St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Public Board Meeting

TO BE HELD ON WEDNESDAY 29TH MAY 2019
IN THE BOARDROOM, LEVEL 5, WHISTON HOSPITAL

AGENDA				Paper	Presenter
09:30	1.	Employee of the Month		Verbal	Chair
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 24th April 2019		Attached	
		5.1	Correct Record & Matters Arising	Verbal	
		5.2	Action Log	Attached	
Performance Reports					
10:10	6.	Integrated Performance Report		NHST(19) 39	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) 40	Ann Marr
10:40	8.	Committee Report – Quality		NHST(19) 41	Val Davies
10:50	9.	Committee Report – Finance & Performance		NHST(19) 42	Jeff Kozer
BREAK					
11:10	10.	Committee Report – Audit		NHST(19) 43	Su Rai
		10.1	Adoption of Annual Accounts	NHST(19) 44	

Other Board Reports				
11:20	11.	Quarterly Complaints, Claims and Incidents report	NHST(19) 45	Sue Redfern
11:30	12.	Approval of Quality Account	NHST(19) 46	Sue Redfern
11:40	13.	Single Oversight Framework: Annual Board Declarations	NHST(19) 47	Nicola Bunce
11:45	14.	Board and Committee Effectiveness Review	NHST(19) 48	Nicola Bunce
11:55	15.	Information Governance Annual Report	NHST(19) 49	Christine Walters
12:05	16.	Trust Objectives 2018/19 and End of Year Review	NHST(19) 50	Ann Marr
Closing Business				
12:20	17.	Effectiveness of Meeting	Verbal	Chair
	18.	Any Other Business		
	19.	Date of Next Meeting – Wednesday 26th June 2019		

St Helens and Knowsley Teaching Hospitals NHS Trust

Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Board meeting held on Wednesday 24th April 2019 in the Boardroom, Whiston Hospital

PUBLIC BOARD

Chair:	Mr R Fraser	(RF)	Chairman
Members:	Ms A Marr	(AM)	Chief Executive
	Mr D Mahony	(DM)	Non-Executive Director
	Ms S Rai	(SR)	Non-Executive Director
	Mr J Kozer	(JK)	Non-Executive Director
	Mr P Growney	(PG)	Non-Executive Director
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Prof K Hardy	(KH)	Medical Director
	Mrs S Redfern	(SRe)	Director of Nursing, Midwifery & Governance
	Mr N Khashu	(NK)	Director of Finance
	Mrs C Walters	(CW)	Director of Informatics
	Ms N Bunce	(NB)	Director of Corporate Services
	Mr R Cooper	(RC)	Director of Operations & Performance
	Dr T Hemming	(TH)	Director of Transformation
In Attendance:	Ms J Byrne	(JBy)	Executive Assistant *(Minute Taker)*
	Cllr A Lowe	(AL)	Halton Council *(Co-opted member)*
	Mr K Lomas	(KL)	Local Democracy Reporter for St Helens Star
	Ms L Thomas	(LT)	Senior Communications Officer, STHK
Apologies:	Mrs V Davies	(VD)	Non-Executive Director
	Mr T Foy	(TF)	Governing Body Lay Member, St Helens CCG *(Co-opted member)*

1. Employee of the Month

The Employee of the Month Award for April 2019 was presented by RF to James Lewis, Ward Manager, Ward 4F (Paediatrics).

2. Apologies for Absence

Apologies were noted as above.

3. Declaration of Interests

There were no declarations of interest.

4. Minutes of the previous meeting held on 27th March 2019

4.1. Correct Record

4.1.1. The minutes were accepted as a correct record, once the following changes were made:

4.1.2. Minute 10.7 on page 9 was amended to include the word “received”;

4.1.3. Minute 17.3 – the minute should be amended to reflect that the Trust, New Hospitals and Vinci Facilities - Combined Heat and Power Plant – was also shortlisted for the Property and Estates Management Service Provider of the Year.

4.2. **Action List**

4.2.1. Minute 12.7 (25.07.18) - Corporate departments to be included in the QWR schedule – SRe confirmed the meeting schedule had been updated.

4.2.2. Minute 11.8 (27.03.19) – analysis of 40% increase in turnover since 2012 – NK confirmed this analysis would be presented at the Finance & Performance Committee meeting in May.

5. Integrated Performance Report (IPR) – NHST(19)30

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

5.2. **Quality Indicators**

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

5.2.2. There had been no never events in March and one reported during the year (in July 2018).

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

5.2.4. In March (month 12), there were 4 C.Diff positive cases reported, making the total for the year 21 cases, however a number were still subject to appeal. The annual tolerance was 40.

5.2.5. There were no grade 3 or 4 avoidable pressure ulcers reported in month or the year.

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

5.2.7. There had been 1 fall resulting in severe harm in February and 14 reported in the year to date.

5.2.8. Venous thromboembolism (VTE) assessment performance for February 2019 was 96.24%. Year to date performance was 95.97% against a target of 95%.

5.2.9. HSMR (April to November) for 2018/19 was 94.3.

5.3. Operational Indicators

5.3.1. RC presented the update on the operational performance.

5.3.2. All cancer performance was reported a month behind due to the validation process, so the figures related to February. The 62-day cancer standard was below the target of 85.0% at 82.6% for the month, but the year-to-date performance remained above target at 88.2%. Detailed discussions had taken place in both Quality and Finance & Performance Committees to understand the dip in performance, which was attributed to patients rearranging appointments, complex (including multiple Trusts) pathways and access to diagnostics.

5.3.3. The 31-day cancer target was achieved with 97.7% performance against a target of 96%.

5.3.4. The 2-week cancer standard was also achieved with 96.0% against a target of 93%.

5.3.5. A&E access time performance was 72.6% in March (type 1) and the all types mapped footprint performance was 85.9%. Board members noted the sustained and continuing increase in attendances and RC confirmed that in-depth discussions in relation to A&E and cross-organisation working to review the whole patient journey was ongoing at the Executive level with detailed assurance reports to the Finance & Performance Committee.

5.3.6. Whiston A&E had the highest volume of ambulance attendances in Cheshire & Merseyside and Great Manchester during March. Ambulance notification to handover time was 12:48 minutes on average, against a target of 15 minutes. Whiston had achieved this target for 10 of the last 12 months.

5.3.7. The average number of Super Stranded patients (patients with a length of stay of greater than 21 days) during March 2019 was 115 compared with 154 in March 2018, which was a 25% reduction year on year. New targets had been set by NHSE/I for 2019/20 and discussions were ongoing with local system partners to plan how they could be achieved.

5.3.8. The 18-week referral to treatment target (RTT) was achieved in February 2019 with 93.2% (target = 92%). The 6-week diagnostic target was also achieved with 99.9% (target = 99%). There were no patients on the waiting list for over 52 weeks.

5.3.9. DM congratulated the A&E team for dealing with the high number of attendances. It was noted there had been 425 attendances at the A&E Department the previous day. DM asked if the Trust had corridor patients and RC confirmed that this was monitored and reported to NHSE/I every day and although there were occasions when patients had to wait in the corridor, there were no patients treated in corridor.

5.4. **Financial Indicators**

5.4.1. NK gave a verbal update on the outturn financial position as a full finance report was not produced in April, due to year end.

5.4.2. The draft accounts for 2018/19 had now been submitted. In line with the agreed plan the Trust had achieved a deficit of £6m; however the previous week the Trust had been notified that it had been allocated a further £5.1m to support the year end position, which meant the Trust would now be reporting a £0.5m deficit.

5.4.3. Agency spend of £8.2m was an improvement on the previous year.

5.4.4. The Trust had transacted £14.9m CIP in the year, which was 3.8% of turnover.

5.4.5. NK confirmed the Finance & Performance and Audit Committees had been made aware of an asset lives depreciation guidance interpretation which resulted in a risk of £0.5m to the Trust.

5.4.6. NK also gave an update on the 2019/20 contract discussions with commissioners and the areas where final agreement was still needed.

5.5. **Workforce Indicators**

5.5.1. AMS presented the update on the workforce indicators.

5.5.2. Absence in March was 5.2%. AMS confirmed the sickness rate was in line with other acute trusts, however, a task and finish group was working through a number of ideas to improve attendance that had been generated at a recent workshop.

5.5.3. SR queried whether the target for 2019/20 would be 4.5%. AMS confirmed that she felt the Trust should have an ambitious target and 4.5% would represent a significant reduction compared to 2018/19.

5.5.4. Qualified nursing and HCA sickness was 5.6% in March. Qualified Nursing and Midwifery sickness was 4.5%.

5.5.5. Mandatory training compliance for the core skills framework subjects was 95.3% (target = 85%). Appraisal compliance was 89.6% which was above the target of 85%.

6. Committee Report – Executive – NHST(19)31

6.1. AM presented the report summarising the key issues considered by the Executive Committee at meetings held during March 2019. The key issues highlighted to the Board from the report were:

6.2. Business Case for international recruitment – this funding had been approved because of the importance of maintaining safe staffing levels, and international recruitment had been successful in bringing new clinical staff to the Trust, who had integrated well into the ward teams. The business case to continue

funding this small specialist recruitment team was therefore very compelling for patient safety and financially because of the savings on bank and agency staff. RF believed the greatest advertisement for the Trust was recommendation from friends and peers and believed the CQC 'Outstanding' rating would help encourage people to want to work for the Trust. He believed the pastoral support the Trust provided must have helped greatly in embedding staff into the Trust.

6.3. KH had noticed a palpable difference on wards during the last winter as a result of the additional nurses, which was reflected in the increased safer staffing rates and demonstrated that the capacity and demand modelling that had been undertaken had been accurate in predicting the staffing requirements. Board members agreed that this was a prudent investment.

6.4. Quality Matron Business Case – the fixed-term post was to be introduced to address an outcome from a recent patient survey asking for more information to be made available. The incumbent would also look at the best ways of communicating the information to patients.

6.5. Skin Cancer Service Business Case – the business case had been approved to expand the cancer nurse specialist and support worker establishment to respond to increasing demand and improve support for cancer patients.

6.6. Halton Urgent Treatment Centre (UTC) Procurement – the bid document and the financial modelling had been revisited by the Executive Committee in response to the late changes relating to the estates costs for the Runcorn UTC. The final bid had been submitted on 5th April and a decision on contract award by Halton CCG was expected in early June.

6.7. Sustainability and Transformation Capital – proposals to increase capacity for Same Day Emergency Care (SDEC) at Whiston Hospital with the £4m STP capital allocation were discussed. A number of working groups had been established to develop the detailed specifications for each area to feed into the final business case (FBC), that was required by NHSE/I.

6.8. DM asked if the regulators continued to monitor agency spend. AMS confirmed that the Trust continued to submit a weekly return to NHSE/I. SR believed progress made with the staff bank would also minimise the use of agency staff.

6.9. 5-Year Capital Plans – the new St Helens & Whiston hospitals were now 10 and 8 years old respectively and equipment was starting to need to be replaced. In response, a 5-year rolling capital programme was being introduced to provide oversight of the need for replacements and upgrades.

6.10. Following discussion about item 3.5 it was agreed that JK would meet with CW to review the role of the Non-Executive Directors on the Health Informatics Service (HIS) Board. **ACTION: JK/CW**

7. Committee Report – Quality – NHST(19)32

7.1. In the absence of VD, PG presented the Chair's report to the Board, which summarised key issues arising from the Quality Committee meeting held on 16th April and reports from the Patient Safety, Patient Experience and Clinical

Effectiveness Councils. There were no specific issues that had been identified for escalated to the Board, from the committee.

7.2. Maternity Survey - members reviewed progress against the action plan which had been developed following the 2018 national maternity survey. In order to evaluate the impact of the actions the maternity service had conducted a snapshot survey in April 2019 of all women seen by the service on one day.

7.3. DM commented that he had completed 3 Quality Ward Rounds with the Maternity unit during his time as a non-executive director and had observed their improvement journey over the years. AM reflected that continuous improvement was part of the culture of the organisation across all services.

7.4. The committee had received the draft Annual Quality Account for review.

7.5. The committee had received the results of the quarterly medicines storage and security audits. Performance across all areas was not consistent and the Director of Nursing was putting in place a series of daily, weekly and spot checks by the Heads of Nursing & Quality within the Care Groups, together with the Matrons and Ward Nurse Managers. NK confirmed the formal quarterly audits by the Medicines Management team would also continue for areas not demonstrating full compliance and the process extended to community services.

7.6. Annual Inpatient Survey Report - the committee received an analysis of the 2018 survey and the action plan that had been developed to address any areas where the Trust performed less well compared to previous years or the national average. The three key areas identified for focused actions were patient information, communication and person-centred care. AM highlighted that the new Quality Matron would be addressing these areas and commented that there continued to be a dissonance between the inpatient survey results and the friends and family test feedback from patients.

7.7. SR had attended the Walton Centre NHSFT Board meeting and had been asked how STHK Trust had achieved such a high flu staff vaccination rate (95%). Directors reflected it was likely to be attributable to a culture of acceptance and teamwork and a big message of collective responsibility to protect our patients, friends and family.

7.8. PG was aware that knife crime appeared to be increasing and asked whether more patients were attending A&E Department as a result. RC confirmed that the Trust had not seen an increase in numbers, but there had been local incidents and the Trust was actively engaged in initiatives with local schools to target 14 to 16 year olds and discuss the impact of knife crime. In addition, as part of a social media campaign for #NoMoreKnives in October 2018, the Trust had joined forces with colleagues across the region to promote the important message that knife crime was not welcome on our streets.

7.9. KH confirmed tackling the causes of knife crime was a priority for St Helens People's Board, the membership of which comprised NHS, local Government, police, fire and third sector organisations from across the borough.

7.10. PG reported on a recent quality ward round on ward 5A, which had been very impressive. One of the issues raised had been the consistency of medical staff cover. KH responded that junior doctors in training worked shifts and rotated through different departments and services to gain the experience they needed and the most important consideration for patient care was the quality of the handover between clinical teams.

7.11. The report was noted.

8. Committee Report – Finance & Performance – NHST(19)33

8.1. JK presented the Chair's report to the Board which summarised key issues arising from the Finance & Performance Committee meeting held on 18th April, which had included feedback from the Procurement Council and Capital Planning Council.

8.2. The Committee had reviewed the IPR and the actions being taken to improve the in-month performance against the 62-day cancer target, although the year-to-date performance had continued to exceed the national target.

8.3. Indicative year-end financial figures, subject to the submission of the annual accounts, were presented to the committee and the improved financial position noted.

8.4. The Committee was informed of the ongoing issue around asset revaluation. The 2018/19 financial figures currently assumed no impact. This issue remained under discussion with Trust auditors.

8.5. The Committee was updated on the current contractual sign off progress. Contracts were yet to be signed with two commissioners.

8.6. The Committee reviewed the presentation from the ADO for Urgent Care, Emergency Department Consultant, and Associate Medical Director. The Committee noted the detailed information included within the presentation and the increased level of assurance of being quantifiable outcomes.

8.7. The Committee had scrutinised the CIP plans for 2019/20 and was assured at the volume and value of schemes already rated as green.

8.8. Board members noted the report.

9. Committee Report – Audit – NHST(19)34

9.1. SR presented the Chair's report to the Board which summarised key issues arising from the Audit Committee meeting held on 17th April.

9.2. The external auditors reported that they were in the process of reviewing the draft accounts and did not foresee any significant issues.

9.3. Internal audit progress (MIAA) – several finalised reports were presented to the committee with updates on the recommended actions being given by the management leads.

9.4. Head of Internal Audit (MIAA) opinion 2018/19 on the internal control process was substantial assurance.

9.5. The anti-fraud annual report for 2018/19 and work plan for 2019/20 were received.

9.6. The committee had also received the draft Quality Account for 2018/19.

9.7. The level of over 90-day aged debt was brought to the Committee's attention. KH queried whether it was the same debtors or whether there were more organisations owing money to the Trust. NK confirmed it was both and it was an indication of the financial strain across the sector and the fact that the Trust was now had a £1b cash turnover each year, as a result of the Lead Employer contracts and junior medical staff payrolls. NK agreed to calculate the proportion of debt compared to turnover and report back to the Audit Committee. NK also reminded the Board that the lead employer contract also allowed the Trust to charge interest on overdue payments and that the majority of the £6m was due to slow paying NHS organisations rather than non-payment.

9.8. NK asked Board to note that the Audit Committee had reviewed and approved the Annual Audit Plan for 2019/20.

9.9. No meeting of the auditor panel had been required at this meeting.

9.10. Board members noted the report.

10. Strategic and Regulatory Update Report – NHST(19)35

10.1. NB presented highlights from the report which provided Board members with and update on key policy and regulatory developments.

10.2. Operational Plan 2019/20 – NB confirmed the final plan had been submitted in accordance with the national timetable.

10.3. Workforce Disability Equality Standard (WDES) - the new standard was designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the NHS. The WDES had been mandated, through the NHS Standard Contract to apply to NHS Trusts and Foundation Trusts from 2019/20. In the first year, NHS provider organisations were required to review their data and take action on key areas that supported the full implementation of the WDES.

10.4. SR asked how many of the workforce had a declared disability. AMS confirmed the data was collected via ESR but the numbers were lower than would be expected across the NHS which was why the emphasis in this first year would be to encourage staff to declare their disability so the data and following action plans would be meaningful.

10.5. An interim report following a clinical review of NHS access standards was published in March 2019. This report proposed updating several of the current performance measures to help staff improve patient care and remove barriers for Trusts that were seeking to modernise the delivery of treatment. The

proposals had received a mixed response from professional bodies but were now being tested at a number of Trusts across the country to assess the impact. Whilst this testing was being undertaken and evaluated the existing waiting time targets would remain in place.

10.6. The interim Workforce Implementation Plan was published on 6th March 2019, seeking views on the emerging ideas and acknowledging that aspirations and detailed plans beyond 2019/20 would be subject to the conclusion of the Comprehensive Spending Review, later in the year. AMS commented that the final strategy was now unlikely to be published before the Trust workforce strategy was due to be refreshed in July.

10.7. New guidance had been introduced since the last Trust annual report was published suggesting that Trusts should consider the application of GDPR to the publication of information about Directors in the annual report and accounts. NB confirmed that the information disclosures had not changed, and the same information would be published as in previous years and was in line with the statutory requirements of Directors and as advised on appointment to a Board position.

10.8. AM asked what the process would be if a director objected to the inclusion of their information. SR believed the auditors would need to be informed in any event to complete the audit. All members of the Board confirmed they understood the reasons for disclosure of this information in the annual report and accounts.

10.9. Board members noted the update.

11. Corporate Risk Register (CRR) – NHST(19)36

11.1. NB presented the report covering the Trust risks identified and reviewed in March 2019, which was a snap shot, rather than a summary of the quarter.

11.2. The total number of risks on the Trust risk register was 741.

11.3. 10 risks that scored 15 or above had been escalated to the CRR.

11.4. DM noted 50% of the CRR risks related to workforce issues. AMS believed this reflected national workforce challenges, and would be the case in the majority of acute Trusts.

11.5. SR queried the high number of risks that had been closed in the period (90). NB confirmed these were CIP risks which were closed as they were transacted at the end of the financial year.

11.6. DM asked what NB drew from reviewing the register. NB confirmed there were no surprises; risks were identified, monitored and closed when appropriate and the CRR risks reflected the issues and concerns that were being discussed at the Board and its committees.

11.7. SR asked if the risk register changed very much and NB confirmed that there was considerable movement in the risks over time. It was agreed that in the next quarterly report NB would include a comparison of the risk register at the same

time the previous year. **ACTION: NB to add to the next quarterly report.**

11.8. SR confirmed the internal auditors had reviewed both risk management and the Board Assurance Framework (BAF) and had provided assurance that the processes were robust and they were successful in highlighting the important issues for the Board.

11.9. RF believed this demonstrated the Trust was using its risk management process and had an active risk register.

11.10. Board members noted the report.

12. Review of the Board Assurance Framework (BAF) – NHST(19)37

12.1. NB presented the BAF for review by Board members and confirmed risks had been realigned to the 2019/20 Trust Objectives and reviewed in light of the progress made since the last review in January.

12.2. Board members approved the proposed changes to the BAF.

13. Learning from Deaths Quarterly Report 2018/19 Q3 – NHST(19)38

13.1. KH presented a summary of mortality reviews that had taken place in Q3 (October to December 2018), to provide assurance that all deaths in the specified groups had been reviewed and key learning had been disseminated throughout the Trust.

13.2. KH described one of the ways in which the Trust had worked together with the community, primary care and the CCG to improve outcomes for local residents. A key theme identified from mortality reviews had been undiagnosed atrial fibrillation, which greatly increased risk of stroke. A Community Nurse had been appointed and had identified a very large number of people who had since been prescribed appropriate medication. The Trust therefore anticipated a fall in stroke mortality and disability from stroke, as a result of sharing and acting on this learning.

13.3. SR asked why August 2018 showed the highest number of identified concerns from the reviews undertaken of the deaths in scope. KH thought that as the numbers were small in all months this was natural variation, and that no trends or themes had been identified from this cohort of reviews. It was also noted that the number of deaths each month varied considerably reflecting the national seasonal variations in mortality rates.

13.4. SR was assured by the summary at the bottom of the report that information was being shared and getting through to the right people throughout the organisation.

13.5. RF observed that only 1% of the mortality reviews resulted in an outcome where the death may have been impacted by a problem in care delivery or service provision, which was below the 3% national average. KH acknowledged that STHK crude mortality had been dramatically lower than the UK for the last 10 years and SHMI was also lower, but further improvements

could always be made and the Trust should aim for 0%.

