A&E: Total time in A&E: % < 4 hours (Whiston: Type 1) | F&P | ▲ | Jan-19 | 67.3% | 74.9% | 95.0% | 78.2% |  | Accident and Emergency Type 1 performance for January was 67.3%. The all type mapped STHK Trust footprint performance was 83.4%. Type 1 attendances for January 2019 were 10,020 compared with 9,514 in December 18. January 19 was 8% higher than January 18 (9281) .<br><br>An Executive led urgent and emergency care summit took place on September 12th, which brought together senior clinical and managerial leaders from across the organisation, with the purpose of formulating a plan to improve 4 hour performance. Five improvement workstreams were established; they 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.<br><br>Whiston ED had the highest volume of ambulances in C+M and GM (3133) in January 19. Ambulance notification to handover time was 16.39 mins on average (target 15 mins). Although the target was missed by 1 minute and 39 seconds, this year was 8 minutes better than last January.<br><br>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 January 2019 was 49 less per day compared with January 18. (111 in Jan 19 v 163 in Jan 19) which is a 28% reduction year on year, so although the NHSE 25% challenge was not quite achieved there was still a significant improvement compared with the previous 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. | 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.<br>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.<br>Flow through the Hospital<br>New and refreshed workstreams aimed at improving discharges before midday also supported by a media campaign #HomeForLunch. Daily board rounds and afternoon huddles.<br>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 | ▲ | Jan-19 | 83.4% | 87.5% | 95.0% | |  | | | | |
| A&E: 12 hour trolley waits | F&P | ▲ | Jan-19 | 0 | 0 | 0 | 0 |  | | | | |

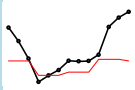
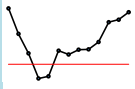
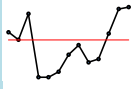
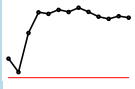
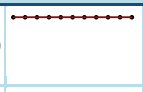
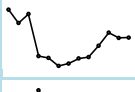
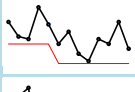
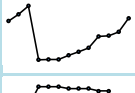
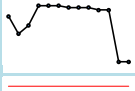
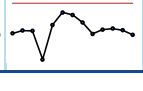
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

| | Committee | | Latest Month | Latest month | 2018-19 YTD | 2018-19 Target | 2017-18 | Trend | Issue/Comment | Risk | Management Action | Exec Lead |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **PATIENT EXPERIENCE (continued)** | | | | | | | | | | | | |
| MSA: Number of unjustified breaches | F&P | ▲ £ | Jan-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 | Jan-19 | 28 | 218 | No Target | 224 |  | % new (Stage 1) complaints resolved in month within agreed timescales continues to improve overall although there was a dip in September, October and November, which was recovered to 100% responded to within agreed timescales in December. | 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 very low. | SR |
| Complaints: New (Stage 1) Complaints Resolved in month | Q | T | Jan-19 | 17 | 193 | No Target | 270 |  | | | | |
| Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales | Q | T | Jan-19 | 100.0% | 91.2% | No Target | 67.0% |  | | | | |
| DTOC: Average number of DTOCs per day (acute and non-acute) | Q | T | Jan-19 | 22 | 18 | No Target | 20 |  | In January 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 | Jan-19 | 322 | 310 *Jun-Jan | | |  | | | | |
| Average number of Super Stranded patients per day (21+ days LoS) | Q | T | Jan-19 | 114 | 116 *Jun-Jan | | |  | | | | |
| Friends and Family Test: % recommended - A&E | Q | ▲ | Dec-18 | 85.8% | 86.0% | 90.0% | 87.5% |  | The YTD recommendation rates remain slightly below target for A&E but improved slightly in December; inpatients, maternity (antenatal and postnatal community)are above target. All saw a slight in-month improvement other than maternity - birth which saw a slight dip. | 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 is in the process of attending all team meetings to engage with staff and raise the profile of the FFT programme and continues 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. Area's 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 | ▲ | Dec-18 | 93.5% | 94.8% | 90.0% | 95.8% |  | | | | |
| Friends and Family Test: % recommended - Maternity (Antenatal) | Q | | Dec-18 | 100.0% | 99.2% | 98.1% | 98.5% |  | | | | |
| Friends and Family Test: % recommended - Maternity (Birth) | Q | ▲ | Dec-18 | 96.8% | 97.8% | 98.1% | 97.9% |  | | | | |
| Friends and Family Test: % recommended - Maternity (Postnatal Ward) | Q | | Dec-18 | 94.8% | 95.3% | 95.1% | 96.6% |  | | | | |
| Friends and Family Test: % recommended - Maternity (Postnatal Community) | Q | | Dec-18 | 100.0% | 97.6% | 98.6% | 98.1% |  | | | | |
| Friends and Family Test: % recommended - Outpatients | Q | ▲ | Dec-18 | 94.5% | 94.1% | 95.0% | 94.5% |  | | | | |

**Jan-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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **WORKFORCE (appendices pages 53-60)** | | | | | | | | | | | | |
| Sickness: All Staff Sickness Rate | Q F&P UOR | ▲ | Jan-19 | 6.1% | 4.9% | Q1 - 4.25%<br>Q2 - 4.35%<br>Q3 - 4.72%<br>Q4 - 4.68% | 4.7% |  | In January overall absence deteriorated from 5.79% to 6.1%. This exceeds the Q3 target of 4.72% and is higher than this time last year. The year to date absence is also higher at 4.9% compared to 4.7% in 2017-18. Qualified & HCA sickness has risen slightly from 7.1% to 7.4%. YTD absence has increased to 6/1% against the target of 5.3%. | Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme. | A Workforce Wellbeing action plan based on NHS Employers and NHSI recommendations was approved by November Workforce Council to drive an improvement in attendance levels. Processes are subject to continual review to increase rigour of management against the policy. Monthly meetings take place in wards/departments to support line managers to deliver their action plans. Deep dives by HRBP's with support including OD plans, stress and resilience support for wards continue with continued oversight to F&P. A large scale review of the current managing attendance policy has started in line with "Just Culture" with the aim of driving improvements in engagement levels and attendance. An element of this includes a workshop including HR, HW&WB, operational and staff side colleagues to review our approach to improve levels of attendance. | AMS |
| Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas | Q F&P UOR | T | Jan-19 | 7.4% | 6.1% | 5.3% | 5.7% |  | | | | |
| Staffing: % Staff received appraisals | Q F&P | T | Jan-19 | 89.3% | 89.3% | 85.0% | 88.4% |  | Mandatory Training compliance exceeds the target by 10% and has fallen slightly by 0.3% from December. Appraisal compliance is above the target by 4.3% and has improved by 0.2% from December. | 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 | Jan-19 | 95.0% | 95.0% | 85.0% | 92.5% |  | | | | |
| Staff Friends & Family Test: % recommended Care | Q | ▲ | Q2 | 92.6% | | No Contract Target | | | Whilst response rates fluctuate we remain in the top 3 acute Trusts in our region for both response and recommendation rates. | Staff engagement, recruitment and retention. | The Q3 survey in the form of the National staff survey has now closed, with results expected to be published on 26th February 2019 . | AMS |
| Staff Friends & Family Test: % recommended Work | Q | ▲ | Q2 | 83.6% | | No Contract Target | | | | | | |
| Staffing: Turnover rate | Q F&P UOR | T | Jan-19 | 0.6% | | No Target | |  | Staff turnover remains stable and well below the national average of 14%. | | Turnover is monitored across all departments as part of the Trusts Recruitment & Retention Strategy with action plans to address areas where turnover is higher than the trust average. 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 | Jan-19 | 3.0 | 3.0 | 3.0 | 3.0 |  | At the end of M10 StHK has reported a surplus of £1.1m including PSF; this equates to a deficit of £4.7m excluding PSF. The Trust was instructed by NHSI to remove Q1, Q2 & Q3 PSF relating to A&E performance and the Trust hasn't achieved the finance related PSF in month 10.<br><br>Better payment compliance is currently not being achieved on invoice numbers but is being achieved on value. | 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.<br><br>Executives to engage external stakeholders regarding progress of transformational programmes that will assist in delivering the Cost Improvement Programme.<br><br>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 | Jan-19 | 11,683 | 11,683 | 19,000 | 12,325 |  | | | | |
| Reported surplus/(deficit) to plan (000's) | F&P UOR | T | Jan-19 | 1,088 | 1,088 | 10,993 | 5,001 |  | | | | |
| Cash balances - Number of days to cover operating expenses | F&P | T | Jan-19 | 8 | 8 | 2 | 12 |  | | | | |
| Capital spend £ YTD (000's) | F&P | T | Jan-19 | 7,093 | 7,093 | 9,516 | 9,180 |  | | | | |
| Financial forecast outturn & performance against plan | F&P | T | Jan-19 | (5,994) | (5,994) | 10,993 | 5,001 |  | | | | |
| Better payment compliance non NHS YTD % (invoice numbers) | F&P | T | Jan-19 | 90.9% | 90.9% | 95.0% | 91.4% |  | | | | |

