St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 27TH MARCH 2019
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

AGENDA				Paper	Presenter
09:30	1.	Employee of the Month		Verbal	Chair
		1.1	February 2019		
		1.2	March 2019		
09:40	2.	Patient Story		Verbal	
10:00	3.	Apologies for Absence		Verbal	
	4.	Declaration of Interests		Verbal	
	5.	Minutes of the Previous Meeting held on 27th February 2019		Attached	
		5.1	Correct Record & Matters Arising	Verbal	
		5.2	Action Log	Attached	
Performance Reports					
10:10	6.	Integrated Performance Report		NHST(19) 21	Nik Khashu
		6.1	Quality Indicators		Sue Redfern
		6.2	Operational Indicators		Rob Cooper
		6.3	Financial Indicators		Nik Khashu
		6.4	Workforce Indicators		Anne-Marie Stretch
Committee Assurance Reports					
10.30	7.	Committee Report – Executive		NHST(19) 22	Ann Marr
10:40	8.	Committee Report – Quality		NHST(19) 23	Val Davies
10:50	9.	Committee Report – Finance & Performance		NHST(19) 24	Jeff Kozer
BREAK					
Other Board Reports					
11:10	10.	Approval of Opening Budget 2019/20		NHST(19) 25	Nik Khashu

11:25	11.	Approval of Trust Objectives for 2019/20	NHST(19) 26	Ann Marr
11.40	12.	CQC Registration	NHST(19) 27	Sue Redfern
11.45	13.	Annual Mixed Sex Declaration	NHST(19) 28	Sue Redfern
11:50	14.	2018 Staff Survey Results & Action Plan	NHST(19) 29	Anne-Marie Stretch
Closing Business				
12:05	15.	Effectiveness of Meeting	Verbal	Chair
	16.	Any Other Business		
	17.	Date of Next Meeting – Wednesday 24th April 2019		

TRUST PUBLIC BOARD ACTION LOG – 27TH MARCH 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 2019.**	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
3.	27.02.19 (7.7)	Marshalls Cross performance metrics to be included as part of the Integrated Performance Report from April 2019.	RC/NK	24.04.19
4.	27.02.19 (7.11)	Andrew Hill, Lead Stroke Consultant, to be invited to the Quality Committee meeting in July to update members on Q1 performance.	VD	For QC
5.	27.02.19 (8.3)	Corporate departments to be included in the QWR schedule.	SRe	24.04.19

INTEGRATED PERFORMANCE REPORT

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: NHST(19)21
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).

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

There were no C.Difficile (CDI) positive cases reported in February 2019. YTD there have been 17 cases . In comparison, there were 21 cases for the same period in 2017-18. The annual tolerance for CDI for 18-19 is 40.

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

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

During the month of January 2019 there was 1 fall resulting in severe harm , which occurred in the Emergency Department (YTD Severe and above category fall = 12 compared with 22 last year)

Performance for VTE assessment for January 2019 was 95.37%. YTD performance is 95.95% against a target of 95%.

YTD HSMR (April to October) for 2018-19 is 96.5

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: HTth March 2019

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (January 2019) at 86.7%. The 31 day target was achieved with 98.1% performance against a target of 96%. The 2 week rule target was also achieved with 94.4% against a target of 93.0%.

Accident and Emergency Type 1 performance for February 2019 was 70.2%. The all type mapped STHK Trust footprint performance was 84.7%**.** Type 1 attendances for February 2019 were 9,186 compared with 10,020 in January 19. February 19 was 9.27% higher than February 2019 (8,406) .

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

Whiston ED had the highest volume of ambulances in C+M and GM (2762) in February 2019. Ambulance notification to handover time was achieved with 13:53 mins on average (target 15 mins).

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 February 2019 was 44 less per day compared with February 18. (156 per day in Feb 18 v 112 in Feb 19) which is a 28% reduction year on year. Medical and Surgical clinical /managerial teams and all CCG partners are actively engaged in the achievement of the reduction in superstranded and progress is monitored daily and weekly.

The 18 week referral to treatment target (RTT) was achieved in January 2019 with 93.3% 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 M11 StHK has reported a deficit of £1.9m including PSF; this equates to a deficit of £7.8m 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 months 10 & 11.
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 £13.2m delivered against a plan of £11.7m. 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 M11 were £5.7m. With the deterioration in the financial position and loss of PSF funding this will have a significant impact on cash over the final two months of the year and therefore will require revenue support in the months of February and March. The Trust also 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 also puts significant strain on the Trust cash balances. The Trust now shares the non-compliant organisations with regulators to assist in obtaining payment. The total requested support for these two months totals £13.9m of which £3.8m has been received in February and £10.4m in March.

The Trust revised its forecast position in month 9 as agreed with NHSi, at month 11 the Trust has reduced that deficit position by £0.250m to report an outturn of £5.7m including PSF (£11.6m excluding PSF). The financial performance in the month delivers a Use of Resources level of 3 (YTD) and 4 (FOT).

Human Resources

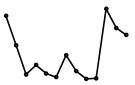
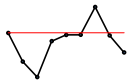
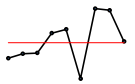
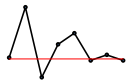
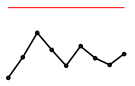
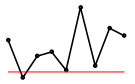
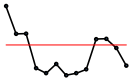
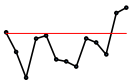
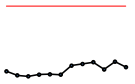
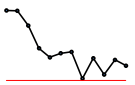
In February, overall absence decreased from 6.1% to 5.3% (0.8% reduction) Although this is a decrease, this exceeds the Q4 target of 4.68% and 5% YTD. Qualified & HCA sickness has decreased from 7.4% to 6.3%, a reduction of 1.1%. Qualified Nursing & Midwifery sickness has significantly decreased by 1.3% from 6.4% to 5.1%.
Mandatory Training compliance is 95.3% (target = 85%). Appraisal compliance is 89.3% (target = 85%).

The following key applies to the Integrated Performance Report:

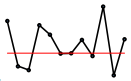
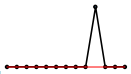
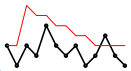
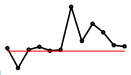
▲ = 2018-19 Contract Indicator
▲£ = 2018-19 Contract Indicator with financial penalty
● = 2018-19 CQUIN indicator
T = Trust internal target
UOR = Use of Resources

Feb-19

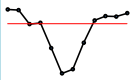
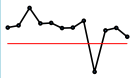
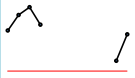
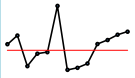
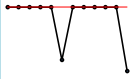
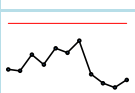
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	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	Feb-19	2.5%	2.1%	No Target	2.4%		Further improvement in SHMI (governments preferred measure) and HSMR. Weekend admission mortality is a noisy metric.	Patient Safety and Clinical Effectiveness	Continue measures to improve clinical effectiveness and reduce unwarranted variation. Documentation of comorbidities is still below expected - actions to correct this will further improve standardised mortality measures.	KH
Mortality: SHMI (Information Centre)	Q	▲	Sep-18	0.99		1.00						
Mortality: HSMR (HED)	Q	▲	Oct-18	92.0	96.5	100.0	99.1					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Oct-18	100.7	103.1	100.0	95.8					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Sep-18	99.6	101.0	100.0	101.2		The trust historically has a relatively high percentage of readmissions, but when adjusted for 'expected' falls within national norms.	Patient experience, operational effectiveness and financial penalty for deterioration in performance	The Trust continues to work internally and with healthcare partners to minimise unnecessary readmissions.	KH
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Oct-18	90.6	90.8	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	Oct-18	114.1	110.5	100.0	99.2					
% Medical Outliers	F&P	T	Feb-19	0.3%	0.5%	1.0%	2.3%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in LoS, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place. Continued focused management of all patients requiring discharge support. A review of the Trust bed model has resulted in reconfiguration of some surgical beds to medical thus significantly reducing outliers to almost zero through recent months. Medical cover plans are in place ahead of winter increases expected.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Feb-19	68.2%	45.3%	52.5%	48.7%		Failure to step down patients within 4 hours who no longer require ITU level care.	Quality and patient experience	Critical care step down patients discussed at all Emergency Access Meetings. 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	▲	Jan-19	71.4%	70.9%	90.0%	69.5%		eDischarge performance remains poor. Inpatient performance is stable and is not expected to improve until new (pending) electronic solutions are implemented. Outpatient performance requires investigation is improving as Medway issues are addressed.		Pending ePR, we have devised an automated eDischarge notification which will be computer generated and send within 24 hours. Thereafter a full discharge summary will be sent within 14 days.	KH
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Jan-19	89.4%	84.9%	95.0%	89.5%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Jan-19	95.9%	96.4%	95.0%	99.1%					

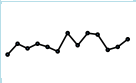
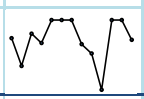
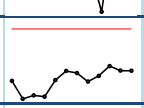
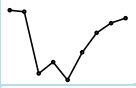
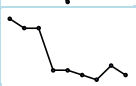
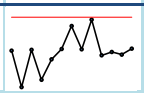
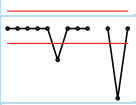
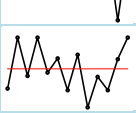
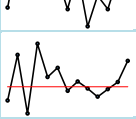
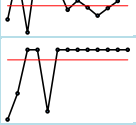
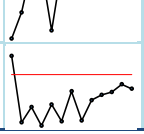
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	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	▲£	Feb-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	Feb-19	99.6%	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	Feb-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	▲£	Feb-19	0	1	0	2		MRSA: as a result of a contaminated sample there has been 1 X positive MRSA specimen (Nov-18). Internal RCAs on-going with more recent cases of C. Difficile.	Quality and patient safety	The Infection Control Team continue to support staff to maintain high standards and practices. They also monitor and undertake RCA for any hospital acquired BSI and CDI. CDI and Antibiotic wards rounds continue to be undertaken on appropriate wards.	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲£	Feb-19	0	17	40	19					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Feb-19	2	28	No Target	22					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Jan-19	0	0	No Contract target	0		No grade 3 or 4 avoidable pressure ulcers YTD	Quality and patient safety	The Trust provides ongoing tissue viability training for all nursing staff including bank staff . New pressure ulcer reduction actions being implemented.	SR
Number of falls resulting in severe harm or death	Q	▲	Jan-19	1	12	No Contract target	22		1 severe harm fall reported in January 2019 (ED)	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	▲£	Jan-19	95.37%	95.95%	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		Feb-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	Jan-19	96.6%	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 was collected for 20 working days from the 30th Jan 19-27 Feb 19. The late census data is taken 1pm-2pm each day. The final report will indicate care hours excess/care hours short for each area.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Jan-19	0	0	No Target	1					

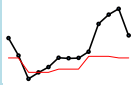
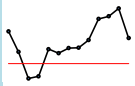
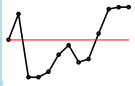
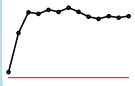
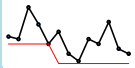
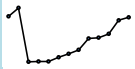
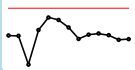
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 43-51)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Jan-19	94.4%	91.4%	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 2. Capacity demand review on going at speciality level	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Jan-19	98.1%	98.0%	96.0%	97.7%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Jan-19	86.7%	88.7%	85.0%	87.4%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Jan-19	93.3%	93.3%	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	▲	Feb-19	99.8%	99.8%	99.0%	100.0%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Jan-19	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Feb-19	1.0%	0.8%	0.8%	0.6%		There was one breach of the 28 day re-list target in January due to difficulties in communicating with the patient.	Patient experience and operational effectiveness Poor patient experience	Proactive system in place to monitor, manage and prevent cancelled operations within the care group. Lessons learned from the 28 day re-list patient in January have been feedback to the relevant departments for learning and reflection.	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Jan-19	97.9%	99.4%	100.0%	99.4%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Feb-19	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Feb-19	70.2%	74.5%	95.0%	78.2%		Accident and Emergency Type 1 performance for February 19 was 70.2%. The all type mapped STHK Trust footprint performance was 84.7%. Type 1 attendances for February 2019 were 9,186 compared with 10,020 in January 19. February 19 was 9.27% higher than February 19 (8,406) . Five improvement workstreams (streaming, emergency department delivery, assessment areas, inpatient flow and ward daily discharges) are actively working on improving patient flow and are being governed through the Urgent and Emergency Care Council which meets monthly and is chaired by CEO. Whiston ED had the highest volume of ambulances in C+M and GM (2762) in February 2019. Ambulance notification to handover time was achieved with 13:53 mins on average (target 15 mins).	Patient experience, quality and patient safety	The urgent and emergency care transformation plan has several interconnected work streams designed to improve overall 4 hour access performance. Emergency Department/Front Door processes in place including 'walk in' streaming, Stretcher Triage streaming and internal departmental efficiencies and exit from ED. GP streaming in place as per NHSE recommendations. Flow through the Hospital New and refreshed workstreams aimed at improving discharges before midday also supported by a media campaign #HomeForLunch. Daily board rounds and afternoon huddles. Twice weekly discharge tracking meetings to manage medically optimised and DTOC escalation. Monthly Executive Multi-Agency Discharge Events (MADE) continue across the whole system to remove barriers and blocks that prevent patients with complex needs being discharged safely from hospital. Following 6a ECIP event and system resilience planning, commenced daily AMU/ED huddles and Community Matron in reach which is proving beneficial. Frailty in-reach to ED commenced. 1pm Frailty/ED/SpR safety huddle in place. New COPD pilot in place from December.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Feb-19	84.7%	87.3%	95.0%						
A&E: 12 hour trolley waits	F&P	▲	Feb-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	▲ £	Feb-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	Feb-19	20	238	No Target	224		% new (Stage 1) complaints resolved in month within agreed timescales continues to improve overall and remains above target.	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	Feb-19	22	215	No Target	270					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Feb-19	90.9%	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	Feb-19	325	311 *Jun-Feb							
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Feb-19	112	116 *Jun-Feb							
Friends and Family Test: % recommended - A&E	Q	▲	Feb-19	86.2%	86.0%	90.0%	87.5%		The YTD recommendation rates remain above target for inpatients, antenatal and postnatal, but slightly below target for A&E, delivery, community postnatal and outpatients.	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. Areas continue to review comments to identify any emerging themes or trends, and significantly negative comments are followed up with the contributor if contact details are provided to try and resolve issues.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Feb-19	95.0%	94.6%	90.0%	95.8%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Feb-19	100.0%	98.6%	98.1%	98.5%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Feb-19	100.0%	98.0%	98.1%	97.9%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Feb-19	98.0%	95.5%	95.1%	96.6%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Feb-19	100.0%	97.7%	98.6%	98.1%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Feb-19	94.6%	94.2%	95.0%	94.5%					