13.6. Following a suggestion from SR it was agreed that the progress made in developing and implementing the learning from deaths culture should be included as one of the key messages from the Board in the next Team brief.

13.7. Board members noted the report.

14. Effectiveness of Meeting

14.1. RF asked KT for his reflections on the meeting.

14.2. KT stated it was refreshing to see a Trust that, despite its outstanding CQC rating did not rest on its laurels and showed a continuing desire to improve. KT also commented on the late publication of the meeting papers, which had been because of the bank holiday weekend.

14.3. RF thanked KT for his comments.

15. Any Other Business

15.1. RF thanked PG and his colleagues for participating in the recent Trust Charity abseil at both Whiston and St Helens Hospitals. PG noted it was a fantastic event with great engagement.

15.2. RF confirmed the recruitment process for replacement Non-Executive Directors was now live with a closing date of 30th April.

16. Date of Next Meeting

16.1. The next meeting will be held on Wednesday 29th May 2019 at 09:30 hrs in the Executive Boardroom, Level 5, Whiston Hospital, L35 5DR.

Chairman: …….

Date: 29th May 2019 …….

TRUST PUBLIC BOARD ACTION LOG – 29TH MAY 2019

No	Date of Meeting (Minute)	Action	Lead	Date Due
1.	25.07.18 (12.7)	AMS to include employee relations' cases time to resolve KPIs in future HR Indicators reports. **To be reported from July 2019.**	AMS	~~30.01.19~~ 31.07.19
2.	30.01.19 (14.9)	AMS/SRe to review the exit interviews process to ensure it is comprehensive and lessons are being learnt to improve retention.	AMS/SRe	31.07.19
~~3.~~	~~27.02.19 (8.3)~~	~~Corporate departments to be included in the QWR schedule~~. **ACTION CLOSED**	~~SRe~~	~~24.04.19~~
4.	27.03.19 (11.8)	NK to analyse the reasons for the 40% increase in turnover since 2012 and report back to Finance & Performance Committee and share with Board members.	NK	For F&P
5.	24.04.19 (6.1.9)	CW/JK to meet outside of the Board meeting to discuss the HIS Board.	CW	-
6.	24.04.19 (7.4)	SRe to provide a compliance update relating to safe storage and security of medicines following on from the latest Medicines Management Audit.	SRe	29.05.19
7.	24.04.19 (12.2)	NB to add a comparison of previous year to Corporate Risk Register for benchmarking purposes to the next quarterly report.	NB	31.07.19

INTEGRATED PERFORMANCE REPORT

St Helens and Knowsley Teaching Hospitals NHS Trust

Paper No: NHST(19)39
Title of Paper: Integrated Performance Report
Purpose: To summarise the Trusts performance against corporate objectives and key national & local priorities.

Summary

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

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

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

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

Patient Safety, Patient Experience and Clinical Effectiveness

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

There were 0 Never Events in April 2019.

There were 0 cases of MRSA in April 2019.

There were 3 C.Difficile (CDI) positive cases reported in April 2019. YTD there have been 3 cases .
In comparison, there were 2 cases for the same period in 2018-19. The annual tolerance for CDI for 2019-20 is 48.
There were a total of 13 CDI cases in 2018-19 compared to 19 in the same reporting period 2017-18.

There were no grade 3 or 4 avoidable pressure ulcers reported in 2018/19.

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for April 2019 was 98.1%. 2018/19 full year performance was 96.5%.

During the month of March 2019 there were 4 falls resulting in severe harm , which all occurred in ward areas. Full year 2018/19 there were 18 falls compared with 22 for the year 2017/18).

Performance for VTE assessment for March 2019 was 95.6%. Full year 2018/19 performance was 95.94% against a target of 95%.

YTD HSMR (April to January) for 2018-19 is 98.2

Corporate Objectives Met or Risk Assessed: Achievement of organisational objectives.
Financial Implications: The forecast for 19/20 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: 29th May 2019

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (March 2019) at 90%. The 31 day target was achieved with 100% performance against a target of 96%. The 2 week rule target was also achieved with 95.7% against a target of 93.0%.

Accident and Emergency Type 1 performance for April 2019 was 71.4%. The all type mapped STHK Trust footprint performance was 83.9%**.** Type 1 attendances for April 2019 were 9,909 compared with 10,021 in March 2019. April 2019 was 9% higher than April 2018 (9,087).

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 2926 ambulances conveyances in April 2019. Ambulance notification to handover time was achieved with 14:45 mins/seconds on average (target 15 mins). Whiston achieved this target for 10 months out of 12 in 2018/19 compared with only 5/12 months the previous year.

In 2018/19 the organisation achieved a 28% year on year reduction in the number of super stranded patients (length of stay 21day+) against a target of 25%. For 2019/20, the target reduction set by NHSI/E has increased to 40% by year end. The average number of super stranded patients during April 2019 was 28 less per day compared with April 18. (157 per day in April 18 v 129 in April 19). 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 March 2019 with 92.4% compliance (Target 92%). The 6 week diagnostic target was achieved in April with 99.9% (Target 99%). There were no 52 week+ waiters.

Financial Performance

At the March 2019 Board the Trust agreed to accept the issued Control Total of a £2.6m deficit excluding the Provider Sustainability Fund (PSF). This allowed the Trust to access £6.5m of PSF assuming the planned deficit is achieved.
Key assumptions within the plan include:-
- Full achievement of CQUINs
- Activity within planned levels
- Achievement of CIPs (£16.1m)
- Agency spend within cap levels

Surplus/Deficit - At the end of M1 StHK has reported a deficit of £0.8m which is in line with agreed plans and assumes full achievement of PSF funding. The Trust has utilised c£0.7m of non-recurrent options to achieve the reported deficit.
The annual target for agency is £7.6m which is an increase of £0.3 on 2018/19 cap. Agency expenditure at month 1 is £0.6m which is £0.1m under our planned trajectory.
The Trust is forecasting to have a surplus of £3.9m including PSF funding.
At month 1 the Trust is ahead of the CIP target of £0.375m by £0.039m and has plans to the value of £18.0m in year and £19.9m recurrently. The Trust has currently transacted 2.9% which is 1.8% greater than the 1.1% included within national planning assumptions.

Human Resources

In April, sickness was 4.9% which was 0.65% higher than the Q1 target of 4.25% and higher than this time last year. Qualified & HCA sickness remains higher than target by 0.3%. All qualified Nursing & Midwifery sickness was 0.75% above target .

Mandatory Training compliance is 91.8% (target = 85%). Appraisal compliance is 86.8% (target = 85%).

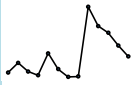
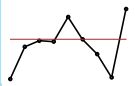
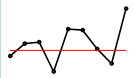
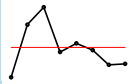
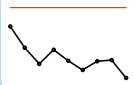
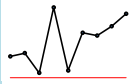
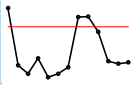
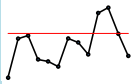
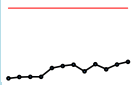
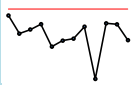
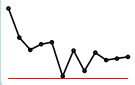
The following key applies to the Integrated Performance Report:

▲ = 2018-19 Contract Indicator (2019-20 indicators not yet available)
▲£ = 2018-19 Contract Indicator with financial penalty (2019-20 indicators not yet available)
● = 2018-19 CQUIN indicator (2019-20 indicators not yet available)
T = Trust internal target
UOR = Use of Resources

Apr-19

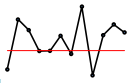
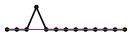
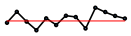
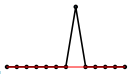
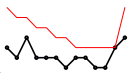
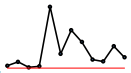
St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2018-19 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 31-37)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Apr-19	2.1%	2.1%	No Target	2.2%		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	▲	Jan-19	102.1		100.0	98.2					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Jan-19	75.1		100.0	102.7					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Dec-18	98.9		100.0	99.9		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	Jan-19	92.1		100.0	90.3		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	Jan-19	112.6		100.0	113.3					
% Medical Outliers	F&P	T	Apr-19	0.3%	0.3%	1.0%	0.5%		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	Apr-19	38.8%	38.8%	52.5%	45.7%		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	▲	Mar-19	73.7%		90.0%	71.3%		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	▲	Mar-19	82.8%		95.0%	85.0%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Mar-19	96.1%		95.0%	96.4%					

Apr-19

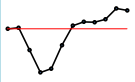
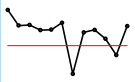
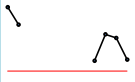
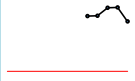
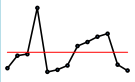
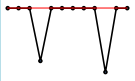
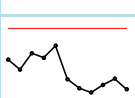
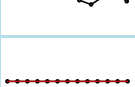
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2018-19 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (continued)												
Stroke: % of patients that have spent 90% or more of their stay in hospital on a stroke unit	Q F&P	▲	Mar-19	87.5%		83.0%	85.7%		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	▲£	Apr-19	0	0	0	1		No never events reported YTD	Quality and patient safety		SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Apr-19	99.1%	99.1%	98.9%	99.1%		Achieving standard YTD	Quality and patient safety	Reducing hospital acquired harm is a key priority for the quality and risk teams, the continued development of both risk assessments and harm mitigation strategies will further reduce the risk of harm to patients	SR
Prescribing errors causing serious harm	Q	T	Apr-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	▲£	Apr-19	0	0	0	1		Internal RCAs on-going with more recent cases of C. Difficile.	Quality and patient safety	The objective (i.e. target) for cases of CDI set for our Trust in 2019-20 by NHS Improvement (NHSI) is no more than 48 cases. From April 2019 onwards, the Trust's objective will include community onset healthcare associated: cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks. All CDI cases are subject to an Exec RCA review	SR
Number of confirmed hospital acquired C Diff	Q F&P	▲£	Apr-19	3	3	48	13					
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Apr-19	1	1	No Target	31					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Mar-19	0		No Contract target	0		No grade 3 or 4 avoidable pressure ulcers YTD	Quality and patient safety	The Trust provides ongoing tissue viability training for all nursing staff including bank staff . New pressure ulcer reduction actions being implemented.	SR
Number of falls resulting in severe harm or death	Q	▲	Mar-19	4		No Contract target	18		Fall resulting in severe harm reported from Newton Rehabilitation unit , Seddon Suite, Ward 1C and Ward 5C	Quality and patient safety	RCA is currently being undertaken. Bespoke improvement work in areas being undertaken, including development and adoption of falls risk assessment in ED, medical ward rounds focussing on risk of falls.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲£	Mar-19	95.60%		95.0%	95.94%		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	Mar-19	3		No Target	26					
To achieve and maintain CQC registration	Q		Apr-19	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards. Trust rated as outstanding following the 2018 inspection.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Apr-19	98.1%	98.1%	No Target	96.5%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	Safe Care Allocate has been implemented across all inpatient wards. The shelford dependenecy has been is currently being analysed	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Apr-19	0	0	No Target	0					

Apr-19

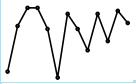
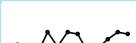
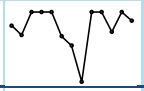
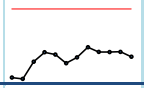
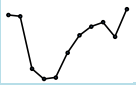
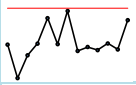
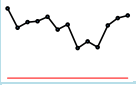
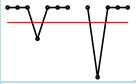
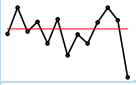
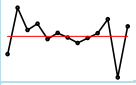
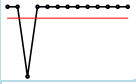
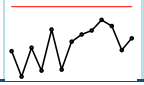
St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2018-19 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 43-51)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Mar-19	95.7%		93.0%	92.2%		2 week and 31 day Targets achieved in month. 62 Day target met but pressures remain with Consultant workforce constraints (Radiological capacity in Breast and Dermatology patient rearrangements) contributed to the performance	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 3. Breast strategy meeting to develop plan and recovery arranged 17.5.19 4. Eastern sector hub negotiations ongoing	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Mar-19	100.0%		96.0%	98.1%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Mar-19	90.0%		85.0%	88.3%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Mar-19	92.4%	92.4%	92.0%	92.4%			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 is in ensuring RMS delivers in a sustainable and manageable way	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Apr-19	99.9%	99.7%	99.0%	99.9%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Mar-19	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Apr-19	0.6%	0.6%	0.8%	0.8%		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	▲ £	Mar-19	100.0%		100.0%	99.5%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Apr-19	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Apr-19	71.4%	71.4%	95.0%	74.3%		Accident and Emergency Type 1 performance for March 19 was 72.6%. The all type mapped STHK Trust footprint performance was 84.7%. Type 1 attendances for February 2019 were 10,021 compared with 9,186 in February 19. Five improvement workstreams (streaming, emergency department delivery, assessment areas, inpatient flow and ward daily discharges) are actively working on improving patient flow and are being governed through the Urgent and Emergency Care Council which meets monthly and is chaired by CEO. Whiston ED had the highest volume of ambulances in C+M and GM (3067) in march 2019. Ambulance notification to handover time was achieved with 13:53 mins on average (target 15 mins).	Patient experience, quality and patient safety	The urgent and emergency care transformation plan has several interconnected work streams designed to improve overall 4 hour access performance. Emergency Department/Front Door processes in place including 'walk in' streaming, Stretcher Triage streaming and internal departmental efficiencies and exit from ED. GP streaming in place as per NHSE recommendations. Flow through the Hospital New and refreshed workstreams aimed at improving discharges before midday also supported by a media campaign #HomeForLunch. Daily board rounds and afternoon huddles. Twice weekly discharge tracking meetings to manage medically optimised and DTOC escalation. Monthly Executive Multi-Agency Discharge Events (MADE) continue across the whole system to remove barriers and blocks that prevent patients with complex needs being discharged safely from hospital. Following 6a ECIP event and system resilience planning, commenced daily AMU/ED huddles and Community Matron in reach which is proving beneficial. Frailty in-reach to ED commenced. 1pm Frailty/ED/SpR safety huddle in place. New COPD pilot in place from December.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Apr-19	83.9%	83.9%	95.0%	87.1%					
A&E: 12 hour trolley waits	F&P	▲	Apr-19	0	0	0	0					

Apr-19

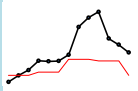
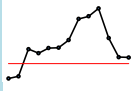
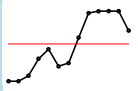
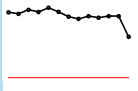
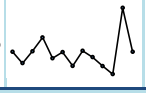
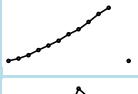
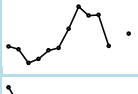
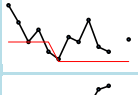
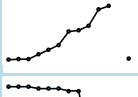
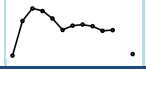
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2018-19 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Apr-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	Apr-19	25	25	No Target	266		% new (Stage 1) complaints resolved in month within agreed timescales continues to improve overall and remains above the 90% 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 extremely low.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Apr-19	25	25	No Target	241					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Apr-19	96.0%	96.0%	No Target	92.1%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Mar-19	20		No Target	19		In March 2019 the average number of DTOCS (patients delayed over 72 hours) was 20.		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	Apr-19	334	313 *Jun-Apr							
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Apr-19	130	117 *Jun-Apr							
Friends and Family Test: % recommended - A&E	Q	▲	Apr-19	88.7%	88.7%	90.0%	86.0%		The YTD recommendation rates remain above target for inpatients, antenatal and postnatal, but slightly below target for A&E, delivery and outpatients, with improvement seen in these areas in April. Antenatal and community postnatal achieved 100% recommendation rates.	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 Quality Matron, Patient Experience and Governance and the Patient Experience Manager continue to attend team meetings to engage with staff and raise the profile of the FFT programme and to work with staff in each area where performance is below target. At least two members of staff have been identified in each area to take responsibility for production of the 'you said, we did' posters which are used to identify specific areas for improvement. Easy to use guides were issued to each ward to support completion and the posters are now distributed centrally to ensure that each ward has up-to-date posters. Areas continue to review comments to identify any emerging themes or trends, and significantly negative comments are followed up with the contributor if contact details are provided to try and resolve issues.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Apr-19	95.9%	95.9%	90.0%	94.7%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Apr-19	100.0%	100.0%	98.1%	98.7%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Apr-19	93.8%	93.8%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Apr-19	96.8%	96.8%	95.1%	94.8%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Apr-19	100.0%	100.0%	98.6%	98.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Apr-19	94.4%	94.4%	95.0%	94.2%					

Apr-19

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2018-19 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 53-60)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Apr-19	4.9%	4.9%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	5.0%		In April, sickness was 4.9% which was 0.65% higher than the Q1 target of 4.25% and higher than this time last year. Qualified & HCA sickness remains higher than target by 0.3%. YTD absence so far remains lower that the 6.1%, outturn from 2018-19 target but is higher than the annual target of 5.3%.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	A large scale review of the current attendance management policy has commenced in line with "Just Culture" with the aim of driving improvements in engagement levels and attendance. A workshop held in March was well attended from all staff groups and a task and finish group has been established with attendees from management, HR, HWWB and staffside. The HR Operational Team & Absence Support Team continue to support managers and staff with regards to absence and implementation of the policy. HR and HWWB are the level of DNA's for appointments and the escalation process to managers along with stopping pay for persistent non-engagement in the support and management process.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Apr-19	5.6%	5.6%	5.3%	6.1%					
Staffing: % Staff received appraisals	Q F&P	T	Apr-19	86.8%	86.8%	85.0%	89.6%		Appraisal compliance exceeds the target by 1.8% but has seen a reduction of 3.8% since March. Mandatory training compliance is above the target by 6.8%. A reduction of 3.5% since March.	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	Apr-19	91.8%	91.8%	85.0%	95.3%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q4	91.9%		No Contract Target			For both questions the Trust returned the best scores nationally.	Staff engagement, recruitment and retention.	The Q1 survey within Medical Care Group is expected to open in June 2019 .	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q4	79.7%		No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Apr-19	0.8%	0.8%	No Target	9.2%		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	Apr-19	3.0	3.0	3.0			At the March 2019 Board the Trust agreed to accept the issued Control Total of a £2.6m deficit excluding the Provider Sustainability Fund (PSF). This allowed the Trust to access £6.5m of PSF assuming the planned deficit is achieved. Key assumptions within the plan include:- - Full achievement of CQUINs - Activity within planned levels - Achievement of CIPs (£16.1m) - Agency spend within cap levels 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	Apr-19	413	413	16,100						
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Apr-19	(753)	(753)	3,900						
Cash balances - Number of days to cover operating expenses	F&P	T	Apr-19	11	11	2						
Capital spend £ YTD (000's)	F&P	T	Apr-19	277	277	9,072						
Financial forecast outturn & performance against plan	F&P	T	Apr-19	3,900	3,900	3,900						
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Apr-19	87.9%	87.9%	95.0%						

APPENDIX A

NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

			Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-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%	100.0%	100.0%	100.0%	95.7%	88.9%	100.0%	100.0%	100.0%	100.0%	96.0%	83.3%	100.0%	96.5%	85.0%		97.0%		
	Total > 62 days		0.0	0.0	0.0	0.0	0.5	1.5	0.0	0.0	0.0	0.0	0.5	2.5	0.0	5.0			3.5		
Lower GI	% Within 62 days	▲ £	75.0%	100.0%	76.5%	100.0%	100.0%	92.3%	100.0%	36.4%	88.9%	100.0%	87.5%	72.7%	80.0%	86.6%	85.0%		84.0%		
	Total > 62 days		1.5	0.0	2.0	0.0	0.0	0.5	0.0	3.5	1.0	0.0	1.0	1.5	1.0	10.5			12.5		
Upper GI	% Within 62 days	▲ £	100.0%	80.0%	77.8%	80.0%	66.7%	62.5%	77.8%	66.7%	33.3%	63.6%	84.6%	88.9%	75.0%	74.7%	85.0%		87.2%		
	Total > 62 days		0.0	1.0	1.0	0.5	0.5	1.5	1.0	0.5	1.0	2.0	1.0	0.5	1.5	12.0			5.0		
Urological	% Within 62 days	▲ £	86.2%	93.8%	90.2%	78.8%	80.7%	97.1%	80.6%	90.3%	75.0%	89.4%	85.2%	87.8%	90.9%	86.0%	85.0%		82.5%		
	Total > 62 days		2.0	1.0	2.0	3.5	5.5	0.5	3.0	1.5	3.5	2.5	2.0	2.5	1.5	29.0			37.0		
Head & Neck	% Within 62 days	▲ £	100.0%	50.0%	66.7%	33.3%	62.5%	42.9%	83.3%	50.0%	80.0%	57.1%	25.0%	0.0%	100.0%	57.1%	85.0%		64.6%		
	Total > 62 days		0.0	0.5	0.5	2.0	1.5	2.0	0.5	1.0	0.5	1.5	1.5	0.5	0.0	12.0			8.5		
Sarcoma	% Within 62 days	▲ £	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%			50.0%	85.2%	85.0%		66.7%		
	Total > 62 days		0.0	0.0	0.0	0.5	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.5	2.0			2.5		
Gynaecological	% Within 62 days	▲ £	77.8%	87.5%	72.7%	75.0%	100.0%	72.7%	50.0%	62.5%	100.0%	81.8%	57.1%	88.9%	77.8%	77.8%	85.0%		78.2%		
	Total > 62 days		1.0	0.5	1.5	0.5	0.0	1.5	0.5	1.5	0.0	1.0	1.5	0.5	1.0	10.0			12.0		
Lung	% Within 62 days	▲ £	100.0%	87.0%	95.8%	88.9%	100.0%	100.0%	81.8%	66.7%	94.1%	100.0%	92.9%	81.8%	92.9%	90.4%	85.0%		84.7%		
	Total > 62 days		0.0	1.5	0.5	0.5	0.0	0.0	1.0	2.0	0.5	0.0	0.5	1.0	0.5	8.0			11.5		RC
Haematological	% Within 62 days	▲ £	83.3%	100.0%	100.0%	100.0%	100.0%	66.7%	90.9%	50.0%	85.7%	66.7%	50.0%	0.0%	83.3%	76.7%	85.0%		80.6%		
	Total > 62 days		1.0	0.0	0.0	0.0	0.0	1.0	0.5	1.0	1.0	1.0	2.0	2.0	1.0	9.5			9.5		
Skin	% Within 62 days	▲ £	92.5%	100.0%	91.2%	97.6%	93.8%	98.1%	93.3%	84.6%	90.2%	98.0%	93.7%	88.1%	94.9%	93.4%	85.0%		95.2%		
	Total > 62 days		2.0	0.0	2.5	0.5	1.5	0.5	3.0	4.0	2.5	0.5	2.0	2.5	1.0	20.5			13.0		
Unknown	% Within 62 days	▲ £	75.0%	100.0%	100.0%		100.0%	75.0%	100.0%	100.0%	100.0%		100.0%	66.7%	100.0%	93.9%	85.0%		78.4%		
	Total > 62 days		1.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.5	0.0	1.0			4.0		
All Tumour Sites	% Within 62 days	▲ £	89.6%	94.1%	90.1%	90.3%	89.0%	89.1%	90.9%	77.8%	88.4%	89.0%	86.7%	82.6%	90.0%	88.3%	85.0%		87.4%		
	Total > 62 days		8.5	4.5	10.0	8.0	9.5	9.5	9.5	16.0	10.0	8.5	12.0	14.0	8.0	119.5			119.0		
Cancer 31 day wait from urgent GP referral to first treatment by tumour site (rare cancers)																					
Testicular	% Within 31 days	▲ £				100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%			90.0%	85.0%		100.0%		
	Total > 31 days					0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0			1.0			0.0		
Acute Leukaemia	% Within 31 days	▲ £			100.0%			0.0%	100.0%							66.7%	85.0%		100.0%		
	Total > 31 days				0.0			1.0	0.0							1.0			0.0		
Children's	% Within 31 days	▲ £															85.0%				
	Total > 31 days																				