APPENDIX A

| | | | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | 2018-19 YTD | 2017-18 Target | FOT | 2017-18 | Trend | Exec Lead |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cancer 62 day wait from urgent GP referral to first treatment by tumour site** | | | | | | | | | | | | | | | | | | | | | |
| Breast | % Within 62 days | ▲ £ | 100.0% | 100.0% | 75.0% | 100.0% | 100.0% | 100.0% | 100.0% | 95.7% | 88.9% | 100.0% | 100.0% | 100.0% | 100.0% | 98.1% | 85.0% | | 97.0% | | |
| | Total > 62 days | | 0.0 | 0.0 | 2.5 | 0.0 | 0.0 | 0.0 | 0.0 | 0.5 | 1.5 | 0.0 | 0.0 | 0.0 | 0.0 | 2.0 | | | 3.5 | | |
| Lower GI | % Within 62 days | ▲ £ | 78.6% | 80.0% | 91.7% | 75.0% | 100.0% | 76.5% | 100.0% | 100.0% | 92.3% | 100.0% | 36.4% | 88.9% | 100.0% | 88.3% | 85.0% | | 84.0% | | |
| | Total > 62 days | | 1.5 | 2.0 | 0.5 | 1.5 | 0.0 | 2.0 | 0.0 | 0.0 | 0.5 | 0.0 | 3.5 | 1.0 | 0.0 | 7.0 | | | 12.5 | | |
| Upper GI | % Within 62 days | ▲ £ | 100.0% | 100.0% | 63.6% | 100.0% | 80.0% | 77.8% | 80.0% | 66.7% | 62.5% | 77.8% | 66.7% | 33.3% | 63.6% | 70.5% | 85.0% | | 87.2% | | |
| | Total > 62 days | | 0.0 | 0.0 | 2.0 | 0.0 | 1.0 | 1.0 | 0.5 | 0.5 | 1.5 | 1.0 | 0.5 | 1.0 | 2.0 | 9.0 | | | 5.0 | | |
| Urological | % Within 62 days | ▲ £ | 96.6% | 60.9% | 96.8% | 86.2% | 93.8% | 90.2% | 78.8% | 80.7% | 97.1% | 80.6% | 90.3% | 75.0% | 89.4% | 85.5% | 85.0% | | 82.5% | | |
| | Total > 62 days | | 0.5 | 9.0 | 0.5 | 2.0 | 1.0 | 2.0 | 3.5 | 5.5 | 0.5 | 3.0 | 1.5 | 3.5 | 2.5 | 23.0 | | | 37.0 | | |
| Head & Neck | % Within 62 days | ▲ £ | 80.0% | 33.3% | 66.7% | 100.0% | 50.0% | 66.7% | 33.3% | 62.5% | 42.9% | 83.3% | 50.0% | 80.0% | 57.1% | 58.3% | 85.0% | | 64.6% | | |
| | Total > 62 days | | 0.5 | 1.0 | 0.5 | 0.0 | 0.5 | 0.5 | 2.0 | 1.5 | 2.0 | 0.5 | 1.0 | 0.5 | 1.5 | 10.0 | | | 8.5 | | |
| Sarcoma | % Within 62 days | ▲ £ | 50.0% | 33.3% | 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 | | 0.5 | 1.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.5 | 0.0 | 0.0 | 0.0 | 1.0 | 0.0 | 0.0 | 1.5 | | | 2.5 | | |
| Gynaecological | % Within 62 days | ▲ £ | 55.6% | 90.9% | 66.7% | 77.8% | 87.5% | 72.7% | 75.0% | 100.0% | 72.7% | 50.0% | 62.5% | 100.0% | 81.8% | 78.5% | 85.0% | | 78.2% | | |
| | Total > 62 days | | 2.0 | 0.5 | 0.5 | 1.0 | 0.5 | 1.5 | 0.5 | 0.0 | 1.5 | 0.5 | 1.5 | 0.0 | 1.0 | 7.0 | | | 12.0 | | |
| Lung | % Within 62 days | ▲ £ | 100.0% | 80.0% | 100.0% | 100.0% | 87.0% | 95.8% | 88.9% | 100.0% | 100.0% | 81.8% | 66.7% | 94.1% | 100.0% | 90.6% | 85.0% | | 84.7% | | |
| | Total > 62 days | | 0.0 | 1.5 | 0.0 | 0.0 | 1.5 | 0.5 | 0.5 | 0.0 | 0.0 | 1.0 | 2.0 | 0.5 | 0.0 | 6.0 | | | 11.5 | | RC |
| Haematological | % Within 62 days | ▲ £ | 76.9% | 100.0% | 88.9% | 83.3% | 100.0% | 100.0% | 100.0% | 100.0% | 66.7% | 90.9% | 50.0% | 85.7% | 66.7% | 85.7% | 85.0% | | 80.6% | | |
| | Total > 62 days | | 1.5 | 0.0 | 0.5 | 1.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.0 | 0.5 | 1.0 | 1.0 | 1.0 | 4.5 | | | 9.5 | | |
| Skin | % Within 62 days | ▲ £ | 97.7% | 100.0% | 95.5% | 92.5% | 100.0% | 91.2% | 97.6% | 93.8% | 98.1% | 93.3% | 84.6% | 90.2% | 98.0% | 93.8% | 85.0% | | 95.2% | | |
| | Total > 62 days | | 0.5 | 0.0 | 1.0 | 2.0 | 0.0 | 2.5 | 0.5 | 1.5 | 0.5 | 3.0 | 4.0 | 2.5 | 0.5 | 15.0 | | | 13.0 | | |
| Unknown | % Within 62 days | ▲ £ | 100.0% | 100.0% | | 75.0% | 100.0% | 100.0% | | 100.0% | 75.0% | 100.0% | 100.0% | 100.0% | | 96.0% | 85.0% | | 78.4% | | |
| | Total > 62 days | | 0.0 | 0.0 | | 1.0 | 0.0 | 0.0 | | 0.0 | 0.5 | 0.0 | 0.0 | 0.0 | | 0.5 | | | 4.0 | | |
| All Tumour Sites | % Within 62 days | ▲ £ | 90.6% | 85.2% | 89.1% | 89.6% | 94.1% | 90.1% | 90.3% | 89.0% | 89.1% | 90.9% | 77.8% | 88.4% | 89.0% | 88.9% | 85.0% | | 87.4% | | |
| | Total > 62 days | | 7.0 | 15.0 | 8.0 | 8.5 | 4.5 | 10.0 | 8.0 | 9.5 | 9.5 | 9.5 | 16.0 | 10.0 | 8.5 | 85.5 | | | 119.0 | | |
| **Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)** | | | | | | | | | | | | | | | | | | | | | |
| Testicular | % Within 31 days | ▲ £ | 100.0% | 100.0% | | | | | 100.0% | 100.0% | 100.0% | 0.0% | 100.0% | 100.0% | 100.0% | 87.5% | 85.0% | | 100.0% | | |
| | Total > 31 days | | 0.0 | 0.0 | | | | | 0.0 | 0.0 | 0.0 | 1.0 | 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

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| **Paper No:** NHST(19)13 |
| **Title of paper:** Executive Committee Chair's Report – February 2019 |
| **Purpose:** To provide assurance to the Trust Board on those matters delegated to the Executive Committee. |
| **Summary:**<br><br>The paper provides a summary of the issues considered by the Executive Committee at the meetings held during January 2019.<br><br>There were a total of 4 Executive Committee meetings held during this period. The Executive Committee agreed:<br><br>• The Trust policy for awarding Local Clinical Excellence Awards for 2018/19;<br>• That the first business case in support of the primary care strategy should be developed;<br>• Proposals to ensure full utilisation of the apprenticeship levy.<br><br>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, and the Board Assurance Framework. There was also a weekly progress report on the action taken to resolve the Medway PAS outpatient issues.<br><br>There are no specific issues that require escalation to the Board, not already considered at the January Board meeting or covered on the agenda of the February meeting. |
| **Trust objectives met or risks addressed:** All 2018/19 Trust objectives. |
| **Financial implications:** None arising directly from this report. |
| **Stakeholders:** Patients, Patients Representatives, Staff, Commissioners, Regulators |
| **Recommendation(s):** That the report be noted |
| **Presenting officer:** Ann Marr, Chief Executive |
| **Date of meeting**: 27th February 2019 |

**CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE**
**January 2019**

## 1. Introduction

There were 4 Executive Committee meetings in January 2019.

## 2. 10th January 2019

### 2.1 National Cancer Patient Experience Survey

The Director of Nursing, Midwifery and Governance introduced members of the cancer team who had analysed the Trust's results and benchmarked them with other providers in the Cheshire and Merseyside Cancer Alliance.

The response rate in each specialty was reviewed and the themes coming from the responses examined. On the majority of questions the Trust was performing at or above the national average.

The action plan developed in response to the survey was reviewed and changes agreed to focus on the themes that would have the greatest impact on patient experience, and how improvements would be measured and monitored.

### 2.2 Southport and Ormskirk Pathology Service

The pathology management team had been invited to present to the Southport and Ormskirk Hospitals Trust Executive Team on the changes to the pathology service since the start of the contract. This was a very positive story of stabilisation and significant improvement in performance.

### 2.3 Trust Board Agenda

The Director of Corporate Services presented the draft Trust Board agendas for review.

### 2.4 Risk Management Council Chair's Report

The Director of Corporate Services presented the chair's report from the Risk Management Council, which included an update on those risks escalated to the Corporate Risk Register. It was also reported that MIAA were currently reviewing the Trust risk management processes.

### 2.5 Review of the Board Assurance Framework (BAF)

The Director of Corporate Services presented the BAF for review. Recommended changes would be presented to the Trust Board in January for approval.

### 2.6 Information Governance Training Compliance

The Director of Informatics presented a report detailing current compliance across each care group. The Trust needed to achieve 95% compliance by 31st March 2019 to meet the standards in the NHS Digital Data Security and Protection Toolkit. Progress would continue to be monitored on a weekly basis.

### 2.7 Medway Update

The Director of Informatics reported on progress with the different Medway workstreams and benefits realisation plans. Improvements to the outpatient scheduling systems were awaited.

### 2.8 2019/20 Contract Negotiations

The Director of Finance and Information provided feedback from the first contract negotiation meeting for 2019/20 following the publication of the national planning guidance. Commissioners had asked to review zero LoS patients and re-admissions. There was a schedule of further meetings planned for the coming weeks.

## 3. 17th January 2019

### 3.1. Major Incident Training

Jim Deacon, Head of Emergency Planning, NHS England attended the meeting and gave an update on the role of the Executive on-call during a major incident, which had been requested as part of the Trust emergency preparedness response plans.

### 3.2 Mandatory Training and Appraisals

The Deputy CEO/Director of HR presented the monthly figures for December which showed an improvement.

### 3.3 Integrated Performance Report (IPR)

The Director of Finance and Information presented the performance on the key performance indicators for December. Changes to the narrative were agreed. A&E access target performance in December was discussed in detail, and it was noted that a presentation on the full urgent and emergency care transformation programme was to be given at the Finance and Performance Committee.

### 3.4 Southport and Ormskirk Hospitals NHST - HR Services

The Deputy CEO/Director of HR reported that in 2016 the Trust had been asked to assist Southport and Ormskirk Hospitals NHST by providing their complete HR service on a caretaker basis. The new management team at Southport and Ormskirk were now preparing to return most of these services to in-house provision, from April 2019. The Trust would continue to provide both payroll and transactional HR to Southport and Ormskirk.

### 3.5 Medway

The Director of informatics provided an update on the roll out of NEWS2 and electronic prescribing (EPMA). The progress with the St Helens shared care record was also noted and the plans to develop business intelligence functionality as the next phase of development.

Solutions for the clinic reviews and patient communications remained in development.

### 3.6 Marshalls Cross Medical Centre

Following the CQC inspection the service had developed a draft action plan to address the informal feedback. This had been updated when the draft reports were received for factual accuracy checking. The Director of Operations and Performance confirmed that all actions had either been completed or were on track to be completed within the agreed timescales. Recruitment and retention of GPs remained challenging, but a recent advertisement had attracted a number of suitable candidates, which was encouraging.

### 3.7 Newton Hospital

The Director of Nursing, Midwifery and Governance reported that there was an outbreak of norovirus at Newton Community Hospital, which was currently being investigated.

## 4. 24th January 2019

### 4.1 Local Clinical Excellence Awards

The Deputy CEO/Director HR presented a paper detailing the proposed arrangements for awarding local clinical excellence awards. This had been developed in line with the national guidance. The Local Negotiating Committee (LNC) had been consulted and would nominate members to sit on the awards panel. The national award criteria plus some specific local criteria were agreed.

### 4.2 Safer Staffing Report and Vacancy Dashboard

The Director of Nursing, Midwifery and Governance presented the figures for November and December 2018. The overall fill rate remained above 95% for registered nurses and care staff.