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2018-19 YTD	2018-19 Target	2017-18	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 53-60)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Feb-19	5.3%	5.0%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	4.7%		In February, absence improved from 6.1% to 5.3%, a 0.8% reduction. Although an improvement, it remains higher than the Q4 target of 4.68% and higher than this time last year. Qualified & HCA sickness has decreased from 7.4% to 6.3%, a reduction of 1.1%. YTD absence remains at 6.1%, above the 2018-19 target of 5.3%.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	A 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	Feb-19	6.3%	6.1%	5.3%	5.7%					
Staffing: % Staff received appraisals	Q F&P	T	Feb-19	89.3%	89.3%	85.0%	88.4%		Mandatory Training compliance exceeds the target by 10.3% and has risen slightly by 0.3% from January. Appraisal compliance is above the target by 4.3%, unchanged from January.	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	Feb-19	95.3%	95.3%	85.0%	92.5%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2	92.6%		No Contract Target			For both questions the Trust returned the best scores nationally.	Staff engagement, recruitment and retention.	The Q4 survey has launched within Corporate and Clinical Support Services Directorates with results expected to be published on 1st April 2019 .	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2	83.6%		No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Feb-19	0.4%		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	Feb-19	3.0	3.0	3.0	3.0		At the end of M11 StHK has reported a deficit of £1.96m including PSF; this equates to a deficit of £7.8m 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 months 10 & 11. 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. Executives to engage external stakeholders regarding progress of transformational programmes that will assist in delivering the Cost Improvement Programme. The approval of invoices within the Trust is impacting compliance. The Finance department will continue to work with areas of the Trust that need to improve.	NK
Progress on delivery of CIP savings (000's)	F&P	T	Feb-19	13,175	13,175	19,000	12,325					
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Feb-19	(1,962)	(1,962)	10,993	5,001					
Cash balances - Number of days to cover operating expenses	F&P	T	Feb-19	6	6	2	12					
Capital spend £ YTD (000's)	F&P	T	Feb-19	7,586	7,586	9,516	9,180					
Financial forecast outturn & performance against plan	F&P	T	Feb-19	(5,744)	(5,744)	10,993	5,001					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Feb-19	91.0%	91.0%	95.0%	91.4%					

APPENDIX A

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

			Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	2018-19 YTD	2018-19 Target	FOT	2017-18	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲ £	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	95.7%	88.9%	100.0%	100.0%	100.0%	100.0%	96.0%	97.8%	85.0%		97.0%		
	Total > 62 days		0.0	2.5	0.0	0.0	0.0	0.0	0.5	1.5	0.0	0.0	0.0	0.0	0.5	2.5			3.5		
Lower GI	% Within 62 days	▲ £	80.0%	91.7%	75.0%	100.0%	76.5%	100.0%	100.0%	92.3%	100.0%	36.4%	88.9%	100.0%	87.5%	88.2%	85.0%		84.0%		
	Total > 62 days		2.0	0.5	1.5	0.0	2.0	0.0	0.0	0.5	0.0	3.5	1.0	0.0	1.0	8.0			12.5		
Upper GI	% Within 62 days	▲ £	100.0%	63.6%	100.0%	80.0%	77.8%	80.0%	66.7%	62.5%	77.8%	66.7%	33.3%	63.6%	84.6%	73.0%	85.0%		87.2%		
	Total > 62 days		0.0	2.0	0.0	1.0	1.0	0.5	0.5	1.5	1.0	0.5	1.0	2.0	1.0	10.0			5.0		
Urological	% Within 62 days	▲ £	60.9%	96.8%	86.2%	93.8%	90.2%	78.8%	80.7%	97.1%	80.6%	90.3%	75.0%	89.4%	85.2%	85.5%	85.0%		82.5%		
	Total > 62 days		9.0	0.5	2.0	1.0	2.0	3.5	5.5	0.5	3.0	1.5	3.5	2.5	2.0	25.0			37.0		
Head & Neck	% Within 62 days	▲ £	33.3%	66.7%	100.0%	50.0%	66.7%	33.3%	62.5%	42.9%	83.3%	50.0%	80.0%	57.1%	25.0%	55.8%	85.0%		64.6%		
	Total > 62 days		1.0	0.5	0.0	0.5	0.5	2.0	1.5	2.0	0.5	1.0	0.5	1.5	1.5	11.5			8.5		
Sarcoma	% Within 62 days	▲ £	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		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	▲ £	90.9%	66.7%	77.8%	87.5%	72.7%	75.0%	100.0%	72.7%	50.0%	62.5%	100.0%	81.8%	57.1%	76.4%	85.0%		78.2%		
	Total > 62 days		0.5	0.5	1.0	0.5	1.5	0.5	0.0	1.5	0.5	1.5	0.0	1.0	1.5	8.5			12.0		
Lung	% Within 62 days	▲ £	80.0%	100.0%	100.0%	87.0%	95.8%	88.9%	100.0%	100.0%	81.8%	66.7%	94.1%	100.0%	92.9%	90.8%	85.0%		84.7%		
	Total > 62 days		1.5	0.0	0.0	1.5	0.5	0.5	0.0	0.0	1.0	2.0	0.5	0.0	0.5	6.5			11.5		RC
Haematological	% Within 62 days	▲ £	100.0%	88.9%	83.3%	100.0%	100.0%	100.0%	100.0%	66.7%	90.9%	50.0%	85.7%	66.7%	50.0%	80.7%	85.0%		80.6%		
	Total > 62 days		0.0	0.5	1.0	0.0	0.0	0.0	0.0	1.0	0.5	1.0	1.0	1.0	2.0	6.5			9.5		
Skin	% Within 62 days	▲ £	100.0%	95.5%	92.5%	100.0%	91.2%	97.6%	93.8%	98.1%	93.3%	84.6%	90.2%	98.0%	93.7%	93.7%	85.0%		95.2%		
	Total > 62 days		0.0	1.0	2.0	0.0	2.5	0.5	1.5	0.5	3.0	4.0	2.5	0.5	2.0	17.0			13.0		
Unknown	% Within 62 days	▲ £	100.0%		75.0%	100.0%	100.0%		100.0%	75.0%	100.0%	100.0%	100.0%		100.0%	96.6%	85.0%		78.4%		
	Total > 62 days		0.0		1.0	0.0	0.0		0.0	0.5	0.0	0.0	0.0		0.0	0.5			4.0		
All Tumour Sites	% Within 62 days	▲ £	85.2%	89.1%	89.6%	94.1%	90.1%	90.3%	89.0%	89.1%	90.9%	77.8%	88.4%	89.0%	86.7%	88.7%	85.0%		87.4%		
	Total > 62 days		15.0	8.0	8.5	4.5	10.0	8.0	9.5	9.5	9.5	16.0	10.0	8.5	12.0	97.5			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%	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	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

Paper No: NHST(19)22
Title of paper: Executive Committee Chair's Report
Purpose: To provide assurance to the Trust Board on those matters delegated to the Executive Committee.
Summary: The paper provides a summary of the issues considered by the Executive Committee at the meetings held during February 2019. There were a total of 3 Executive Committee meetings held during this period. The Executive Committee agreed: • The Informatics system priorities for 2019/20 • Proposals to review the Trust telephony needs for the future • Plans to upgrade to Windows 10 across the Trust and create a replacement programme for desk top computers 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. There were also weekly progress reports on the action taken to resolve the Medway PAS outpatient issues. There are no specific issues that require escalation to the Board.
Trust objectives met or risks addressed: All 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 March 2019

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE
February 2019

1. Introduction

There were 3 Executive Committee meetings in February 2019. The meeting scheduled for 7th February did not go ahead due to a number of Directors attending important external meetings.

2. 14th February 2019

2.1 Maternity Services Future Plans

The Director of Nursing, Midwifery and Governance introduced the Interim Head of Midwifery who presented the future plans for the maternity service including: increasing the number of births in the Midwifery Led Unit to 25% by April 2019, implementing the national targets for continuity of care, and achieving the 2019/20 CNST incentive scheme. The committee discussed the Cheshire and Merseyside Women's and Children's Network plans, including the local bid for a "pop up birth centre". There were also updates on plans for the centralised CTG monitoring system, a maternity anaesthetic rota and compliance with K2 training.

2.2 Risk Management Council (RMC) Chair's Report

The Director of Corporate Services presented the Chair's report from the RMC, including the risks that had been escalated to the Corporate Risk Register. The report included a summary from the CIP Council and Information Governance Steering Group.

2.3 Integrated Performance Report

The Director of Finance and Information presented performance against the key performance indicators for January. Changes to the commentary were agreed. It was noted that HSMR performance had improved and was currently the best ever reported.

2.4 Information Governance Training

The Director of Informatics presented the weekly update on achieving compliance with the level of Information Governance training required to meet the NHS Digital Data Security and Protection Toolkit standards. There remained a considerable challenge to ensure the standard was met by 31st March.

2.5 Medway Update

The Director of Informatics gave a progress report on the current projects being implemented, including: NEWS2, e-Handover and electronic prescribing. The final solution for patient booking and letters was discussed in detail and short term contingency plans to maintain the increased capacity within the team were agreed.

2.6 EU Exit Preparations

The Director of Nursing, Midwifery and Governance had attended a regional briefing with Keith Willetts the National Strategic Commander for emergency preparedness. The

Trust continues to comply with all the national requirements and guidance that has been issued.

3. 21st February 2019

3.1 Quality Account Improvement Objectives

The Assistant Director of Nursing attended the meeting to present the progress made in achieving the quality improvement objectives in last year's Quality Account and to review the long list of objectives for 2019/20 for inclusion in the 2018/19 Quality Account. It was agreed that more information was needed to finalise the shortlist for consultation with staff and stakeholders, and the item would be revisited in early March.

3.2 Mandatory Training and Appraisals

The Deputy CEO/Director of HR presented the monthly figures for January which showed a further improvement.

3.3 CQUIN Report

The report provided an overview of CQUIN performance, covering; quarter 3 performance, forecast outturn for 2018/19 and the proposed changes to CQUINs for 2019/20. Commissioners had approved £1.445m of payments, with £263k outstanding at quarter 3. The main area of concern was the tobacco and alcohol support CQUIN, as the Trust could not yet record and report the advice and support being offered to patients on the Medway system. The areas of risk for the full year forecast position and the quarter 4 mitigating actions were reviewed and agreed.

3.4 Safer Staffing Report

The Deputy CEO/Director of HR presented the report on behalf of the Director of Nursing. The January figures showed a Registered Nurse overall fill rate of 96.65% and a care staff overall fill rate of 111.73%. The committee discussed the relationship between the fill rates and care hours per patient per day (CHPPD), and requested further analysis to increase assurance.

3.5 Clinical Systems Implementation Timetable

The Director of Informatics presented the proposed timetable for the implementation order of new clinical systems over the next 12 months, including the short term priorities of NEWS2 and EPMA. The priority order was agreed.

3.6 Medway

The Director of Informatics provided an update on the plans for e-handover and bed management. The Trust had been nominated for the next national Fast Follower Programme, which would support the faster implementation of full Medway functionality.

3.7 Cheshire and Merseyside Health and Care Partnership

The Chief Executive provided feedback from a recent Chief Executives' meeting which had discussed: financial performance and plans for 2019/20, plans for the development

of stroke hubs across the whole of Cheshire and Merseyside, and discussion of future Integrated Care System footprints.

The Chief Executive had also attended a Knowsley PLACE leaders meeting, and commented on the developing plans for the Borough.

4. 28th February 2019

4.1 Commissioner Quality and Performance Group (CQPG)

The Director of Nursing, Midwifery and Governance provided an overview of the 26th February meeting. The Intensive Care Unit had delivered the service review presentation, which had included patient stories. The Trust had also provided assurance on how patient safety and experience had been maintained during the pressurised winter period.

4.2 Information Governance Training Compliance

The Director of Informatics presented the latest compliance figures, which demonstrated improvement but with further work needed to achieve the target by 31st March.

4.3 Learning Statement Progress Report

The Director of Nursing, Midwifery and Governance introduced the report and the committee reviewed progress in achieving the 21 learning objectives agreed with the Coroner as a result of the recent inquest. 13 of the actions had already been completed and good progress was being made in delivering the remaining 8 actions. The Trust's sepsis screening tool and policy had been compared to other local A&E departments which treated children, and further safeguards had been put in place to improve initial triage, screening, record keeping and simulation training for staff. There was also an increased senior medical presence in the department and improved guidance on escalation. There was discussion of the options to secure a Paediatric Emergency Medicine Consultant for the department.

4.4 Oral Surgery Service Development Proposals

The Director of Operations and Performance presented proposals to reduce waiting times and increase capacity to treat complex oral surgery patients at St Helens Hospital. It was agreed that these proposals should be considered in the wider context of the plans for outpatient and theatre capacity at St Helens Hospital, before a final decision could be made.

4.5 Review of Telephony

The Director of Informatics presented proposals to review the current Trust telephony service and develop options for improvement. It was recognised that the current switchboard system was nearing the end of its useful life and plans for replacement should take advantage of modern capability. In order to improve performance, short term additional capacity was approved for the switchboard team. A review of the options and needs of the organisation was also commissioned to inform a future business case.

4.6 Desktop Estate Business Case

The Director of Informatics presented a business case detailing proposals to migrate to Windows 10 and to upgrade the Trust's current desktop computers, many of which were more than 6 years old, and made the use of modern clinical systems slow for frontline staff. The committee approved the first stage of the plans to ensure all desktops could support the migration to Windows 10. The funding options for the wider replacement programme would be reviewed by the Director of Finance and considered in light of the 5 year capital programme.

4.7 Medway

The Director of informatics reported that a Project Board had now been established to take forward the patient letter solution.

ENDS

TRUST BOARD

Paper No: NHST(19)23

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

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

Summary:

QC(19)036 Complaints Update Report:

- 20 1st stage complaints were received and opened in February 2019; a decrease of 8 from January 2019 and an increase of 1 from February 2018
- At the end of February 2019, there were 54 open 1st stage complaints; a decrease of 9 from January 2019
- The Trust responded to 91.3% of 1st stage complaints within agreed timeframes during February 2019, a decrease compared to 100% in January 2019
- Clinical treatment was the primary cause of complaint in February 2019, which is consistent with previous months
- 4.6% decrease in PALS contacts compared to the previous month
- Communication was the main reason for enquiries to PALS in February 2019

QC(19)037 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.
- There were no C.Difficile positive cases reported. YTD there have been 17 cases. The annual tolerance is 40 cases.
- No grade 3/4 pressure ulcers reported.
- Safer staffing fill rate was 96.6% for January. YTD performance is 96.2%.
- There was 1 inpatient fall in January resulting in severe harm with 12 YTD in the severe category, by comparison there was 22 last year.
- VTE assessment performance was 95.37% for January, YTD performance is 95.95% against a target of 95%.
- YTD HMSR is 96.5

QC(19)038 Safer Staffing Reports:

- M11 demonstrates a sustained month on month improvement with a RN overall fill rate of 98.56% and care staff overall fill rate of 113.90%.

QC(19)039 Fasting Audit Update

- A further audit of 30 planned elective patients was undertaken. No harm to patients was found.
- Evidence shows that there is compliance with the policy.
- Recommendations include continuing to ensure awareness of the fasting policy at local induction, adding as a subject for Senior Nurse walk around spot checks and development of a leaflet specifically for AED and Trauma patients. 63% of patients were still fasted in excess of 6 hours

QC(19)040 Healthcare Safety Investigation Branch (HSIB) Update

- STHK currently have three HSIB investigations ongoing, one of which is a serious incident.

QC(19)041 Saving Babies Lives Update

- A quarterly self-assessment is undertaken by each maternity service to assess progress with each element of the care bundle and returned to the Strategic Clinical Network SCN.
- In November 2018 the maternity service self-assessed progress with implementation of the care bundle as:
  - Element 1-3 - fully implemented
  - Element 4 – almost fully implemented

QC(19)042 midwifery Staffing, Acuity & Red Flag Report

- The report demonstrates compliance with the Birth Rate Plus acuity model ratio for safe midwifery staffing, inclusive of midwifery one-to-one care in labour.
- The data collected for Q3 2018 demonstrates safety within maternity services and no current actions are required. Midwifery staffing ratio has improved from 1:32 in October 2018 to 1:27 in December 2018 which has consequently seen the reduction in the number of red flag incidents.

Feedback from Councils/Committees:

QC(19)043 Patient Safety Council

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

- Pregabalin and Gabapentin (analgesic agents) will be reclassified as schedule 3 from 1st April 2019, and will be exempted from CD storage requirements, however will still be requested on CD requisition and CD prescription. The council supported the proposal to adhere to schedule 3 requirements, ceasing the current local requirement of the storage of these of drugs as schedule 2 in CD cupboards.

QC(19)044 Patient Experience Council

The PEC summary page was noted by the Committee. There were no items for escalation.