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)40
Title of paper: Executive Committee Chair's Report
Purpose: To provide assurance to the Trust Board on those matters delegated to the Executive Committee.
Summary: The paper provides a summary of the issues considered by the Executive Committee at the meetings held during April 2019. There were a total of 4 Executive Committee meetings held during this period. The Executive Committee agreed: • Operational Management Capacity Business Case • Clinical Education development plans • St Helens CCG Community Services – Looked after children • Matron seven day cover capacity review The Executive Committee also considered regular assurance reports covering: appraisal and mandatory training compliance, the Risk Management Council and Corporate Risk Register, Board Assurance Framework, safer staffing monthly report. There was also a review of the implementation of NEWS2. There are no specific issues that require escalation to the Board.
Trust objectives met or risks addressed: All 2019/20 Trust objectives.
Financial implications: None arising directly from this report.
Stakeholders: Patients, Patients' Representatives, Staff, Commissioners, Regulators
Recommendation(s): That the report be noted
Presenting officer: Ann Marr, Chief Executive
Date of meeting: 29th May 2019

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE
April 2019

1. Introduction

There were 4 Executive Committee meetings in April 2019. At every meeting the committee reviews any bank or agency staff requests that would breach the NHSI cost thresholds.

2. 4th April 2019

2.1 Halton CCG Urgent Treatment Centre (UTC) Services Procurement

The Director of Finance and Information updated the committee on the development of the Trust bid to provide the UTCs in Halton, and the additional work that had been undertaken to identify an alternative location for the Runcorn UTC, following confirmation from the commissioners that the existing facilities at Halton Hospital would not be available to all bidders. The Executive debated the risks and opportunities of submitting the bids for both lots in the procurement and agreed that the Trust should continue in the process.

2.2 Trust Board Agenda

The Director of Corporate Services presented the draft Trust Board agendas for the April public and strategy meetings for review. The committee also reviewed the action log from the previous meetings.

2.3 Falls Data – Model Hospital

The Director of Nursing, Midwifery and Governance presented a paper which clarified how falls data was presented on the Model Hospital. This was taken from the safety thermometer, which is a snap shot gathered over 2 days each month. The data therefore does not show the total number of falls at each NHS organisation and will be misleading. It was agreed that the NHSE/I team that run model hospital should be made aware of this issue. Actual falls data was also presented for the year with analysis that demonstrated the majority of falls happen between 8.00pm – 10.00pm. The reasons for this were debated and it was agreed that options to consider alternative shift patterns for nurses would be evaluated.

2.4 Clinical Director Forum

The Medical Director presented proposals for a re-launch of the Clinical Director forum, to become a key communication and engagement channel between the executive team and senior clinicians. The proposals were agreed.

2.5 NHSE/I Medical Director

The Medical Director had met with David Levy the new Medical Director for the NHSE/I North Region. There was discussion about how to ensure an active Medical Directors forum.

3. 11th April 2019

3.1 Marshalls Cross - Improvement Actions

The Director of Operations and Performance presented the draft improvement plan for submission to the CQC. It was agreed that further work was required on the submission to reflect the impact of the actions already undertaken to address the issues raised by the CQC at the time of the inspection.

3.2 Operational Management Capacity Business Case

The Director of Operations and Performance presented a business case seeking approval for additional posts for the Trust's operational management infrastructure to be able to respond to growth in existing services, the needs of new services acquired by the Trust and to ensure there was sufficient capacity to manage the transition and mobilisation of planned service developments. Some of the posts in the case were approved and others deferred for future consideration.

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

The Director of Corporate Services presented the Chair's report from the RMC and briefed committee on those risks that had been escalated to the CRR during March. A number of risks had been realigned to the new Care Primary and Community Care which had formally come into effect on 1st April. The Council had reviewed the Major Incident Policy, which had been revised to reflect the lessons learnt from the IT outage earlier in the year.

3.4 Board Assurance Framework (BAF)

The Director of Corporate Services presented the BAF following the quarterly review with lead Directors. This was approved for submission to the next Trust Board.

3.5 eMews Audits

The Director of Nursing, Midwifery and Governance had prepared the report which detailed the improvement in eMews compliance for the timely assessment and recording of clinical observations, as demonstrated through a series of unannounced audits to different service areas.

3.6 Refusal of treatment

The Director of Nursing, Midwifery and Governance had prepared the report which detailed legal advice on the Trusts position if a maternity patient refuses the advised clinical treatment e.g. caesarean section/induction of labour. The advice was that the patient had the right to refuse, and the important issue for the Trust was to document the advice and information given to patients and their informed consent. A review of recent cases at the Trust confirmed that this process was already embedded in practice within the service.

3.7 Internal audit plan 2019/20

The Director of Finance and Information presented the proposed internal audit plan for the coming 12 months, to ensure the most important areas had been identified for review. The final plan was to be presented at the next Audit Committee meeting for approval.

3.8 Bank and Agency Spend

The Deputy CEO/Director of HR presented the month 11 report on bank and agency spend, noting the increase in requests over the winter period and the increased fill rate with Trust bank staff. Next steps across Cheshire and Merseyside were to agree a locum "rate card" and internally work would focus on triangulation between staff absence and requests for bank and agency staff.

3.9 Integrated Performance Report (IPR)

The Director of Finance and Information presented the draft IPR for March; the in-month performance against the 62 day cancer target was discussed in detail. Committee reviewed the metrics and agreed the commentary for the final report.

3.10 Thames Valley Lead Employer Contract

The Deputy CEO/Director of HR briefed committee on the request to take over the Thames Valley lead employer contract, following the withdrawal of the current service provider. A paper would be presented in the private Board meeting, due to the commercial nature of the negotiations.

4. 18th April 2019

4.1 Primary Care Strategy

The Director of Operations provided an update on the due diligence and preparatory work that had been undertaken with the GP practice the Trust was hoping to work with. Financial modelling had been completed and this was reviewed and the risks and assumptions discussed. Approval was given for the team to move forward with the next phase of detailed negotiations with the partners and a paper prepared for the Trust Remuneration Committee.

4.2 Clinical Education – development plans for post and undergraduate training

Changes to the existing staffing structure in the Clinical Education team were agreed, within the overall budget, to better align to the expectations of University Partners and Medical Schools. An expansion of the clinical tutor establishment to support increased students was also approved from the additional income that would be allocated to the Trust. The importance to staff retention and satisfaction of investing to meet training and career development expectations was acknowledged.

4.3 Closure of Agenda for Change (AfC) band 1

The Deputy CEO/Director of HR provided an update on the work that had been undertaken to implement the 2018 national pay agreement, where the AfC band 1 pay grade was to be phased out. The staff affected at the Trust are Facilities Management

staff working for Medirest, under the retention of employment (ROE) arrangements. A formal consultation and engagement process had been undertaken with staff to explain the changes and the impact for each individual. No new staff are recruited to the band 1 grade. Training plans for the staff to develop the skills and competencies of a band 2 were also being developed.

4.4 Mandatory Training and Staff Appraisal Report

The Deputy CEO/Director of HR presented the monthly report for the staff reporting to each Director. There was an improvement compared to the previous month and overall the target of 85% for both mandatory training and staff appraisals was being achieved.

4.5 Safer Staffing Report

The Director of Nursing, Midwifery and Governance presented the safer staffing report for March 2019. Overall fill rates remained above the 95% Trust target.

4.6 Year End Provider Sustainability Fund (PSF) Allocation

The Director of Finance and Information reported that he had received confirmation from NHSE/I that the Trust would receive an additional £5.1m of PSF monies, which would improve the year end position.

4.7 Junior Doctor Cover – Medical Care

The Deputy CEO/Director of HR briefed committee on the issues with Junior Doctor cover following the recent rotation and the actions that were being proposed to improve the situation.

5. 25th April 2019

5.1 NEWS2 Implementation Update

The Director of Informatics and the Director of Nursing, Midwifery and Governance presented an update phase 1 of the implementation of the NEWS2 to the inpatient wards, to enable the Trust to improve the screening for Sepsis. The roll out had been very successful and the new system to record patient assessment on IPod devices linked to the eVitals module had gone smoothly, despite the speed of the change programme. The next phase would involve an electronic NEWS2 tool for the Accident and Emergency Department (to replace the current paper based system).

5.2 Clinical Quality and Performance Group (CQPG) feedback

The Director of Nursing, Midwifery and Governance provided feedback from the recent CQPG meetings with Commissioners covering acute services and the St Helens Community Services contract. The eDischarge process had been discussed and there had been a service impact presentation by Community Intermediate Care Services based at Newton Hospital.

5.3 St Helens CCG Community Services Request

The Director of Operations introduced a report detailing the request from St Helens CCG to become the lead provider for the looked after children (LAC) service. This is a small

service, but complex to deliver. The committee debated the scope of the due diligence process that would need to be undertaken, and agreed to hold further discussions with the CCG.

5.4 2018 National Inpatient Survey

The Director of Nursing, Midwifery and Governance introduced a briefing paper on the results of the 2018 National Inpatient Survey. There were three areas that the Trust had prioritised for improvement based on the survey results; the time patients wait for a bed on a ward; ensuring patients always have enough to drink and improving feedback to patients following a procedure. An improvement plan had been developed and delivery would be monitored by the Patient Experience Council.

5.5 Maternity Services KPI Review

The Maternity Service had undertaken a review of the KPIs reported on the Maternity dashboard and proposed a number of changes to ensure they remained aligned to national guidance and the use of benchmarking where national targets had not been set. The changes were agreed.

5.6 Same Day Emergency Care (SDEC) Capacity Scheme

The Director of Operations presented the update from the project team on the development of the final plans and business case in relation to the £4m STP capital allocation. There were 5 linked work streams, which had all been progressed, and it was agreed that the detailed scheme would be presented at the next Trust Board meeting.

5.7 Matron Seven Day Cover

The Director of Nursing, Midwifery and Governance presented a paper detailing the benefits of formalising Matron cover at Whiston seven days a week all year round (not only during winter escalation). The proposals required additional investment and it was agreed that part of the proposal should be approved at this time, with the other options to be considered following a comprehensive review of the duties and roles of weekend staffing.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)41

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

Purpose: To summarise the meeting papers from the 21 May 2019 and escalate issues of concern.

Summary:

QC(19)067 Saving Babies Lives Update: The second version of the care bundle brings together five elements of care that are widely recognised as evidence based and/or best practice and includes a greater emphasis on continuous improvement.

QC(19)068 HSIB Presentation: There have been 4 cases reported to the HSIB since February 2019. Two investigations are underway, one investigation from March is delayed pending parental consent as family are not engaging with the HSIB, and one case has been delayed at the family's request to allow the funeral to take place.

QC(19)069 Mandatory & Resuscitation Update: The Mandatory and Resuscitation update will be discussed at the Executive Committee prior to review at the Quality Committee next month.

QC(19)070 SMR/HMSR Report: The latest Renal Failure SMR was statistically higher than expected at 135.4. The Acute Medicine team are in the process of undertaking a case note review of 75 patient deaths to establish if there are any issues around care. The final report will be presented to the Clinical Effectiveness Council in July.

QC(19)071 CQC Update:

- 42 actions have been identified and are being addressed within the action plan.
- Marshalls Cross Medical Centre was rated as requires improvement, however it was recognised that the Trust had only formally been providing the services since March 2019.

QC(19)072 IPR:

- 0 never events have been reported year to date against a target of 0.
- 0 MRSA cases were reported against a target of 0.
- There were 3 C.Difficile positive cases reported. YTD there have been 3 cases. The annual tolerance is now 48 cases, which is an increase of 8 to allow for community cases. There were a total of 13 CDI cases in 2018/19 compared to 19 in the same period 2017/18. 1 of the cases is being appealed as a possible community acquired case, the result is awaited.
- No grade 3/4 pressure ulcers were reported.
- Safer staffing fill rate was 98.1% for April. YTD performance is 96.5%.
- There was 4 in-patients falls in April resulting in severe harm with 18 YTD in the severe category; by comparison there were 22 last year.
- VTE assessment performance was 95.6% for March. YTD performance is 95.94% against a target of 95%.
- YTD HMSR is 98.2.

QC(19)073 Draft Quality Account: The Director of Nursing and the Assistant Director of Patient Safety attended two events to present the Quality Account to our CCG, Healthwatch and council colleagues on 10 May 2019. The presentation was well received with 3 minor additions requested.

QC(19)074 Patient Safety Council: The PSC summary page was noted by the Committee. There were no items for escalation.

QC(19)075 Incidents/SIRI/SUI/Never Events Thematic Report:

- There were a total of 1212 incidents reported in March 2019, a 5.46% decrease on 2018.
- There were no never events reported.

- 8 StEIS incidents have been reported, 5 incidents closed and 9 reports were submitted.

QC(19)076 Patient Experience Council: The PEC summary page was noted by the Committee. There were no items for escalation.

National & Local Patient Survey Reports: There is nothing to report this month.

QC(19)077 Quality Care Assessment Tool (QCAT): The report will be reviewed and discussed in detail at the Executive Committee before approval can be given to the revised framework.

QC(19)078 Clinical Effectiveness Council: The summary page was noted and the following highlighted:

- NELA data collection: significant improvements have been made, KH requested congratulations to be passed to the team.
- NCEPOD: 3 active studies, 2 completed studies awaiting national report, 6 completed studies with updates on actions, 1 planned new study in design phase. Issues with receiving recommendations to be discussed with Ash Bassi as lead.

QC(19)079 Mortality Surveillance Report: Local and national performance standards have been met and sustained in Q3. Red and amber rated cases were discussed and actions outlined. Themes identified relate to end of life planning, delays and the accuracy of death certificates.

QC(19)080 Clinical Audit Programme and Progress Report: This paper was deferred pending further discussion.

QC(19)081 NICE Guidance Compliance Report: This paper was deferred pending further discussion.

QC(19)082 National Clinical Reviews/Surveillance Reports/CQC Insight Reports: The Trust has performed well against HLO1 and HLO4 however HLO5b (the proportion of non-commercial contract studies achieving first participant recruited within 30 days) is a challenging target outside of the Trust's control.

QC(19)083 Workforce Council: The summary page was noted by the Committee, there were no items for escalation.

QC(19)084 Safer Staffing Reports: M1 saw a 1.09% increase in the RN overall fill rate from M12 (97.05%); with fill rates still above target. The Care Staff overall fill rate for M1 has increased by 3.52% with fill rates being 114.01%. In comparison to the same period last year M1 (2018): overall RN Fill rate was 93.39%; overall Care Staff Fill rate was 113%.

Items to be brought to the attention of the Board:

- The CQC action plan is on track, 42 actions have been identified and are being addressed within an action plan.
- Marshalls Cross Medical Centre was rated as requires improvement, however it was recognised that the Trust had only formally been providing the services since March 2019. The Trust confirmed to the CQC on 23 April 2019 that actions were being undertaken to improve each area identified as not reaching the standard expected.

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: 29 May 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)42

Title of paper: Committee Report – Finance & Performance

Purpose: To report to the Trust Board on the Finance and Performance Committee, 23rd May 2019

Summary:

Agenda Items

For Information

- Integrated Performance Report
  - The Committee discussed the below target performance for sickness and the underlying factors for it.
  - The Committee noted the HSMR position and further plans to improve this going forward.
- Finance Report
  - The Trust is reporting a £0.8m deficit YTD in line with plan. £0.7m of non-recurrent resources were utilised to achieve this position.
  - Capital resources of £0.3m were utilised in month and the Trust has plans for the entire programme.
  - The Trust delivered a UoR of 3 in line with plan.
  - The financial position includes potential Provider Sustainability Funding (PSF) of £0.3m. It was noted the PSF for 2019/20 relates solely to financial performance, as the A&E element has been removed.
  - The Trust had a cash balance of £11.4m at the end of April which equates to c.11 days of operating expenses.
  - The following risks were noted by the Committee:
    - Cash
    - Changes to taxation around pension allowances which will affect the consultant body and other highly paid staff
    - Challenges from CCG's on CQUIN/Contracts/Coding & Counting changes from 2018/19. (These have been provided for as part of the accounts).
- Briefings were accepted from:
  - Procurement council
  - CIP council
- Reconciliation of Revenue Changes
  - The Committee noted the contents of the paper which showed how the Trust's revenue has growth from £279m in 2012/13 to £402m in 2018/19.
- Capital Programme 2019/20
  - The paper detailed the process undertaken by the Capital Planning Council to allocate the £1.5m of discretionary capital projects.
  - It was noted the Trust had yet to receive its capital resource limit (CRL) from the DoH.
- A&E Performance
  - The Committee reviewed the presentation from the ADO for Urgent Care, Emergency Department Consultant, and Associate Medical Director.
  - There was also an additional presentation on UEC workstreams to improve patient flow.

- The Committee noted the detailed information included within the presentation.

For Assurance

- CIP Programme update
  - The Committee noted the £12.2m of CIP delivered at month 1 which was an increase of £10.1m on the previous year.
  - The Committee took assurance from the 2019/20 CIP plan and the high level of recurrent schemes forecast.
- CIP Programme update – MCG
  - The committee took assurance from the number of schemes the care group have been able to identify as green at an early point in the year.
  - It was noted within the presentation that the care group are also focussing on financial controls as well as CIP delivery.

Risks noted/Items to be raised at Board

- Financial risks around cash, pension allowances and CCG challenges
- A&E performance and the impact the wider Trust bed capacity has on this performance

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: Denis Mahony, Non-Executive Director

Date of meeting: 29th May 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19) 43/44

Title of paper: Committee Report – Audit

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

Summary:
A meeting of the Audit Committee was held on 22nd May 2019. The following matters were discussed and reviewed:

Annual Accounts, Quality Account and Annual Report

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

- **Presentation of the audited annual accounts for 2018/19** – The accounts were presented by Dave Brimage, Assistant Director of Finance, to the Audit Committee with a view to approval of the accounts by the Audit Committee on behalf of the Trust Board after consideration of the external auditor's Audit Findings Report (see below).

- **The Audit Findings Report (ISA260) –** This was presented by John Farrar of Grant Thornton, the Trust's external auditors. The report was a positive report and included an unqualified opinion both on the Trust's financial accounts and Value for Money. The Audit Committee noted and accepted the report subject to a minor amendment which has now been actioned.

- **Approval of the Trust's accounts** – The Audit Committee approved the Trust's audited financial accounts for 2018/19 under delegated powers and on behalf of the Trust Board following consideration of the presentations above.

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

- **Presentation of the Trust's Quality Account for 2018/19** – The Quality Account was presented by Sue Redfern, the Director of Nursing.

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

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

    - It contained at least all the mandatory disclosures required;
    - It reflected what was in the annual accounts where figures were quoted and;
    - those figures audited in the annual report by the External Auditor (ie. Remuneration, Pension and Pay Multiplier numbers) were verified to Trust records and calculations.

  The Annual Report was approved by the Audit Committee.

Annual Meeting Effectiveness Reviews of Committees

- Nicola Bunce presented a report covering all committees of the Board. The Audit Committee noted and accepted the report and recommended for approval to the Trust Board.