### 4.3 Primary Care Strategy

The Director of Operations and Performance reported that a Programme Board had now been established and the due diligence assessment was being completed. The first business case was now being developed for consideration by the Trust Board in February.

### 4.4 Medway

The Director of Informatics presented the latest update. It was agreed that an internal review needed to be undertaken to understand when the manual validation of outpatient appointments would be able to stop. This was a cost pressure for the Trust and an acceptable and reliable electronic solution was needed as soon as possible.

### 4.5 One Halton

The Chief Executive gave an update from a meeting she had attended with the senior leaders of organisations working in Halton towards integrating the care system.

### 4.6 Stroke

The Director of Integration gave an update on the agreement that had now been reached to treat all stroke patients from Mid Mersey at the Trust from 1st April 2019.

## 5. 31st January 2019

### 5.1 Apprenticeship Levy

The Deputy CEO/Director of HR introduced the report which summarised the current position in relation to the apprenticeship levy and proposals for future action.

There are currently 116 apprenticeships in operation across the organisation, on a rolling programme. However, not all the levy funds are currently being utilised and will start to progressively be lost if not committed within 24 months. Options including expanding the range of band 2 – 4 apprenticeships, and a comprehensive suite of leadership and management development apprenticeships to support the talent management strategy were agreed. The use of the levy to support place based development and the wider health and social care economy would also be explored.

### 5.2 Inquest

Following a recent inquest it was agreed that an independent review of the department concerned would be commissioned, the internal pathways would be audited against national guidance and the Trust's SUI/SIRI process would be reviewed.

### 5.3 IT Outage

The Director of Informatics provided a briefing on the IT outage that had occurred on Monday 28th January, and the investigation into the cause. The Committee also reviewed the Trust business continuity responses and the impact on some outpatient appointments.

### 5.4 CQPG

There was a summary of the items that had been discussed at the last meeting and it was noted that there were no matters of concern relating to quality.

### 5.5 Information Governance Training Compliance

The Director of Informatics presented the latest compliance data for the staff reporting to each Director. There had been an improvement and further actions put in place for groups who could not access e-learning.

### 5.6 Medway

The Director of Informatics provided an update on the NEWS2 programme, e-handover and bed management development. The review of outpatient booking and patient communications was ongoing.

## 5.7 ETTF Bids

The Director of Informatics informed the committee of the successful bids that had been made to the ETTF fund on behalf of St Helens, Knowsley and Halton CCGs.

## 5.8 NHS Pensions

The committee discussed the impact of the lifetime allowance and annual tax allowances on some staff and the potential implications for staff not being prepared to undertake additional hours, and on the wider retention of staff who were high earners or had long service. It was noted that this had been raised in recent evidence to the Medical and Dental Staff Pay Review Body.

**ENDS**

St Helens and Knowsley Teaching Hospitals NHS Trust

# TRUST BOARD

**Paper No:** NHST(19)14

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

**Purpose:** To summarise the meeting papers from the 19 February 2019 and escalate issues of concern.

**Summary:**

**QC(19)016 Complaints Update Report:**

- The Trust responded to 100% of 1st stage complaints within agreed timeframes during January 2019, the same as December 2018.
- No new cases were referred to the PHSO in January 2019.
- There was 1 second stage complaint received and opened in January 2019.
- There has been 29% increase in PALs contacts compared to previous month. There has been a 0.8WTE increase in staff to cope with the additional demand.

**QC(19)017 IPR:**

- 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. The RCA indicated that the patient came to no harm.
- There was 1 C.difficile positive case reported. YTD there have been 20 cases. The annual tolerance is 40 cases. 3 cases will be appealed on 5 March 2019.
- No grade 3/4 pressure ulcers reported.

**QC(19)018 Safer Staffing Reports:**

- M10 demonstrated an improvement on M9 with a RN overall fill rate of 96.65% and care staff overall fill rate of 111.73%

**QC(19)019 Quality Ward Round Update**

- 59 ward rounds scheduled in 2018 were completed and feedback has been provided.
- Local action plans will be consistently monitored for assurance at all Care Group governance meetings. Quality Matrons and business analysts are in the process of developing a system that will be able to undertake a thematic review of all actions across the 59 areas but will also have an oversight of the progress against individual action plans.

**QC(19)020 QCAT Framework Update**

- The revised framework will be available for implementation from April 2019. This will incorporate the KLOE domains to enable a robust process of continual audit and quality improvements.
- The redesign of the scoring matrix will introduce a platinum accreditation to reward wards and specialised areas who are able to demonstrate a sustained outstanding performance.
- Current position: 12 wards have attained 'Gold' status, 14 wards attained 'Silver' status and 1 ward is rated as 'Bronze'.

**QC(19)021 Mortality Surveillance Report**

- Local and national performance standards will be met and sustained in Q2.
- Red and amber rated cases were discussed and actions outlined. Themes identified relate to the quality of case notes and the accuracy of death certificates.

**QC(19)022 Learning from Deaths Report, Q2 Priorities**

- Patients who fall in hospital frequently have incomplete falls risk assessments. It is vital that nursing staff complete the risk assessments fully and individualise care plans to protect patients and the staff caring for them, ensuring the communication works to deliver the right plan for each patient.

- When a patient is suspected of having a GI bleed, review their medications and temporarily withhold antiplatelets (including aspirin) and anticoagulants until they have had the endoscopy. When in doubt, consult a senior member of staff.

**QC(19)023 CNST Update**

- It is anticipated that the Trust will be fully compliant with all 10 mandated safety actions.
- A Board declaration is required for submission by noon on 15 August 2019; a paper will be presented to Board in May.

**QC(19)024 Maternal & Neonatal Health Safety Collaborative**

As part of the Quality Improvement project recognising and managing the deterioration in babies by improving the neonatal sepsis pathway. The aim to increase the number of eligible babies who receive intravenous antibiotics within an hour from decision to screen without separation of mum and baby by 75% by March 2019. Currently achieving 100%.

**QC(19)025 ATAIN Action Plan Update**

The trust Maternity and Paediatric services are working jointly on the action plan to address the programme aims. The action plan progress is being monitored locally.

**QC(19)026 Shelford Audit Update**

The Shelford Audit update was provided as part of the Safer Staffing report. A full report will be presented in April.

**QC(19)027 IPC Q2 Data Comparison:**

- MRSA: 1 positive blood sample – contaminant no harm to the patient. 2 cases in 2017-18.
- CDI: 20 with 3 for appeal. 19 cases in 2017-18.
- MSSA Bacteraemia: 26. 22 cases in 2017-18.
- Outbreaks 2 due to Norovirus (Newton hospital) and Pseudomonas aeruginosa bacteraemia (ward 4E).
- Influenza: 537 cases influenza detected in patients attending the Trust from beginning of October to end of January.

**QC(19)028 Orthopaedic Infections Report**

- 7 infections reported: 4 of which were hip infections: 1 deep seated (avoidable) and 3 superficial (unavoidable), 3 knee infections were all superficial (avoidable)
- The Trust self-assessment indicates 92.16% compliance with the criteria and actions implemented.

**QC(19)029 & 30 Mandatory & Resuscitation Training Update**

- Detailed review of training currently set as mandatory for all staff groups to determine its ongoing need, to whom it specifically applies and how it will be delivered, monitored and reported.
- Revised categories of mandatory training based on statute, national mandate or local (Trust need). i.e. Core, Core Clinical, Essential.
- Identification of an executive lead for each subject, who will have responsibility for working with Subject Matter Experts (SME), ensuring only training that is essential is assigned to one of the above categories, defining the target groups and monitoring of performance.
- Updated training policy which clearly defines the responsibilities of all parties involved in the various processes.
- Updated Resuscitation training Levels 2 and 3 (BLS/ILS) refined to target specific groups.

**QC(19)031 UTI Collaborative Presentation**

- E.coli is the commonest cause of UTI. UTI is the commonest cause of bacteraemia's in England and 37% of positive blood cultures at StHK in 2017/18.
- The trust aims to reduce the number of patients acquiring HCAI UTI/CAUIs by 5% within 3

months. Following the introduction of the collaborative, a new fluid balance policy has been developed together with a hydration risk assessment and patient leaflets.
- Further work is ongoing between the AKI team and catering staff to investigate how to promote hydration further. There is also the development of a continence assessment tool and resource folder for wards to promote alternatives to catheterisation.

**Feedback from Councils/Committees**:

**QC(19)032 Patient Safety Council**
The PSC summary page was noted by the Committee. The following was highlighted:
- The council identified issues with training recorded on IT platform 'Moodle' and interface with ESR records. There is a risk that all training profile is not transferred to ESR system, which may influence information available with compliance requirement and expected standards with training.

**QC(19)033 Patient Experience Council**
The PEC summary page was noted by the Committee. The following was highlighted:
- Improved access to car parking for patients following the opening of Delph Lane staff car park and NHS free wi-fi will be in pace in the next few weeks.

**QC(19)034 Clinical Effectiveness Council**
No report was received, a full update will be provided in March.

**QC(19)035 CQPG**
The CQPG meeting was moved from 19th to 26th February, any issues will be escalated to the Committee in March.

**Policies/Documents for Approval:** None received.
**Policies/Documents for Approval by Councils:** None received.

***Items to be brought to the attention of the Board:***
- Performance metrics noted to be adequate in the Safer Staffing fill rates.
- Noted the new approach to acuity measures in order to obtain the appropriate staffing levels.
- Changes noted to Mandatory and Essential training.
- Streams of improvement noted in the Maternity Incentive Scheme (CNST) which require Board approval prior to August 2019.
- Urgent work required on fluid balance throughout the trust as revealed in the UTI collaborative.
- Falls risk assessment documentation to be handed over at the patient's bedside.
- Further consideration of the assurance required on the Mortality Surveillance Group findings.