QC(19)045 Clinical Effectiveness Council

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

- MET: Showed 8am and 8pm spikes in calls received.
- SMR/HSMR figures: Acute and unspecified renal failure flagged high mortality.
- NICE Q3 report: there are concerns regarding evidence of compliance.
- LAB performance: Issues around communication of critical results, working to increase turnaround time, severely hampered by workforce issues relating to retirement and unfilled posts.
- Alcohol Related Liver Disease: This review was generated due to a high mortality rate. All patients were considered to have un-survivable disease.
- The Deteriorating Patient and NEWS2 policies were chair approved outside of the meeting.

QC(19)046 Workforce Council

The Workforce Council summary page was noted by the Committee. There were no issues to escalate.

Policies/Documents for Approval:

- CQC Registration Annual Report
- Mixed Sex Declaration

Items to be brought to the attention of the Board:

- Congratulations to all on the CQC Outstanding rating
- Radiology Department has been recommended for the Imaging Services Accreditation Scheme (ISAS) to UKAS, also the first in C&M.
- NICE – review evidence of compliance and build in a 6 monthly review at Quality Committee
- 95.4% of HCAs received the flu vaccine this year
- Mixed Sex Declaration confirmed no breaches this year
- Concern that Clinical Effectiveness Council not always quorate when there are some serious concerns discussed. Request more detailed notes on the report

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 March 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)24

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance and Performance Committee, 21st March 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 reduced in month from 6.1% down to 5.3% a 0.8% reduction.
- 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 Trust has been asked by regulators to defer some capital schemes into next financial year if possible, it was not yet known if this would be possible.
  - The committee was informed that the financial outturn has improved compared to the forecast outturn agreed at the December Board. This was due to greater controls around winter expenditure during Q4.
- Briefings were accepted from:
  - CIP Council
  - Service Improvement Council
- A&E Performance
  - The Committee reviewed the presentation from the ADO for Urgent Care, Emergency Department Consultant, 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.

For Assurance

- CIP Programme update
  - The committee noted the improvement in green rated schemes and that the forecast delivery of c£14.9m which had improved compared to previous forecasts.
  - The Committee received assurance around CIP scheme for Urology and General Surgery. The scheme was fully compliant with the Trusts Quality Impact Assessment.
  - The committee took assurance from the c70% of schemes identified for 2019/20

which are green and will be sufficiently worked up to be transacted during Q1.

- CIP Programme update – SCG
    - The committee received a presentation from the Surgical 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. The committee took assurance from the high level of engagement within the care group that had enabled them to feel confident to delivering the 2019/20 CIP.

- Financial Planning Update – Final Plans
    - The committee reviewed the changes from the draft financial plan to the final plan.
    - As a result of RICS guidance the Trust will have to increase its depreciation value in year by £2.1m, this will result in an increase to the CIP target for 2019/20.
    - The committee took assurance from the high level of CIP already identified but were concerned that this was a further central pressure that had to be dealt with locally.
    - The committee reviewed the risk and assumptions within the plan and endorsed its approval to Trust Board.

Risks noted/Items to be raised at Board

- Forecast outturn – The Trust has improved its FCO by £0.25m compared to M10 but still remains behind plan.
- Non-recurrent measures utilised within financial position and forecast and have been considered as part of the 2019/20 plan.
- A&E performance remains challenging but took reassurance from the hard work of the team in trying to improve.
- The committee was delighted that the meeting was attended by four clinical leaders from within the Trust and appreciated their insightful input.
- The committee endorsed the 2019/20 financial plans for approval by the Trust Board.
- The potential deferment of Public Dividend Capital schemes into next year's plan.

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 March 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)25
Title of paper: 2019/20 Financial Plans - Final
Purpose: To present the financial statements of the 2019/20 financial year
Summary: In line with national planning guidance the Trust must submit a one year financial and operational plan on the 4th April 2019. The financial plans have been reviewed by the Finance & Performance Committee from January through to March with the planning assumptions and risks fully explored. The plans included within the paper enable the Trust to accept the control total issued by NHSI which will allow the Trust to access the provider sustainability fund.
Corporate objectives met or risks addressed: Financial Performance, Efficiency & Productivity.
Financial implications: N/A
Stakeholders: Trust Board, Trust Regulators, St Helens Cares
Recommendation(s): 1. The Board to approve the plan for submission on 4th April and note the financial, activity and quality performance that must be achieved; 2. The Board approves the plan as the opening budgets for the 2019/20 financial year.
Presenting officer: Nikhil Khashu, Director of Finance & Information
Date of meeting: 27th March 2019

1. Executive Summary

1.1 The purpose of this paper is to provide an update to the Trust Board on the final financial plans for St Helens and Knowsley Teaching Hospitals (STHK) for the 2019/10 financial year.

1.2 The government announced a five year funding settlement in June 2018 which provides an additional £20.5bn a year to the NHS by 2023/24. The NHS Long Term Plan (NHSLTP) was developed in response to this, which sets out plans to improve the quality of care and health outcomes over the next ten years. 2019/20 is set to be the first year in the delivery of the NHSLTP. All NHS organisations submitted draft plans on the 12th February and have to submit final plans by the 4th April.

1.3 The Trust has been offered Sustainability and Transformation funding (PSF) based on the acceptance of the control total issued by NHSI. The Trust will receive £6.5m of PSF if submitted plans deliver a deficit of £2.6m. The PSF will be solely earned by the delivery of the financial plan; there are no links to performance metrics compared to previous years.

1.4 The Trust has submitted a financial plan of a £2.6m deficit in line with the control total issued by NHSI. In order for the Trust to deliver this plan it will need to deliver £16.1m of Cost Improvement Schemes (CIP) which equates to c3.8% of turnover. Delivery of the financial plan will enable the Trust to access £6.5m of PSF which will enable the Trust to deliver an overall surplus of £3.9m for 2019/20.

1.5 This paper sets out the high level assumptions and risks included within the plan for 2019/20. Despite this being the final plan the national timetable has left some risk in delivery of the financial plan as a result of them not being concluded, these include:

- CQUIN guidance has recently been issued and has not yet been agreed with commissioners.
- Health Education England contracts have not yet been provided
- The 2019/20 tariff prices are still in draft and subject to consultation with final prices only expected in March 2019.
- The Trusts Capital Resource Limit (CRL), which supports the capital programme, will only be agreed after submission.

2. NHS Long Term Plan and New Financial Framework

2.1 The NHS Long Term Plan (NHSLTP) published in January 2019 announced a new service model for the NHS in which patients get more options, better support and more joined up care. The key areas of priority discussed within the plan are:

- Primary Care networks - focussing on integrated working for GPs, community health and social care teams; and investment in primary and community health services to provide support to people living in their own homes and in care homes

- Same Day Emergency Care model - this will be rolled out across all acute hospitals with the aim to reduce pressure on A&E departments

- Prevention and health inequalities - funding will be available for prevention programmes such as smoking, obesity, alcohol and air pollution and will be redistributed to those areas with higher health inequalities

- Care quality and outcomes - priorities will be extended to children and young people; as well as other major health conditions such as cancer, cardiovascular disease, stroke, diabetes, respiratory illness and adult mental health

- Workforce – pressures to be addressed through expansion of additional clinical training places, new routes into nursing and expansion of international recruitment

- Digital technologies – for example roll out of telemedicine, digital GP services and Digital Personal Health Records across the NHS to act as an enabler for many of the service changes set out in the plan

2.2 The plan also sets out a long term financial settlement, with major reforms to the financial framework of the NHS, payment systems and incentives. A number of measures will be taken to ensure that being in financial balance is achievable, initially for providers in 2019/20 and all NHS organisations by 2023/24.

2.3 An allocation of £1bn is to be transferred from the Provider and Sustainability Fund into urgent and emergency care tariffs. This is intended to reduce the gap between the price paid and the cost of delivering non-elective care. The proposed impact to the Trust for this change is c£7m.

2.4 There is a new £1.05bn Financial Recovery Fund (FRF) in 2019/20. This is allocated on a non-recurrent basis to providers who have accepted a deficit control total, after applying Provider Sustainability Funding. The Trust has been offered £6.5m of PSF with the requirement to deliver a £3.9m surplus and therefore is not eligible for an FRF allocation.

2.5 The intention of NHSI is to end the control total regime and in 2020/21 any remaining PSF funds will be transferred into the FRF and no trusts will be allocated a control total. Only Trusts in deficit who agree a financial recovery plan will be able to access the FRF. The expectation is that with additional financial support and through delivering multi-year efficiency plans, by 2023/24 no trust will be reporting a deficit. NHSI has also indicated they may require providers to deliver a minimum surplus level in the future.

2.6 In addition, NHSI intend to work with the Department of Health and Social care review the capital and cash regimes for trusts. This will include the rate of interest paid on both historic debt and new loans. The guidance states that in 2019/20 capital expenditure will be subject to additional controls and alludes to future changes in the capital regime; however it's not clear at this point what impact these will have. This may affect the Trust in utilising the surplus that has been included within the final plans to support the capital programme.

2.7 All providers are expected to plan against rebased control totals. The Trust has been offered £6.5m of PSF which will enable the Trust to deliver a £3.9m surplus. In

2019/20 100% achievement of the PSF will be linked to financial performance; therefore the Trust must deliver its control total in order to receive its allocated PSF funding.

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

3. Changes to national tariff system

3.1 The planning guidance sets out expected changes to the national tariff, which are currently subject to consultation and are due to be published in March.

3.2 In addition to the £1bn transfer of PSF funding into non-elective prices; 1.25% (half) of CQUIN values will be transferred into core prices. The remaining 1.25% CCG & 1.0% Specialist Commissioning CQUIN values will still be based on delivery of national key performance indicators and the guidance on these is yet to be released. The Trust has planned for full CQUIN delivery during 2019/20.

3.3 National tariffs have been reduced by 0.36% to cover the costs of new centralised procurement arrangements.

3.4 Maternity prices have been adjusted to remove CNST premiums previously included in the tariffs.

3.5 The tariff uplift factor will be set at 3.8% which includes adjustments for the impact of the 2018/19 and 2019/20 Agenda for Change pay awards, but excludes any impact of the proposed increases to employers pension contributions and the transfer of the PSF funding and CQUIN values. This is partially offset by an efficiency factor of 1.1%, resulting in an overall uplift of 2.7%. Pension contributions will be paid centrally by the Department of health and Social Care (DHSC) during 2019/20.

3.6 A new “blended payment” approach for emergency care activity will be introduced in 2019/20. This will apply where the value of CCG commissioned emergency care activity with a provider is above £10m in 2019/20 and will cover non elective admissions, ED attendance and Ambulatory/Same Day Emergency Care. This will entail two elements; a fixed element based on locally agreed planned activity levels and a variable element, set at 20% of tariff prices. The trust must agree baseline values with at least three CCGs (Knowsley, St Helens and Halton) and activity above or below this baseline price will be paid or credited at 20% of tariff. A “break glass” clause will apply if actual activity levels are significantly different from planned levels and should this be reached; the Trust will need to agree how to revise the fixed payment with commissioners.

3.7 At the time of writing the Trust has offered its main commissioners a local variation on the tariff proposal. This includes PbR up to the Trusts recommended commissioning value with a blended approach thereafter.

3.8 The marginal rate emergency care tariff (MRET) and 30 day readmissions rule will be abolished for 2019/20, on a finally neutral basis between providers and commissioners.

3.9 The national methodology used to calculate provider market forces factor (MFF) has been updated for 2019/20. This will mean a significant change in income for some providers; therefore the changes will be implemented over five years. This will have an adverse impact on the Trust's income of approximately £2m over the five years. A £481k reduction in income relating to MFF changes has been assumed in the 2019/20 financial plans, included within tariff changes.

4. Planning Assumptions and Key Deliverables

4.1 The Trust has planned for activity in 2019/20 based on trends experienced over the last three years to inform its planning activity assumptions. The below table shows the percentage growth in activity assumed in the activity plans by point of delivery, compared to forecast outturn.

GP Referrals	3.7%	
NEL Admissions	9.0%	
A&E Attendances	4.6%	
OP Attendances	3.5%	(includes reductions for virtual fracture clinics)
Daycase activity	3.6%	
Elective activity	1.3%	

4.2 Systems and organisations will be expected to demonstrate how they will deliver key requirements as highlighted set out in the operational planning guidance.

4.3 Emergency Care:

- Same Day Emergency Care (SDEC) - every provider with Type 1 Emergency Departments will be expected to deliver SDEC services for 12 hours a day, 7 days a week by September 2019
- Urgent Treatment Centres – expectation that the majority will be set up and designated as such by December 2019
- Reductions in avoidable admissions by establishing acute frailty services
- Long stay patients – deliver a 40% or more reduction in long stay patients (21 days or more) against the 207/18 baseline
- Delayed Transfers of Care (DTOC) – maintain performance where the target has been achieved in 2018/19
- Ambulance handovers – zero handovers of over 30 minutes (in total) and ensure that no patients are cared for in a hospital corridor.

4.4 Referral to Treatment Times (RTT):

- Patient choice – those patients waiting for six months or longer must be contacted and given the option of faster treatment at an alternative provider.
- All providers to further improve their waiting list position during 2019/20
- Expectation that no patients will be waiting longer than 52 weeks for treatment
- Diagnostic tests - 99% of patients should be seen within six weeks

- Direct access to MSK first contact practitioners should be available to all patients
- Delivery of current cancer access targets remains a priority

4.5 Within the planning guidance efficiency targets have been set at either 1.1% (for organisations with an underlying surplus) or 1.6%, for organisations with an underlying deficit. As a result of the Trusts underlying deficit the minimum efficiency target would be 1.6%.

5. Integrated System Planning

5.1 STPs are expected to continue to focus on working together to improve services and identify efficiency opportunities for the whole system.

5.2 All STPs will have to produce a system operating plan for 2019/20 based on an "open book approach" and organisations will be expected to take collective responsibility for the delivery of their plans.

The plan will have two elements:

- An overview setting out how the system will use its resources to meet population need
- Aggregated system data, comprising activity, workforce, finance and contracting data for each member for the STP

5.3 System control totals will be set for each STP which will be the sum of the individual control totals. All STPs will have the opportunity to propose neutral changes agreed by all parties to organisation control totals, the Trust has not been involved in any discussions around movement to the control total.

6. Financial Planning Process

6.1 The Trust continues to engage with all budget holders and Senior Leaders through various forums, which include:

- Finance and Performance Committee
- Care Group Finance and Performance Committees
- Team to Team
- Capital Planning Council
- Executive Committee
- CIP Council
- Budget review meetings with key leads and heads of service within each care group/ division

All Care Groups and Corporate functions have been engaged by their respective financial lead to ensure that they are fully apprised of the current planning processes and have ample opportunity to engage within the process.

6.2 Financial budgets that have formed the building block of the financial plan have been developed on a detailed "bottom up approach" utilising the recurrent run-rate as the starting point.

6.3 The following assumptions have been made within the plan to continue the strong financial management that is already in place within the Trust:

- All vacant posts funded at the bottom of the scale
- No additional funding allocated for avoidable cost pressures
- Inflation and incremental increases have been calculated on their own specific rates

The above principles should help to ensure that the Trust has set a reasonable yet challenging budget to ensure the best possible value for money within the resources that are available.

7. Income and Expenditure plans

7.1 The Trust was forecasting a £6m deficit in 2018/9 (including PSF funding) when the draft plans were submitted, this has marginally improved by £0.25m as a result of the costs of winter being less than forecast. The final plans propose a delivery of a £2.6m deficit that will allow the Trust to access £6.5m PSF upon delivery of the plan. The table below details the main drivers of the movement between the 2018/19 FCO position the draft plan for 2019/20 and the proposed final plan.