NB. There was no requirement for a meeting of the Trust's Auditor Panel on this occasion.
Corporate objectives met or risks addressed: Contributes to the Trust's Governance arrangements
Financial implications: None as a direct consequence of this paper
Stakeholders: The Trust, its staff and all stakeholders
Recommendation(s): For The Board to note and ratify the approval by the Audit Committee of the Trust's financial accounts for 2018/19, the letter of representation and annual report and to approve the findings of the annual meeting effectiveness reviews (as accepted by the Audit Committee)
Presenting officer: Su Rai, NED and Chair of Audit Committee
Date of meeting: 29th May 2019

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)45

Title of paper: Aggregated incidents, complaints & claims report for quarters 3 and 4 2018-19

Purpose:

The purpose of this paper is to present an overview of incidents, complaints, PALS and claims activity and performance during quarters 3 and 4 (Q3 and Q4) 2018-19 and to identify if there are any key themes or trends that need further investigation. It is to provide the Board with assurance that there are systems and processes in place to report and manage these issues.

Summary for 1st October 2018 to 31st December 2019 (Q3) and 1st January 2019 to 31st March 2019 (Q4):

Incidents

- Total incidents in Q3 & Q4
  - Q3 there were 3808 (0.5% increase from Q2)
  - Q4 there were 3594 (5.6% decrease from Q3)
- Total patient incidents in Q3&Q4
  - Q3 there were 3184 (1.1% decrease from Q2)
  - Q4 there were 2972 (6.7% increase from Q3)
- Total patient incidents graded as moderate harm or above
  - Q3 there were 50 (15.3% decrease from Q2)
  - Q4 there were 40 (20% decrease from Q3)
- The rate of patient incidents per 1,000 bed days Q3&Q4
  - Q3 was 48.5 (2.1% increase from Q2)
  - Q4 was 43.0 (11.4% decrease from Q3)
- The rate of incidents resulting in moderate harm or above per 1,000 bed days
  - Q3 was 0.7 (22.2% decrease from Q2)
  - Q4 was 0.6 (14.3% decrease from Q3)
- Incidents which were StEIS reportable
  - Q3 had 15 (66.7% increase from Q2)
  - Q4 had 13 (13.3% decrease from Q3)

Complaints Q3

- 68 1st stage complaints were received and opened - increase of 13.3% compared to Q2
- Closed 2 less 1st stage complaints than received

Complaints Q4

- 78 1st stage complaints were received and opened - increase of 14.7% compared to Q3
- Closed 11 less1st stage complaints than it received

PALS Q3

- PALS contacts increased by 7% compared to Q2 (625 compared to 585)

PALS Q4

- PALS contacts increased by 28% compared to Q3 (799 compared to 625)
- Communications remains the leading reason for enquiries to PALS

Clinical Negligence Claimants Q3

- 24 new clinical negligence claims - decrease of 11 from the 35 received in Q2

Clinical Negligence Claims Q4

- 44 new clinical negligence claims - increase of 20 from the 24 received in Q3

Activity

Activity continues to rise (see tables below), which may have contributed to the increase in complaints and PALS contacts, specifically the increase in A&E attendances and the increase in waiting times during this period may have had an impact on the number of PALS contacts

Q3 activity	+/- compared to Q3 2017-18	+/- compared to Q2 2018-19
Spells including well babies	+3%	+4%
Outpatient attendances (seen)	+3%	+4%
A&E attendances (Type 1)	+1%	+2%

Q4 activity	+/- compared to Q4 2017-18	+/- compared to Q3 2018-19
Spells including well babies	+4%	-0.5%
Outpatient Attendances (seen)	+0.4%	+1.2%
A&E Attendances (Type 1)	+6%	+0.1%

Corporate objectives met or risks addressed: Safety – We will embed a learning culture that reduces harm, achieves good outcomes and enhances the patient experience.

Financial implications: There are no direct financial implications arising from this report

Stakeholders: Patients, carers, commissioners, regulators and Trust staff.

Recommendation(s): Members are asked to review the report and consider if there are any issues that need to be referred to the Quality Committee for further investigation.

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

Date of meeting: 29th May 2019

1. Introduction

This report highlights if there are any trends and the learning derived from incident reporting, complaints, claims and PALS enquiries received by the Trust. The information includes all reported incidents, complaints, PALS and litigation (claims and inquests). The Trust uses the same Datix system to record reported incidents, complaints, PALS enquiries and claims. This allows the Trust to link any related occurrences.

The data included in this report covers Q3 (1st October 2018 to 31st December 2018) and Q4 (1st January 2019 – 31st March 2019).

1.1 Governance of Complaints, Incidents and Claims

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

1.2 Reasons and Themes

The table below compares the top five reasons for incidents, complaints, PALS and claims for all reported during Q3 and Q4, to identify if there are any common themes.

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

Incidents	Q3	Q4	Complaints	Q3	Q4	PALS	Q3	Q4	Clinical Negligence Claims	Q3	Q4
Accident that may result in personal injury	1020	987	Clinical Treatment	34	33	Communi-cations	123	158	All specialities failure to diagnosis/delay in diagnosis	7	14
Implementation of care or ongoing monitoring/ review	623	542	Patient Care/ Nursing Care	7	13	Appointments	101	126	Fail/delay treatment	3	2
Clinical assessment (investigations, images and lab tests)	328	367	Values and Behaviours (Staff)	7	7	Clinical Treatment	83	98	Failure to recognise complications of treatment	3	3
Access, Appointment, Admission, Transfer, Discharge	341	305	Appointments	1	9	Patient Care/ Nursing Care	78	78	Failure to warn (informed Consent)	2	1
Medication	317	301	Admissions & Discharges (excl.delayed discharge re care package)	5	4	Admissions & Discharges (excl.delayed discharge re car package)	53	77	Delay in performing an operation	1	0

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

Table 2: Colour scheme for themes

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

The top category in each of the four areas has been consistent for the last five quarters and the other reasons for each area have also remained in the top five, except for claims, where there is some fluctuation due to the small numbers.

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

2. Incidents

During Q3 2018-19 3808 incidents were reported by staff, with 15 incidents reported to StEIS and 50 categorised as moderate harm, severe harm or death. In comparison, during Q4 2018-19 there were 3594 incidents reported with 13 reported to StEIS and 40 categorised as moderate or above.

Charts 1 and 2 below show the Trust's incident reporting activity from Q1 2017-18 to Q4 2018-19. This shows an increase in incident reporting but a downward trend in levels of significant harm resulting from the incidents. This might be a positive indication of an improving culture of reporting.

Chart 1: total incidents reported

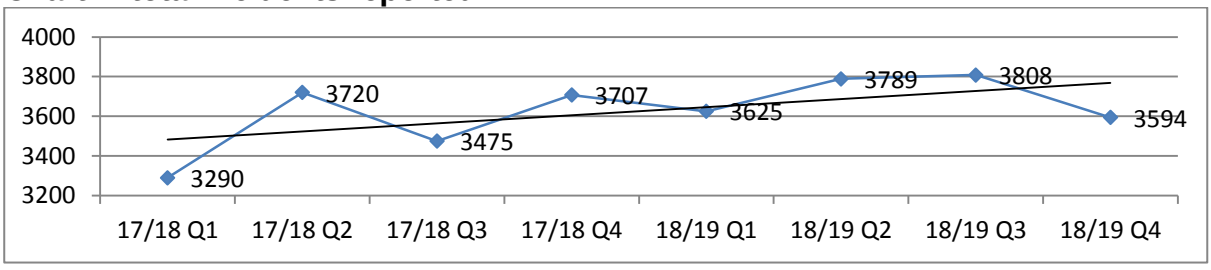
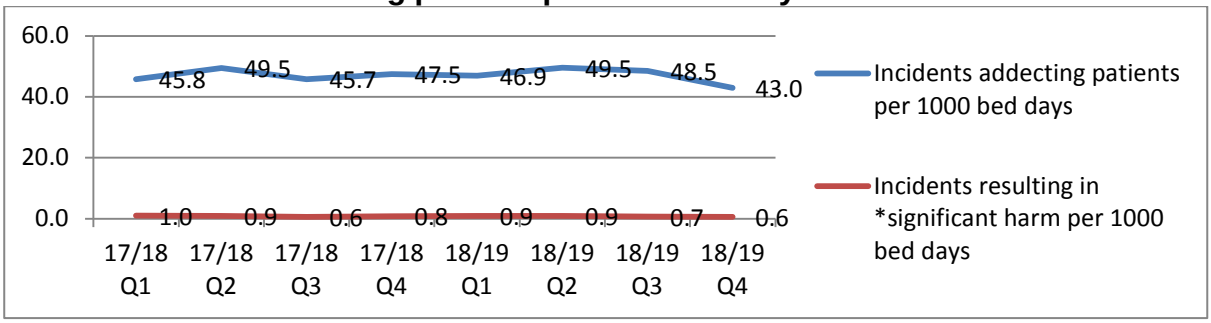


Chart 2: Incidents affecting patients per 1000 bed days



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

Table 3: Comparison of Trust's rates (as per NRLS data) of harm against national rates (October 2016 - September 2018)

	Oct 2016 - Sept 2017		Oct 2017 - Sept 2018	
	Trust %	National %	**Trust %**	National %
No harm	**83.6%**	73.8%	**86.1%**	74.7%
Low	**14.5%**	22.9%	**12.4%**	22.1%
Moderate	**1.5%**	2.8%	**1.3%**	2.6%
Severe	**0.3%**	0.3%	**0.2%**	0.3%
Death	**0.1%**	0.2%	**0.1%**	0.2%

**Trust data correct as of 09/05/2019 using all incidents currently graded for harm.*

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

2.1. Thematic analysis of incidents reported to StEIS* in Q3 & Q4 2018-19

In Q3 the Trust reported 15 incidents to StEIS and 13 in Q4. Only those incidents outlined in the Serious Incident Reporting Framework are reported on StEIS. These include any incident where the Trust causes severe harm or death, information governance (IG) breaches, allegations of abuse and a number of other categories.

Table 4: Incidents reported to StEIS in Q3 & Q4 2018-19

	2018-19 Q3	2018-19 Q4
Slips, trips, falls and collisions	7	5
Cancer - Diagnosis failed or delayed	3	2
Labour or delivery - other	2	1
Some other medical condition	0	2
Infection control	0	1
Discharge	0	1
Abuse by the staff to the patient	0	1
Appointment	1	0
Connected with the management of operations / treatment	1	0
Images for diagnosis (scan / x-ray)	1	0

2.2. Actions taken as a result of serious incidents

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

Examples of the actions taken include:

- A new written process for management of radiology discrepancy incidents to ensure responsibility for duty of candour is clear has been incorporated into the Serious Incident Standard Operating Procedure
- Risk assessment process has been developed for use in the Emergency Department
- All Mohs surgery is now delivered under the governance and leadership of the Plastic Surgery Directorate

Lessons learned from incidents are shared via the bi-monthly safety bulletin included in Team Brief and through each Care Group governance meetings.

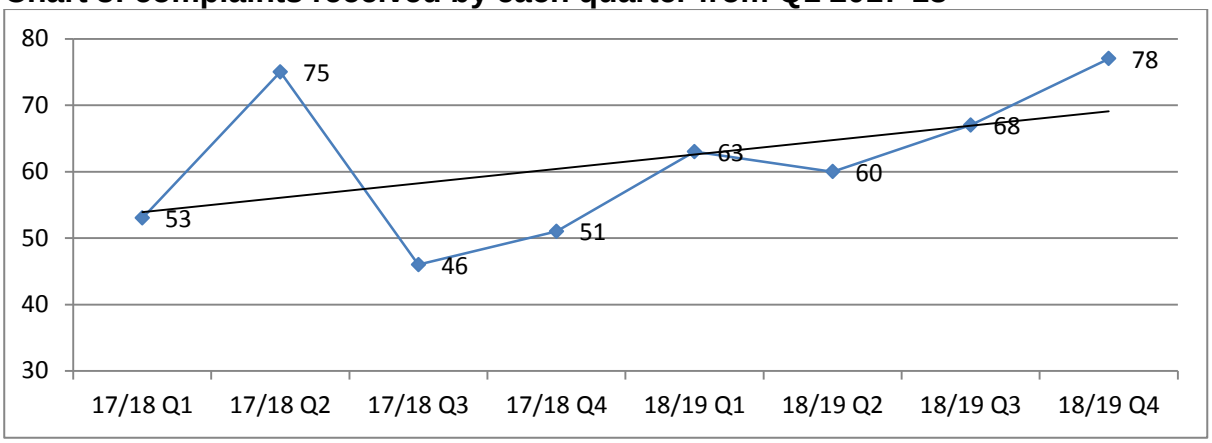
3. Complaints

In Q3, 68 1st stage complaints were received and opened; an increase of 13.3% compared to the previous quarter. The Trust closed two less 1st stage complaints than it received in Q3.

In Q4, 78 1st stage complaints were received and opened, an increase of 14.7% compared to the previous quarter, and 67 were closed.

The chart below contains 1st stage complaints (written and verbal) received by quarter, since April 2017. This shows an increase in the overall number of complaints received in the last four quarters.

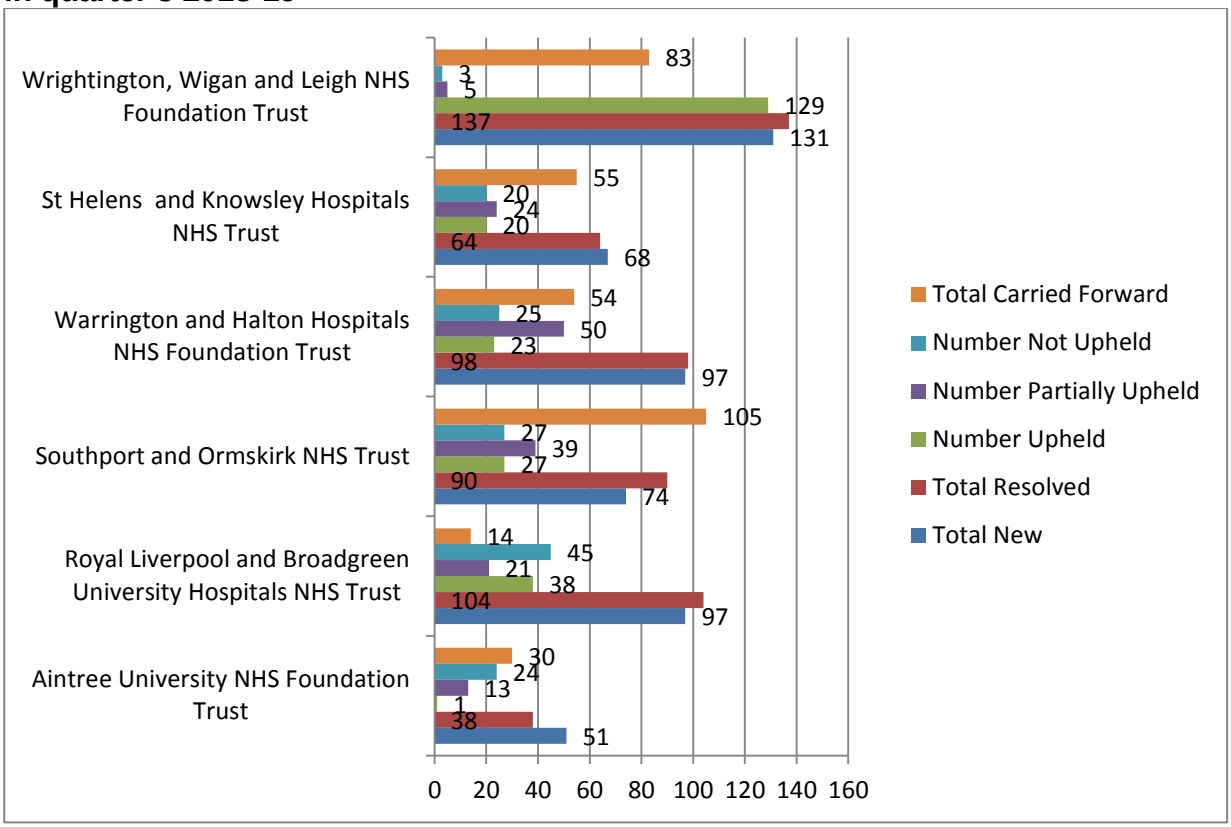
Chart 3: complaints received by each quarter from Q1 2017-18



3.1. Complaints – local and national comparison

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

Chart 4: Comparison of number of written 1st stage complaints received and resolved in quarter 3 2018-19



Q3 figures indicate that the Trust has the second lowest received written complaints compared to other local trusts. In addition, the Trust has the second lowest number of complaints upheld. Quarterly benchmarking is not available for Q4 yet.

3.2. Actions taken as a result of complaints

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

Privacy and Dignity

- Staff to ensure that they explain the Trust's dignity procedures to patients before any test or procedure is carried out which might compromise their dignity

Communications

- Staff reminded of the expected standard of service when dealing with enquires and of their responsibilities to provide regular updates to those raising concerns
- Staff to ensure that they communicate clearly in order that patients understand their treatment before leaving their appointments/ward.
- De-brief for neonatal deaths should have a neonatal consultant in attendance and all de-brief with fetal medicine involvement should have a consultant with specialist interest in fetal medicine in attendance

- Staff nurses reminded to wear their identity badges at all times and to introduce themselves at the start of every shift

Patient Care/Nursing Care

- All staff to ensure that medication is obtained from the Omnicell when not available on the ward
- Undertake a review of the processes for paediatric referrals required following birth.
- Discharge papers sent to Community Midwife and GP should accurately reflect NIPE examination
- Investigation identified an error in new lung function equipment, which has now been rectified
- A new template for plastic surgery secretariat to use to inform GP and breast surgeons of any abnormal reports that they are made aware of. The aim of this is to ensure that investigation reports are sent from plastic surgery without delay
- Additional triage training provided to staff

Clinical treatment

- Reminders sent out to all Consultant Radiologists who carry out radiology reporting to ensure that they re-familiarise themselves with the importance of using ALERT codes
- Nursing staff in the ward to receive training on removing PICC lines

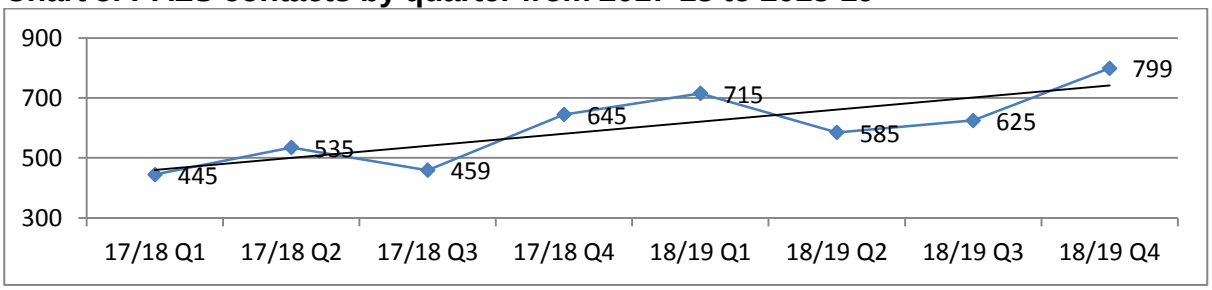
Values and Behaviours

- Additional staff have been appointed following expansion in the Lilac Centre
- New patient experience board has been placed in the Lilac Centre
- New pager system has been implemented meaning that patients no longer have to sit and wait in the Lilac Centre waiting room
- Staff have been reminded of the importance of returning telephone calls and following up on any actions
- Training in Customer Service for Receptionist
- Staff have been reminded in the safety huddle re: personal telephone calls

4. PALS

There were 625 PALS contacts/enquiries during Q 3 2018-19. This represents a 6.8% increase compared to the previous quarter, and a 27.4% increase compared to the equivalent quarter in 2017-18.

Chart 5: PALS contacts by quarter from 2017-18 to 2018-19



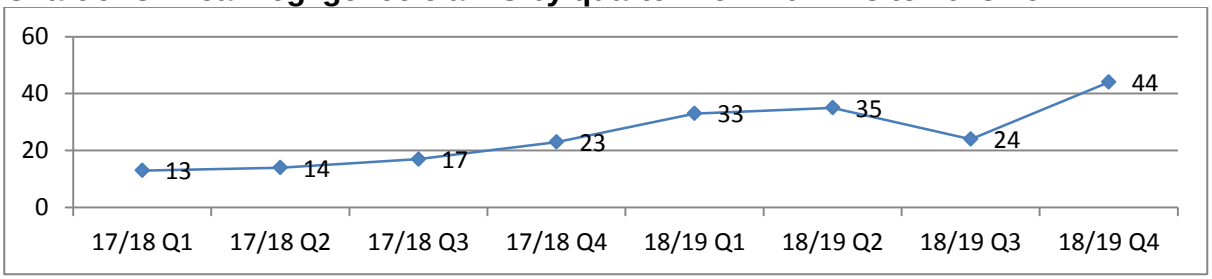
In Q4 2018-19, there were 799 PALS contacts/enquiries. This represents a 27.8% increase compared to the previous quarter, and a 23.8% increase compared to the equivalent quarter in 2017-18.

The main themes for PALS contacts in Q3 and Q4 are shown in table 1 above and remain generally consistent with communications remaining the leading reasons for PALS contacts.