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| **Corporate objectives met or risks addressed:** Five star patient care and operational performance. |
| **Financial implications:** None directly from this report. |
| **Stakeholders:** Patients, the public, staff and commissioners |
| **Recommendation(s):** It is recommended that the Board note this report. |
| **Presenting officer:** Chair of Committee |
| **Date of meeting**: 27 February 2019 |

St Helens and Knowsley Teaching Hospitals NHS Trust

# TRUST BOARD

**Paper No:** NHST(19)15

**Title of paper:** Committee Report – Finance & Performance

**Purpose:** To report to the Trust Board on the Finance and Performance Committee, 21st February 2019

**Summary:**

**Agenda Items**

**For Information**

- Integrated Performance Report
  - The committee were informed that the Cancer standards for 62 day, 31 day and 2 week rule were all achieved in January.
  - RTT performance in line with time scales agreed. The RTT performance was in excess of 92% reporting a compliance with statutory standards. The Trust is continuing to work towards reducing the waiting list below the March 2018 level.
  - The Trust has reduced super stranded by 28% year on year which is in excess of national expectations.
  - Staff sickness continues to be behind target at 6.1% but mandatory training and appraisal rates were above the target compliance rates.
- Finance Report
  - The Trust is behind the YTD annual plan due to non-achievement of PSF and pressures within the organisation.
  - The Trust has utilised c.75% of its capital allocation YTD and plans are in place to use the full resource.
  - The committee was informed that the financial outturn continues to be in line with plans submitted to the Board in December.
  - NHSI have approached the Trust to see whether it would be able to improve on the revised forecast outturn position submitted at month 9. The Trust will endeavour to improve its financial position where possible and will monitor this over the coming months.
- Learning from inpatient deaths
  - The Medical Director updated the Committee on the key learning priorities from Inpatient Deaths. The two main priorities were patient falls and GI bleeds.
- Draft financial plans
  - The Committee were updated on the progress of the financial plans for 2019/20 and the assumptions underpinning them. The risks highlighted were:
    - Potential changes to asset lives haven't been reflected
    - Final tariff prices are due to be published until March
    - Contracts with commissioners during March
    - Discussions with regulators about the redemption of previous revenue loans are still ongoing.
- Briefings were accepted from:
  - CIP Council
  - Service Improvement Council

**For Assurance**

- A&E Performance
    - The Committee reviewed the presentation from the ADO for Urgent Care, Emergency Department Consultant, ADO from Medical Care and Associate Medical Director.
    - The Committee praised the work of the team to support performance in A&E acknowledging their continued efforts in difficult circumstances.
    - The Committee requested a review of ambulances attending Whiston from out of area to be reviewed with NWAS for an understanding of the reasons behind them.
    - The Committee were updated on the workstreams ongoing within A&E and felt assured that the executive team were closely monitoring these actions.
    - The Committee felt assured of the progress being made on the 'Home for Lunch' campaign and associated workstreams.
- CIP Programme update
    - The committee noted the improvement in green rated schemes and that the forecast delivery of c£14.5m in line with previously agreed forecasts.
    - For 2019/20 the Committee requested 'NEDs spot check' be reintroduced to give them visibility of individual schemes and the QIA process linked to it.
    - There is c.50% of schemes identified for 2019/20 which are green and will be sufficiently worked up to be transacted during Q1.
- CIP Programme update – MCG
    - The committee received a presentation from the Medical Care ADO that demonstrated the progress on the CIP within the Care Group for both 2018/19 and plans for 2019/20. The committee were assured that plans were progressing to achieve next year's target.

**Risks noted/Items to be raised at Board**

- Forecast outturn – Although in line with previous reported positions this is off the agreed 2018/19 plan.
- Non-recurrent measures utilised within financial position and forecast
- A&E performance
- Underlying financial position
- Potential increase to depreciation charge in I&E if revaluation of assets change is adopted.
- Draft plan for 2019/20 - Contract alignment exercise is still on-going with our commissions and a further tariff is published in March.

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| **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**: 27th February 2019 |

St Helens and Knowsley Teaching Hospitals NHS Trust

# TRUST BOARD

**Paper No:** NHST(19) 16

**Title of paper:** Committee Report – Audit

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

**Summary:** The Audit Committee met on 13th February 2019.

The following matters were discussed and reviewed:

External Audit :

- External audit update report (GT)
- External audit plan which was approved by the Committee (GT)
- Trust response to "emerging Issues and developments questions" raised in above update report (DoF)
- Annual report timetable (DoCS)

Internal Audit:

- Internal audit progress and follow-up report (MIAA) – One audit report received limited assurance (Newton Hospital Locality Review) which included three recommendations classified as high risk, one of which related to controlled drugs. This was considered by the Committee as disappointing given the work done since the CQC inspection and the DoN has been asked to provide an update to the Audit Committee at the next meeting in April.

Anti-Fraud Services:

- Anti-fraud progress report (MIAA)
- AntI-fraud work plan which was approved by the Committee (MIAA)
- Routine review of the Trust's anti-fraud, bribery and corruption policy. Some minor revisions to the policy were necessary as a result, for example, of organisational name changes. The Committee agreed to recommend the updated policy to the Board for approval (MIAA)

Trust Governance and Assurance:

- The Director of Nursing update including update from Quality Committee (DoCS on behalf of 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 30th December 2018 (ADoF).
- Aged debt analysis as at the end of January 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:

- Annual report on use of Trust's seal (DoCS)

- 2017/18 Reference costs (SLRA)
- Annual review of Trust's register of interests and register of hospitality, sponsorship and casual gifts (ADoF)

Key:

GT= Grant Thornton (external auditor)

MIAA = Mersey Internal Audit Agency (internal audit and anti-fraud services)

DoF = Director of Finance

DoN = Director of Nursing, Midwifery & Governance

DoCS = Director of Corporate Services

ADoF = Assistant Director of Finance (Financial Services)

SLRA = SLR Accountant

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

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

**Financial implications:** None as a direct consequence of this paper

**Stakeholders:** The Trust, its staff and all stakeholders

**Recommendation/Escalation:** For the Board to:

(i) approve the revised Anti-Fraud, Bribery and Corruption Policy;
(ii) note the high level of over 90 day aged debt.

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

**Date of meeting**: 27th February 2019

# TRUST BOARD

**Paper No: NHST(19)17**

**Title of paper:** Committee Report – Charitable Funds Committee

**Purpose:** To brief the Board on the main issues discussed and decisions made at the Committee meeting on 21st February 2019.

**Summary**

**Action Log**

Discussions are still ongoing around the physical presence of the Charity within the hospital, though, on occasions, there is a temporary presence in the main reception area.

Action is to be taken to implement the administrative review around the rationalisation of charitable funds. There were discussions around Charity Champions in each area.

Further thought is to be given to the idea of a Charity Lottery in the future but present plans have been halted.

1. Financial position - The Committee noted the level of investments and recent income and expenditure. It was also noted that some of the investment portfolio has been redeemed because of increased expenditure.

2. Approval of expenditure - a presentation was given by Andrew O'Brien, Directorate Manager, to promote the case for a Specular Microscope for Ophthalmology. The various advantages and outcomes of having this piece of equipment were discussed. The expenditure was approved by the committee subject to the answer to a question raised around its interface with present Trust record requirements.

3. Fundraising update
   - Mrs E Titley, Charity Manager, gave details of fundraising activities that have taken place eg the pink pigs for funds towards post-operative breast cancer items and the bi-annual fundraising event for the Burney Breast Unit
   - The committee was also informed that the Charity Abseil is proving more popular than previous years
   - There were discussions around targeted fundraising
   - A Charity newsletter has been produced and is to be distributed

4. Any other business – Mrs E Titley, Charity Manager, announced that she is leaving the Trust at the end of March to pursue a new career.

**Corporate objective met or risk addressed:** Contributes to the Trust's objectives regarding Finance, Performance, Efficiency and Productivity.

**Financial implications:** None directly from this report.

**Stakeholders:** The Trust, its staff and all stakeholders.

**Recommendation(s):** The Board are asked to note the contents of the report.

**Presenting officer:** Paul Growney, Non-Executive Director and Committee Chair

**Date of meeting:** 27th February 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

# TRUST BOARD

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| **Paper No:** NHST(19)18 |
| **Title of paper:** Strategic and Regulatory Update Report – February 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:**<br>The report provides a briefing on the key policy and regulatory developments including;<br>1. 2019/20 Operational Planning<br>2. Kerr Report - Empowering NHS Leaders to Lead<br>3. Developing Workforce Safeguards<br>4. Kark Report - Review of the Fit and Proper Persons Test<br>5. Brexit Preparedness |
| **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):**<br>The Board is asked to note the report. |
| **Presenting officer:** Nicola Bunce, Director of Corporate Services |
| **Date of meeting:** 27th February 2019 |

# Strategic and Regulatory Update Report – February 2019

## 1. 2019/20 Operational Planning

The Trust submitted the draft operational plans to NHS Improvement on 12th February, in line with the national timetable. This includes confirmation of the Trusts acceptance of the proposed Control Total and preliminary financial, activity and workforce plans.

The final Board approved plans have to be submitted on 4th April 2019, following the conclusion of contract negotiations with Commissioners, which are scheduled for completion by 21st March 2019.

## 2. Kerr Report - Empowering NHS Leaders to Lead

The report was published in November 2018, following a request by Jeremy Hunt, when he was Secretary of State for Health and Social Care. The review was undertaken to make recommendations on how to better attract, support and retain people in senior leadership positions in the NHS.

Many of the suggestions have subsequently been reflected in the NHS Long Term Plan and are being translated into a Workforce Implementation Plan being developed by Baroness Dido Harding, Chair of NHS Improvement and Julian Hartley, CEO of Leeds Teaching Hospitals.

The key recommendations are;

a) Create a National Talent Board, supported by regional talent management pipelines to ensure a flow of suitably trained and experienced people for the most senior NHS roles
b) Develop a recruitment strategy to attract more people for outside the NHS
c) A “new deal” for leaders to give them the space and time to make changes to complex organisations with historic financial and/or quality problems
d) Incentivise successful leaders to work in challenged organisations
e) Align the expectations of senior leaders and health systems across the NHS regulators
f) Agree a behavioural compact to reduce the bullying culture experienced by senior leaders
g) Create a leaner, coordinated single regulatory and assurance system to reduce the administrative burden on senior leaders of provider organisations

## 3. Developing Workforce Safeguards

The guidance published by the NHS Improvement (NHSI) sets standards of governance and reporting in relation to safe staffing across all staff groups. The requirements are mandatory and will be monitored via the Single Oversight Framework (SOF) and also an additional statement being required in the annual governance statement for the organisation, to confirm that staffing governance processes are safe and sustainable.

The requirements from April 2019 are;

- The Director of Nursing and Medical Director must confirm in a statement to their Board that they are satisfied with the outcome of any assessment of staffing is safe, effective and sustainable.
- Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and executive leaders. The Board should discuss the workforce plan in a public meeting.
- There is an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard, which is reported to the board every month.
- An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the Board by ward or service area twice a year.
- Any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.
- Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners (ACPs) is considered a service change and must have a full QIA.
- Given day-to-day operational challenges, trusts must have systems in place to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes.

The Trust already has many of these processes in place, as a result of the 2016 National Quality Board recommendations, that are being reviewed and enhanced to meet the new regulatory standards.

## 4. Kark Report - Review of the Fit and Proper Persons Test

As part of its response to the Kirkup review into Liverpool Community Health NHS Trust, the Department of Health and Social Care commissioned Tom Kark QC to review the scope, operation and purpose of the Fit and Proper Person Test (FPPT). This report was published on 6th February 2019.

The review identified a number of issues with the way that the FPPT is currently being applied and used and made 7 recommendations;

a) All directors (executive, non-executive and interim) should meet specified standards of competence to sit on the board of any health providing organisation. Where necessary, training should be available.
b) That a central database of directors should be created holding relevant information about qualifications and history
c) The creation of a mandatory reference requirement for each Director

d) The FPPT should be extended to all Commissioners and other appropriate Arms-Length Bodies (including NHSI and NHSE)
e) Setting up of an organisation which will have the power to suspend and to disbar directors covered by Regulation 5, who are found to have committed Serious Misconduct
f) In relation to Regulation 5 (3) (d) of the Regulations, the words “been privy to” should be removed.
g) Further work is done to examine how the FPPT works in the context of the provision of social care and whether any amendments are needed to make the test effective.