	£m						
	Income	**Expenditure**	***EBITDA***	**ITDA**	***Net Surplus/Deficit***	**Tech Adj**	**Surplus/Deficit**
2018/19 Forecast outturn (M9)	**394.9**	**(375.9)**	**19.0**	**(25.1)**	**(6.1)**	**0.1**	**(6.0)**
Less PSF	(5.8)		(5.8)		(5.8)		(5.8)
Less Non recurrent	(4.2)	(3.2)	(7.4)		(7.4)		(7.4)
Less Fines & Winter	1.0	3.0	4.0		4.0		4.0
Add MRET	0.8		0.8		0.8		0.8
Add Extra Working Day	1.0		1.0		1.0		1.0
FOM Procurement Saving		0.8	0.8		0.8		0.8
National Pay & Prices	(3.4)	(11.0)	(14.4)	(0.6)	(15.0)		(15.0)
Local Pressures		(1.5)	(1.5)	(1.5)	(3.0)		(3.0)
Tariff Changes	5.5		5.5		5.5		5.5
Tariff Uplift	8.5		8.5		8.5		8.5
Growth	7.0	(7.0)	0.0		0.0		0.0
CIP		14.0	14.0		14.0		14.0
2019/20 DRAFT Plan	**405.3**	**(380.8)**	**24.5**	**(27.2)**	**(2.7)**	**0.1**	**(2.6)**
Depreciation change			0.0	(2.1)	(2.1)		(2.1)
Corporate CIP		2.1	2.1		2.1		2.1
Stroke Expansion	3.7	(3.7)	0.0		0.0		0.0
Income changes (net)	1.9	(1.9)	0.0		0.0		0.0
2019/20 FINAL Plan	**410.9**	**(384.3)**	**26.6**	**(29.3)**	**(2.7)**	**0.1**	**(2.6)**
Allocated PSF	6.5		6.5		6.5		6.5
2019/20 Plan Including PSF	**417.4**	**(384.3)**	**33.1**	**(29.3)**	**3.8**	**0.1**	**3.9**

7.2 During 2018/19 the Trust utilised non-recurrent benefits to deliver the forecast outturn. As these benefits are not available in 2019/20 the Trust will need to set a higher CIP to deliver a more sustainable and recurrent underlying position.

7.3 The income and activity plan has been produced using the 2018/19 forecast outturn as starting point adjusting for any non-recurrent income streams, as well as the full year effect of any in year service developments and growth assumptions.

7.4 The Trust has worked closely with commissioning organisations on agreeing contracts for the forthcoming year; indicatively proposals have been discussed with all parties but at the time of publishing remain un-signed.

7.5 National pay and prices have been set at 3.8% with a 1.1% efficiency deflator. The national uplifts include allocations for 2018/19 pay awards and 2019/20 but does not include any allocation for employer pension contributions. While employer contributions will increase in 2019/20 this uplift will be paid directly by the DHSC therefore no provision for this increase has been included within the Trusts plans.

7.6 The Trust has planned for full achievement of all CQUIN schemes in 2019/20, and will review this position when the national guidance is published. The Trust has not planned for any KPI failures included in the NHS contract that would incur penalties.

7.7 The table below shows the change in activity level between forecast outturn and the plan for 2019/20.

Point of Delivery	2018/19 FOT at Month 10	2019/20 Plan Including Growth	% Growth 19/20 v 18/19
Accident & Emergency	109,330	114,347	5%
Non Elective Spells	73,858	80,510	9%
Elective Spells	7,029	7,117	1%
Day Cases	43,514	45,101	4%
Maternity Pathway	6,313	6,308	0%
Outpatient First Attendances	124,639	130,200	4%
Outpatient Follow Ups	293,346	304,813	4%
Outpatient Procedures	99,450	100,508	1%
Rehabilitation	16,865	17,514	4%
Audiology	3,194	3,049	-5%
Direct Access	981,853	1,016,426	4%
Unbundled Diagnostic Imaging	58,383	59,100	1%
Excess Bed Days	9,826	13,068	33%
Other Non PbR	93,928	94,900	1%
Total	**1,921,527**	**1,992,960**	

7.8 The change in Non Elective spells includes the full implementation of the Hyper Acute Stroke Unit expansion which will begin from April 2019.

7.9 The increase in Excess Bed Days is as a result of changes in trim points within impatient stay tariffs, these changes are mandated through the published national tariffs.

See Appendix B for further detail on activity changes.

8. Cost Improvement Plans (CIP)

8.1 The 2019/20 plans require the delivery of a £16.1m CIP, this represents c3.8% of the Trusts planned turnover for the year. This has increased from the draft plan as a result of the RICS guidance change in relation to asset lives. This has meant that the

Trust will incur a further £2.1m additional depreciation in year. The Trust increased the asset lives in previous years as a result of guidance issued by NHSI in order to support the financial position of the provider sector.

8.1 The Trust has made significant progress in identifying schemes to deliver this target with 71% RAG rated as green.

Risk Rating	In Year £'000s
Green	£11,390
Amber	£5,300
Red	£2,700
Total	**£19,390**

8.2 As in previous years schemes are identified by the respective Care Groups and back office functions and then assessed to ensure that there are no patient safety or quality concerns via the quality impact assessment (QIA) process.

8.3 The cost improvement plans are embedded within the income and expenditure plans, therefore any non-delivery of the savings target will manifest itself within the I&E performance throughout the year.

8.4 There is no CIP mitigation reserve included within the plan. As a result the Trust will be looking to identify schemes of c£23m in year to allow for a 70% conversion rate. As in previous years any schemes that are not delivered will remain as potential opportunities for future years.

8.5 To support the delivery of the CIP the Trust will utilise the skills and expertise from the Care Group based Business Partners/Service Transformation team and the continued roll out and adaptation of the Model Hospital. This will be supplemented by the Getting it Right First Time (GIRFT) reports in year as well as any STP wide initiatives.

8.6 The Trust is currently engaged in Health Economic summits within the St Helens cares. While this may not deliver savings during 2019/20 it is putting initiatives in place to deliver system wide opportunities in future years. This will enable the Trust to work collaboratively with its local partners to ensure sustainable Health services over the next 5 years.

8.7 The Finance team and Service Improvement Team are also working with the operational and clinical teams to develop further CIP plans and timescales for delivery. This will involve use of national initiatives such as the Model Hospital and GIRFT (Getting It Right First Time) reviews.

9. Capital planning, Statement of Financial Position (Balance Sheet) and Cash

9.1 The latest forecast outturn for 2018/19 (as at month 11) shows an outturn DHSC Revenue Support loan balance of £19.129m* and a Salix loan balance of £2.108m. The Salix loan was used to fund the Trust's Combined Heat and Power capital scheme which recently became operational, is interest free and is anticipated to be repaid over 5 years in equal twice yearly instalments (payable in October and April) of £0.211m starting from October 2019 onwards. (*This includes a temporary loan

for Q3 PSF, £2.693m, to be repaid in April 2019 subject to receipt of Q3 PSF from NHSE beforehand.)

9.2 No additional DHSC loans or loan repayments are anticipated other than the element relating to Q3 PSF. In addition to the above the Trust will repay capital debt relating to the PFI scheme (through the PFI unitary payment) and also capital repayments relating to finance leases.

9.3 The plans assume no worsening in the wider health economy's ability to service its debt to the Trust. An environment of arguably increasing cash pressures on organisations renders this a risk. The summarised cash flow statement can be found within Appendix C of the paper.

9.4 The Trust's land and buildings are valued* using the alternative single site methodology and VAT is excluded from PFI valuations. The Trust has currently no surplus estate and therefore does not anticipate any sales of surplus assets.

(*The Trust has recently been advised that RICS guidance has changed for valuers and that this has had a significant and adverse impact on economic lives used in the calculation of depreciation. This is a national issue which NHSI are aware of and effects many organisations including the Trust. The values of assets in the month 11 forecast outturn include the estimated impact of the revaluation.) . The detailed balance sheet can be found within Appendix D of the paper.

10. Interest, Tax, Depreciation and Amortisation (ITDA)

10.1 Depreciation has been based on the current profile of the Truss assets. The current plan now reflects the change in guidance issued by RICS. This is a national issue that has placed an increased pressure on providers to deliver their control total.

10.2 The current plans assume that no revenue loans will be required. The Trust will be required to pay back the Q3 PSF received during 2018/19; this has been scheduled for April 2019.

10.3 The current plans and forecasts assume payment from Commissioners in line with contractual agreements which is one quarter in advance.

10.4 The Trust is assuming no deterioration or improvement in the aged debt relating to Lead Employer contracts. This will continue to be managed separately in order to understand and respond to any changes within the working capital.

10.5 The Trust is assuming no PDC payments within year but has planned for additional PDC to be received in line with the Ambulatory Care development agreed nationally.

11. Capital

11.1 The capital plan is funded from internally generated depreciation, an allocation of PDC in respect to the Ambulatory Care development and internally generated cash

from the surplus planned for 2019/20. The depreciation figure has increased from the draft plan as a result of the change in asset lives.

11.2 The Capital Plan includes PFI lifecycle replacement costs deferred from previous year's UP funding. It also includes a small amount for finance lease renewals, an allowance set aside for other expenditure including new and replacement equipment and essential developments. PFI lifecycle costs are recognised at actual replacement costs at the time of delivery; the figures above are only estimated costs and are therefore subject to potential change.

11.3 The indicative Capital allocations are as per the below:

Capital Loan repayments:

CHP	£0.2m
PFI	£8.2m
Finance Leases	£0.2m

Capital Expenditure:

PFI Lifecycle Maintenance – Buildings	£0.7m (funded from 19/20 PFI UP)
Ambulatory Care	£1.2m
Managed Equipment Services	£0.6m
Contingency	£0.5m
Capital to Revenue	£0.5m
Discretionary (Capital Council/Execs)	£3.7m

Non-Cash items

PFI MES Lifecycle Replacement	£0.3m (funded from 19/20 PFI UP)
Lease	£0.1m (initial recognition is non-cash)

11.4 The approach for capital planning will be managed via the capital planning council which will report back to F&P Committee and the Executive Committee

The capital plan can be found in Appendix E of the paper.

12. Use of Resources

12.1 The Use of Resources Rating superseded the Financial Sustainability Risk Rating in October 2016 and consists of the following 5 equally weighted metrics:

- Liquidity Ratio,
- Capital Servicing Capacity
- I&E Margin,
- I&E Margin Variance from Plan
- Agency metric (measures performance against the planned agency ceiling)

12.2 The Use of Resources Overall Rating is determined by the above scores with an override methodology, this methodology is:

- Scoring a 4 on any metric means the overall rating can be no higher than 3
- If the Control total has been accepted the rating can be no higher than 2
- If the Control total has been rejected the rating can be no higher than 3

- A provider in special measures will be scored 4

12.3 The table below shows the Trust UoRR rating for outturn 2018/19 and 2019/20 plan

Plan Risk Ratings	FOT 2018/19	Plan 2019/20
Capital Service Cover rating	4	4
Liquidity rating	4	4
I&E Margin rating	4	2
Variance From Control total rating	4	1
Agency rating	2	1
Overall Plan Risk Ratings	4	3

13. Risks

13.1 There are a number of risks and outstanding issues at this stage in the planning cycle which may impact on the draft financial plans.

Risk	Mitigation
Actual activity growth is in line with the planning assumptions	Regular monthly reviews at Care Group F&P meetings/Team to Team
Agreement of CRL	Discussions are ongoing with regulators
Contracts still to be agreed with Commissioners	Discussion ongoing with key contacts
Commissioner affordability of projected demand	STP LTFM / discussions with commissioners on underlying positions
CQUIN guidance has only recently been issued; deliverability yet to be assessed	Documentation shared with key stakeholders, regular monitoring meetings with DoN, milestones to be agreed with commissioners
Delivery of £16.1m CIP target, the target is above the 1.6% mandated nationally	Regular update at F&P Committee both Trustwide and through presentations from Care Groups, workstreams ongoing with Service Improvement team
Health Education England contracts have not yet been provided	HEE contract is funded to 2018/19 levels, a further reconciliation will take place when the contract is received
The 2019/20 final tariff prices have been released this week, full impact of the changes are not known at this time	Final tariff impact will be brought to F&P Committee for further review of risks and mitigations

14. Conclusion

14.1 The Trust has produced a financial plan that delivers the control total issued by NHSI allowing the Trust to accept the control total for the final submission.

14.2 The plan is underpinned by delivery of the respective activity plans and a 3.8% CIP target this has increased by £2.1m from the draft plan as a result of guidance changes in relation to asset lives.

14.3 The Trust will not require any cash support from the proposed plans.

15. Recommendations

15.1 The Trust Board are asked to consider the contents of the current plans and to approve them for the 2019/20 financial year.

Appendix A – I&E Plan & Profile

	Plan 2018/19 £m	Forecast 2018/19 £m	Plan 2019/20 £m
Operating income from patient care activities	318.7	318.7	349.2
Other operating income	85.6	79.7	68.2
Total Income	**404.3**	**398.4**	**417.4**
Employee Expenses	(241.6)	(241.6)	(250.5)
Operating Expenses	(126.4)	(137.5)	(133.8)
Total Operating Expenses	**(368.0)**	**(379.1)**	**(384.3)**
EBITDA	**36.3**	**19.3**	**33.1**
ITDA	(25.5)	(25.1)	(29.3)
Impairments	0.0	(4.2)	0.0
Surplus / Deficit	**10.8**	**(10.0)**	**3.8**
Technical Adjustment	0.2	4.3	0.1
Surplus / Deficit	**11.0**	**(5.7)**	**3.9**

	£m's												
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Operating income from patient care	28.03	28.81	27.85	29.42	27.98	27.85	30.63	30.04	28.01	30.95	29.47	30.13	349.16
Other operating income	5.47	5.47	5.47	5.58	5.58	5.58	5.79	5.79	5.79	5.90	5.90	5.90	68.23
Total Income	**33.5**	**34.3**	**33.3**	**35.0**	**33.6**	**33.4**	**36.4**	**35.8**	**33.8**	**36.8**	**35.4**	**36.0**	**417.4**
Employee Expenses	(19.49)	(19.90)	(20.38)	(20.53)	(20.71)	(20.79)	(20.87)	(21.23)	(21.27)	(21.61)	(21.63)	(22.04)	(250.46)
Operating Expenses	(12.36)	(12.50)	(11.51)	(11.15)	(12.39)	(10.48)	(11.18)	(11.24)	(10.72)	(11.27)	(10.56)	(8.49)	(133.85)
Total Operating Expenses	**(31.8)**	**(32.4)**	**(31.9)**	**(31.7)**	**(33.1)**	**(31.3)**	**(32.0)**	**(32.5)**	**(32.0)**	**(32.9)**	**(32.2)**	**(30.5)**	**(384.3)**
EBITDA	**1.6**	**1.9**	**1.4**	**3.3**	**0.4**	**2.2**	**4.4**	**3.4**	**1.8**	**4.0**	**3.2**	**5.5**	**33.1**
ITDA	(2.41)	(2.41)	(2.41)	(2.43)	(2.43)	(2.43)	(2.43)	(2.44)	(2.44)	(2.45)	(2.45)	(2.54)	(29.27)
Surplus / Deficit	**(0.8)**	**(0.5)**	**(1.0)**	**0.9**	**(2.0)**	**(0.3)**	**2.0**	**0.9**	**(0.6)**	**1.5**	**0.7**	**3.0**	**3.8**
Technical Adjustment	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.09
Surplus / Deficit inc PSF	**(0.8)**	**(0.5)**	**(1.0)**	**0.9**	**(2.0)**	**(0.3)**	**2.0**	**0.9**	**(0.6)**	**1.5**	**0.7**	**3.0**	**3.9**

Note:

1. Depreciation element of CIP has been included in month 12

Appendix B – Activity Plan 2019/20

Point of Delivery	2018/19 FOT at Month 10	Adjustments to Contract Baseline	Starting Contract Baseline	Developments & Trend Growth	2019/20 Plan Including Growth
Accident & Emergency	109,330	285	109,615	4,732	114,347
Non Elective Spells	73,858	592	74,450	6,060	80,510
Elective Spells	7,029	106	7,135	-18	7,117
Day Cases	43,514	-174	43,340	1,761	45,101
Maternity Pathway	6,313	-30	6,283	25	6,308
Outpatient First Attendances	124,639	5,167	129,806	394	130,200
Outpatient Follow Ups	293,346	5,268	298,613	6,200	304,813
Outpatient Procedures	99,450	-2,561	96,889	3,618	100,508
Rehabilitation	16,865	1,719	18,584	-1,070	17,514
Audiology	3,194	-34	3,160	-111	3,049
Direct Access	981,853	-1,803	980,050	36,376	1,016,426
Unbundled Diagnostic Imaging	58,383	-478	57,905	1,195	59,100
Excess Bed Days	9,826	3,289	13,115	-47	13,068
Other Non PbR	93,928	-1,796	92,132	2,767	94,900
Total	**1,921,527**	**9,550**	**1,931,078**	**61,882**	**1,992,960**

Appendix C – Summarised Statement of Financial Position (Balance Sheet)

	2018/19 Outturn £m	2019/20 Plan £m
NON CURRENT ASSETS	**262.0**	**258.0**
Current Assets		
Inventories	3.7	3.7
Receivables & Other Current Assets	36.3	34.1
Cash at Bank and in Hand	2.0	1.6
Total Current Assets	**42.0**	**39.4**
Current Liabilities		
Payables and Other Current Liabilities	(56.2)	(50.4)
Total Current Liabilities	**(56.2)**	**(50.4)**
Net Current Assets / (Liabilities)	**(14.2)**	**(11.0)**
Non Current Liabilities*	(256.9)	(251.1)
TOTAL ASSETS EMPLOYED	**(9.1)**	**(4.1)**
Taxpayers' Equity		
Public Dividend Capital	66.6	67.8
Retained Earnings Reserve	(85.8)	(82.0)
Revaluation Reserve	10.1	10.1
TOTAL TAXPAYERS' EQUITY	**(9.1)**	**(4.1)**

Appendix D – Summarised Cash Flow

	2018/19 Outturn £m	2019/20 Plan £m
EBITDA	**19.3**	**33.2**
Excluding Non-Cash Items	0.0	0.0
Movement in Working Capital		
Inventories / receivables / payables / provisions etc	(9.6)	2.1
CF from Operations	**9.7**	**35.3**
Capital Expenditure		
Capital Spend	(9.6)	(7.2)
Capital Receipts	0.0	0.0
CF before Financing	**0.1**	**28.1**
Interest payment / net of receipts	(16.8)	(18.4)
Capital and other loan repayments (PFI, leases, loans)	(21.8)	(11.3)
PDC dividends paid (-) / refunded (+)	0.0	0.0
PDC receipts / new loans inc Salix	28.8	1.2
Net Cash Inflow / (Outflow)	**(9.7)**	**(0.4)**
Opening Cash Balance	**11.7**	**2.0**
Net Cash Inflow / (Outflow)	(9.7)	(0.4)
Closing Cash Balance	**2.0**	**1.6**

Appendix E – Outline Capital Programme

Capital Cash Management 2019/20	
Funding:	**£m**
Internal	
Depreciation (excluding donated assets depreciation)	10.7
I&E surplus	3.9
External	
PDC Advance *	1.2
Total funding	**15.8**
All Capital Commitments:	
Capital spend (discretionary)	5.3
Capital spend (PDC advance)	1.2
PFI – element of 2019/20 UP relating to Buildings lifecycle replacements	0.7
PFI – element of 2019/20 UP relating to MES lifecycle replacements	0.0
PFI – element of 2019/20 UP relating to borrowings repayment	8.1
Salix loan repayment	0.2
Leases – element of charges relating to borrowings repayment	0.2
Total capital commitments	**15.8**

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)26

Title of paper: 2019 - 20 Trust Objectives

Purpose: To agree the Trust objectives for 2019 - 20

Summary:

1. The Trust Board agree objectives each financial year to ensure that the Trust continuously improves its quality and performance and implements new initiatives/national policies and service developments.
2. The objectives are aligned to support the achievement of the Trust's operational plan and the furtherance of its strategic direction and vision to deliver Five Star Patient Care.
3. The objectives have traditionally been split into 9 categories; 5 representing the Trust's Five Star Patient Care criteria of; care, safety, pathways, communication, and systems. There are then 4 categories covering; organisational culture and support for the workforce, operational performance, financial performance, efficiency and productivity and strategic plans
4. A member of the Executive Team takes lead responsibility for each of the objectives and they are built into the individual's personal objectives for the year.
5. As far as possible progress against each of the objectives is translated into key performance indicators or measurable targets that are reported via the Integrated Performance Report (IPR) or through the governance structure, to provide regular assurance of delivery to the Board.
6. There are also two formal reviews of progress incorporated into the Trust Board annual work plans; in November and May each year.
7. Setting and monitoring the delivery of the annual plan and objectives is a key role for the Board and part of the CQC Well Led assessment.

Trust objective met or risk addressed: Delivery of the annual operational plan.

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

Stakeholders: Staff, Regulators and Health System Partners.

Recommendation(s): The Board approves the 2019 - 20 Trust objectives.

Presenting officer: Ann Marr, Chief Executive.

Date of meeting: 27th March 2019.

Proposed Trust Objectives 2019/20

Objective	Lead Director	Measurement	Governance Route
1. 5 STAR PATIENT CARE – Care ***We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families***			
1.1 Maintain weekday improvements and achieve greater consistency of discharge planning 7 days a week 1.1.1 Consistently achieve 33% of discharges before midday 1.1.2 Increase discharges at the weekend to be at least 85% of the weekday average	DoOps	33% of patients to leave hospital by noon on the day of discharge. 85% of the weekday average discharges to be achieved before noon at the weekends.	Finance and Performance Committee
1.2 Improve the Trust processes for booking outpatient appointments and communicating with patients	DoI and DoOps	Reduced DNA rates Reduced % of appointments rearranged Reduced complaints	Finance and Performance Committee
1.3 Make further progress to achieve the national seven day services clinical standards across the Trust 1.3.1 Increase the reported % of patients receiving a senior clinical review each day 1.3.2 Increase the reported % of patients being assessed by a Consultant within 14 hours of admission	MD	Achieve the national targets for 90% of patients	Quality Committee

Objective	Lead Director	Measurement	Governance Route
2. 5 STAR PATIENT CARE – Safety ***We will embed a culture of safety improvement that reduces harm, improves outcomes and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care***			
2.1 Ensure timely and effective assessment and delivery of care within the emergency department (QA Priority)	DoOPs	• Patients triaged within 15 minutes of arrival • First clinical assessment median time of <2 hours • Compliance with NEWS2, and escalation of patients who trigger • 100% compliance with sepsis screening and treatment guidance	Quality Committee
2.2 Reduce the rate of avoidable harm from falls, by a further 10% compared to 2018/19 2.2.1 Falls – 10% reduction from 2018/19 baseline for moderate and severe harm 2.2.2 Implement the national CQUIN high impact changes to prevent falls for all inpatients	DoN	Delivery of the Falls Strategy objectives and continue to undertake RCA's and share lessons learnt from all falls. Audit of; lying and standing BP, prescribing of hypnotics and undertaking mobility assessments within 24 hours of admission	Quality Committee
2.3 Implement a new system to improve the monitoring of cardiotocography (CTG) for fetal heart rate abnormalities to ensure patients receive the right interventions at the right time	DoN	Implement the new monitoring system and train staff in its use Report on alerts and any reasons for override Monitor outcomes and any changes in practice	Quality Committee
2.4 Implement changes as a result of lessons learnt from the systems for reviewing hospital deaths	MD	Publication of quarterly learning from deaths reports Audit of lessons learnt and changes in practice	Trust Board

Objective	Lead Director	Measurement	Governance Route
3. STAR PATIENT CARE – Pathways ***As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient***			
3.1. Continue work to increase the percentage of e-discharge summaries sent within 24 hours to 85%	DoI	Achieve 85% of discharge summaries sent to Primary Care within 24 hours by Q3 2019/20	Quality Committee
3.2. Maximise the benefits of providing Primary and Community Health Services to support integrated care 3.2.1 Deliver end to end pathways to reduce duplication and number of handoffs e.g. Urgent and Emergency Care, Frailty and the development of Community Rapid Response Teams	DoOps	Improved patient experience Reduced rate of A&E attendances and hospital admissions	Quality Committee
3.3. Develop plans to maximise ambulatory care pathways and assessment services at the Trust to support the introduction of Same Day Emergency Care (SDEC) and increase bed capacity.	DoOps and DoCS	Develop the Full Business Case for approval of the capital schemes and commence work on site by the end of Q3	Trust Board
4. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**			
4.1 Increase the proportion of patients who report that they have received an appropriate amount of information in a way they can understand, to meet their needs (QA Priority)	DoN	Improve scores for responses to questions relating to patient information in patient questionnaires and national surveys	Quality Committee
4.2 Reduce the number of new legal claims against the Trust arising from A&E, Obstetrics and Gynaecology, and Orthopaedic Surgery	DoN	Reduce that conversion rate of complaints and incidents to claims Improve systems for learning lessons from previous claims and ensuring they remain embedded	Quality Committee
4.3 Use patient feedback to shape service developments and improvement plans – identifying themes from all sources of feedback e.g. F&FT, Healthwatch, patient surveys, ask Ann e mails, complaints, PLACE 4.3.1 Produce a thematic annual report from all patient feedback 4.3.2 Agree and deliver 2 -3 priority initiatives that will have the greatest impact on improving patient experience 4.3.3 Publicise the changes made and the difference it has made to patients in the Quality Account	DoN	Feedback from Healthwatch F&F test responses and approval ratings. National Patient Surveys Annual PLACE assessment You said we did reports	Quality Committee

Objective	Lead Director	Measurement	Governance Route
5. **5 STAR PATIENT CARE – Systems** **We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes**			
5.1 Make the most effective use of new electronic systems to support staff to deliver high quality care (QA Priority) 5.1.1 Electronic Prescribing 5.1.2 NEWS – early waring scores to identify deteriorating patients 5.1.3 E- Handover	DoI	• Reduction in medication errors • Improved discharge processes • More timely communications with GPs and community services • Earlier identification and initiation of treatment for deteriorating patients	Quality Committee
5.2 Improve the Trusts systems for booking outpatient appointments and communicating with patients	DoI	Reduce DNA rates Reduce appointments being re-arranged less than 6 weeks in advance	Executive Committee
5.3 Embed the use of SafeCare across the Trust, to make the most effective use of the skills of the nursing workforce and ensure optimal deployment of nursing resources. 5.2.1 Alignment of staffing utilisation with patient acuity and flows information to improve bed days, care hours per patient and the safe deployment of staff 5.2.2 Utilisation of SafeCare to support nursing capacity and demand modelling	DoN	Auto roster consistently used by all wards for roster production by September 2019 Safer staffing reports – maintain over 90% fill rates Care Hours Per Patient – maintain 3 hours	Quality Committee
5.4 Embed and optimise the use of the Shared Care Record by health and social care professionals to support the objectives of integrated care in St Helens.	DoI	Shared care record used for joint care planning for St Helens patients by March 2020	Executive Committee
6 DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE ***We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce that feel valued and supported to care for our patients.***			
6.1 Implement innovative approaches to recruitment and retention 6.1.1 Recruit 80 permanent new nurses to the Trust 6.1.2 Recruit 50 nurses via international recruitment/global learners programme 6.1.3 Increase opportunities for retire and return, and promote flexible working 6.1.4 Increase development opportunities including rotational programmes	DoHR	HR Strategy and key Indicators Reports	Trust Board

Objective	Lead Director	Measurement	Governance Route
6.1.5 Expand the Trust support programme for new clinical staff including; apprenticeships, preceptorship and whole career development initiatives			
6.2 Continue to make improvements to the Trust so it is increasingly recognised as an employer of choice. 6.2.2 Act on feedback from staff survey to include an increase in rate of appraisals, staff satisfaction in care they provide and reduction in staff experiencing physical violence from patients 6.2.3 Conduct local impact assessment surveys, to provide continuous feedback from staff 6.2.4 Implement new Talent Management and appraisal tools	DoHR	HR indicators reports NHS Staff Survey Action Plan monitoring WRES Action Plan monitoring	Quality Committee
6.3 Optimise the apprenticeship levy to support staff in realising their potential. 6.3.1 Offer a broad range of apprenticeship schemes to all staff groups to develop skills and aid retention 6.3.2 Utilise the apprenticeship levy to continue to support the development of new roles such as nursing associates, apprenticeship nurse degrees, advanced care practitioners and physician associates.	DoHR	HR indicators reports Apprenticeship Levy % allocations Recruitment to 12 nurse associates and 20 apprenticeship nurse degree places	Trust Board
6.4 Implementation of Activity Manager to support capacity and demand planning 6.4.1 Implement Activity Manager in theatres, surgical specialities and medicines management 6.4.2 Continue to roll out of e-Rostering to include all clinical staff	DoHR	Activity Manager implemented in theatres by Q2 e-Rostering embedded for Medical Staff and Specialist Nurses during 2019/20	Executive Committee
7 OPERATIONAL PERFORMANCE ***We will meet and sustain national and local performance standards***			
7.1 Plan to achieve national performance access standards including: 7.1.1. The agreed trajectory for emergency access standards 7.1.2. Cancer treatment standards 7.1.3. 18 week access to treatment for planned care	DoOps	IPR	Finance and Performance Committee

Objective	Lead Director	Measurement	Governance Route
7.1.4. Diagnostic tests completed within 6 weeks 7.1.5. Ambulance handover times			
7.2 Ensure activity levels meet the Trust operational plans by the use of benchmarking and comparative data e.g. GIRFT and Model Hospital to achieve activity and productivity improvements	DoOps	Improve comparative GIRFT performance Model Hospital IPR	Finance and Performance Committee
8 FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY ***We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money***			
8.1 Use benchmarking and reference costs information to achieve best practice and the meet the cost improvement target; 8.1.1 Maintain reference cost index of less than 100 8.1.2 Maintain performance against the three procurement efficiency standards	DoF	Annual Reference Costs NHSI Annual Benchmarking review Annual procurement performance score Model Hospital	Finance and Performance Committee
8.2 Work with partners as part of the Cheshire and Merseyside Health and Social Care Partnership and developing Integrated care systems to provide collaborative corporate services, where cost improvement or quality benefits can be demonstrated; 8.2.2 HR Services 8.2.3 Business Information 8.2.4 Informatics and IT 8.2.5 Financial Services	DoF	Annual Reference Costs NHSI Annual Benchmarking review Annual procurement performance score Model Hospital	Finance and Performance Committee
9 STRATEGIC PLANS ***We will work closely with NHS Improvement, and commissioning, local authority and provider partners to develop proposals to improve the clinical and financial sustainability of services***			
9.1 Working with health system partners we will develop local plans to implement the ambitions of the NHS Long Term Plan for our catchment populations 9.1.1 Work with primary care to support the introduction of Primary Care Networks 9.1.2 Create whole pathway metrics and reporting systems to demonstrate the benefits of integrated care	DoInt	IPR & Corporate Activity Reports Develop common pathway dashboards	Executive Committee

Objective	Lead Director	Measurement	Governance Route
9.2 Collaborate with partners in the development and implementation of integrated care systems and partnerships in order to benefit patient experience through the provision of integrated high quality, safe, efficient and effective services.	DoT		Executive Committee
9.3 We will meet all the statutory and regulatory standards expected of NHS organisations and maintain the highest standards of governance and use of public money to secure the long-term sustainability of clinical services for local people, collaboratively with partners where appropriate.	DoCS	Meet all reporting and compliance requirements and deadlines Maintain Single Oversight Framework segmentation rating	Trust Board

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(19)27
Title of paper: Care Quality Commission (CQC) compliance and registration
Purpose: This paper provides a summary of policies, process and practices across the Trust to demonstrate how on-going compliance is maintained with the fundamental standards required by the CQC (Appendix 1), to provide assurance to the Board.
Summary: The Trust is required to register with the CQC and has a legal duty to be compliant with the fundamental standards set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). In 2015, the Trust underwent a comprehensive Chief Inspector of Hospitals' visit and was found to be compliant with the fundamental standards, with no requirement for enforcement action in any area. The Trust was rated as good overall with outstanding features and has remained registered with the CQC without conditions. The Trust was re-inspected as part of the next phase of inspections in July/August 2018. The inspection covered the following areas: • Use of resources • Surgery • Urgent and emergency care • Maternity • Community services • Marshalls Cross Primary Care Service • Well-led domain The final report from this report was published on 20th March 2019 and the overall Trust rating was Outstanding. The report did identify three breaches of the CQC regulations in relation to Marshalls Cross Medical Centre, and the Trust has until 23rd April 2019, to submit its action plans demonstrating how it has/or intends to improve this service. Action has already been taken to address the three issues internally, however to close the regulatory breaches these needs to be reviewed and agreed by the CQC. Appendix 1 provides an updated summary of compliance against each of the relevant standards.
Corporate objectives met or risks addressed: Care, safety and communication

Financial implications:

The CQC charges all providers an annual registration fee to cover its regulatory activities.