5. Legal Services

5.1. Clinical negligence claims

Chart 6: Clinical negligence claims by quarter from 2017-18 to 2018-19



In Q3, the Trust received 24 new claims (16 pre-action and 8 formal claims), representing a decrease compared to the 35 new claims in Q2. Sixteen of the new claims were received by the Surgical Care Group (a 15.7% decrease on the previous quarter) and seven by the Medical Care Group (a decrease of 50% on the previous quarter). One claim was received that related to Clinical Support Services.

In Q4, the Trust received 44 new claims (*31 pre-action and 13 formal claims*), representing a significant increase compared to the 24 new claims in Q3. Twenty-nine of the new claims were received by the Surgical Care Group (an 81.25% increase on the previous quarter) and fourteen by the Medical Care Group (an increase of 100% on the previous quarter). 1 claim was received that related to Clinical Support Services (similar to Q4).

5.2. Actions taken as a result of claims

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

Table 5: Learning and actions taken as a result of claims

Incident	Learning and actions
Patient attended ED multiple times with abdominal pain and was discharged. Tragically she subsequently had a cardiac arrest.	The case identified the need to improve reviewing of ECGs in ED and, therefore a standard operating procedure for reviewing ECGs in ED was developed and implemented.
Failure to undertake an X-ray and consequent misdiagnosis of a scaphoid fracture as a sprain.	Need for additional training and, as a result, sessions were provided re appropriate examination & documentation of scaphoid injury. Advice cards about sprains developed for the Emergency Nurse Practitioners.
An urgent vascular referral should have been made following an appointment and a CT angiogram should have been performed given the severity of the patient's condition.	The case identified the need for a platform to discuss these patients' cases and as such a diabetic foot multidisciplinary team meeting was set up to take place every Monday.

In addition to the above, a Task and Finish Group was set up to review Hill Dickinson's reports on maternity and Emergency Departments' clinical negligence claims between 2012 – 2017, which confirmed that the majority of actions taken as a result of claims remain in place or have been superseded by updated practice.

5.3. Benchmarking data for claims

Quarterly benchmarking data is not available for NHS Trusts. However, NHS Resolution does produce annual figures for claims notified in previous financial years.
The figures for clinical negligence claims received 2017-18 for local trusts were published in the last update. Comparisons for 2018-19 will be included once they are made publicly available via NHS Resolution's Factsheet 5.

5.4. Inquests

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

Currently there are 33 open inquests (24 third party inquests and 9 direct Trust involvements). Three inquests were closed in Q3 & Q4; one of which the Trust had direct involvement in and the verdict given was death by natural causes with neglect.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)46

Title of paper: Quality Account 2018-19

Purpose: To provide the Board with the final draft version of the Quality Account for 2018-19 for review and approval.

Summary:

The final draft of this year's Quality Account has been completed in line with the National Health Service (Quality Accounts) Regulations 2010 as amended by the National Health Service (Quality Accounts) Amendment Regulations 2012.

Grant Thornton have reviewed the draft version and have provided their limited assurance report and undertaken an audit of VTE and patient safety indicators, with no issues identified

The Director of Nursing, Midwifery and Governance and Assistant Director of Patient Safety presented the draft Account to a number of partners at two external events on 10th May; one for Halton and one for St Helens and Knowsley.

The Assistant Director of Governance presented to Healthwatch Knowsley on 23rd May.

The feedback from these presentations has led to some suggested minor amendments and additional information on the work undertaken by the Trust. The amendments are listed in section 4.3 of the Quality Account.

Written feedback has been received by Halton Borough Council and the remaining stakeholder feedback will be inserted as soon as it is received. The final Quality Account will be provided to the Communications Team for layout and design purposes. We remain on track to ensure that the final version is ready for upload to the NHS website by the national deadline of 30th June 2019.

The Quality and Audit Committees reviewed the draft at the meetings held on 21st and 22nd May 2019 respectively.

The final draft is attached as Appendix 1.

Corporate objectives met or risks addressed: Care, safety, communication

Financial implications: There are no additional resource requirements arising directly from this report.

Stakeholders: Trust Board, patients, carers, staff, regulators, commissioners, Healthwatch

Recommendation(s): Members are asked to review and approve the final draft of the Quality Account.

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

Date of meeting: 29th May 2019

Appendix 1

St Helens and Knowsley Teaching Hospitals NHS Trust

Quality Account 2018-19

What our patients said about us in 2018-19

I was recently a day patient at the Holbrook Unit for minor surgery. From the moment I entered the unit to the time I left, I was treated with the utmost care.
All staff were very friendly and attentive. I was very anxious but the compassion and understanding they showed me was second to none.
Thank you so much to all concerned, you're absolute stars!

The level of care this week from Whiston Delivery, Women's Ward and Special Care Baby Unit for my partner & son has blown me away. Every person working in those areas should be so proud of themselves every time they go home.

I received excellent care and treatment. I was admitted to 3Alpha, Whiston Hospital, with a broken hip. The care and treatment I received were first class. From the porters, tea ladies, cleaners, nurses, X-ray department, doctors and surgeon, I cannot express how kind every member of staff treated me. All staff acted in a professional, caring and friendly manner. I'd like to give a massive thank you to all. Our NHS is wonderful. Whiston Hospital has a lovely atmosphere and I would recommend it to anyone in need of treatment.

Newton Community Hospital
***** 5 star hospital
The hospital gives a great service for the people in the area. The staff are very helpful and always will to help in any way they can. You feel like a human being instead of just a number. It is clean and welcoming, even though no one wishes to be at a hospital. Five star rating from me.

Excellent Care
I attended A&E with an asthma attack late on a Saturday night. The care I received from all the staff was outstanding. I was assessed by a nurse quickly and seen by a Dr almost immediately. Within four hours I was on my way home after full investigations and treatment.
Thank you to the amazing A&E team who made a stressful situation much easier.

I have always had exceptional help and understanding from all of the professionals at Marshalls Cross. I called today to make an appointment for my mum for tomorrow and was greeted by a receptionist who could not have been more helpful. She was friendly, kind, respectful and efficient. I did not feel rushed at any time and they listened very carefully about my concerns for mum's health.
What an amazing ambassador for Marshalls Cross Medical Centre
Thank you so much

I just want to thank you for running such a superb, clean, friendly, professional & welcoming hospital. From the flowers in the car park and ability to find a space! The delightful screens around the beds and excellent space between the beds as well. This has been the best experience of a hospital (private or NHS) in my lifetime. Whether as a patient (the surgery & care I received today was exemplary), relative or visitor.
By profession I am trained to look for faults. I couldn't find even a suggestion of one today. If all of the NHS was run in the same way that St Helens Hospital is, well, this hospital shows how it should be, your staff should be so proud.

Contents

1. Section 1

1.1. Summary of quality achievements in 2018-19

Quality of services overall

- **Outstanding** rating awarded by the Care Quality Commission (CQC), the best possible rating, in the latest report received in March 2019

Patient safety

- Patients received 99.1% new harm-free care during 2018-19, an increase from 98.9% in 2017-18. This is harm occurring whilst an inpatient in the Trust and reported via the NHS Safety Thermometer
- No patients experienced a hospital acquired grade 3 or 4 pressure ulcer for the second year running
- No methicillin resistant staphylococcus aureus (MRSA) bacteraemia, with one contaminant
- Performed significantly better than the threshold of 40 for clostridium difficile
- Reductions in incidents resulting in harm in 2018-19 compared with 2017-18
    - 71% reduction in theatre-related episodes of moderate and above harms from 7 in 2017-18 to 2 in 2018-19
    - 86% decrease in medication incidents resulting in moderate harm or above from 14 in 2017-18 to 2 in 2018-19
    - 36% decrease in harmful medication incidents from 56 in 2017-18 to 36 in 2018-19
    - 18% decrease in falls incidents resulting in severe harm or above from 22 in 2017-18 to 18 in 2018-19
    - 0 prescribing incidents of moderate/severe harms, compared to 4 in 2017-18
- 1st nationally for flu vaccination of frontline staff, achieving 95.4% compared to 87% in 2017-18
- 96.5% fill rate for registered nurses/midwives compared to 93.9% in 2017-18
- Successfully implemented Safe Care Allocate system across all areas to ensure right levels of staff are available to deliver safe patient care
- Implemented the Electronic Prescribing and Medicine Administration (ePMA) system across the Medical Care Group, which is being rolled out Trust-wide. The electronic system enhances safe prescribing and administration process
- Medicines Safety Nurse appointed to oversee medicines safety initiatives
- The Cell Pathology, Microbiology, Clinical Biochemistry and Haematology & Blood Transfusion departments based at Whiston, St Helens, Southport and Ormskirk hospitals have individually been awarded United Kingdom Accreditation Services (UKAS) ISO15189 accreditation for the first time and at the first attempt since the new standards replaced the old CPA accreditation standards. This means that pathology is performing to high international standards with regard to quality and competency
- Trust's Radiology Service was recommended for Imaging Services Accreditation Scheme (ISAS), following a rigorous review – the first trust in Cheshire and Merseyside to receive this award

Patient experience

- Best acute trust nationally for the second year running in 2018 for the Patient Led Assessments of the Care Environment (PLACE), with top marks in the country for; cleanliness, food, privacy and dignity, facilities for patients living with dementia and disabilities, condition, appearance and maintenance of the hospital buildings. The assessment included the Trust's new Intermediate Care Unit at Newton Hospital for the first time
- 96% of inpatients would recommend our services, as recorded by the Friends and Family Test

Clinical effectiveness

- Consistently maintained top 5 rating in the UK overall in the Sentinel Stroke National Audit Programme (SSNAP), delivering sustained excellent performance
- 85.7% of stroke patients spent at least 90% of their hospital stay on a stroke unit, above the national target of 83%
- 96.4% of electronic E-attendance summaries sent for patients attending the Emergency Department (ED) within 24 hours
- Gastroenterology service successfully secured Joint Advisory Group (JAG) accreditation for a further year
- Sustained achievement of the cancer performance targets against the national cancer waiting times standards
- Won the ISD Network innovation award for Improving Patient Outcomes & Efficiency with TeleHealth, the informatics programme that allows clinicians to provide video appointments to patients in both the Stroke and Burns & Plastics services
- Successful in two categories of the North West Coast Research and Innovation awards, winning the Delivery of Commercial Life Science Research award and finalists in the Clinical Research Team of the year award
- Received the prestigious North West Coast Research and Innovation Award 'Taking Research into Practice' for research performed by Michael Lloyd, Medical Education & Training Pharmacist

Well-led

National staff survey

- Best acute trust in the NHS for the third consecutive year with outstanding results, published in March 2019, with the Trust rated as the **best place to work and receive treatment in the NHS**
- Recognised, for the third year running, as being the top acute Trust in the entire country for staff engagement, staff motivation and pride in the quality of care provided to patients
- Highest marks in the following areas
    - Positive organisational culture of safety
    - Quality of care
    - Staff engagement
    - Staff morale
    - Equality, diversity & inclusion
    - Providing a safe environment for staff

Staff

- Disability Confident Employer accreditation in place until 2020

- The Trust was reassessed for the Navajo Charter Mark in 2019 and was successfully reaccredited. This is an equality mark signifying good practice, commitment and knowledge of the specific needs, issues and barriers facing lesbian, gay, bisexual, transgender, intersex and questioning (LGBTIQ) individuals
- Health, Work and Wellbeing Service successfully re-accredited for Safe Effective Quality Occupational Health Standards (SEQOHS). Feedback from the SEQOHS Assessors included being nationally recognised as an exemplary service, the assessors made particular reference to the acquisition and streamlining of services with Southport and Ormskirk Hospital NHS Trust and the excellent service being provided to Lead Employer
- Awarded the prestigious Defence Employer Recognition Scheme Silver Award, based on its commitment to helping members of the Armed Forces community gain employment following service for their country
- Jayne Gore, Clinical Lead for Intermediate Care, named Community Nurse of the Year by St Helens CCG for her hard work, commitment & dedication to providing the highest possible care to our local community
- Joanne Battensby won the Midwife of the Year at the British Journal of Midwifery Practice Awards 2019
- Sarah Hynes, Health Care Assistant, was awarded a Cavell Star Award, which are given to staff who shine bright and show exceptional care
- Sarah Jones, Specialist Midwife for Improvement and Education, won the Royal College of Midwifery's Thompsons Members' Champion Award 2019
- Maternity Services won the Midwifery Team Award for their outstanding contribution to maternity and midwifery services from the Northern Maternity & Midwifery Festival Awards
- Diabetes Team highly commended in both National Hypoglycaemia Awareness week and Insulin Safety Week for their awareness initiatives and promotional work which took place across the community and hospital sites within the Trust
- Finance Director, Nik Khashu, was named Finance Director of the Year in the Non-Profit Organisation category at the regional Finance Director of the Year awards, sponsored by Accountable Recruitment, Grant Thornton, HSBC and Hill Dickinson

Services and Infrastructure

- Won the Care and Health Integration Award at the Municipal Journal Achievement Awards in London as part of St Helens Cares collaboration
- Library and knowledge services attained a score of 100% compliance in the annual library quality assurance framework, one of only 10 in the country to achieve this
- Won the Hospital Cleaning Award at the Health Business Awards
- Won the Property and Estates Management Service Provider of the Year at the 2019 HSJ Partnership Awards (St Helens and Knowsley Teaching Hospitals Trust, New Hospitals, Vinci Facilities and Medirest)
- St Helens & Whiston hospitals were highly commended at the North West in Bloom Awards. St Helens Hospital also received a special award for the best hospital grounds in the North West

The Trust continues to celebrate success internally, hosting our 14th Annual Staff Awards presentation evening in April 2018. The awards celebrate the hard work and achievements of staff in providing excellent patient care every day of the year. The

readers of the St Helens Star newspaper awarded the Maternity Department the prestigious People's Choice award, highlighting the appreciation that patients and their families have for the excellent care they receive.

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

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

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

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

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

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

St Helens and Knowsley Teaching Hospitals NHS Trust's Vision

St Helens and Knowsley Teaching Hospitals NHS Trust's Values and ACE Behavioural Standards

The Trust's vision is the driving force for our focus on continuous improvement, supported by the Clinical Strategy. The Strategy outlines the Trust's commitment to improving both quality and efficiency with the specific aim of promoting a culture of continuous value improvement, underpinned by robust systems and processes and individual and collective accountability. It focusses on a small number of improvements that are key local health economy priorities. The Strategy was refreshed in 2018 and is supported by an implementation plan, which will be monitored by the Quality Committee going forward.

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

In addition, the Trust has an embedded quality care accreditation programme which measures leadership, patient care, safety and experience on all wards. The Quality Care Accreditation Tool (QCAT) programme ensures that individual ward areas are clear on the quality standards required and any shortfalls requiring an improvement plan. The QCAT incorporates a range of quality indicators into the final score, including CQC fundamental standards, nursing care indicators and harm-free care scores. It also incorporates the Friends and Family Test results, staff training and appraisal rates and patient care and safety standards, including nutrition and hydration, falls, pressure ulcers and infections. Both the nursing care indicators and the QCAT use peer review to provide assurance on the quality of care being provided to patients. The outcomes of the QCAT programme are reported to the Quality Committee via the Patient Experience Council. In 2018-19 the QCAT was supplemented by a programme of in-depth quality reviews based on the CQC's key lines of enquiry. In 2019-20, the format of the QCAT will be reviewed and enhanced to combine the revised key lines of enquiry.

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

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

We continue to work with our local Healthwatch partners to improve our services, and Healthwatch representatives are key members of the Patient Experience and the Patient Safety Councils, which report to the Trust Board's Quality Committee, ensuring effective representation in the oversight and governance structure of the Trust. Patients, carers, patient representatives and members of the public are invited to attend the open Patient Engagement Group events and to contribute to discussions about the services provided and future plans.

This Quality Account details the progress we have made with delivering our agreed priorities and our achievement of national and local performance indicators, highlighting any challenges and the initiatives undertaken to work towards realising our vision of 5-star patient care. It also includes a summary of our key strategies. It outlines our quality improvement priorities for 2019-20, which were subject to consultation with staff, patient representatives and our commissioners.

I am pleased to confirm that the Trust Board of Directors has reviewed the Quality Account for 2018-19 and confirm that it is a true and fair reflection of our performance and that, to the best of our knowledge, the information contained within it is accurate. We hope that it provides you with the confidence that high quality patient care remains our overarching priority and that it clearly demonstrates the progress we have made.

We recognise that our staff are our greatest asset and we acknowledge their professionalism, commitment and dedication as they work tirelessly to provide excellent care for our patients and their carers. This was reiterated by the excellent rating of outstanding confirmed by the CQC in March 2019. On behalf of the Trust Board, I would like to thank all of our staff who have contributed to our many exceptional achievements, during another extremely challenging year.

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

2. Section 2

2.1. About us

2.1.1. Our services

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

The Trust has just over 700 inpatient beds, with circa up to 40 additional escalation beds and provides the majority of its services from two main sites at Whiston and St Helens hospitals, both of which are state-of-the-art, purpose built modern facilities that are well-maintained. Whiston Hospital houses the Emergency Department, the maternity unit, children and young people's service and all acute care beds. St Helens Hospital houses day-case and elective surgery, outpatients, diagnostic facilities, rehabilitation beds, the Lilac Centre (a dedicated cancer unit, linked to Clatterbridge Centre for Oncology) and Marshalls Cross Medical Centre (primary care services). The Trust provides outpatient and diagnostic services in a small number of other settings. The Trust also provides intermediate care services at Newton Hospital, which has 30 inpatient beds, and a range of community services, including Contraception and Sexual Health Services (CaSH), frailty, falls, Healthy Heart, continence and chronic obstructive pulmonary disease (COPD) services. In addition, the Trust provides community adult nursing services in St Helens, which are delivered by North West Boroughs Healthcare NHS Foundation Trust under contract. These services were rated as good by the CQC at their last inspection in 2018-19.

The intermediate care service continues to promote and support the ability to step patients up from their own home, as well as supporting the discharge of patients from hospital. The service has multidisciplinary input including GP, therapy, nursing and geriatrician to ensure patients receive the right level of care.

The role of the Community Frailty Service is to provide Comprehensive Geriatric Assessments (CGA) of frail older people in St Helens, to ensure that there is a plan in place that will support them to live at home. Frailty is a condition associated with aging and is linked to co-morbidity that increases a person’s vulnerability to minor stressors and, as such, requires appropriate management to promote well-being. The service provides a 2 hour response for those patients who are at risk of hospital admission and a 72 hour response time for assessment of complex frail and multi-morbid patients to help prevent crisis and promote wellbeing. Since April 2018 the Frailty service have responded to 692 referrals, working alongside community teams to support patients to remain in their own homes/care home and provide advance care planning and end of life care in the community.

The Healthy Heart team provide the cardiac rehabilitation service for patients who have had a heart attack on an 8 week programme and is based in Fingerpost Medical Centre, in St Helens town centre. The Healthy Heart team also provide a Community Heart

Failure service to the patients of St Helens, which is a Consultant-led service, delivered with Nurse Specialists. It offers community clinics and home visits by the nursing team. The COPD service is community service based in Lowe House in the centre of St Helens town. This is a nurse specialist led/consultant supported service that provides home visits to avoid hospital admissions and early supported discharge from the Trust. This team also support a pilot service to avoid hospital admissions, where patients are seen as soon as possible and an assessment made to identify if the patient can be supported at home.

The CaSH Service operates clinics across St Helens and Halton. Community based clinics offer predominantly contraception services with asymptomatic screening for sexually transmitted infections (STIs). This includes provision of long acting reversible contraception (LARC). St Helens Hospital provides predominantly STI and HIV based services with an on-site laboratory offering microscopy. The service also has a dedicated health improvement team and TAZ young person's clinic (19 and under) open six days per week at The Millennium Centre in St Helens.

The Trust Board is committed to continuing to deliver safe and high quality care. The Trust has had another extremely challenging year, set within the financial challenges facing the NHS. There has been a continued increase in demand for the majority of services, as the Trust continues to be one of the busiest acute hospital trusts in the North West of England. It has an excellent track record of providing high standards of care to its population of approximately 350,000 people across St Helens, Knowsley, Halton and South Liverpool, as well as further afield. The Trust was extremely disappointed to have one never event relating to a retained foreign object in theatre, outlined in more detail below. The Trust uses incidents as opportunities for learning and, therefore, has detailed action plans in place to address any issues arising from any investigations undertaken. This is reflected in the findings of the 2018 CQC inspection, which reported many examples of widespread learning.

The Trust has remained busy during 2018-19 and continues to see an increase in activity across most areas, as shown in the table below, particularly in non-elective admissions and ED attendances. The average length of stay for non-elective admissions is 6.2 days.

	2017-18	2018-19	% change
Non-elective admissions	54,423	57,456	5.57%
Elective admissions	49,873	50,443	1.14%
Births	4,094	4,051	-1.05%
Emergency Department attendances (as reported)	111,340	115,734	3.95%
Emergency Department attendances (excluding GPAU)	106,319	109,605	3.09%

2.1.2. Our staff and resources

The Trust's annual total income for 2018-19 was £402 million. We employ more than 5900 members of staff and we are the lead employer for Health Education North West, Health Education Midlands, Health Education East of England and Palliative Care

London and are responsible for nearly 9,000 trainee specialty doctors based in hospitals and general practice (GP) placements throughout England.

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

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

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

The average staff turnover rate in the Trust for 2018-19 was 9.99%, which is 2.93% better than the national rate of 12.92% for the national acute sector (latest data available is December 2018).