Matt Hancock, SoS for Health and Social Care has accepted the first two recommendations and has charged Baroness Dido Harding to examine the other recommendations as part of the development of the NHS Long Term Plan Workforce Implementation plans.

## 5. Brexit Preparedness

Professor Keith Willets, Director for Acute Care at NHS England has been appointed as the EU Exit Strategic Commander for the NHS. Further clarification has been issued to NHS organisations on the expected planning for 29th March, in the event that no EU Exit deal is approved by parliament. A regional emergency preparedness network and chain of command has also been established and the Director of Nursing, Midwifery and Governance identified as the Trusts lead director (as the Director responsible for emergency preparedness, resilience and response (EPPR)). In this capacity the Director of Nursing, Midwifery and Governance attended a regional workshop on 13th February.

The Trust has completed all the actions required by the DHSC in relation to medical equipment and supplies, medicines and workforce.

**END**

St Helens and Knowsley Teaching Hospitals NHS Trust

# TRUST BOARD

| |
|---|
| **Paper No** NHST(19)19 |
| **Title of paper:** St Helens and Knowsley Teaching Hospital NHS Trust's progress against the Clinical Negligence Scheme for Trusts (CNST) Maternity incentive Scheme. |
| **Purpose:** To provide an overview and assurance of the maternity services current position to meeting the 10 mandated criteria of the outlined maternity safety actions. |
| **Summary:** To provide a GAP analysis and action plan to meet the requirements as identified by NHS resolution and the Department of Health. The expectation is that the Trust will be compliant with all 10 mandated safety actions. A board declaration is required for submission to NHS Resolution by 12 noon on Thursday 15th August 2019 |
| **Corporate objectives met or risks addressed:** Care; Safety; Pathways; Communication and Systems |
| **Financial implications:** Yes, 10% discount on the CNST maternity premium for 2019/20 |
| **Stakeholders:** The Trust; staff; patients; commissioners |
| **Recommendation(s):** To provide assurance that satisfactory progress is being made towards achieving the 10 mandated safety criteria. Members are asked to note and approve the paper. |
| **Presenting officer:** Sue Redfern, Director of Nursing, Midwifery & Governance |
| **Date of meeting**: 27th February 2019 |

## Summary

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

In order to incentivise improvement in the delivery of best practice and safer care, NHS Resolution will be making a 10% (at least) reduction in the CNST maternity contributions of trusts who are able to demonstrate compliance with the 10 criteria agreed by the National Maternity Champions by the CNST incentive scheme for 2019/20. This is also directly aligned to the Intervention objectives in the *Five year strategy: Delivering fair resolution and learning from harm* and *NHS Longer Term Plan.*

The ten maternity safety actions are summarised here:

**Safety action 1**: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

**Safety action 2**: Are you submitting data to the Maternity Services Data Set to the required standard?

**Safety action 3**: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions into Neonatal units Programme?

**Safety action 4**: Can you demonstrate an effective system of medical workforce planning to the required standard?

**Safety action 5**: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

**Safety action 6**: Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?

**Safety action 7**: Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

**Safety action 8**: Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

**Safety action 9**: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

**Safety action 10**: Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme

**GAP Analysis and Action Plan**

St Helens and Knowsley Teaching Hospitals NHS Trust

| Key | |
|---|---|
| Red | No progress/update to complete action |
| Amber | Actions in progress to completion |
| Green | Action completed |

# Maternity Incentive Scheme – Year 2
# Ten Safety Actions

| Safety Action & Deadline | Safety Criteria | GAPS (as of 12/2/19) | RAG Red, Amber Green | Action Plan | Date For Completion |
|---|---|---|---|---|---|
| **Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?** | | | | | |
| 1 a)<br><br>**Deadline:**<br><br>15th August 19 | A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 to 15th August 2019 have been started within four months of each death. | • **PMRT's have been started for eligible cases from 12th December 2018 to current date, safety action ongoing no current GAP's.** | | • **JS to ensure that all eligible PMRT's are opened immediately when required.**<br>• **JK to monitor that all eligible cases have been openined immediately if required and provide SJ with an audit for evidence folder.** | **August 2019** |
| 1 b)<br><br>**Deadline:** | At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 to 15th | • **Awaiting information form JK.** | | • **JK to set up database for** | **August 2019** |

# Maternity Incentive Scheme – Year 2
# Ten Safety Actions

| Safety Action & Deadline | Safety Criteria | GAPS (as of 12/2/19) | RAG Red, Amber Green | Action Plan | Date For Completion |
|---|---|---|---|---|---|
| 15th August 2019 | August 2019 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death. | | | **quality assurance inclusive of timescales for evidence folder.** | |
| 1 c)<br><br>**Deadline:**<br><br>15th August 2019 | In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 to 15th August 2019, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought. | • **Safety action ongoing no current GAP's.** | | • **JK to monitor and review that all eligible women have received a letter to outline the investigation process and offer the parents the opportunity to raise concerns about care.**<br>• **JK to produce audit trail for evidence folder.** | **August 2019** |
| 1 d)<br><br>**Deadline**:<br><br>15th August 2019 | Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans from 12th of December 2018 to 15th August 2019. | • **STHK Maternity services does not currently produce a quarterly report.** | | • **JK to produce a Perinatal Mortality report for March Clinical Effectiveness Council from 12th December 2018.**<br>• **JK to produce quarterly Perinatal Mortality report as a standing** | **August 2019** |

# Maternity Incentive Scheme – Year 2
# Ten Safety Actions

| Safety Action & Deadline | Safety Criteria | GAPS (as of 12/2/19) | RAG Red, Amber Green | Action Plan | Date For Completion |
|---|---|---|---|---|---|
| | | | | **item for Maternity and Gynaecology Quality and Governance meeting/Clinical Effectiveness Council.** | |
| **Are you submitting data to the Maternity Services Data Set to the required standard?** | | | | | |
| 2<br><br>**Deadline:**<br><br>MSDS data from January 2019 to be submitted by 31st March 2019 | NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met and whether the overall score is enough to pass the assessment. It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria (see appendix).<br>This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and readiness for implementing the next version of the dataset (MSDSv2). | • **A review of November 2018 data submission by IR identified that STHK Maternity Services is achieving the 14 out of the 19 criteria required which indicates that STHK Maternity is projected to achieve the minimum standard.**<br>• **GAP's for data collection are relating to categories 6*,7*, 8*, 13* & 18* (*see appendix 1).** | | • **IR is aiming for full complience to achieve 19 out of 19 of the data. collection criteria.**<br>• **A data review excerise is underway to compare Maternity Medway data against the MSDS submissions, CI and LR have identified a discrepency in data that is related to to categories 6*,7*, 8*, 13* & 18*.**<br>• **IR has contacted System C to** | **31st March 2019** |

# Maternity Incentive Scheme – Year 2
# Ten Safety Actions

| Safety Action & Deadline | Safety Criteria | GAPS (as of 12/2/19) | RAG Red, Amber Green | Action Plan | Date For Completion |
|---|---|---|---|---|---|
| | | | | **resolve the issues identified to enusre accurate data transfer for MSDS submissions.** | |
| **Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?** | | | | | |
| 3 a)<br><br>**Deadline:**<br><br>31st January 2019 | Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care. | • **All guidelines, polices and pathways relating to neonatal transitional care that is provided on postnatal ward have been jointly approved by both Maternity and Paediatric Governance groups and are embedded into clinical practice.**<br>• **Local Neonatal Unit (LNU) Operational policy Version 2 requires a minor update.**<br>• **Jaundice guideline and pathway require update.** | | • **SJ organising minor ammendments to LNU policy with FH.**<br>• **FH cirulated Jaundice guideline for comments and SJ will ensure that this is completed.** | **Completed**<br><br>**Minor ammedments for completion February 2019** |

# Maternity Incentive Scheme – Year 2
# Ten Safety Actions

| Safety Action & Deadline | Safety Criteria | GAPS (as of 12/2/19) | RAG Red, Amber Green | Action Plan | Date For Completion |
|---|---|---|---|---|---|
| 3 b)<br><br>**Deadline:**<br><br>3rd February 2019 | A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2. | • **KJ has confimed that a data collection process has been established to produce commisioner returns. Files are produced through the National Payment Grouper.**<br>• **CW and DM have confimed that payment is received under Payement by Results from the CCG's.**<br>• **SA and DM identified that Maternity have the expendature budget whilst Paediatrics have the income budget for clinical care delivery relating to HRG XA04.** | | • **SA, DM and CW to review to review the funding relating to HRG XA04 as Maternity are providing some of the clinical activities outlined by the NCCMDS but Paediatrics are receiving the payments.** | **Completed**<br><br>**Review to be completed by April 2019** |
| 3 c)<br><br>**Deadline:**<br><br>10th March 19 | An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews. | • **Action plan developed.**<br>• **Action plan has not yet been agreed by the LMS or ODN.** | | • **ATAIN action plan to be presented at Quality Committee 19th February 2019 by JK**<br>• **SJ to circulate agreed action plan to the LMS on the 14th February for discusion in the NWCSCN Safety** | **March 2019** |

# Maternity Incentive Scheme – Year 2
# Ten Safety Actions

| Safety Action & Deadline | Safety Criteria | GAPS (as of 12/2/19) | RAG Red, Amber Green | Action Plan | Date For Completion |
|---|---|---|---|---|---|
| | | | | **SIG, JF is attending.**<br>• **SJ to contact ODN for local plans to review action plan.** | |
| 3 d)<br><br>**Deadline:**<br><br>19th May 19 | Progress with the agreed action plans has been shared with your Board and your LMS & ODN | • **Process to be formalised to achieve action with LMS and ODN.** | | • **Action plan to be reviewed at April 2019 Quality Committee**<br>• **SJ to contact LMS and ODN with regards to regional processes for monitoring of actions plans**<br>• **Embedd action plan review into monthly 'Working Well' together meetings.**<br>• **Action plan part of Board Level maternity safety Champions meeting standard agenda.** | **May 2019** |

# Maternity Incentive Scheme – Year 2
# Ten Safety Actions

| Safety Action & Deadline | Safety Criteria | GAPS (as of 12/2/19) | RAG Red, Amber Green | Action Plan | Date For Completion |
|---|---|---|---|---|---|
| **Can you demonstrate an effective system of medical workforce planning to the required standard?** | | | | | |
| 4 a)<br><br>**Deadline:**<br><br>15th August 2019 | Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: *'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'* In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps. | • **Currently no action plan in place.** | | • **NB is currently reviewing survey results to access if an action plan is required and will feedback to SJ and TI.**<br>• **SJ awaiting response from NB who is reviewing currently training for Junior doctors.** | **August 2019** |
| 4 b)<br><br>**Deadline:**<br><br>15th August 2019 | An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 for a sixth month period between January 2019 and June 2019. | • **Standard NOT MET 1.2.4.6 *'Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff'***<br>• **There is dedicated theatre and midwifery staff for elective Caesarean Section list but not dedicated Anaesthetic staff. There is an elective list all day on Mondays and Thursdays and half day elective lists on Tuesdays, Wednesdays and Fridays.**<br>• **No current action plan in place.** | | • **Buisness plan under construction by JC and VG to address standard 1.2.4.6.**<br>• **Action plan to be developed and ratified by Trust Board by May 2019.** | **May 2019** |