2018-19 fee = £245,392*

2019-20 fee estimate = £272,000

*0.071% of turnover

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

Recommendation(s):

For the Trust Board to:

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

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

Date of meeting: 27 March 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

Compliance with CQC Regulations and Fundamental Standards

Key	This paper was updated on 5th March 2019
	Full assurance in place in STHK
	Process in place, further work required until full assurance can be given
	No assurance in place
	Position not yet assessed and, therefore, not known
	Not applicable

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Further actions to strengthen compliance if required
No FS maps to this regulation	5 - Fit and proper persons: directors	People with director-level responsibility for meeting the standards are fit to carry out this role.	**Well-led**	Remuneration	DoHR		Process in place for confirming all current Directors including Non-Executive Directors meet the required standard, which is applied to all new appointments and renewed annually.	Chair approved process in place and adhered to for existing post-holders and all new starters.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Further actions to strengthen compliance if required
No FS maps to this regulation	6 - Requirement where the service provider is a body other than a partnership	Provider is represented by an appropriate person nominated by the organisation who is responsible for the management of regulated activity.	**Well-led**	Executive	DoNMG		Director of Nursing, Midwifery and Governance is the Accountable Person registered with the CQC.	Director of Nursing registered with the CQC as responsible officer and confirmed in updated certificate received May 2016.
No FSs map to this regulation	8 - General	Registered person must comply with regulations 9 to 19 in carrying on a regulated activity	**Well-led**	Quality	DoNMG		See information below for compliance	See below

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Further actions to strengthen compliance if required
1	9 - Person-centred care	Providers must do everything reasonably practicable to put patients at the centre and to reflect personal preferences, taking account of people's capacity and ability to consent.	Safe, **Caring,** Responsive	Quality	DoNMG		All patients are assessed on admission and have comprehensive treatment/care plans in place. Trust has examples of adjustments made to meet individual needs, including electronic alerts, health passports, side-rooms, additional staffing where needed, promotion of John's Campaign to support carers who wish to stay with patients/carer beds, hearing loops & communication aids. In outpatients, double, early and late appointments are used along with desensitising visits to clinics. Specialities have developed their own pathway supporting people with additional needs and include imaging, endoscopy and pre-operative assessment. For complex patients, best interest decision-making and journey planning involving multi-disciplinary teams are routine. The patient story to the Board in January 2019 highlighted the care provided to a patient with learning disabilities in the Emergency Department. Mental Capacity Act included in mandatory training with 95% compliance achieved year-to-date in 2018-19, significantly above the target of 85%. Consent Policy in date and available on the Trust's intranet. Compliance with nursing care indicators is regularly audited and reported to each ward and the Patient Experience Council on a quarterly basis, with improved performance noted in the latest report received in February 2019.	The Trust received an overall rating of outstanding for the caring domain, with examples of compliance sited in the CQC inspection report, including the fact there were sufficient numbers of trained nursing and support staff with an appropriate skill mix to ensure that patients' needs were met appropriately and promptly. The CQC observed positive interactions when staff were seeking consent.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Further actions to strengthen compliance if required
2	10 - Dignity and respect	Have due regard to the Equality Act 2010 protected characteristic – staff demonstrating compassion and respect. Maintain privacy **at all times**, including when sleeping, toileting and conversing.	Safe, **Caring,** Responsive	Quality	DoNMG		The Trust's values include respectful and considerate and these are reiterated at interview, on induction and during appraisals. Privacy and dignity assessed as part of CQC inspection and external PLACE assessments. Trust rated best nationally in latest PLACE assessment. 2018 inpatient survey results state 95% patients' privacy maintained definitely and 5% to some extent. On-going observation through internal quality reviews. Any areas of concern highlighted through the complaints process are responded to and actions taken to address shortfalls. Additional structural changes made in 2016 to the Coronary Care Unit to enhance privacy and dignity of patients. Eliminating Mixed Sex Accommodation Policy in place, which requires any breaches to be reported via the Datix system. Annual mixed sex declaration submitted to the Board each March and no breaches reported for over two years.	

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Further actions to strengthen compliance if required
3	11 - Need for consent	All people using the service or those acting lawfully on their behalf give consent. (Meeting this regulation may mean not meeting other regulations eg this might apply in regard to nutrition and person centred care. However, providers must not provide unsafe or inappropriate care just because someone has consented.)	**Safe,** Responsive	Quality	MD		Up-to-date Consent Policy in place and patients are consented using standard Trust forms for all procedures. Annual consent audit undertaken as part of the clinical audit programme which is reported to the Clinical Effectiveness Council. CQC observed positive interactions when staff were seeking consent.	

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Further actions to strengthen compliance if required
4	12 - Safe care and treatment	Assessing risks against health and safety standards, mitigating risks, staff providing care have relevant qualifications, competence, skills and experience, ensure premises and equipment used are safe for intended purpose. Ensure sufficient quantities of medicines/equipment to remain safe. Proper oversight of safe management of medicines. Infection prevention and control (IPC).	**Safe**	Quality; Workforce Council; Executive	DoHR, DoNMG, DoCS,		H&S risk assessments in place and outlined in H&S Policy & supporting documents. Work place inspections reported to Health and Safety Committee which reports to Workforce Council and programme of environmental checks in place reporting to Patient Experience Council, with high levels of compliance noted. Relevant checks against job description/person specification undertaken as part of recruitment process for all staff. Annual appraisals confirm staff have maintained knowledge and expertise to undertake roles and responsibilities. Missed doses of medication are recorded in patient notes, on Datix and are audited. Pharmacy undertake audits of missed doses and security, providing feedback to individual wards for improvement. Improvements noted in the latest medicines security audits reported to the Quality Committee. Programme of medical device maintenance in place. Compliance with infection prevention is audited monthly and root cause analysis undertaken on any serious incidents, including CDiff/MRSA cases. No MRSA bacteraemia (one contaminant) reported year to date in 2018-19 and CDiff cases below the threshold of 40. In relation to Marshalls Cross Medical Centre actions have been taken to strengthen the processes for; • Follow up of uncollected prescriptions • Monitoring of NICE guidelines • Managing patients on high risk medicines • Undertaking risk assessments	

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Further actions to strengthen compliance if required
5	13 - Safeguarding service users from abuse and improper treatment	Zero tolerance approach to abuse and unlawful discrimination and restraint, including neglect, degrading treatment, unnecessary restraint, deprivation of liberty. All staff to be aware of local safeguarding policy and procedure and actions needed if suspicion of abuse.	**Safe**	Quality, Workforce	DoNMG, DoHR		The Trust has a zero tolerance approach to abuse, discrimination and unlawful restraint. The Trust has a Raising Concerns Policy and also Disciplinary Policy and Procedure in place for any staff who fail to meet the Trust's values and ACE behavioural standards. Each clinical area has a Safeguarding file with key information to ensure all suspicions are reported appropriately. Safeguarding level 1 is the minimum mandatory requirement for all staff, with level 2&3 targeted at those who require it, ie those working with children and young people and those in decision-making roles respectively. Compliance with training reported to the Quality Committee in January noted the targets were met for all three levels for children and adults. Awareness of Deprivation of Liberty Safeguards (DoLS) is included in induction and mandatory training. The Trust provides training in conflict resolution. CQC inspection report highlighted that the relevant policies and procedures are in place, with robust training and support from the Safeguarding Team to ensure patients receive appropriate care.	Training compliance requirements for the Trust to be reviewed following release of updated: Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Further actions to strengthen compliance if required
6	14 - Meeting nutritional and hydration needs	People who use services have adequate nutrition and hydration to maintain life and good health.	**Effective**	Quality	DoNMG		Nutrition and hydration screening tools in place (MUST) and relevant patients have food charts. There is a red tray and red jug system in place for patients who require additional support with eating and drinking. All general wards operate protected mealtimes. Patients are regularly assessed to note any changes in nutrition and hydration status. Trust rolled out the Malnutrition Universal Screening Tool (MUST) for adults to ensure compliance with NICE guidance in 2015 which is now included in the electronic risk assessments. Improved compliance in the recording of MUST scores and implementation of relevant care plans has been noted. In addition, electronic fluid balance charts to support appropriate recording of hydration are now in place. The volunteer service has increased the number of trained dining companions to further support patients during meal times.	

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Further actions to strengthen compliance if required
7	15 - Premises and equipment	Premises and equipment are clean, secure, suitable, properly used/maintained, appropriately located and able to maintain standards of hygiene. Management of hazardous/clinical waste within current legislation. Security arrangements in place to ensure staff are safe.	**Safe**	Quality	DoCS		The Trust was rated best acute Trust for Patient Led Assessments of the Care Environment (PLACE) programme in 2017 and 2018. The Trust achieved top marks in the country in every area of the inspection, including; • cleanliness • food • privacy and dignity • facilities for patients living with dementia and disabilities • condition, appearance and maintenance of the hospital buildings A comprehensive internal environmental audit is undertaken and reported to the Patient Experience Council. Workplace inspections and COSHH risk assessments in place. Waste Management Policy in place with regular awareness raising and training provided for staff. Security service provided 24 hours per day and Lone Worker Policy in place.	

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Further actions to strengthen compliance if required
8	16 - Receiving and acting on complaints	All staff to know how to respond when receiving a complaint. Effective and accessible system for identifying, receiving, handling and responding to complaints, with full investigation and actions taken. Providers must monitor complaints over time looking for trends and areas of risk.	**Responsive**	Quality	DoNMG		Staff aware of how to manage complaints at a local level, including local resolution where possible, with involvement of PALS. Improvements to the management of complaints remain ongoing, with effective system in place via Datix for recording and monitoring each complaint. Themes and actions taken identified and reported to Patient Experience Council and the Quality Committee, to support Trust-wide lessons learned.	

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Further actions to strengthen compliance if required
9	17 - Good governance	Robust assurance and auditing processes in place to drive improvement in quality and safety, health, safety and welfare of patients and staff. Effective communication system for users/staff/ regulatory bodies/ stakeholders so they know the results of reviews about the quality and safety of services and actions required.	**Well-led,** Responsive	Board	CEO		An annual Board effectiveness review is undertaken, including a review of the Board Committees and the outcomes are considered by the whole Board. Progress in delivering the Trust's objectives is reported to the Board annually and these are then refreshed for the next year. The Board and its committees review key performance indicators via the integrated performance report (IPR) monthly, identifying areas where compliance could be improved to target actions appropriately. MIAA review the governance arrangements within the Trust, including compliance with the CQC processes. External Audit review the annual governance statement. The Trust complies with the NHS Publication scheme, with an internal team briefing system in place to ensure staff are aware of the results of external reviews. Ward accreditation scheme in place (Quality Care Assessment Tool – QCAT) that is aligned to CQC standards. This was supplemented with a programme of quality reviews in 2018. CQC noted that there was effective staff engagement in the development of the Trust's vision and values, which were widely understood across the organisation. In relation to Marshalls Cross Medical Centre actions have been taken to put in place; • Audit programmes to monitor quality and identify areas for improvement • Undertake risk assessments	

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Further actions to strengthen compliance if required
10	18 - Staffing	**Sufficient numbers** of suitably qualified, competent, skilled and experienced persons deployed to meet CQC requirements.	**Safe, Effective**	Workforce Council	DoHR		Comprehensive workforce strategy in place supported by Recruitment and Retention Strategy, including targeting workforce hotspots and proactive international recruitment for both medical and nursing staff. The Trust has collaborated with Masaryk University, Brno, Czech Republic to recruit 16 newly qualified doctors who trained using the English syllabus in 2018. There is an active recruitment programme for the nursing and midwifery workforce, on-going throughout the year. The Trust is exploring all possible opportunities to attract and retain nurses, midwives, operating department practitioners (ODPs) and allied health professionals: • On-boarding/retention of new and existing staff including flexible working, self-rostering, itchy feet discussions, career clinics, assigning a buddy, welcome pack/information, retire and return initiatives • Delivering apprenticeship programmes from local health care cadets at further education colleges through to part-time registered nurse degrees and OPD apprenticeships • Implementation of the new nursing associate role, with 16 trainees commencing the programme in 2019 • Implementing the STHK Preceptorship, Mentorship and Leadership three year foundation programme to enhance retention, which will be updated in line with new Nursing and Midwifery Council (NMC) standards, 121 nurses on the programme from April 18-March19 • Implemented e-rostering for allied health professionals to ensure the most effective rostering and planning of work There is a comprehensive workforce performance dashboard, which enables detailed monitoring/oversight. A safer staffing report is presented every month to the Board, with detailed staffing review reported to the Board including nurse establishment and patient acuity. In relation to Marshalls Cross Medical Centre action has been taken to ensure sufficient numbers of suitably qualified, competent, skilled and experienced people to provide formal clinical leadership.	

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Further actions to strengthen compliance if required
11	19 - Fit and proper persons employed	Staff to be of good character with appropriate qualifications, competence, skills and experience ie all staff are fit and proper – honest, trustworthy, reliable and respectful	**Well-led**	Workforce Council	DoHR		Effective procedures in place for pre-employment and on-going revalidation of relevant staff. The Trust has range of HR policies and procedures in place. Staff are aware of the requirement to raise any concerns about patient care and anything that may affect them personally in fulfilling their duties. MIAA review recruitment as part of ongoing audit cycle to provide external assurance on compliance with policy and procedure.	
No FS maps to this regulation	20 - Duty of candour	Open and transparent with people who use services/people acting lawfully on their behalf. Promote culture of openness, transparency at all levels, with focus on safety to support organisational and personal learning. Actions taken to ensure bullying and harassment is tackled in relation to duty of candour.	**Safe**	Quality Committee	DoNMG		Electronic reporting system, Datix, amended to include mandatory field to confirm compliance with Duty of Candour Compliance included in serious incident Board report Training is provided to staff within the following training programmes: • Trust's induction. • Mandatory training • Root cause analysis training There are a number of routes for raising concerns across the Trust, including speak in confidence electronic system launched in 2016-17 as a route for staff to report concerns anonymously. Assistant Director of Patient Safety appointed as Freedom to Speak Up Guardian, with 4 additional guardians to ensure staff have wide access. CQC confirmed in their inspection report that the Trust has good systems in place to fulfil its obligations in relation to the Duty of Candour Regulations.	