Significant recruitment challenges remain within specific specialties and for specific roles, in particular: medical, nursing and scientific staff. The Trust is proactive in addressing these challenges and has established the Trust 'brand' via social media as an employer of choice, using online and other media advertisement with open days and nursing campaigns. There have been 67 medical gaps since April 2018 and a number of actions have been taken to address these, including developing new roles such as physician associates, physician assistants and advanced clinical practitioners. The full rollout of e-rostering for the junior doctor and non-training grade medical workforce will be completed by March 2020 and will support improved demand and capacity modelling to ensure the most effective use of the Trust's medical workforce.

In addition, the Trust hosts regular recruitment events and uses international recruitment to ensure vacancies are filled. The Trust has collaborated with Masaryk University, Brno, Czech Republic in the recruitment of sixteen newly qualified doctors who trained in Brno using the English syllabus in 2018. These new recruits joined the Trust for two years as Clinical Fellows at foundation year one and two to fill vacancies resulting from the reduced numbers of allocated posts from the North West Deanery. The scheme returned to Brno in March 2019 to recruit up to sixteen more newly qualified doctors for August 2019, to maintain a constant stream of medical support for the Trust. This provides the opportunity to reduce agency spend and maintain continuity of care. The doctors have the same opportunities to access further training in the North West, which keeps the talent pool local. They are a valuable asset to the Trust and our delivery of patient care.

The Medical Training Initiative (MTI) is a mutually beneficial scheme run by each Royal College that provides non-training grade doctors from overseas with the opportunity to work and train in the UK. The scheme is underpinned by the Diploma in UK Medical Practice, which all MTI candidates are expected to achieve. The Trust has successfully recruited, using the MTI scheme and the British Association of Physicians of Indian Origin (BAPIO) training scheme, three senior fellows in paediatrics, two specialty doctors in emergency medicine and one specialty doctor in radiology.

The Trust is also exploring all possible opportunities to attract and retain nurses, midwives, operating department practitioners (ODPs) and allied health professionals (AHPs), including:

- On-boarding and retention of new and existing staff including flexible working, self-rostering, itchy feet discussions, career clinics, assigning a buddy, welcome packs/information, retire and return initiatives
- An active recruitment programme for the nursing and midwifery workforce, ongoing throughout the year, both locally and internationally
- Delivering apprenticeship programmes, from local health care cadets at further education colleges through to part-time registered nurse degrees and ODP apprenticeships
- Implementation of the new nursing associate role, with 16 trainees commencing the programme in January 2019
- Implementing the St Helens and Knowsley Teaching Hospitals NHS Trust Preceptorship, Mentorship and Leadership three year foundation programme to enhance retention, with 121 nurses on the programme from April 2018 to March 2019. This will be updated in line with new Nursing and Midwifery Council (NMC) standards
- Implemented e-rostering, e-job planning and activity manager for allied health professionals to ensure the most effective rostering and planning of work

Nursing and midwifery safer staffing levels are reported externally, with details of the total planned number of hours of registered and care staff measured against the total number of actual hours worked to produce a monthly fill rate as a % for nights and days on each ward. Agency, bank, overtime, extra time hours, discharge coordinators and ward managers' supernumerary management days are included in the actual hours worked totals in accordance with the guidance. The acceptable monthly fill rate is 90% and over, which the Trust consistently exceeds overall. There is Executive Committee scrutiny of the individual areas that fall below 90% each month to review the actions in place to reduce the risk of any recurrence. The safer staffing figure, however, does not analyse skill mix or the impact of temporary staff on a shift-by-shift basis, which can have an impact on the quality of care provided. The Trust has an embedded daily process for reviewing nurse staffing levels across the Trust, with a daily matron huddle, that ensures all areas have appropriate nursing staff and skill mix to support the delivery of high quality care and to maximise patient safety. The introduction of SafeCare Allocate in 2018-19 will enable more effective review of staffing levels and patient acuity by ward going forward.

The Trust also reports Care Hours per Patient per Day (CHPPD), which is calculated from the total actual hours worked in a month divided by the monthly total of the midnight

count of inpatients in the ward. The Trust's position is reported monthly as part of the mandated safer staffing report. The wards facing ongoing challenges with recruitment are generally the wards that are unable to meet the safer staffing 90% fill rate consistently.

2.1.3. Our communities

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

2.1.4. Our partners

The Trust continues to be fully engaged in the work of the health and social care partnership in Cheshire and Merseyside, leading on a number of the priority work programmes on behalf of the health system. In line with the requirements of the NHS Long Term Plan, published in January 2019, the Trust is contributing to the development of the Cheshire and Merseyside system five year transformation plan, which will be submitted in autumn 2019. The Trust is working with other providers across Cheshire and Merseyside to create a Pathology Services Network and a Diagnostic Imaging Network to improve access, response times and service resilience for the whole system.

The Trust is also working at "Place" level with partners in its three local health systems of St Helens, Knowsley and Halton to progress plans for creating integrated care systems. This work encompasses partnership working with Local Authorities, other NHS provider trusts and the Clinical Commissioning Groups (CCGs). Each Borough is at a different stage of development with its proposals for Integrated Care Systems and is adopting different solutions based on their geography; however the common purpose is to facilitate greater collaborative and integrated working across organisational boundaries to improve the health of the population. Some of the structural changes proposed in the NHS Long Term Plan will require national policy or even legislative change, however, the Trust is already working with partners wherever it can to remove barriers and deliver more integrated and personalised care. Examples developed during 2018-19 include:

- Working with Halton, Knowsley and St Helens boroughs, to reduce long stay patients who can be cared for in community settings and do not need to stay in an acute hospital bed
- Expansion of the Community Frailty Service, which provides early assessment and intervention in the Emergency Department or in the individual's home to prevent a hospital admission

- Continuation of our relationship with North West Boroughs Healthcare NHS Foundation Trust to deliver adult nursing community services for St Helens
- Creation of four locality community teams in St Helens, who work closely with groups of GP practices to support their local population, whereby community-based services are wrapped around clusters of GP practices in each locality, with integrated adult nursing teams working with practice nurses, physiotherapists and social care, for example, with similar arrangements for children's team, including mental health services. The community matrons co-ordinate the caseloads, assigning these to the most appropriate team member
- System working to reduce delayed discharges, with Knowsley playing an integral part of the Safer Start initiative which contributed to meeting demand during this winter
- Knowsley discharge team based on site at Whiston Hospital which is contributing to a positive Knowsley position
- Developing ways to improve the delivery of health and social care as part of One Halton with system partners
- Development of reablement team to reduce delayed discharges with St Helens and Halton local authorities, with plans to roll out to Knowsley
- Working with Halton GPs to develop clinical networks to strengthen the working relationships between the Trust's specialty consultants and GPs to support the management of patients in primary care
- Working collaboratively with St Helens CCG to improve diabetes care in primary and community care with specialist support, which may be expanded to other CCG areas
- Working with care homes to provide education and training on pressure ulcer prevention
- Introduction of a shared care record, which allows all parts of the health and care system to view a patient's information
- Working together to maximise out of hospital bed capacity to cope with the increased demands of winter
- Development of the Accident and Emergency Delivery Board for the mid-Mersey region that coordinates and standardises the approach to urgent and emergency care across primary, community and secondary care services, including the inputs from Social Care services that enable the whole system response, to seeing and treating people in the most appropriate setting in a timely manner
- Further work has also been undertaken to reduce unwarranted variation in clinical services, for example, with the creation of the Hyper Acute Stroke Unit at Whiston Hospital, that provides the initial specialist care and treatment of patients from St Helens, Knowsley, Halton and Warrington who have had a stroke
- The Trust continues to work with commissioners, Clatterbridge Cancer Centre and other partners to agree the future location of the Eastern Sector Cancer Hub, which will improve the accessibility of chemotherapy services in the mid-Mersey region

Attendance at the Health and Well-Being Boards (or equivalent) in our catchment boroughs helps the Trust to respond to the local health improvement priorities and develop strategies with commissioners to target specific population groups.

The Trust actively participates in the mid-Mersey patient safety and healthcare associated infection collaboratives. This includes working in partnership with primary care, Local Authorities and commissioners to ensure the services we provide meet the

needs of our local population and to share lessons learned as widely as possible. Staff attend and contribute to a wide range of expert clinical groups both locally and nationally to ensure that the Trust continues to provide services based on best practice evidence. This includes;

- The North West intravenous/aseptic non-touch technique (ANTT) forum meetings
- Antimicrobial resistance collaborative which is, for example, standardising the guidance and pathways for urinary tract infection management
- Work on the identification and timely thrombo-prophylactic management of atrial fibrillation to prevent stroke
- Work with the University of Liverpool and Aintree Hospitals NHS Foundation Trust on a collaborative research project on diabetes care
- Collaboration with Edge Hill University on the development of their new undergraduate medicine curriculum to widen access to medical training
- Collaboration with University of Liverpool to widen access to medical training (the Anfield Project)
- Working with Liverpool John Moores University to develop extended roles (including non-medical prescribing) for nurses, physiotherapists and other health professionals

The Trust continues to maintain close working relationships with Healthwatch, NHS Improvement and the Care Quality Commission, as well as local voluntary organisations that work with people in their own communities and homes to prevent hospital admissions.

There is excellent partnership working with the construction and facilities services providers at the Trust which ensures that we continue to offer an excellent environment and facilities for patients, visitors and staff.

2.1.5. Technology and information

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

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

Informatics have continued to work closely with the operational and clinical teams to strengthen and enhance the security of our clinical and operational systems. The following initiatives have taken place:

- All clinical and administrative systems have been amalgamated under a Unified Threat Management solution, which has been implemented to further enhance the security of our systems and information

- Enhanced monitoring of all systems is now in place and Informatics is working very closely with all Information Asset Owners and Information Asset Administrators in the hospital to ensure systems meet with national requirements
- A dedicated network and security manager commenced in post in April 2018
- Mersey Internal Audit Agency (MIAA) completed an audit of the Trust's Toolkit submission (as required of larger NHS organisations) and the Trust maintained their rating of 'Significant Assurance'

The following initiatives have taken place during 2018-19:

- New Patient Administration System (Medway) was implemented, which is a major building block for the development of a clinical electronic patient record, a key ambition in the Trust's IT strategy. Hardware across the Trust was replaced to support the Medway Patient Administration System project (156 desktops replaced)
- An integrated local care system, the St Helens Shared Care Record, has been launched which seeks to further develop person centred services and support. All local GPs, hospitals, community, mental health and social care services are working together to make it possible for health and social care workers to look at relevant information about patients to make the best clinical decisions

  A shared record means that:
  - Health and social care workers have the most up-to-date and accurate information about each patient's health, medications, treatment and care plan
  - Patients get the right treatment and care in the most appropriate place
  - Reduction in duplicate appointments and tests
  - Reduced need for patients to repeat their medical or social care history

These two major initiatives will deliver:
- Improvements to the patient journey and decision-making capability
- Clinical transformation across a wider footprint, fostering positive working relationships with health economy partners and providing better care to patients wherever they are treated

- The Electronic Prescribing and Medicines Administration System (ePMA) went live across the Medical Care Group wards and Emergency Department. For patients this will mean appropriate medication is given, reducing unnecessary life-threatening exposure to adverse drug related accidents and delayed and missed doses. For clinicians this will mean decision support at the point of prescription, improved legibility, a reduction in transcription errors and improved and effective communication between pharmacy, medical and nursing staff
- Wards have been provided with drug trolleys and mobile computer carts to facilitate the revised workflows, enabling optimal use of the ePMA solution
- The network has been upgraded to support the major clinical system initiatives that have taken place during this year and to ensure that it is future-proofed
- The Electronic Transfer of Care to Pharmacy (eTCP) implementation – in March 2018 the Trust began electronic transmission of discharge medication information to Community Pharmacies. The total local health economy savings as a result of Trust referrals was £289,858 (figures based from April to July 2018). Patients will benefit

from this initiative because ward pharmacists in the hospital will be able to identify to community pharmacies those patients who will benefit from post-discharge medication reviews. This means that patients are not taking medication that can be stopped or need to be changed after their stay in hospital

- System upgrades have been completed for Sexual Health (Lillie), Audiology (Auditbase) and Pathology (Telepath) systems
- An additional 1700 clinicians across the Trust now have access to the Summary Care Record (SCR). SCR provides summary patient information to clinical staff from GP systems, enabling hospital clinicians to have visibility of patients' prescriptions from primary care
- Following a successful bid to the Innovation Agency in 2017, the Trust has continued to develop the Telehealth project, offering video consultations as an alternative to physical outpatient appointments following discharge from hospital for patients who have had a stroke and for patients who have a drain in place following plastics surgery. Telehealth provides the technology for consultants to engage with patients via webcam technology. This means that patients and consultants do not need to be in the same location to conduct consultations. This project went live and responses to the initiative from both patients and clinicians have been extremely positive. Home environmental visits were also piloted with Stroke Occupational Therapists.
- For the Telehealth project, the Hospital Trust was shortlisted for: "Best Not-for-Profit Project" at the Digital Leaders Awards, "Telehealth Category" at the Health Business Awards and was the Winner of the 2018 ISD Innovation Award
- Internally, the Health Informatics structure has been reviewed and revised to align services and capability to enhance Digital Systems innovation, delivery and on-going management. There has also been emphasis on business development and ensuring clinical engagement in all phases of system implementations
- The Library and Knowledge Services attained a score of 100% compliance in the annual library quality assurance framework, one of only 10 in the country to achieve this. They were also highly commended in the Trust's staff awards
- The service worked on alignment with other neighbouring healthcare organisations to enable agile working. The Informatics Service is leading on a joined-up Wi-Fi solution (Govroam) which will provide a single Wi-Fi solution across Cheshire and Merseyside enabling staff to work seamlessly across NHS and Local Authority locations.

2.2. Summary of how we did against our 2018-19 Quality Account priorities

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

2.2.1. Progress in achieving 2018-19 quality goals

Quality Improvement Goal	Outcome delivered	Progress
Maintain effective assessment and monitoring of all patients in the Emergency Department.	Achieved	High compliance with the monitoring of modified early warning scores for patients in line with the requirements of the Trust policy was confirmed by audits. • Modified Early Warning Score (MEWS) undertaken for all patients attending ED • Introduction of patient clinical information displayed on TV screen including MEWS • Electronic MEWS (eMEWS) display at the ED coordinator hub and zone for senior leadership visibility • Allocation of additional resources to ensure patient observations and MEWS completed for patients in waiting areas • Adoption and compliance with Paediatric MEWS • Regular MEWS compliance and escalation audits undertaken
Reduce further the rate of avoidable harm from falls, pressure ulcers and medication incidents	Achieved	• 18% decrease in falls incidents resulting in severe harm or above • No grade 3 or grade 4 hospital acquired pressure ulcers • 18% reduction in avoidable grade 2 pressure ulcers • 8% reduction in total number of avoidable pressure ulcers (all grades) • 86% decrease in medication incidents resulting in moderate harm or above from 2017-18 to 2018-19 • 36% decrease in harmful medication incidents

Implement change as a result of lessons learned from incidents and complaints.	Improved	Audit conducted against the following processes to ensure lessons learned from incidents and complaints shared widely throughout the Trust. • Development and sharing of Trust-wide bimonthly safety briefing • Introduction and embedding of daily safety huddles across all inpatient areas, with sharing of key learning from incidents and complaints • Quarterly Trust learning points identified through mortality review process, shared across multiple forums and governance meetings • Sharing of learning and auditing through weekly senior nurse walk about • Development of weekly incident review process, sharing lessons immediately learned from incidents The audit has demonstrated that all of the above processes are embedded in the organisation. The CQC inspection report published in 2019 highlighted many examples of changes made as a result of lessons learned.
Increase the percentage of e-discharge summaries sent within 24 hours to 85%	Not achieved	Achieved 71.3% 2018-19 compared to 69.5% for 2017-18. The Trust is continuing to roll out the electronic prescribing record (ePR) which will support improvement in this area. In addition, the Trust is systematically introducing a series of digital solutions that will ultimately result in more timely electronic discharge summaries. An interim IT solution has been identified and the Trust is working with the Clinical Quality and Performance Group to implement this effectively, in such a way that does not disrupt GP systems and processes.

Improve the effectiveness of discharge planning	Improved	A number of actions have been taken to improve effectiveness of discharge planning including, home for lunch initiative with 79% more overnight stay medical patients being discharged before noon in March 2019 compared to March 2018; reducing the number of patients with delayed discharges, in particular super stranded patients with a 25% decrease in reported figures for March 2019 when compared to March 2018; • Throughout the year there has been a consistent improvement in the percentage of overnight medical patients discharged by midday. In March 2019 the Trust achieved 28.4%, however there is further work required to achieve the target of 33% consistently across all in-patient wards • There is targeted work to increase weekend discharges as part of the Executive-led Urgent and Emergency Care Council improvement programme • A Trust-wide communications initiative has been undertaken to improve information to patients and relatives about hospital discharge
Make the most effective use of the skills of the nursing workforce by implementing an electronic system (SafeCare) to ensure optimal deployment of nursing resources	Achieved	• SafeCare has been rolled out successfully to 29 adult inpatient wards at Newton, St Helens and Whiston • The lead nurse has been appointed and commenced in post in January 2019. • Safer staffing fill rates are 96.5% for 2018-19 • Patient acuity/dependency and staffing levels for these wards are entered three times daily into SafeCare and can be viewed and shared across the Trust
Further embed the seven day services clinical standards across the trust	Improved	7-day service provision has been improved. • The latest NHS England (NHSE) 7-day services audit shows that the Trust is achieving all of the standards for 7-day consultant led services, except patients assessed by a consultant within 14 hours of admission, which has improved to 64%. The Trust is, therefore, making progress towards the 2020 national targets • The Trust has expanded other services to 7 days including the frailty service, extended opening hours for pharmacy at the weekend and increased therapy presence at the weekend

2.3. Quality priorities for improvement for 2018-19

The Trust's quality priorities for 2019-20 are listed below with the reasons why they are important areas for quality improvement. The views of stakeholders and staff were considered prior to the Trust Board's approval of the final list. The consultation included an on-line survey that was circulated to staff, commissioners and patient representatives, as well as placed on the Trust's website for public participation. In addition, Healthwatch members of the Trust's councils and our commissioners were asked for their views on what should be included in the list of priorities.

The consultation was undertaken using SurveyMonkey with 163 responses received, an increase from 84 received last year. Analysis of the responses has shown overall agreement and support for the proposed quality improvements for 2019-20, in particular the priority to ensure timely and effective assessment and delivery of care within the Emergency Department, which scored 97.5%. Increasing the proportion of patients who report that they have received an appropriate amount of information to meet their needs in a way they can understand scored 95%. Maximising the effectiveness and utilisation of new electronic systems to improve the timeliness and effectiveness of patient care scored 92.5%. A number of respondents suggested that services to support patients with drug and alcohol issues should be considered as a priority. This is one of the 2019-2020 national CQuIN objectives and, therefore, the Trust will continue to focus on this area.

No.	Quality domain	Objective	Rationale	Lead Director	Measurement	Governance Route
1.	Safety	Ensure timely and effective assessment and delivery of care within the Emergency Department	The Trust remains committed to providing the timely assessment and delivery of appropriate care to maintain patient safety.	Director of Nursing, Midwifery and Governance	• Patients triaged within 15 minutes of arrival • First clinical assessment median time of <2 hours over each 24 hour period • Compliance with the Trust's Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger • 100% compliance with sepsis screening and treatment guidance	Quality Committee

2.	Effectiveness	Maximise the effectiveness and utilisation of new electronic systems to improve the timeliness and effectiveness of patient care	The Trust has introduced a number of new electronic systems, including electronic prescribing and administration of medicines (ePMA), National Early Warning Score (NEWS) and e-Handover**,** which allows medical and nursing handover notes to be available to all team members at all times. The Trust aims to optimise the use of these systems.	Director of Informatics	• Reduction in medication errors • Improved discharge • Improved communications with GPs and community services • Earlier identification and initiation to treatment for deteriorating patients • Reduction in overall length of stay for patients	Quality Committee
3.	Patient experience	Increase the proportion of patients who report that they have received an appropriate amount of information to meet their needs in a way they can understand	Findings from the national inpatient survey indicate that a significant proportion of patients do not receive the right level of information at the right time	Director of Nursing, Midwifery and Governance	• Improved scores for responses to patient questionnaires for questions relating to receiving the right level of information	Quality Committee

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

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

2.4.1. Review of services

During 2018-19, the Trust provided and/or sub-contracted £318m NHS services. The St Helens and Knowsley Teaching Hospitals NHS Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2018-19 represents 100% of the total income generated from the provision of NHS services by the St Helens and Knowsley Teaching Hospitals NHS Trust for 2018-19.

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

2.4.2. Participation in clinical audit

2.4.2.1. Participation in Quality Account audits 2018-19

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

It should be noted that some audits are listed as one entity on the published list, however will involve a number of individual projects being undertaken under this single heading, e.g. NCEPOD; as detailed below:

- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - 3 individual audits
- Chronic Obstructive Pulmonary Disease (COPD) Audit programme - 3
- Falls And Fragility Fractures Programme (FFFAP) – 2

During 2018-19, 45 national clinical audits and 3 national confidential enquiries covered relevant health services that St Helens and Knowsley Teaching Hospitals NHS Trust provides.