# Maternity Incentive Scheme – Year 2
# Ten Safety Actions

| Safety Action & Deadline | Safety Criteria | GAPS (as of 12/2/19) | RAG Red, Amber Green | Action Plan | Date For Completion |
|---|---|---|---|---|---|
| **Can you demonstrate an effective system of midwifery workforce planning to the required standard?** | | | | | |
| 5 a)<br><br>**Deadline:**<br><br>15th August 2019 | A systematic, evidence-based process to calculate midwifery staffing establishment has been done for any three month period between January and July 2019. | | | • **SA undertaking tabletop top midwifery work force planning exercise 28th February 2019.** | **August 2019** |
| 5 b)<br><br>**Deadline:**<br><br>15th August 2019 | The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service or any three month period between January and July 2019. | • **Current monitoring in Red Flag report produced by NJ.** | | • **NJ to produce quarterly 'Acuity, Staffing and Redflags' for March 2019 Quality Committee.**<br>• **Monthly monitoring to be undetaken of Red Flag at Maternity and Gynaecology Quality and Governance Meeting.** | **August 2019** |
| 5 c)<br><br>**Deadline:**<br><br>15th August 2019 | Women receive one-to-one care in labour (this is the minimum standard that Birth rate+ is based on) or any three month period between January and July 2019. | | | • **NJ producing a 'Safety, Staffing and Red Flag' report for March 2019 Quality** | **August 2019** |

# Maternity Incentive Scheme – Year 2
# Ten Safety Actions

| Safety Action & Deadline | Safety Criteria | GAPS (as of 12/2/19) | RAG Red, Amber Green | Action Plan | Date For Completion |
|---|---|---|---|---|---|
| | | | | Committee.<br>• NJ to produce quarterly 'Safety, Staffing and Red Flag' report as standing item for Quality Committee.<br>• GL undertaking a monthly birth rate plus excericse for review by SA. | |
| 5 d)<br><br>**Deadline:**<br><br>15th August 2019 | A bi-annual report that covers staffing/safety issues is submitted to the Board or any three month period between January and July 2019. | • No current bi annual report to address staffing/safety issues. | | • NJ producing a 'Safety, Staffing and Red Flag' report for March 2019 Quality Committee.<br>• NJ to produce bi-annual 'Safety, Staffing and Red Flag' report as standing item for Quality Committee. | August 2019 |
| **Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?** | | | | | |
| 6 | Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March | • JK currently produces SBL's report for Quality Committee. | | • JK to provide SBL's update | March 2019 |

# Maternity Incentive Scheme – Year 2
# Ten Safety Actions

| Safety Action & Deadline | Safety Criteria | GAPS (as of 12/2/19) | RAG Red, Amber Green | Action Plan | Date For Completion |
|---|---|---|---|---|---|
| **Deadline:**<br><br>July 2019 | 2016) in a way that supports the delivery of safer maternity services.<br><br>Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s). | | | **paper for March 2019 Quality Committee.** | |
| **Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?** | | | | | |
| 7<br><br>**Deadline:**<br><br>July 2019 | Evidence should include:<br><br>Acting on feedback from, for example a Maternity Voices Partnership.<br><br>User involvement in investigations, local and or Care Quality Commission (CQC) survey results.<br><br>Minutes of regular Maternity Voices Partnership and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women. | | | | **Completed**<br><br>**Ongoing review of evidence for folder until July 2019** |
| **Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?** | | | | | |
| 8<br><br>**Deadline:**<br><br>15th August 2019 | Evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year through Board sight of a staff training database or similar. | • **Current complience for Midwifery Staff (Midwives and Support Staff) is 85%.**<br>• **Current complience for Obstetric Medical staff is 70%.**<br>• **Current complence for Obstetric Anaesthetic Medical staff is 100%.**<br>• **Current complience for Theatre staff is 0%.** | | • **JR has allocated all midwives to training who are out of date for training to meet the target of 90% by May 2019.**<br>• **TS has allocated all Obstericians training who are** | **May 2019**<br><br>**Ongoing monitoring will be required form May to ensure complience** |

# Maternity Incentive Scheme – Year 2
# Ten Safety Actions

| Safety Action & Deadline | Safety Criteria | GAPS (as of 12/2/19) | RAG Red, Amber Green | Action Plan | Date For Completion |
|---|---|---|---|---|---|
| | | | | out of date for training to meet the target of 90%by May 2019.<br>• PG has allocated all relevant theatre staff to training to all relevent staff to meet the target of 90% by May 2019.<br>• VG has allocated all Obstetric Anaesthetists to future training to ensure consistency at 90% complience<br>• TS to provide obstetric staff training database to JR for evidence folder.<br>• VG to provide anaesthetic staff training database to JR for evidence folder.<br>• JR to monitor complience locally. | |

# Maternity Incentive Scheme – Year 2
# Ten Safety Actions

| Safety Action & Deadline | Safety Criteria | GAPS (as of 12/2/19) | RAG Red, Amber Green | Action Plan | Date For Completion |
|---|---|---|---|---|---|
| | | | | | |
| **Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?** | | | | | |
| 9 a)<br><br>**Deadline:**<br><br>27th January 2019 | The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within:<br>i. the trust<br>ii. the Local Learning System (LLS) | | | | **Achieved** |
| 9 b)<br><br>**Deadline:**<br><br>27th February 2019 | The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues | | | • **Ward managers to provide minute of ward meetings.** | **Achieved** |
| 9 c)<br><br>**Deadline:**<br><br>27th March 2019 | The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues | | | • **STHK Maternity to redesign Safety report to ensure that this is user friendly for all staff to access.**<br>• **NJ to ensure that feedback from safety concerns is a standing item on ward meeting** | **March 2019** |

# Maternity Incentive Scheme – Year 2
# Ten Safety Actions

| Safety Action & Deadline | Safety Criteria | GAPS (as of 12/2/19) | RAG Red, Amber Green | Action Plan | Date For Completion |
|---|---|---|---|---|---|
| | | | | **agendas.**<br><br>• **Concenrs raised from ward meetings or other sources to be discused in 'Working Well' Together meeting and to be esculated to Board level safety Champions meeting by SA and TI.** | |
| **Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?** | | | | | |
| 10<br><br>**Deadline:**<br><br>August 2019 | Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme from the 1st April 2018-31st March 2019? | • **All relevent cases have been reported to NHS Resolution's Early Notification scheme as of the 12th February 2019. Safety action ongoing no current GAP's** | | • **JK to perform ongoing audit of all relevent cases to ensure that all cases have been resported.** | **August 2019** |

| Key (Professionals) | |
|---|---|
| **CI** | **Claire Inwood** |
| **CW** | **Chris Woods** |
| **DM** | **Dave Miles** |
| **FH** | **Fiona Healy** |
| **IR** | **Ian Roberts** |
| **GL** | **Grace langton** |
| **JB** | **Janet Bentham** |
| **JC** | **John Clayton** |
| **JF** | **Joanne Ford** |
| **JK** | **Jacqui Kourellias** |
| **JR** | **Janette Robinson** |
| **JS** | **Julie Sanderson** |
| **KJ** | **Karent Jones** |
| **LR** | **Lisa Roberts** |
| **NB** | **Nick Bennett** |
| **NJ** | **Nicki Jones** |
| **SA** | **Sue Ainsworth** |
| **SJ** | **Sarah Jones** |
| **TI** | **Tennyson Idama** |
| **TS** | **Tabussum Safdar** |
| **VG** | **Vandana Goel** |

## Appendix 1

| Assessment to cover January 2019 data submitted for the deadlines of March 2019, one criteria relates to data between October 2018 and March 2019, submitted to deadlines December 2018 - May 2019, and one around MSDSv2 data for April 2019 being submitted to the deadline of June 2019 | |
|---|---|
| | **Mandatory categories 1-3 must be met to pass Safety action 2** |
| 1 | January 2019 data contained at least 90% of HES births expectation, based on number of days in month (unless reason understood) |
| 2 | MSDSv2 readiness questionnaire completed and returned to NHS Digital within required timescales |
| 3 | Submit MSDSv2 data for April 2019 by the submission deadline of end of June 2019 |
| | **14 of the 19 optional categories 4-22 must be met to pass Safety action 2** |
| 4 | Made a submission in each of the six months October 2018 - March 2019 data, submitted to deadlines December 2018 - May 2019 |
| 5 | January 2019 data contained valid smoking at booking for at least 80% of bookings |
| 6 | January 2019 data contained valid smoking at delivery for at least 80% of births |
| 7 | January 2019 data contained all of the tables 501, 502, 404, 409, 401, 406, 408, 602 (unless justifiably blank) |
| 8 | January 2019 data contained all of the tables 101, 102, 103, 104, 112, 201, 205, 305, 307, 309, 511 (unless justifiably blank) |
| 9 | January 2019 data contained method of delivery for at least 80% of births |
| 10 | January 2019 data contained valid baby's first feed for at least 80% of births |
| 11 | January 2019 data contained valid in days gestational age for at least 80% of births |
| 12 | January 2019 data contained valid presentation at onset for at least 80% of births where onset of labour recorded |
| 13 | January 2019 data contained valid labour induction method (including code for no induction) for at least 80% of births where onset of labour recorded |
| 14 | January 2019 data contained valid place type actual delivery for at least 80% of births |
| 15 | January 2019 data contained valid site code for at least 80% of births |
| 16 | January 2019 data contained valid genital tract trauma code for at least 80% of vaginal births |
| 17 | January 2019 data contained valid Apgar score at five minutes for at least 80% of births |
| 18 | January 2019 data contained valid fetus outcome code for at least 80% of births |
| 19 | January 2019 data contained valid birth weight for at least 80% of births |
| 20 | January 2019 data contained valid figure for previous live births for at least 80% of bookings |
| 21 | MSDSv2 event or webinar attended in late 2018 / early 2019, or had 1:1 call with one of the NHS Digital team in lieu of attendance |
| 22 | January 2019 data contained valid (including "Not Stated") ethnic category (Mother) for at least 80% of bookings. |

**End**

St Helens and Knowsley Teaching Hospitals NHS Trust

# TRUST BOARD

**Paper No:** NHST(19)20

**Title of paper:** 7-Day Services Board Assurance Statement

**Purpose:** Assurance and information


**Summary:**

The Seven Day Hospital Services (7DS) Programme aims to ensure that patients requiring emergency admission receive high-quality, consistent care every day of the week by enabling early and consistent senior decision making along with provision of other urgent services.