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position	Further actions to strengthen compliance if required
No FS maps to this regulation	20A - Requirement as to display of performance assessments	Notify via all websites and in each premise where services are provided the latest CQC rating, including principal premises. The information is to include the CQC's website address and where the rating is to be found and for each service/premise the rating for that service/premise.	**Responsive,** Well-led	Executive	DoCS		Ratings available on internet with links to the full reports using the CQC widget. Full list of clinics and sites where services provided collated for staff to display ratings in individual clinics.	

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)28
Title of paper: Elimination of Mixed Sex Accommodation - Declaration
Purpose: To provide assurance to the Trust Board that the Trust has complied with the national guidance to eliminate mixed sex accommodation.
Summary: All Trusts are required to make annual declaration confirming compliance with the guidance in relation to elimination of mixed sex accommodation. Failure to comply with the guidance could result in significant financial penalties for breach of contractual standards, unless it would be in the overall best interests of the patient or is their personal choice. The annual declaration must be published on the Trust website. For 2018/19 there have been no mixed sex breaches reported and the Trust is able to make the annual declaration.
Corporate objectives met or risks addressed: Safe and effective care
Financial implications: Financial penalties apply if breaches occur
Stakeholders: All staff and external partners
Recommendation(s): The Board approves the declaration of compliance in relation to the elimination of mixed sex accommodation
Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance
Date of meeting: 27th March 2019

Eliminating Mixed Sex Accommodation Declaration

1. Background

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

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

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

1.4 The Trust can continue to declare its compliance for 2018/19.

2. Declaration of Compliance

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

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

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

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

3. Data collection and performance

3.1 2018/19 year to date there has been zero mixed sex breaches reported via Unify (the national reporting system).

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

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

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

4. Current Situation

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

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

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

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

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

5. Patient experience

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

6. Recommendation

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

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)29
Title of paper: 2018 NHS Staff Survey Trust Board Report
Purpose: To provide the Trust Board with an overview of the outcomes of the Staff Survey for 2018 and recommended actions.
Summary: This paper highlights the outcome from the 2018 staff survey which is overwhelmingly positive. Under the new reporting scheme, the Trust has recorded best score nationally for 6 out of the 10 themes and second best nationally for 2 out of the 10. The five year look back revealed progress on 8 of the 10 themes since 2017, with scores for 2 of the themes significantly higher than 2017. There are some areas of concern which will form the basis of the 2019-2020 action plan, most notably: The quality of appraisals, health & wellbeing and violence by patients on staff.
Corporate objectives met or risks addressed: Developing Organisational Culture and supporting our workforce, Safety, Communication
Financial implications: No new financial requirements from this paper
Stakeholders: Staff, Staff Side colleagues, Service users, Line Managers, CCG, CQC.
Recommendation(s): Members are asked to approve: The Board is requested to note the outcomes and accept for progression into a detailed milestone plan interventions to address the proposed actions.
Presenting officer: Anne-Marie Stretch, Director of HR & Deputy CEO
Date of meeting: 27th March 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

2018 NHS Staff Survey Report

1. INTRODUCTION

304 NHS organisations in England took part in the 2018 NHS Staff Survey. Over 1.1 million NHS staff where invited to participate using an online or postal self-completion questionnaire. Responses were received from over 497,117 NHS staff, a response rate of 46% (45% in 2017). All full-time and part-time staff that were directly employed by an NHS organisation on 1st September 2018 were eligible.

The survey, administered on our behalf by Quality Health, was sent to a sample of 1250 staff determined by the total number of staff employed on a national sliding scale. The sample was generated at random from all those employed on 1st September 2018 and included those on maternity leave. The official sample size for the Trust was the same as in 2017.

St Helens and Knowsley Teaching Hospitals NHS Trust (STHK/ the Trust) took part in the survey throughout October and November 2018, the results of which were published nationally on 26th February 2019.

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

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

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

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

http://www.nhsstaffsurveyresults.com/

2. QUESTIONNAIRE CONTENT

The core questionnaire used for the 2018 survey has been updated with additional questions introduced which now feed into the new reporting scheme.

Following feedback from NHS organisations regarding ongoing issues with key finding based reporting, such as inconsistency in the scale, large numbers of KFs, demand for faster results, the 32 key findings have been replaced by the below 10 themes.

- Equality, diversity & inclusion
- Health & wellbeing
- Immediate managers

• Morale
• Quality of appraisals
• Quality of care
• Safe environment - Bullying & harassment
• Safe environment - Violence
• Safety culture
• Staff engagement

The themes are positively scored on a 0 to 10 point scale, a higher score indicating a better result. The list of questions feeding into each theme is presented in Appendix 1. There are also a number of questions which are reported independently.

In addition to the new themes, question-level data is presented in the updated benchmark reports for all questions included in the core questionnaire. The question-level results are reported as percentages.

3. RESPONSE RATE

3.1 Local

625 completed questionnaires were returned from an initial sample of 1250. The response rate to the Staff Survey was therefore **51%** (625 usable responses from a final sample of 1,231). As in 2017, the response rate is **best in the North-West.**

3.2 National

The average national response rate for Acute Trusts in England was 44%, 7% less than that of St. Helens & Knowsley Teaching Hospitals, which places the Trust in the **highest (best) 20%** nationally, with the highest response rate being 72%.

3.3 Respondent Demographics

The 625 respondents comprised the following groups:

Gender	%	Age	%
Male	19	66+	1
Female	79	51-65	37
Prefer to self-describe	1	41-50	25
		31-40	20
		21-30	15

Ethnicity	%	Sexual orientation	%
White	93	Heterosexual	92
Asian/Asian British	4	Gay man	1
Black/ Black British	1	Bisexual	1
Chinese and other ethnic groups	1	Prefer not to say	5

Religion	%	Physical or mental health conditions	%
No religion	27	Yes	18
Christian	67	No	82
Hindu	1		
Muslim	1		
Any other religion	1		
Prefer not to say	3		

Length of Service	%	Occupational Group	%
More than 15 years	35	AHP, Scientist, Technical	22
11-15 years	13	Medical & Dental	6
6-10 years	12	Nurses & Midwives	27
3-5 years	17	Healthcare Assistants	11
1-2 years	15	Wider Healthcare Team	31
Less than 1 year	8	General Management	1
		Other occupational group	2

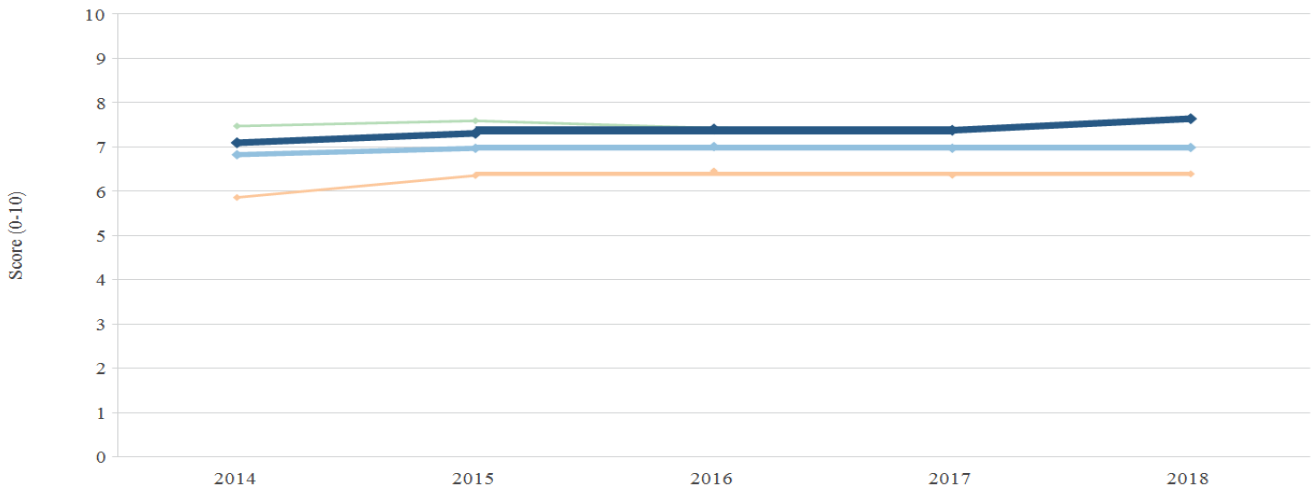
4.0 RESULTS

4.1 Overall Staff Engagement

Staff Engagement is calculated as an average from the scores of the following three sub-sections:

- Advocacy (staff recommendation of the trust as a place to work or receive treatment);
- Motivation (staff motivation at work);
- Involvement (staff ability to contribute towards improvement at work).

Scores fall between 0 and 10, where the higher the score, the more engaged the staff.



	2014	2015	2016	2017	2018
Best	7.5	7.6	7.4	7.4	7.6
StHK	7.1	7.3	7.4	7.4	7.6
Average	6.8	7.0	7.0	7.0	7.0
Worst	5.9	6.4	6.5	6.4	6.4

Fig.1

The above graphics indicate that our trust has the **best score nationally** for the third consecutive year, with a significant improvement since 2014.

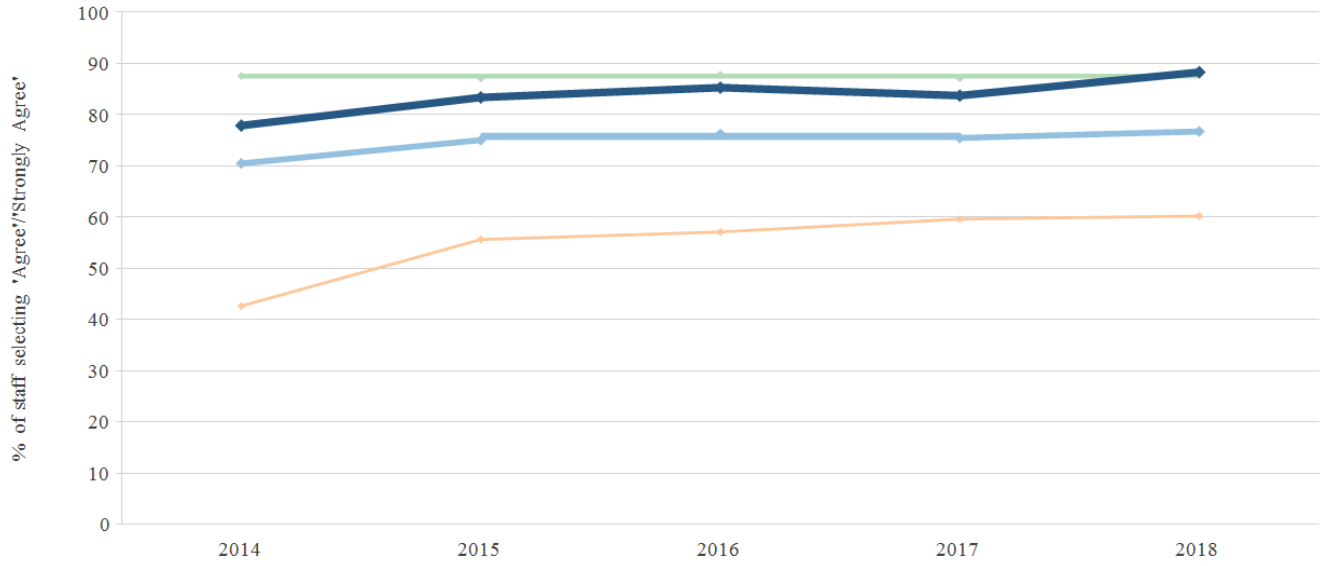
The most notable contributory responses to this overall indicator of staff engagement are the 'Staff Friends and Family test questions, staff members' willingness to recommend the Trust as a place to work and staff members' willingness to recommend the Trust as a place to receive care treatment", for which the Trust returned the **best scores nationally,** 81% and 87.3% respectively.

4.2 Patient Focus

88.3% of staff agreed that care of patients/service users is the organisation's top priority, the **best nationally** for acute trusts.

Responses to this question contribute to the Advocacy sub-section.

The five year look back (Fig.2) shows a 10.4% score increase since 2014, further underlining the Trust's commitment to placing the patient at the centre of all we do.



	2014	2015	2016	2017	2018
Best	87.6%	87.1%	87.8%	87.1%	88.3%
StHK	77.9%	83.4%	85.3%	83.7%	88.3%
Average	70.5%	75.0%	76.2%	75.5%	76.7%
Worst	42.6%	55.6%	57.1%	59.6%	60.2%

Fig. 2

4.3 Themes

4.3.1 Results

Out of the 10 themes, the Trust holds the **best score nationally** for 6 and second best nationally for 2, with the remaining 2 themes performing above the national average.

Fig.3 also indicates a positive trend since 2014 on 4 themes (Equality, diversity & inclusion; Safe environment – Violence; Safety culture; Staff engagement), the latter having the highest increase in the last 5 years, from 7.1 to 7.6. Also, 8 theme scores are higher than the 2017 ones, with Safety Culture and Staff Engagement significantly improved since last year.

Morale

In the 2018 survey, a measurement for staff morale was introduced. The Trust has obtained the **best score nationally,** which is 6.7.

Theme	Score (where measured)					Current national position
	2014	2015	2016	2017	2018	
Equality, Diversity & Inclusion	9.3	9.4	9.4	9.4	9.6	Best nationally
Morale	-	-	-	-	6.7	Best nationally
Quality of Care	-	8.1	8.2	7.9	8.1	Best nationally
Safe Environment – Bullying & Harassment	-	8.4	8.5	8.3	8.5	Best nationally
Safety Culture	-	7.0	7.0	7.0	7.2	Best nationally
Staff Engagement	7.1	7.3	7.4	7.4	7.6	Best nationally
Immediate Managers	-	7.0	7.1	7.0	7.2	Second best nationally
Safe Environment – Violence	-	9.3	9.3	9.4	9.5	Second best nationally
Health & Wellbeing	-	6.6	6.8	6.6	6.5	Better than national average
Quality of appraisals	-	5.5	5.8	5.6	5.7	Better than national average

Fig.3

4.3.2 Notable data contributing to the themes

The most notable scores from the questions used to create the 10 themes are detailed below:

Q.5a (The recognition I get for good work): the 2018 score of 62.5% has improved by 7.7% since 2017, whilst the national average improvement was 3.6%;

Best	65.6%
StHK	62.5%
Average	55.6%
Worst	46.6%

Q.12c (In the last 12 months, how many times have you personally experienced physical violence at work from other colleagues?): significantly and constantly improved since 2015, the 2018 score of 0.6% is the **best score nationally**:

Worst	6.5%
StHK	0.6%
Average	1.6%
Best	0.6%

Q.13c (In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?): although the national average score has decreased, the Trust score of 11.7% has improved and is the **best nationally**;

Worst	28.4%
StHK	11.7%
Average	20.0%
Best	11.7%

Q.15a (In the last 12 months, have you personally experienced discrimination at work from patients/service users, their relatives or other members of the public?): the Trust score has improved since 2017 from 5.0% to 2.8%, being just 0.1% lower the best national score;

Worst	16.4%
StHK	2.8%
Average	6.1%
Best	2.7%

Q.21b (My organisation acts on concerns raised by patients/service users): the Trust 2018 score is the highest in the last 5 years and only 0.7% lower than the best score nationally:

Best	84.6%
StHK	83.9%
Average	72.6%
Worst	56.6%

Q.21c (I would recommend my organisation as a place to work): in addition to retaining the **best score nationally** for the third consecutive year, the 2018 score is at its highest level in the last 5 years, significantly improved since 2017 by 4.1%:

Best	81.0%
StHK	81.0%
Average	62.6%
Worst	39.2%

Q.21d (If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation): constantly and significantly improving since 2014, the 2018 score is the **best nationally,** with 10.8% higher than 5 years ago:

Best	87.3%
StHK	87.3%
Average	71.3%
Worst	39.8%

4.5 Whilst the overwhelming majority of responses are extremely positive, there are 3 themes for which the results are not as we would wish.