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

The table below shows:

- The national clinical audits and national confidential enquiries that St Helens and Knowsley Teaching Hospitals NHS Trust was eligible to participate in during 2018-19.
- The national clinical audits and national confidential enquiries that St Helens and Knowsley Teaching Hospitals NHS Trust participated in during 2018-19.
- The national clinical audits and national confidential enquires that St Helens and Knowsley Teaching Hospitals NHS Trust participated in, and for which data collection was completed during 2018-19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

	National Clinical Audits and Clinical Outcome Review Programmes	**Eligible**	**Participated**	**Rate of case ascertainment % submitted**
1.	Acute Coronary Syndrome or Acute Myocardial Infarction: Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	Continuous Monitoring
2.	BAUS: Nephrectomy Audit	Yes	Yes	Continuous Monitoring
3.	BAUS: Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	Continuous Monitoring
4.	BAUS: Stress Urinary Incontinence	Yes	Yes	Continuous Monitoring
5.	Bowel Cancer: National Bowel Cancer Audit Programme (NBOCAP)	Yes	Yes	Continuous Monitoring
6.	Adult Critical Care: Case Mix Programme - Intensive Care National Audit & Research Centre (ICNARC)	Yes	Yes	Continuous Monitoring
7.	NCEPOD (Child Health)	Yes	Yes	No current studies running during 2018-19
8.	NCEPOD (Surg/Med) 1. Pulmonary embolism study 2. Acute bowel obstruction 3. Long term ventilation	Yes	Yes	1 - 100% 2 - Active 3 - not eligible for data collection stage
9.	Diabetes (Paediatric) NPDA	Yes	Yes	100%
10.	Elective Surgery: National patient-reported outcomes measures (PROMS)	Yes	Yes	Continuous Monitoring
11.	Falls and Fragility Fractures Audit Programme (FFFAP) 1. National Hip Fracture database 2. Physiotherapy hip fracture sprint audit (NHFD)	Yes	Yes	Continuous Monitoring
12.	Inflammatory Bowel Disease (IBD) Programme (Registry)	Yes	Yes	Continuous Monitoring
13.	Learning Disability Mortality review (LeDeR)	Yes	Yes	Active
14.	Severe Trauma: Trauma Audit & Research Network (TARN)	Yes	Yes	Continuous Monitoring
15.	MBRRACE – UK Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	Yes	Continuous Monitoring
16.	National audit-breast cancer in older patients (NABCOP)	Yes	Yes	Active

	National Clinical Audits and Clinical Outcome Review Programmes	Eligible	Participated	Rate of case ascertainment % submitted
17.	National Cardiac Arrest Audit (NCAA)	Yes	Yes	Continuous Monitoring
18.	1. National Chronic Obstructive Pulmonary Disease Audit Programme (COPD) 2. NACAP Asthma (adults) 3. NACAP Asthma (children)	Yes	Yes	1 - Continuous Monitoring 2 - Active 3 - Active
19.	National Comparative Audit of Blood Transfusion Programme 1. National Comparative Audit Of The Management Of Maternal Anaemia 2018	Yes	Yes	Active
20.	Diabetes (Adult): * National Diabetes Audit (Adult) (NDA (A)	Yes	Yes for 2018-19 data set No for 2017-18 data set	Continuous Monitoring
21.	National Emergency Laparotomy Audit (NELA)	Yes	Yes	Continuous Monitoring
22.	National Heart Failure (HF)	Yes	Yes	Continuous Monitoring
23.	National Joint Registry (NJR)	Yes	Yes	Continuous Monitoring
24.	Lung Cancer: National Lung Cancer Audit (NLCA)	Yes	Yes	Continuous Monitoring
25.	Neonatal Intensive and Special Care (National Neonatal Audit Programme (NNAP)	Yes	Yes	Continuous Monitoring
26.	National Ophthalmology Audit	Yes	Yes	Active
27.	Oesophago-Gastric Cancer: National Audit Oesophago-Gastric Cancer (NAOGC)	Yes	Yes	Continuous Monitoring
28.	National Prostate Cancer Audit (NPCA)	Yes	Yes	Active
29.	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	Continuous Monitoring
30.	Royal College of Emergency Medicine (RCEM) Feverish Children (CARE IN ED)	Yes	Yes	Active
31.	RCEM Vital Signs In Adults (CARE IN ED)	Yes	Yes	Active
32.	RCEM Venous Thromboembolism (VTE) Risk In Lower Limb Immobilisation (CARE IN ED)	Yes	Yes	Active
33.	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	Yes	Continuous Monitoring
34.	National Maternity And Perinatal Audit (NMPA)	Yes	Yes	Continuous Monitoring
35.	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12/Rd 3)	Yes	Yes	Active
36.	National Dementia Audit Round 4	Yes	Yes	completed
37.	National Audit of Care at the End of Life (NACEL)	Yes	Yes	100% completed
38.	UK Cystic Fibrosis Registry	Yes	Yes	Continuous Monitoring
39.	National Audit of Intermediate Care (NAIC)	Yes	Yes	Active
40.	British Thoracic Society (BTS) Adult Community Acquired Pneumonia	Yes	Yes	Active

	National Clinical Audits and Clinical Outcome Review Programmes	Eligible	Participated	Rate of case ascertainment % submitted
41.	BTS Non-Invasive Ventilation - Adults	Yes	Yes	Active
42.	Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	Yes	Continuous Monitoring
43.	Reducing the Impact of Serious Infections (antimicrobial resistance and sepsis)*	Yes	Yes	Continuous Monitoring
44.	Surgical Site Infection Surveillance Service	Yes	Yes	Continuous Monitoring
45.	Seven Day Hospital Services	Yes	Yes	Completed
46.	National mortality case record review programme	Yes	Yes	Continuous Monitoring
47.	National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes	Yes	Active
48.	National Audit of Cardiac Rehabilitation	Yes	Yes	Active

2.4.2.2. Other national audits (not on Quality Account list 2018-19)

National audits	Status
STARSURG (Student Audit and Research) audit: Imagine (ileus management)	completed
Samba 18 (Society of Acute Benchmarking Audit)	completed
National audit: sleep-deprived EEG	completed
Operative management of distal radius fractures	completed
Administration of tranexamic acid in lower limb arthroplasty (attilla)	completed
National snapshot audit into surgical lower urinary tract symptoms/benign prostatic hyperplasia (LUTS/BPH) management	completed
RACPC audit programme (Rapid Access Chest Pain Clinic)	Active
Pruritus audit 2019	Active
Flash glucose monitoring audit - Paediatrics (Freestyle Libre)	Active
Flash glucose monitoring audit- Adults (Freestyle Libre)	Active
Fitness for older patients	Active
National audit of seizure management (ED)	Active
Magseed and wire/roll localisation for breast lesions	Active
National audit neo-adjuvant systemic therapy	Active
Breast and cosmetic implant surgery	Active
National 3rd corrective jaw treatment audit	Active
Management of non-gonococcal non-chlamydial urethritis	Active
Each baby counts – National quality improvement project (QIP)	Active
National Perinatal Mortality Review Tool (PMRT) programme	Active
National children and young people diabetes/quality programme	Active

"Flash-mob" audit of intravenous immunoglobulin use in ITP **(**Immune thrombocytopenic purpura)	Active

The reports of 53 national clinical audits were reviewed by the provider in 2018-19 and St Helens and Knowsley Teaching Hospitals NHS Trust has taken and intends to take the following actions to improve the quality of healthcare provided:

Critical Care	
Audit Title	**Outcome/actions**
Intensive Care National Audit Research Centre (ICNARC)	Whiston Hospital participates in ICNARC – case mix programme – collecting information on all patients admitted to critical care – this information produces quarterly quality reports measuring quality indicators with other critical care units – 100% general critical care units participate within England, Wales & Northern Ireland. This information is shared with all relevant members of staff highlighting areas of excellence & any areas that require review, with robust systems in place to ensure information is reviewed and relevant action plans are implemented. Previously Whiston was a national outlier for delayed discharges from critical care and through the processes mentioned there has been improvements to reducing the amount of delayed discharges from critical care.
General Medicine: Department of Medicine for Older People	
Audit Title	**Outcome/actions**
National audit of dementia - round 3 (findings)	• Improve delirium screening by increasing the use of the 4AT test • Integrate the Forget-Me-Not document with nursing documentation on activities of daily living to improve collection of personal information • Increase staff awareness of the availability of snacks for patients with dementia out of hours
Audit Title	
Spotlight audit: Delirium screening and assessment	Planned actions • Development and implementation of a screening tool • Update of the Trust guidance on delirium management
Emergency Department	
Audit Title	**Outcome/actions**
RCEM National Sedation Audit	• A new sedation pathway and patient information leaflet have been developed
Audit Title	**Outcome/actions**
RCEM Pain in Children Audit	• Further work will be undertaken to improve the re-evaluation of pain after analgesia. • Triage teaching has been delivered to paediatric nurses including discussion on pain assessment
Acute Coronary Syndrome or Acute Myocardial Infarction: MINAP	
Audit Title	**Outcome/Actions**
Myocardial Ischaemia National Audit Project MINAP	A new national database has been implemented in March 2019 to collect data and facilitate reporting

NCEPOD: **(National Confidential Enquiry into Patient Outcome and Death)/Child Heath Programme**	
The Trust has participated in all eligible studies during 2018-19. Completed study reports have been disseminated and reviewed with report recommendations implemented or planned.	
Current Active Studies: 1. Long Term Ventilation	**Completed Studies – Awaiting National Report:** 1. Pulmonary Embolism

2. Acute Bowel Obstruction	2. Mental health conditions in young people
Audit Title	**Outcome/actions**
NCEPOD: Acute Heart Failure Study	Discussion points: As specified in the NCEPOD recommendations a protocol for the management of these patients is to be developed, as well as a Heart Failure Multi-Disciplinary Team.

Orthopaedics	
Audit Title	**Outcome/actions**
Administration of Tranexamic Acid (TXA) in lower limb arthroplasty (ATILLA) National Collaborative audit	The local results demonstrated that blood loss was less in patients receiving TXA.
Paediatrics	
Audit Title	**Outcome/actions**
National Paediatrics Diabetes audit 2016-17 report	Planned Actions: • Telephone reminders to be sent 1 week prior and on the day of appointment to improve clinic attendance and reduce DNA rates • Review the feasibility of appointing diabetes administration staff to assist the clinical team • Continue monthly meetings to monitor patients with high HbA1c and link with key workers
Sentinel Stroke National Audit Programme (SSNAP)	
Audit Title	**Outcome/Actions**
SSNAP	Service developments continue to be delivered to sustain the improved outcomes from the audits.
Severe Trauma: Trauma Audit & Research Network (TARN)	
Audit Title	**Outcome/Actions**
TARN	Reports and TARN dashboard are continuously reviewed locally and by the Cheshire & Mersey Major Trauma Network/Operational Delivery Network - no further clinical actions. To review possible changes to reporting structure/ standards to reflect more accurate activity reporting and appropriateness of standards for Trauma Units.

2.4.2.3. Local clinical audit information

The reports of 179 local clinical audits were reviewed by the provider in 2018-19 and St Helens and Knowsley Teaching Hospitals NHS Trust has taken and intends to take the following actions to improve the quality of healthcare provided:

Burns & Plastics	
Audit Title	**Outcome/Actions**
Audit of referral timing for facial palsy patients in Merseyside	Re-educate primary and secondary care staff on St Helens and Knowsley Teaching Hospitals NHS Trust service and current NICE guidelines with a point to encourage early referral. Re-educate based on current evidence (Scottish Bell's palsy study) and re-write a treatment pathway for treatment of suspected facial nerve palsy in ED. Discuss the findings with NICE to put forward a multidisciplinary review based on patient outcomes.
Emergency Department	
Audit Title	**Outcome/Actions**
Review of HIV testing uptake in Emergency Department	Actions: Completed 'a message of the week' for Emergency Department (ED) teaching. Audit results poster

	displayed around the ED department and re-audit for a day, with the findings presented at an ED teaching session for consultants and registrars at the end of June 2018.
Audit Title	**Outcome/Actions**
Management of C-Spine Injuries in the ED	Key success: All patients immobilised and discussed with Neuro-centre. Main outcome: Introduction of C-Spine injury pathway by August 2019 Re-audit planned in the next audit year: 2019-20
Audit Title	**Outcome/Actions**
DNAR-CPR prevalence snapshot documentation audit	100% compliance achieved in most criteria, the remainder fell just short. Recommendation of monthly snapshots to be undertaken going forward
Audit Title	**Outcome/Actions**
Open Fracture Audit	The audit has led to the development of an open fracture pathway and the addition of a camera for the department.
Audit Title	**Outcome/Actions**
De-brief after a critical incident (QIP)	This has resulted in a massive impact on awareness of staff well-being. This practice is being implemented now in other departments and other EDs.
Critical Care	
Audit Title	**Outcome/Actions**
Audit of arterial cannulation in critical care	100% aseptic technique. Successful atrial cannulation at 1st and 2nd attempts higher than audit target. All awake patients had infiltration of local anaesthetic, therefore, no actions needed
General Medicine: Endoscopy Global Rating Scale (GRS) audit programme	
Audit Title	**Outcome/Actions**
• Rectal biopsies in diarrhoea audit • Upper gastrointestinal (UGI) endoscopy – acute upper GI bleed • Quality & safety – of lower gastrointestinal (LGI) endoscopist • Quality & safety of UGI endoscopy peg insertion • Quality & safety of UGI endoscopy • Audit of 30-day mortality & 8-day readmissions post endoscopic procedure • Safety & sedation – use of reversal agents • Comfort during endoscopic procedures audit • Patient Comfort survey	A programme of mandated audits are undertaken each year and presented in January and July, to assess compliance with the GRS standards. Results are discussed from these audits and any necessary actions implemented - some audits are repeated again as part of this rolling programme.
General Medicine: Acute Medical Unit	
Audit Title	**Outcome/Actions**
Time to first consultant review: current practice on the acute medical unit (AMU)	Actions: Assessment bays established on 1B. New consultant appointments to improve flow/bed pressures
Audit Title	**Outcome/Actions**
Venous-thromboembolism (VTE) Champion of the Day: Improving VTE Risk Assessment Completion within 24 hours (QIP)	Significant improvement in patients having VTE risk assessment documented and carried out within 24 hours following introduction of VTE Champion.

General Medicine: Cardiology	
Audit Title	**Outcome/Actions**
Lipid management following Acute Coronary Syndrome (ACS) with compliance against NICE guidelines	To continue to liaise with the laboratory to link the first troponin with a full lipid profile. The cardiology team are going to work to develop some educational material for ED and Medical Assessment Unit to ensure patients post-ACS have lipid profiles measured during admission (prior to high-intensity statin commencement) so that response to therapy can be monitored. To reinforce the structured review of lipids in post-myocardial infarction clinic and advocate patients have their lipids re-checked at 6 months and 1 year. Specialist nurses to continue to tell patients to attend for lipid monitoring in the community at 3 months post-discharge (same information to be passed to GP). This will continue to be achieved through the small changes made to discharge paperwork given to the patient.
General Medicine: Dermatology	
Audit Title	**Outcome/Actions**
Regional azathioprine audit. Azathioprine is a thiopurine immunosuppressant drug that occupies an important place in the management of many autoimmune and inflammatory skin diseases	Creation of an azathioprine pre-treatment pro forma and information bundle to cover all aspects of pre-treatment screening and patient information. A draft pro forma has been produced.
General Surgery	
Audit Title	**Outcome/Actions**
Surgical post-take ward round sheets	Implement changes and review efficacy of these newly improved ward round sheets during a third cycle. Also aim to improve the documentation of VTE assessment in the next audit cycle.
General Surgery - Burney Breast Unit	
Audit Title	**Outcome/Actions**
Breast documentation re-audit	Overall improvement in documentation. Good feedback from clinicians and patients regarding ease of form. Education given to clinicians completing forms.
Palliative Care	
Audit Title	**Outcome/Actions**
Bereavement specification audit	Amend Trust policy and e-learning module for all staff, End of Life steering group tasked the Specialist Palliative Care Team to provide scope and education. Bereavement staff contacting adult safeguarding in first instance for advice on bereavement procedure for next of kin who lack capacity.
Paediatrics	
Audit Title	**Outcome/Actions**
Use of screening tool for the assessment of malnutrition in paediatrics (STAMP) nutritional screening tool of paediatric wards at Whiston hospital	STAMP training to be provided for ward staff, ward managers to make staff available for training.
Audit Title	**Outcome/Actions**
Management of Kawasaki disease (previously called mucocutaneous lymph node syndrome), a common inflammatory disease, caused by various immunological processes and possibly	Pro forma for investigations in guideline. Patient leaflet to include echo follow up.

triggered by infectious agents of childhood	
Audit Title	**Outcome/Actions**
Management of neonatal weight loss to aid breastfeeding/prevent re-admission	Triage form to be completed with either patient details for admission to Children's Observation (ChObs) ward or advice given, these should then be scanned in patient notes. Develop a patient leaflet to be given to new mums on discharge from 2E. Ensure scales are calibrated regularly and staff are educated on correct weighing procedure and calculation of weight %.
Audit Title	**Outcome/Actions**
Prolonged jaundice care audit	Implementation of an integral pathway. Prompts on new pathway regarding questions and full training to be given on use of pathway. One person being responsible for chasing results therefore reduces risk of error. Implementation of a new prolonged jaundice service.
Audit Title	**Outcome/Actions**
Management of prolonged and recurrent febrile seizures in children	Re-education of staff, integrate first aid information into febrile seizures leaflet, discussion of electroencephalogram (EEG) with Epilepsy Team if required.
Obstetrics & Gynaecology	
Audit Title	**Outcome/Actions**
Compliance with Merseyside Child Death Overview Panel (CDOP) multi-agency safe sleeping guidance	Some positive results, recording of discussions needs improvement. Actions: All midwifes reminded to record safe sleep discussion and distribution of safe sleep resources.
Audit Title	**Outcome/Actions**
Audit of maternity and new born records for antenatal and new born screening quality assurance	Contact women early. Midwives to arrange booking appointments before 10 weeks. Results are recorded in the first trimester screening diary and the date the letter is sent out is also recorded. New-born blood spot (NBBS) failsafe is currently being addressed, to be monitored by community clerks and any outstanding after 2.30pm should be escalated to management.
Orthopaedics	
Audit Title	**Outcome/Actions**
Reasons for delayed discharges of knee arthroscopy re-audit	Plan day case surgeries early on the list. On-call registrar to review patients in the evening to avoid any delayed discharges.
Audit Title	**Outcome/Actions**
Fractured Neck of Femur Consent Form audit	The audit found not all risk factors were listed. Immediate actions: A full list of risk factors to be used for #NOF has been circulated amongst the orthopaedic department staff and Trainees are to be made aware of this in induction, to ensure all the information is imparted to patients.
Pathology – Biochemistry	
Audit Title	**Outcome/Actions**
Audit of short synacthen tests (SSTs) A synacthen test checks the function of the adrenal gland. It can help to see whether the body is producing enough steroid hormone (cortisol).	100% of short synacthen tests were performed correctly and the majority interpreted correctly. The criteria for the interpretation of these tests were not clear in some cases. Actions: The Biochemistry standard operating procedure for interpretation of short synacthen tests has now been updated.
Pathology – Microbiology	
Audit Title	**Outcome/Actions**
Clinical review to improve inpatient management of staphylococcus (S) aureus	All adult S aureus bacteraemia at Whiston now receive inpatient infection specialist clinical review.

bacteraemia (QIP)	
Quality & Risk – Nursing	
Audit Title	**Outcome/Actions**
Pain assessment audit	The findings indicated good compliance - no follow up actions needed.
Research, Development and Innovation (RDI)	
Audit Title	**Outcome/Actions**
Research: compliance with good clinical practice re consent, record keeping, storage	Overall, there have been improvements in most areas since the previous audit. However some areas for further improvement still remain. Actions: Ensure each task is documented individually on research project delegation logs. Include delegation logs on progress reports. Ensure that complete copies of the consent form/patient eligibility checklist or information leaflet are scanned into the appropriate section. Re-iterate the importance of documenting patient eligibility and the consent-taking process at research meetings. Investigate if principal investigators (PI) reviews were conducted for the relevant studies (STOPPIT-2 and IONA). Research tabs and alert indicators added and updated. Research, Development and Innovation Administrator to highlight any documents not scanned in colour for Clinical Trials Involving Medicinal Products (CTIMP) studies, and to amend and update accordingly.
Resuscitation Services	
Audit Title	**Outcome/Actions**
Do not attempt cardio-pulmonary resuscitation (DNACPR) and unified (u) DNACPR documentation audit	Areas of good practice were demonstrated, some require improvements. Actions: Ensure Mental Capacity Act assessment forms are available on wards to assist with documentation. Production and circulation of training video to instruct how this must be documented. Education to doctors and nurses to continue, highlight all key concerns via a video to be produced and mandatory training. To move to sole use of the uDNACPR documentation.
Sexual Health	
Audit Title	**Outcome/Actions**
Safeguarding audit – sexual health	• Staff advised to ensure all safeguarding related documentation to be fully completed. • Staff to be advised to notify safeguarding of any attendance of a young person with a Child Sexual Exploitation (CSE) alert noted. • Completion of documentation to be discussed in supervision sessions. • Audit tool to be reviewed and a further audit to be completed in 12 months' time: July 2019.
Trust-wide/Corporate	
Audit Title	**Outcome/Actions**
Trust-wide consent audit programme 2017-18	Improvements were demonstrated across the board from the 1st round (initial) to the 2nd round (re-audit) Action: the Consent Audit programme to be reviewed with a view to moving to electronic data collection (similar to the Trust's record keeping audit programme)
Audit Title	**Outcome/Actions**
Annual generic record keeping audit programme (Trust wide): 2017-18	• High standards of clinical documentation were found in many areas across the Trust, and several specialities regularly achieved 100% compliance with some standards.