Ten clinical standards (CS) were developed, of which four were identified as national priorities on the basis of their potential to positively affect patient outcomes.

CS2: Time to first consultant review - All emergency admissions must have a clinical assessment by a suitable consultant within 14h of the time of admission to hospital.

CS 5: Access to diagnostic tests - Hospital inpatients must have scheduled 7-day access to specialist diagnostic services

CS 6: Access to consultant-directed interventions - Hospital inpatients must have timely 24h access, 7-days a week, to key consultant-directed interventions.

CS8: Ongoing review by consultant - Twice daily if high dependency patients, daily for others

The Trust performed well against the three of the four “priority” 7-Day Services (7DS) Clinical Standards as reported in the clinical audit of June 2018.

National changes to reporting and the introduction of a Trust Board Assurance process will help to direct the organisational response to 7DS Standards. Changes in working practices are expected to improve performance against CS 8 in time for the first formal report to Trust Board in June 2018. Further work will be done to improve performance against CS 2 within current resource, however further work will need to be undertaken to evaluate the resource required to consistently meet Clinical Standard 2 at both weekends and weekdays.


**Corporate objectives met or risks addressed:** Contributes to Care and Safety Objectives

**Financial implications:** None as a direct result of this paper

**Stakeholders:** Patients, staff, regulators

**Recommendation(s):** Gain awareness of 7-Day Standards, receive assurance of plans to improve Trust performance against standards

**Presenting officer:** Dr Peter Williams, Assistant Medical Director, 7-Day Services Lead

**Date of meeting**: 27th February 2019

# Trust Board assurance process for Seven Day Hospital Services Standards

## 1.1 Introduction

The Seven Day Hospital Services Programme aims to ensure that patients requiring emergency treatment receive high quality, consistent care every day of the week. The standards are intended to improve the care given to patients by enabling early and consistent senior decision making along with other urgent services. Ten clinical standards for seven day services (7DS) were developed in 2013 through the 7-Day Services Forum, of which four were identified as national priorities on the basis of their potential to positively affect patient outcomes. These are:

**Clinical Standard 2 - Time to first consultant review**

All emergency admissions must be seen and have a clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours from the time of admission to hospital.

**Clinical Standard 5 – Access to diagnostic tests**

Hospital inpatients must have scheduled 7-day access to specialist diagnostic services including magnetic resonance imaging (MRI), echocardiography and endoscopy.

**Clinical Standard 6 – Access to consultant-directed interventions**

Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions, either on-site or through formally agreed networked arrangements. These interventions include: interventional radiology, interventional endoscopy, emergency renal replacement therapy, urgent radiotherapy, stroke thrombolysis, percutaneous coronary intervention, cardiac pacing.

**Clinical Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others**

All patients with high dependency needs should be seen and reviewed by a consultant twice daily. Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every day, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

## 1.2 Measurement of Trust performance against 7DS Standards

Prior to 2019, providers of acute services completed a bi-annual self-assessment survey, measuring progress against the four priority standards through a combination of case note reviews and self-assessment. Though useful in supporting implementation, highlighting good practice and identifying areas for improvement, this survey placed a significant administrative burden on trust clinical and audit staff as it involved reviewing a large number of patient case notes.

In order to reduce the administrative burden and to allow trust boards to provide direct oversight of progress of performance against 7DS Standards, from 2019 will be measured and reported through a Trust Board assurance framework which will then be shared with NHSI and NHSE. The process will consist of a standard template to assess progress in delivering the 7DS Standards, to be then assured by the trust board before results are submitted to regional and national 7DS teams.

## 1.3 Timeline for implementation of Trust Board Assurance process

Trial Run
Spring 2019

Full Implementation
Summer 2019

In place of the proposed autumn 2018 7DS self-assessment survey, acute trusts will undertake a trial run of the board assurance process.

The trial run will take place from November 2018 to February 2019. All acute trusts will complete the template and gain board assurance of the self-assessment.

As this is a trial, acute trusts are not required to complete any new audits to support these self-assessments. Data from the previous 7DS survey may be used as evidence.

Full implementation of the 7DS board assessment framework will take place in March to June 2019.

This will follow the same process of completing the measurement template and subsequent board assurance of the self-assessment.

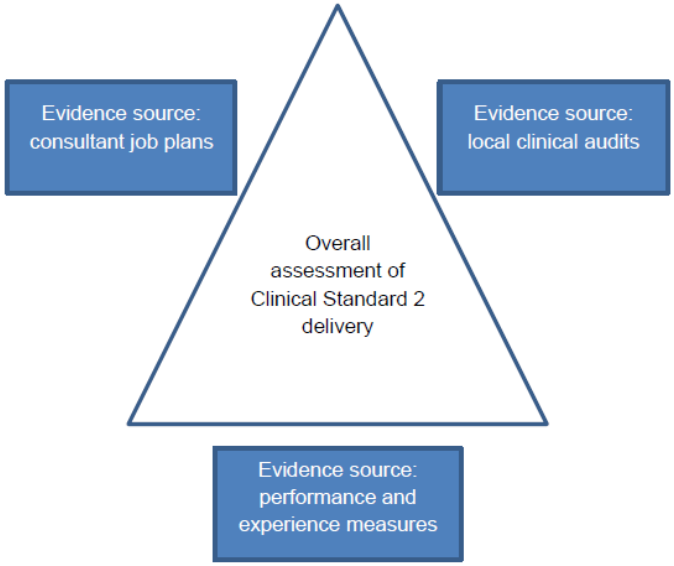
This self-assessment will be based on local data, such as consultant job plans and local clinical audits, as outlined in the full 7DS board assurance framework guidance.

## 1.4 Trust Board Assurance Template

The March 2019 Trust Board Assurance Template is contained within Appendix 1.

## 1.5 Trust Board Assurance Template Supporting Information

### 1.5.1 Clinical Standard 2




Local Clinical Audit

The clinical audit completed in April 2018 revealed the following results:

| | Day of admission | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Mon** | **Tue** | **Wed** | **Thu** | **Fri** | **Sat** | **Sun** | | **Weekday** | **Weekend** | | **Total** |
| Number of patients reviewed by a consultant within 14h | 21 | 25 | 28 | 20 | 14 | 9 | 15 | | 108 | 24 | | 132 |
| Number of patients reviewed by a consultant outside of 14h | 13 | 10 | 11 | 15 | 12 | 4 | 10 | | 61 | 14 | | 75 |
| Total | 34 | 35 | 39 | 35 | 26 | 13 | 25 | | 169 | 38 | | 207 |
| **Proportion of patients reviewed by consultant within 14h of admission to hospital** | 62% | 71% | 72% | 57% | 54% | 69% | 60% | | 64% | 63% | | 64% |

In April 2018, 64% of patients reviewed in the audit were reviewed by a Consultant within 14h of admission (against a clinical standard of 90%), an improvement from 54% in March 2017. These results were further broken down by speciality and reviewed by the Medical Director, Assistant Medical Director with lead for 7-Day Services and the NHSE 7DS team to identify the key areas for improvement.

Job Plans

As part of the Consultant Job Planning cycle for 2018-2019, all Job Plans for Consultants in acute specialities were reviewed by the Trust 7-Day Services lead and found to provide sufficient cover on weekdays to allow Consultant review within 14h of admission, however this was not the case at weekends.

Performance and Experience Measures

There was no evidence from complaints, DATIX or Serious Incident reviews in the period covered by the audit (Spring 2018) to suggest that there was an increase in patient harm at weekends as compared to weekdays. There was no feedback from GMC trainee surveys to suggest that there was a difference in the support given to trainees between weekends and weekdays.

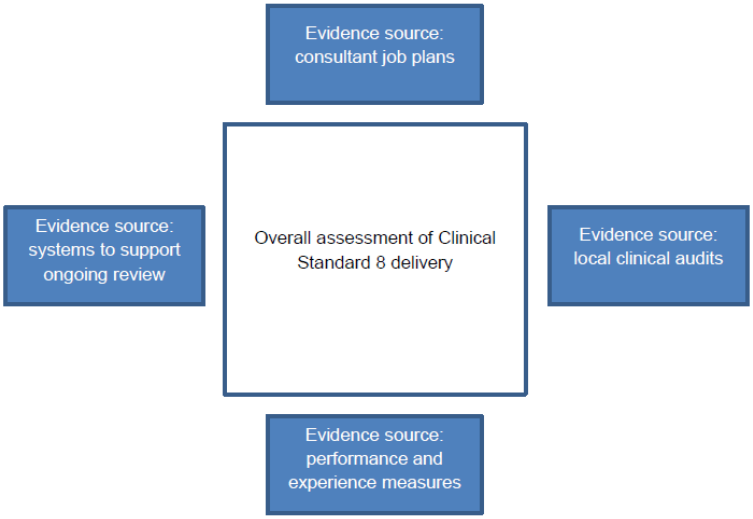
### 1.5.2 Clinical Standard 5

This standard is currently met across the organisation for both weekends and weekdays.

### 1.5.3 Clinical Standard 6

This standard is currently met across the organisation for both weekends and weekdays.

### 1.4.4 Clinical Standard 8




Audit

The clinical audit completed in April 2018 revealed the following results:

| Day of review | Mon | Tue | Wed | Thu | Fri | Sat | Sun | Weekday | Weekend | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Twice daily reviews required & received | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 5 | 2 | 7 |
| Total number of daily reviews required | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 5 | 2 | 7 |
| Percentage - Receiving required twice daily reviews | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

| Day of review | Mon | Tue | Wed | Thu | Fri | Sat | Sun | Weekday | Weekend | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Once daily reviews required & received | 83 | 85 | 86 | 91 | 100 | 57 | 48 | 445 | 105 | 550 |
| Once daily reviews required & not received | 3 | 3 | 2 | 2 | 2 | 7 | 7 | 12 | 14 | 26 |
| Total number of daily reviews required | 86 | 88 | 88 | 93 | 102 | 64 | 55 | 457 | 119 | 576 |
| Percentage - Receiving required once daily reviews | 97% | 97% | 98% | 98% | 98% | 89% | 87% | 97% | 88% | 95% |

This represents an overall failure, despite the standard being met on weekdays and only narrowly missed on weekends. The audit allowed areas for improvement to be identified to improve Trust performance against the standard.

Job Plans

As part of the Consultant Job Planning cycle for 2018-2019, all Job Plans for Consultants in acute specialities were reviewed by the 7-Day Services lead. These were found to be sufficient to provide sufficient cover to meet the standard on weekdays. Provision of Consultant cover within Medicine, Paediatrics and Critical Care was found to be sufficient to meet the standard at weekends however this was not the case for all specialities.

Performance and Experience Measures

There was no evidence from complaints, DATIX or Serious Incident reviews in the period covered by the audit (Spring 2018) to suggest that there was an increase in patient harm at weekends as compared to weekdays. There was no feedback from GMC trainee surveys to suggest that there was a difference in the support given to trainees between weekends and weekdays.