4.5.1. Quality of appraisals.

Although it does not form part of the theme score, it is worth noting that 89.8% of staff reported having an appraisal in the last 12 months, thus underlining the Trust's focus to increase the compliance rate. This is a significant improvement on 2017, whilst the best national score has slightly decreased since last year. It is also the highest score recorded by our Trust in the last 5 years. The theme score has been established by taking into consideration the 'yes, definitely' answers only to the 4 questions, although a significant

number of staff have also chosen the 'yes, to some extent' option, which contributes to the overall positive score, which was 73%.

The Trust's score of 5.7 indicates that the percentage of respondents reporting improvement of quality has increased very slightly since 2017, the staff reporting the least positive experience in relation to their appraisal are predominantly from Corporate Services based at Alex Park, Medirest Whiston, Medicines Management and Community Services St Helens.

4.5.2 Health & wellbeing.

The theme score of 6.5 has decreased by 0.1 since 2017, placing the Trust second/third nationally, only 0.2 below the best score. 46.7% of staff definitely agree that our organisation takes positive action on health & wellbeing, this is the best score nationally. 24.7% of respondents have experienced MSK problems as a result of work activities in 2018, 3.6% higher than in 2017 and 4.5% below the national best. 30.6% of respondents have felt unwell as a result of work related stress and 52.7% have come to work despite not feeling well enough to perform their work duties. The data analysis carried out shows that our efforts to improve the wellbeing should be mainly channelled towards surgeons based at Whiston Hospital, admin & clerical staff from Alex Park, as well as those working at Medirest Whiston, Medicines Management and Community Services St Helens.

4.5.3 Safe environment - violence

Although the Safe environment – Violence theme score of 9.5 is the highest since 2015 and second best nationally, and the percentage of staff experiencing physical violence at work from patients/services users has decreased by 2.8, the score of 15.8% is still below the national average of 14.3%. Data analysis revealed a high percentage of respondents from Medical Care Group based at Whiston and St Helens hospitals (43% and 65% respectively) have experienced violence from patients. These respondents mainly belong to the nursing/midwifery, additional clinical services and medical/dental staffing groups.

All the above three areas have the potential to impact on staff morale, therefore it is imperative that we take steps to address the performance in these questions. Relevant actions will be included as part of the action plan, an outline of which is included at Appendix 3.

5.0 CONCLUSIONS AND RECOMMENDATIONS

The Trust has worked hard over the last 12 months in the delivery of the 2018-19 staff survey action plan and to engage with, support and develop its workforce and would like to recognise the progress made in what continues to be an extremely challenging operational environment.

Following the successful implementation of the 2017-2018 survey action plan, 7 out of the 8 indicators have improved, with the most notable results listed below:

- the number of staff experiencing bullying & harassment from work colleagues has decreased to 11.7%, which is now the best national score;
- improvements leading to best national scores have also been recorded for staff satisfaction with the quality of work and care they are able to deliver (4.28), as well as with the percentage of staff agreeing that their role makes a difference to patients and service users (93%);

- the percentage of respondents appraised has increased by 5.7% to 89.8%, which is the highest score for the last 5 years. This places the Trust at 2.1% above the national average and 5.7% behind the best national score.

The Trust will remain committed to reduce the number of staff working extra hours, as the percentage of respondents working paid extra hours has increased by 2% since 2017, to 43.1%, with focus on the following staffing groups: medical/dental, AHPs and additional professional and scientific.

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

Appendix 3 details the suggested action points, based on those areas where the Trust has responded less favourably when compared to similar organisations. The headline areas recommended for the Board to keep under close review throughout the year are highlighted below and progress will be monitored monthly as part of the combined workforce report through the Workforce Council. Whilst some of the areas of focus are consistent with those from the previous survey results, it should be recognised that progress has been made with the Trust improving its position across a wide range of measures and maintaining its excellent performance when compared to 'like' organisations.

5.1 Publicising the results

Results were presented to staff and managers by Quality Health on 20th March 2018, it is important that staff see the benefits of participating in this survey and are aware both of the outcomes from the Staff Survey and the resultant actions. In support of this, with the support of the Media and Communications team, the results of the staff survey will be publicised through all available channels including:

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

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

6.0 Action required by the Board

The Trust Board are asked to note the content of this report and to approve and support the recommendations. Actions to address the limited areas of concern will be incorporated into the Combined Workforce Action Plan for 2019-2020. This will be monitored by the Workforce Council and assurance of delivery will be provided to the Quality Committee as part of the Board Governance Assurance Framework.

APPENDIX 1 – Questions feeding into the 10 themes

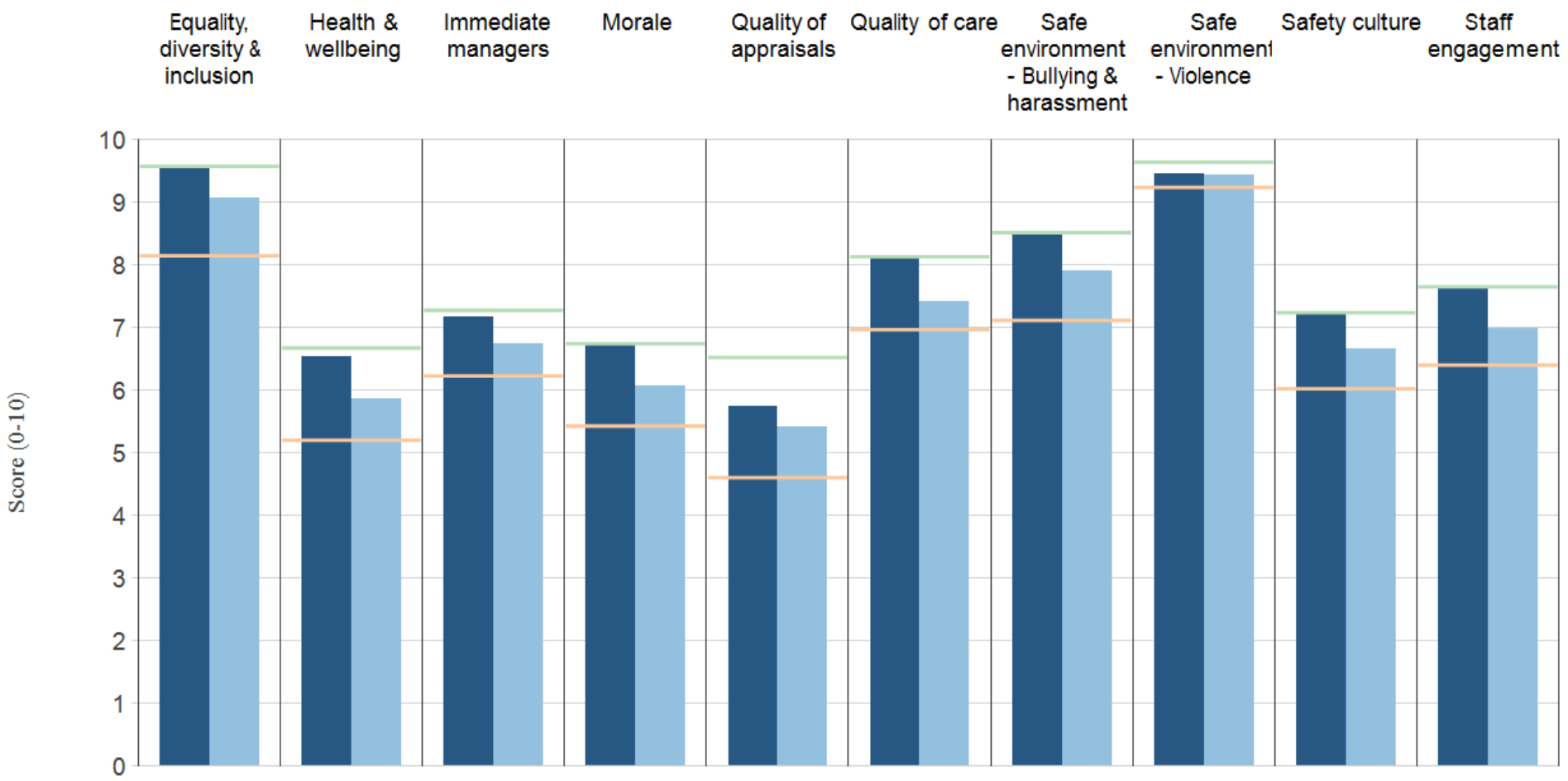
Theme	Questions	%		
		StHK	Best	Av.
1. Equality, diversity & inclusion	“Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?”	94.3	94.3	83.9
	“In the last 12 months have you personally experienced discrimination at work from any of the following? Patients / service users, their relatives or other members of the public”	2.8*	2.7	6.1
	“In the last 12 months have you personally experienced discrimination at work from any of the following? Manager / team leader or other colleagues”	3.7*	3.4	7.7
	“Has your employer made adequate adjustment(s) to enable you to carry out your work?"	81	84.8	72
2. Health & wellbeing	"How satisfied are you with the opportunities for flexible working patterns?"	55.2	60.4	51.9
	“Does your organisation take positive action on health and well-being?”	46.7**	46.7	27.8
	“In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?”	24.7*	20.2	28.7
	“During the last 12 months have you felt unwell as a result of work related stress?”	30.6*	28.9	38.9
	“In the last three months have you ever come to work despite not feeling well enough to perform your duties?”	52.7*	47.6	56.9
3. Immediate managers	“How satisfied are you with each of the following aspects of your job? The support I get from my immediate manager.”	77	77.4	68.6
	“My immediate manager gives me clear feedback on my work.”	66.7	69.2	60
	“My immediate manager asks for my opinion before making decisions that affect my work."	59.9	61.3	54.1
	“My immediate manager takes a positive interest in my health and well-being.”	71.7	74	67
	“My immediate manager values my work.”	75.5	78.5	71.1
	“My manager supported me to receive this training, learning or development.”	60.5	66.1	54.1
4. Morale	“I am involved in deciding on changes introduced that affect my work area / team / department.”	56	62.2	52.6
	“I receive the respect I deserve from my colleagues at work.”	79	79	70.9
	“I have unrealistic time pressures.”	28.3	28.3	21.1
	“I have a choice in deciding how to do my work.”	60.5	61.1	54
	“Relationships at work are strained.”	55.5	55.5	42.9
	“My immediate manager encourages me at work.”	73.3	76.7	68.1
	“I often think about leaving this organisation.”	19.1*	19.1	29.9
	“I will probably look for a job at a new organisation in the next 12 months.”	15*	14	20.8
	“As soon as I can find another job, I will leave this organisation.”	9.6*	8.5	15.1

Theme	Questions	%		
		StHK	Best	Av.
5. Quality of appraisals	“It helped me to improve how I do my job.”	24.8**	35	23
	“It helped me agree clear objectives for my work.”	36.3**	46.3	34.7
	"It left me feeling that my work is valued by my organisation."	33.9**	42.5	32.3
	“The values of my organisation were discussed as part of the appraisal process."	41.9**	52.5	35.1
6. Quality of care	“I am satisfied with the quality of care I give to patients / service users.”	89.4	89.4	80.1
	“I feel that my role makes a difference to patients / service users”	92.7	92.9	89.5
	“I am able to deliver the care I aspire to”	80.9	80.9	66.9
7. Safe environment - Bullying & harassment	“In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public”	24.7*	22.1	28.4
	“In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Managers”	8.8*	8	13.7
	“In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Other colleagues”	11.7*	11.7	20
8. Safe environment - Violence	“In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives or other members of the public”	15.8*	10.1	14.3
	“In the last 12 months how many times have you personally experienced physical violence at work from...? Managers	0.3*	0	0.7
	“In the last 12 months how many times have you personally experienced physical violence at work from...? Other colleagues”	0.6*	0.6	1.6
9. Safety culture	“My organisation treats staff who are involved in an error, near miss or incident fairly.”	63.4	69.5	58.5
	“When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.”	82.3	82.3	69.9
	“We are given feedback about changes made in response to reported errors, near misses and incidents.”	70.2	72	58.9
	“I would feel secure raising concerns about unsafe clinical practice.”	73.8	76.7	69.2
	“I am confident that my organisation would address my concern.”	68.5	69.5	56.8
	“My organisation acts on concerns raised by patients / service users.”	83.9	84.6	72.6
10. Staff engagement	“I look forward to going to work.”	66.9	67.6	59.3
	“I am enthusiastic about my job.”	81.7	81.7	74.8
	“Time passes quickly when I am working.”	83.4	83.4	76.8
	“There are frequent opportunities for me to show initiative in my role.”	77.7	80	72.5
	“I am able to make suggestions to improve the work of my team / department.”	78.8	83.5	74.5
	“I am able to make improvements happen in my area of work.”	60.1	65.9	56.1
	“Care of patients / service users is my organisation's top priority.”	88.3	88.3	76.7

Theme	Questions	%		
		StHK	Best	Av.
	“I would recommend my organisation as a place to work.”	81	81	62.6
	“If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.”	87.3	87.3	71.3

* the lower the score the better
** ‘yes, definitely’ answers only

APPENDIX 2 – National benchmarking of theme results



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
StHK	9.6	6.5	7.2	6.7	5.7	8.1	8.5	9.5	7.2	7.6
Average	9.1	5.9	6.7	6.1	5.4	7.4	7.9	9.4	6.6	7.0
Worst	8.1	5.2	6.2	5.4	4.6	7.0	7.1	9.2	6.0	6.4

APPENDIX 3 – Staff Survey recommended actions 2019-2020

Medical Care Group Whiston			
Recommendation	**Intervention**	**Lead**	**Anticipated deadline**
Percentage of staff experiencing physical violence at work from patients/service users	Review of incidences of patient on staff physical violence to determine causes. Implementation of effective measures to reduce violent incidences.	Carole Whewell, Head of Non-Clinical Risk	June 2019
Staff suffering work related Musculo-skeletal injuries	Review of staff absent as a result of MSK to identify current causes, focusing on Community Services St Helens. Development of planned interventions to reduce the incidents of staff suffering work related MSK.	Linda Lewis, Assistant Director of Health Work and Wellbeing	July 2019
Quality of appraisals	Review data in relation to appraisals completed and quality, in particular focusing on Community Services St Helens.	Adam Rudduck, Assistant Director of Organisation Development	July 2019

Surgical Care Group Whiston			
Recommendation	**Intervention**	**Lead**	**Anticipated deadline**
Staff suffering work related Musculo-skeletal injuries	Review of staff absent as a result of MSK to identify current causes. Development of planned interventions to reduce the incidents of staff suffering work related MSK	Linda Lewis, Assistant Director of Health Work and Wellbeing	July 2019

Clinical Support Services / Corporate Services			
Recommendation	**Intervention**	**Lead**	**Anticipated deadline**
Staff suffering work related musculo-skeletal injuries	Review of staff absent as a result of MSK to identify current causes. Focusing on admin & clerical staff at Alex Park, Medirest Whiston Development of planned interventions to reduce the incidents of staff suffering work related MSK	Linda Lewis, Assistant Director of Health Work and Wellbeing	July 2019
Quality of appraisals	Review data in relation to appraisals completed and quality, in particular focusing on Corporate Services Alex Park, Medirest Whiston and Medicines Management	Adam Rudduck, Assistant Director of Organisation Development	July 2019

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