Systems to support ongoing review

There are processes in place within Medicine to allow Board Round review of all patients every day, although the audit revealed that this is not always consistently documented. There is no routine documentation of the frequency of Consultant review required for each patient, which would prevent unnecessary fails against this standard where it is deemed that this is no longer required (eg. Patients who are medically optimised but have ongoing nursing or therapy needs)

## 1.5 7DS Standards for Continuous Improvement

All 10 7DS clinical standards are vital to consistently high quality care, and taken as a whole, impact positively on the quality of care and patient experience. As well as the four priority 7DS clinical standards, the 7DS programme supports providers to deliver the remaining six standards, referred to as the 7DS Standards for Continuous Improvement.

| Clinical Standard | Evidence to support assurance of progress | Current Performance |
|---|---|---|
| **1. Patient experience** | Information from local patient experience surveys on quality of care/consultant presence on weekdays versus weekends. | No evidence from patient experience or feedback (PALS/complaints) of diminished quality of care at weekends compared to weekdays |
| **3. Multidisciplinary team review** | Assurance of processes for MDT assessment in all specialties with emergency admissions, to enable review of patients with ongoing or complex needs. | Processes in place for MDT review across all specialities during the week and within Medicine and Critical Care at weekends (the areas with greatest need of the MDT approach for Emergency Admissions) |
| **4. Shift handovers** | Assurance of handovers led by a competent senior decision-maker taking place at a designated time and place, with multi-professional participation from the relevant incoming and outgoing shifts. | Senior-led Medical handover in Medicine, Paediatrics and Critical Care for all shifts irrespective of day of week. |
| **9. Transfer to community, primary and social care** | Assurance that the hospital services to enable the next steps in the patient's care pathway are available every day of the week including: discharge co-ordinators, pharmacy services to facilitate discharge, therapies and access to social and community care providers. | Some hospital services are available (pharmacy, therapies) but others are not (Discharge coordinators) meaning that the ability to liaise with social and community care providers is reduced. |
| **10. Quality improvement** | Assurance that provider board-level reviews of patient outcomes cover elements of care and quality that relate to the delivery of high quality care seven days a week. | No evidence from quality and safety reports (DATIX/SIRI) of diminished quality of care at weekends compared to weekdays |

## 1.6 Actions to improve reporting and performance against 7DS Standards

### Action Plan to enhance Trust Board Assurance Process

| Action | Rationale | Review date |
|---|---|---|
| Clinical audit for Trust Board Assurance will be performed within each speciality receiving emergency patients. | Allows each speciality to understand and monitor their own performance against Clinical Standards 2 and 8 and produce their own action plan for improvement. Results will be collated and checked by Trust 7DS Lead | 1/6/19 |
| Change to incident reporting system whereby causes of incidents, complaints, claims or outcomes of structured judgement review can be coded. | Use of the code "Patient care affected by lack of staff/service availability on weekends/holidays/out of hours" allows easier tracking of safety and quality outcomes from any variation in 7-day working. | Lessons learned coding for Serious Incidents (severe harm and death): 31/3/19<br>Lessons learned coding for moderate harm incidents: 31/5/19<br>Lessons learned from complaints coding : 30/9/19 |
| Trust 7DS Lead and Chief Analyst to finalise system for reporting weekend/weekday mortality variation | The current reported SHMI/HSMR does not differentiate between weekdays and weekends, requiring patient level analysis to ascertain statistical and clinically significant variation. | 1/6/19 |

### Action Plan to improve performance against 7DS Clinical Standards

| Action | Rationale | Review date |
|---|---|---|
| Trust Lead for 7 Day Services to create and chair Trust 7DS Steering Group | Allows presentation and comparison of results between specialities, sharing of good practice and accountability for improvements across all disciplines | 1/6/19 |
| Streaming process to be embedded in ED to allow early identification and transfer of patients requiring speciality review | Early transfer of appropriate patients to assessment areas facilitates early discharge and/or Consultant review | 1/4/19 |
| Acute Medicine Consultant Rota reviewed and changed to provide increased afternoon and evening cover | Medical patients make up largest volume of acute admissions. Increased consultant presence will improve proportion of patients reviewed on day of admission | 1/2/19 |
| Paediatric Consultants working in ED in evenings | Increased evening presence of Paediatric Consultants in ED allows earlier Consultants review. | 1/12/18 |
| Frailty Consultant Inreach to ED | Frailty Consultant working in ED each day allows earlier intervention and Consultant review | 2/6/18 |
| Changes to 1st Consultant review process to encourage documentation of need for ongoing daily Consultant review | Not all patients require daily Consultant review; clear documentation of frequency of need for daily review will reduce avoidable fails against CS8. | 1/6/19 |
| Detailed gap analysis within each speciality to ascertain resource required to meet CS2. | Some improvement in performance can be gained via change in practice but consistent performance >90% against CS2 may require increased Consultant presence at weekends or out of hours | 1/8/19 |

## 1.7 Summary

The Trust performed well against the three of the four “priority” 7-Day Services (7DS) Clinical Standards as reported in the clinical audit of June 2018. A change to the reporting process and introduction of Trust Board Assurance will help to focus the organisational response to 7DS Standards. Changes in working practices are expected to improve performance against Clinical Standard 8 in time for the first formal report to Trust Board in June 2018. Further work will be done to improve performance against Clinical Standard 2 within current resource, however further work will need to be undertaken to evaluate the resource required to consistently meet Clinical Standard 2 at both weekends and weekdays.

# St Helens and Knowsley NHS Trust: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2018/19

## Priority 7DS Clinical Standards

| Clinical standard | Self-Assessment of Performance | Weekday | Weekend | Overall Score |
|---|---|---|---|---|
| **Clinical Standard 2**:<br>All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital. | 7DS Audit Results Spring 2018: Weekday 64% of patients seen within 14h of admission. Weekend 63% of patients seen within 14h of admission. Job Plan review shows that the main acute specialities have Consultant job plans which provide sufficient daily consultant presence to support the delivery of 7DS Clinical Standard 2 on weekdays but not at weekends. At present there is no evidence to suggest a difference between weekends and weekdays in the number of patient safety incidents or complaints across the organisation. | No, the standard is not met for over 90% of patients admitted in an emergency | No, the standard is not met for over 90% of patients admitted in an emergency | Standard Not Met |

| Clinical standard | Self-Assessment of Performance | | Weekday | Weekend | Overall Score |
|---|---|---|---|---|---|
| **Clinical Standard 5:**<br>Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:<br>• Within 1 hour for critical patients<br>• Within 12 hour for urgent patients<br>• Within 24 hour for non-urgent patients | Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales? | Microbiology | Yes available on site | Yes available on site | Standard Met |
| | | Computerised Tomography (CT) | Yes available on site | Yes available on site | |
| | | Ultrasound | Yes available on site | Yes available on site | |
| | This standard is met for provision of emergency investigations irrespective of day of the week | Echocardiography | Yes available on site | Yes available on site | |
| | | Magnetic Resonance Imaging (MRI) | Yes available on site | Yes available on site | |
| | | Upper GI endoscopy | Yes available on site | Yes available on site | |

| Clinical standard | Self-Assessment of Performance | | Weekday | Weekend | Overall Score |
|---|---|---|---|---|---|
| **Clinical Standard 6:**<br>Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. | Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements? | Critical Care | Yes available on site | Yes available on site | Standard Met |
| | | Interventional Radiology | Yes available off site via formal arrangement | Yes available off site via formal arrangement | |
| | | Interventional Endoscopy | Yes available on site | Yes available on site | |
| | | Emergency Surgery | Yes available on site | Yes available on site | |
| | The standard is met for provision of emergency interventions irrespective of day of the week. | Emergency Renal Replacement Therapy | Yes available on site | Yes available on site | |
| | | Urgent Radiotherapy | Yes available off site via formal arrangement | Yes available off site via formal arrangement | |
| | | Stroke thrombolysis | Yes available on site | Yes available on site | |
| | | Percutaneous Coronary Intervention | Yes available off site via formal arrangement | Yes available off site via formal arrangement | |
| | | Cardiac Pacing | Yes available on site | Yes available on site | |

| Clinical standard | Self-Assessment of Performance | Weekday | Weekend | Overall Score |
|---|---|---|---|---|
| **Clinical Standard 8:**<br>All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway. | 7DS Audit Results Spring 2018. Weekday: 96.8% of patients requiring once-daily Consultant reviews received this. Weekend: 88% of patients requiring once-daily Consultant review received this. 100% of patients requiring twice-daily Consultant review received this. There is no evidence in patient safety and experience metrics to suggest that there is a difference between weekdays and weekends. Job Plan review shows that some, but not all main acute specialities have Consultant job plans which provide sufficient daily consultant presence to support the delivery of 7DS Clinical Standard 8. Improved documentation on need for ongoing Consultant review is expected to improve performance against this standard. | Once daily: Yes the standard is met for over 90% of patients admitted in an emergency | Once Daily: No the standard is not met for over 90% of patients admitted in an emergency | Standard Not Met |
| | | Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency | Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency | |

## 7DS Clinical Standards for Continuous Improvement

| Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10 |
|---|
| Clinical Standard 1 and 10 (Patient experience and Quality Improvement) are covered within the assessment of CS 2 and 8. Clinical Standard 3 (Multidisciplinary Team Review) is fully met within Medicine and Critical Care (Pharmacy, Physio, Nursing) and partially in the other acute specialities. Clinical Standard 4 (Clinical Handovers) is met across all acute specialities. Clinical Standard 9 (Transfer to Community Care) is partially met within the Trust (Physiotherapy, Pharmacy support for discharge) |

## 7DS and Urgent Network Clinical Services

| | Hyperacute Stroke | Paediatric Intensive Care | STEMI Heart Attack | Major Trauma Centres | Emergency Vascular Services |
|---|---|---|---|---|---|
| **Clinical Standard 2** | Yes, the standard is met for over 90% of patients admitted in an emergency | N/A - service not provided by this trust | N/A - service not provided by this trust | N/A - service not provided by this trust | N/A - service not provided by this trust |
| **Clinical Standard 5** | Yes, the standard is met for over 90% of patients admitted in an emergency | N/A - service not provided by this trust | N/A - service not provided by this trust | N/A - service not provided by this trust | N/A - service not provided by this trust |
| **Clinical Standard 6** | Yes, the standard is met for over 90% of patients admitted in an emergency | N/A - service not provided by this trust | N/A - service not provided by this trust | N/A - service not provided by this trust | N/A - service not provided by this trust |
| **Clinical Standard 8** | Yes, the standard is met for over 90% of patients admitted in an emergency | N/A - service not provided by this trust | N/A - service not provided by this trust | N/A - service not provided by this trust | N/A - service not provided by this trust |

| Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL) |
|---|
| Consultant administered hyperacute stroke service is delivered onsite with ongoing daily Consultant review irrespective of day of admission. |

**Template completion notes**

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.