	• Further improvements are needed for some areas. • Review of the audit analysis process to make it more efficient and timely. • Include additional information in the current guidance notes to assist staff during the data collection process. • Continue to liaise with specialties, directorates and Care Groups regarding the audit process and how to refine and improve compliance with the record keeping process. • Provide one to one/group facilitation to ensure clinical staff are fully aware of the reasons for the audit and how to comply with the record keeping audit process. • Roll out Trust wide 'bite size' record keeping training sessions, for all staff to attend on a 'drop in' basis, ad hoc bespoke sessions will also be offered on request for any groups of staff who may find it difficult to leave clinical areas.

2.4.3. Participation in clinical research

Evidence suggests that NHS trusts that support high quality patient-centred research can show better healthcare outcomes for patients.

St Helens and Knowsley Teaching Hospitals NHS Trust is committed to providing the best possible care to patients and acknowledges that research has been widely recognised as being an important factor in providing high quality care for healthcare organisations.

Research has built the NHS we have today. Getting involved in healthcare research could help shape the NHS for the future, discovering life-saving treatments, uncovering the secrets behind diseases and developing the answers to the problems causing ill health today.

Every year, more than half a million people take part in health research. Patients and members of the public also help design research studies and advise what our priorities for future research should be.

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

The Trust employs a team of specialist research staff to support clinical research across the organisation and to increase recruitment to high quality clinical trials and other robust research studies. The Trust has exceeded its recruitment target for the third consecutive year, with the numbers for 2018-19 being our highest recorded over the three year period.

During 2018-19 the Trust was involved in 84 active studies and the NIHR supported 72 of these, with the remaining 12 studies being local or student studies.

The number of patients receiving relevant health services provided or sub-contracted by St Helens and Knowsley Teaching Hospitals NHS Trust in 2018-19 that were recruited during that period to participate in research approved by a research ethics committee/Health Research Authority:
1388 recruited to NIHR adopted studies, which exceeds the proposed target of 600.

The Trust has impressive research activity across a wide range of clinical specialties. Since 1st April 2018 the RDI department produced RDI permission for 26 new studies, of which 25 were NIHR portfolio adopted studies. The following table displays the specialties of the new studies:

Speciality	Number of Studies – NIHR Portfolio	Non – Portfolio
Anaesthetics /Surgery	1	
Cancer	3	
Care of the Elderly	1	
Critical Care	3	
Diabetes	1	
Gastroenterology	9	
Obstetrics & Gynaecology	3	1
Rheumatology	2	
Stroke	1	
Vascular Surgery	1	

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

Performance benchmarks have been introduced by the National Institute of Health Research (NIHR) for the time taken to initiate and deliver clinical trials within the NHS. The Trust's performance against these benchmarks is published quarterly and the reports are available at:

https://www.nihr.ac.uk/research-and-impact/nhs-research-performance/performance-in-initiating-and-delivering-research/performance-information-on-the-initiation-and-delivery-of-clinical-research.htm

2.4.3.2. Commercially sponsored studies

We have continued to increase our participation in commercially sponsored studies, with 10 commercial studies active within the Trust.

2.4.3.3. Key achievements

The Trust has been recognised as a top recruiting site in a number of areas of research:

- In September 2018, the Trust was again recognised as being one of the top recruiters to the mammographic surveillance in breast cancer patients aged 50 years or over (MAMMO 50) study

- Also in September 2018, the Trust was the top recruiter to the PD COMM study (speech and language therapy interventions for people with Parkinson's disease)
- The Rheumatology Department was alongside three other trusts to have recruited the most MMF patients to the BILAG BR study (Biologics Prospective Cohort: the Use of Novel Biological Therapies in the Treatment of Systemic Lupus Erythematosus (SLE))

2.4.3.4. Other Achievements

- Providing a research management service to Southport and Ormskirk Hospital NHS Trust research department, resulting in the team winning the Trust's 2018 Time to Shine award, which was presented to the team at an awards ceremony in Formby Hall on 12th October 2018
- In March 2019, the Trust was successful in two categories of the North West Coast Research and Innovation awards, winning the Delivery of Commercial Life Science Research award and finalists in the Clinical Research Team of the year award. This was an outstanding achievement and demonstrates our commitment to offering patients and public the opportunity to take part in research.
- Congratulations to Michael Lloyd, Medical Education and Training Pharmacist, whose, "Exploring the impact of pharmacist-led feedback on prescribing behaviour: A qualitative study" was selected as the Best Paper 2018 by the Research in Social and Administrative Pharmacy Journal
- Dr Seamus Coyle, Consultant in Palliative Care, initiated another exciting study, "Investigation of biological changes in urine in lung cancer – a pilot study". The study analyses the urine of patients with lung cancer to look at changes as the disease progresses towards the end of life. Initial results are promising and there are plans to extend the research to include patients with different cancers. The Trust made a major contribution to the study by recruiting a large proportion of the inpatients required for the study
- Currently, lung cancer is number one cause of cancer deaths in UK, with >40,000 new patients every year. In September 2018 a 'ground breaking' study to find personalise Lung Cancer Treatment started at the Trust. The observational clinical trial aims to develop and validate the CancertainTM Test which will personalise the cancer treatment for lung cancer patients
- The Gastroenterology Team has continued to successfully expand its commercial research portfolio. 2018-19 was a very busy year for the team and they are now recognised as a site that exceeds in this specialty
- During 2018-19 we opened three new NIHR portfolio studies in Intensive Care, supported by Dr Ascanio Tridente, Consultant in Intensive Care, and Mr Greg Barton, Specialist Pharmacist in Intensive Care, who agreed to act as Principal Investigators
- All of our other research specialties, including Diabetes, Stroke, Cardiology, Paediatrics and Rheumatology, have worked extremely hard and with their input we are pleased that the annual NIHR recruitment target for 2018-19 was met during quarter 3.
- We are extremely pleased that the CRN NWC has successfully recruited staff from the Trust into local Specialty Research Group (SRG) leads in the following areas :
    - Palliative Care - Dr Seamus Coyle

- Plastic and Hand Surgery – Mr Rowan Pritchard Jones
- Breast Cancer – Miss Tamara Kiernan

These are key roles for our clinicians as they work in partnership with the research network locally. They co-ordinate and oversee activity at a national (UK) level, providing a national forum to share good practice, successes, opportunities and challenges, helping influence and shape the clinical research environment.

- The Trust promoted Research and Innovation to staff and patients via:
  - Social media, and regularly posting good new stories on the Trust's Facebook and Twitter
  - TV screens in the Diabetes outpatient clinic
  - Library Services
  - Training and Education
- International Clinical Trials Day is celebrated around the world, on or near 20th May each year, to raise awareness of the importance of clinical trials for advances in research and healthcare. In May 2018, the research team celebrated with a stall promoting the campaign. This was a great opportunity to promote clinical research trials and let patients, staff and the public know more about the research trials on offer at our Trust.

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

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

2.4.3.5. Research aims for 2019-20

Our aims for 2019-20 are to:

- Include research in the Trust strategy and vision
- Promote and increase engagement in Trust research, by raising awareness of research activities amongst all staff and patients
- Increase research in areas new to research and those areas that are currently research naïve
- Work in partnership with the Clinical Research Network to ensure the NIHR high level objectives are met
- Generate research funding by increasing the number of commercially sponsored studies on our portfolio
- Ensure high quality delivery of studies, to time and on target

2.4.4. Clinical Goals agreed with commissioners

A proportion of St Helens and Knowsley Teaching Hospitals NHS Trust income in 2018-19 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract,

agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018-19 and for the following 12-month period are shown in the tables below:

2.4.4.1. CQuIN targets 2018-19

Commissioner	Scheme Title
Clinical Commissioning Group (CCG)/ Integrated Care System (ICS)	Sustainability and transformation fund (STF)
CCG Acute	NHS Staff Health & Wellbeing: 1a] Staff survey 1b] Healthy food 1c] Flu vaccine
CCG Acute	2a] Timely identification of patients with sepsis 2b] Timely treatment of sepsis 2c] Assessment of a clinical antibiotic review for patients with sepsis 2d] Antibiotic consumption (agent & duration)
CCG Acute	Improving services for people with mental health needs who present to A&E
CCG Acute	Advice & guidance
CCG Acute	9a] Tobacco screening 9b] Tobacco brief advice 9c] Tobacco referral & medication offer 9d] Alcohol screening 9e] Alcohol brief advice or referral
Specialised Commissioning	Right setting: to ensure patients are cared for in the most clinically appreciate setting
Public Health England	NHS staff health & wellbeing
Public Health England	Dental e-referrals & managed clinical network involvement
CCG Community	NHS Staff Health & Wellbeing: 1a] Staff survey 1c] Flu vaccine
CCG Community Including Cardiac	9a] Tobacco screening 9b] Tobacco brief advice 9c] Tobacco referral & medication offer 9d] Alcohol screening 9e] Alcohol brief advice or referral
CCG Community	Improving the assessment of wounds
CCG Community	Personalised Care & Support Planning

The proposed CQuIN targets for 2019-20 will be published on the Trust's website at www.sthk.nhs.uk following agreement with commissioners.

2.4.5. Statements from the Care Quality Commission (CQC)

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

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

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

The latest comprehensive CQC inspection, using the new approach, took place in July and August 2018. The Use of Resources review was undertaken on 5th July, the unannounced inspection took place during the week commencing 16th July, the inspection of Marshalls Cross Medical Centre was completed on 14th August and the planned well-led review completed during the week commencing 20th August.

Teams of inspectors visited Whiston, St Helens and Newton hospitals and the Trust's directly provided community and primary care services during the inspection period to talk to patients, carers and staff about the quality and safety of the care provided. They reviewed care records and observed the care provided. The Trust was able to demonstrate to the inspection team the high standard of work that is undertaken on a daily basis to ensure patients receive excellent care.

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

The Care Quality Commission has not taken enforcement action against St Helens and Knowsley Teaching Hospitals NHS Trust during 2018-19.

St Helens and Knowsley Teaching Hospitals NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission in 2018-19.

St Helens and Knowsley Teaching Hospitals NHS Trust is subject to periodic reviews by the Care Quality Commission and the last review was in July/August 2018. The CQC's assessment of the Trust following that review was outstanding.

The Trust's Emergency Department was rated as requires improvement for the responsive and safety domains, with action plans in place to address the recommendations as outlined in the section below.

As part of the 2018 inspection the CQC inspected Marshalls Cross Medical Centre, which is a new service that the Trust was contracted to provide from March 2018. The inspection identified three areas where the Trust has not yet met the requirements of the CQC regulations for this service. The Trust had already taken action to start to address the issues identified at the time of the inspection in August 2018.

CQC ratings table for St Helens and Knowsley Teaching Hospitals NHS Trust March 2019

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

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

- Deliver comprehensive action plans to address the areas of non-compliance in Marshalls Cross Medical Centre and all should do recommendations, including those areas where the Trust requires improvement in the ED:
    - Ensuring all applicable staff within the ED receive level three children's safeguarding training
    - Continuing attempts to achieve key national targets to enable timely care of patients in ED, including arrival to initial assessment times and the DH decision to admit, transfer or discharge target
    - Clarifying and monitoring the quality and completion of ligature and clinical risk assessments to ensure they are completed as appropriate for all patients requiring them in ED

St Helens and Knowsley Teaching Hospitals NHS Trust has made the following progress by 31st March 2019 in taking such action:

Processes for the following have been strengthened in relation to Marshalls Cross Medical Centre:

- Follow up of uncollected prescriptions
- Monitoring of NICE guidelines
- Managing patients on high risk medicines
- Undertaking risk assessments
- Audit programme to monitor quality and identify areas for improvement
- Ensuring sufficient numbers of skilled and experienced staff to provide formal clinical leadership

2.4.6. Learning from deaths

2.4.6.1. Number of deaths

During Quarters 1-3 2018-19, 1146 of St Helens and Knowsley Teaching Hospitals NHS Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
365 in the first quarter;
374 in the second quarter;

407 in the third quarter;
Data unavailable for Q4 as data reported a quarter behind.

By end of Q3, 431 case record reviews and 16 investigations have been carried out in relation to 1146 of the deaths included in item 2.4.6.1
In 16 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
134 in the first quarter;
146 in the second quarter;
151 in the third quarter;
Data unavailable for Q4 as data reported a quarter behind.

4 representing 0.4% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of:
2 representing 0.5% for the first quarter;
2 representing 0.5% for the second quarter;
0 representing 0.0% for the third quarter;
Data unavailable for Q4 as data are reported a quarter behind.

These numbers have been estimated using the St Helens & Knowsley Teaching Hospitals NHS Trust Royal College of Physicians Structured Judgement Review (SJR).

171 case record reviews and 9 investigations completed after 31-12-2017 which related to deaths which took place before the start of the reporting period.

3 representing 0.6% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the St Helens & Knowsley Teaching Hospitals NHS Trust Structured Judgement Review (SJR) (which uses NCEPOD Quality Score and RAG rating similar to Royal College of Physicians SJR and consistent with Royal College of Physicians and NHS Improvement guidance. This represents the final position for Quarter 4 of 2017-18.

4 representing 0.2% of the patient deaths during 2017-18 are judged to be more likely than not to have been due to problems in the care provided to the patient. This represents all four quarters of 2017-18.

2.4.6.2. Summary of learning from case record reviews and investigations

The Trust has focussed on two key learning priorities for each quarterly report to the Trust Board and is establishing a database that collates all learning from deaths, incidents, complaints, PALS and litigation into a single repository for quarterly thematic analysis and sharing. Key lessons shared in 2018-19 are below:

- Clear and accurate records are essential for clinical decision-making and high quality patient care. Document each patient interaction as soon as possible. The

record should capture what happened during a consultation and inform colleagues who see the patient subsequently, supporting continuity of care
- Older people are more susceptible to sepsis than younger adults. The initial clinical presentation may be non-specific, so clinicians should have a higher index of suspicion and lower threshold for treatment in older people
- Where there is concern that a patient is at risk of falling out of bed, a low rise bed must be used. Bedrails are likely to introduce more risk and should never be used as a form of restraint
- If a patient has a suspected hip fracture and the plain X-ray is normal, but the patient cannot mobilise, request a CT scan within 24 hours. After a normal CT scan if the patient can still not mobilise, please ask the responsible consultant to speak to a radiologist to discuss MRI scan
- Patients who fall in hospital frequently have incomplete falls risk assessments. It is vital that nursing staff complete the risk assessments fully and individualise the care plans to protect patients and the staff caring for them, ensuring the communication works to deliver the right plan for each patient
- When a patient is suspected of having a gastrointestinal (GI) bleed, review their medications and temporarily withhold antiplatelet medication (including aspirin) and anticoagulants till they have had the endoscopy. When in doubt, consult a senior. People with acute upper GI bleeding who take aspirin for secondary prevention of vascular events and in whom haemostasis has been achieved at endoscopy are advised to continue on low-dose aspirin
- Some hospital patients face an uncertain recovery and are sick enough to die despite active treatment. Please ensure that do not attempt cardio-pulmonary resuscitation (DNA-CPR) and ceilings of treatment are proactively discussed with the patient, their family and people important to them. Symptoms control treatments must be provided in parallel with active treatment. Please also consider referral to the specialist palliative care team and note that active and palliative treatments are not mutually exclusive
- When patients present with swallowing difficulties and they are frail or approaching the end of life, do not make them nil by mouth as a “reflex”. Open discussions with the patient and their relatives about the risks and benefits of continuing oral feeding and involve the Speech and Language Therapy (SALT) team

2.4.6.3. Actions taken resulting from learning

The Trust’s Learning from Deaths Policy was updated in January 2019 to incorporate the principles laid down in the National Quality Board document “Learning from Death: Guidance for NHS trusts on working with bereaved families and carers”.

Lessons identified from the structured judgement reviews have been shared with the Trust Board, Quality Committee, Finance & Performance Committee, Clinical Effectiveness Council, Patient Safety Council, Patient Experience Council, Grand Rounds, Team Brief, Intranet Home Page, global email, Medical Care Group (Governance), Surgical Care Group (Governance), Medical Care Group Directorate Meetings, Surgical Care Group Directorate Meetings and Clinical Support Directorate meetings.

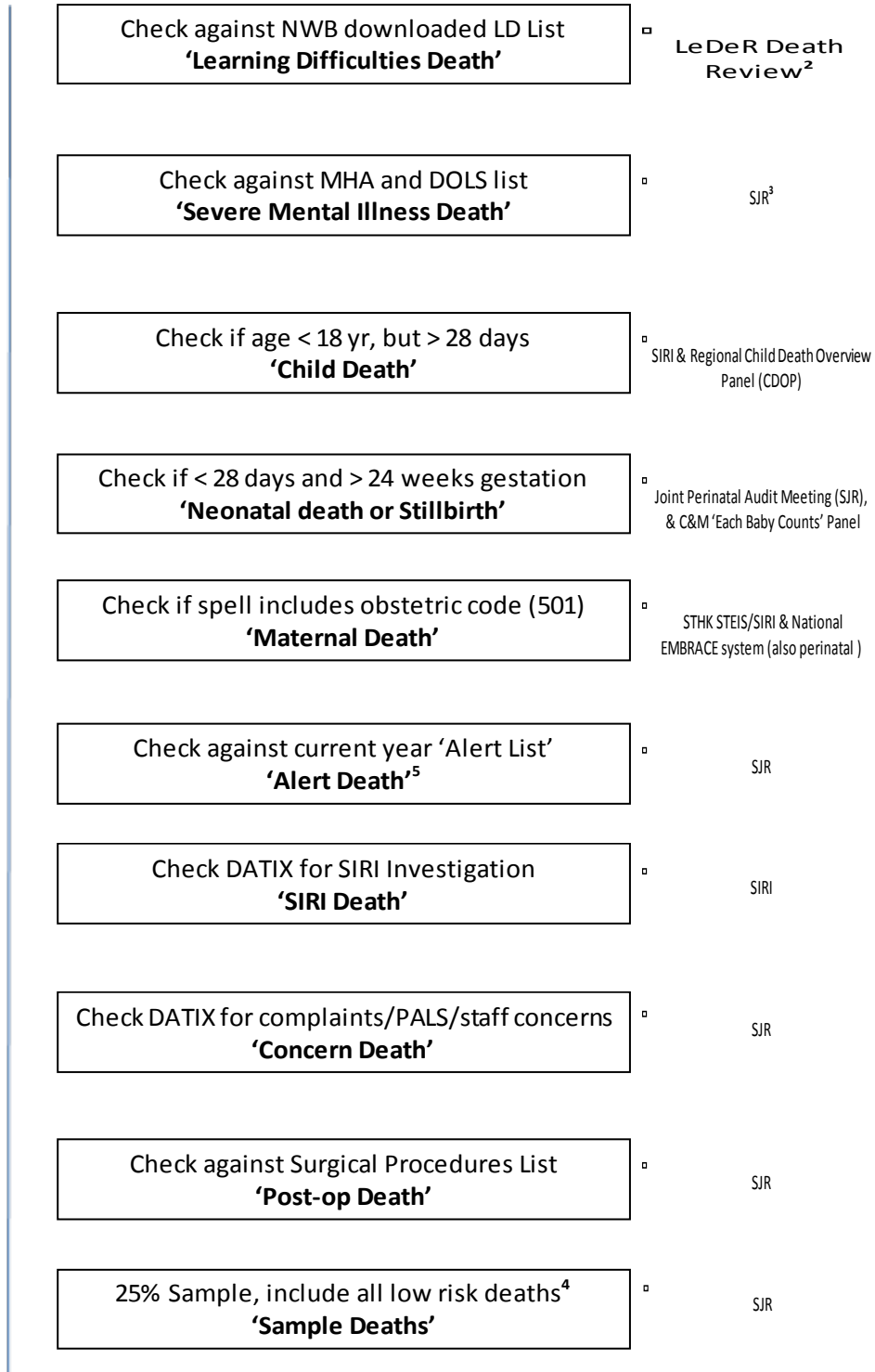
2.4.6.4. Impact of actions taken

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

2.4.6.5. Trust approach to learning from deaths

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

Total Deaths in Scope[1]



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

2.4.7. Priority clinical standards for seven day hospital services

The Seven Day Hospital Services Programme aims to ensure that patients requiring emergency treatment receive high quality, consistent care every day of the week. The standards are intended to improve the care given to patients by enabling early and consistent senior decision making along with other urgent services. Ten clinical standards for seven day services were developed in 2013 through the Seven Day Services Forum, of which four were identified as national priorities for implementation by 2020 on the basis of their potential to positively affect patient outcomes. These are:

Standard 2 - Time to first consultant review

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

Standard 5 – Access to diagnostic tests

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

Standard 6 – Access to consultant-directed interventions

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

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

All patients with high dependency needs should be seen and reviewed by a consultant twice daily. Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every day, seven days a week, unless it has been determined that this would not affect the patient's care pathway. The Trust was audited regularly to indicate performance against the four priority standards and identify areas for improvement.

Latest performance against standards

CS2	CS5	CS6	CS8
64%	94%	100%	95%

In April 2018, 64% of patients involved in the audit were reviewed by a Consultant within 14 hours of admission, an improvement from 54% in March 2017.

The following actions have been put in place to further improve compliance:

Action	Rationale
Trust Lead for 7 Day Services to create and chair Trust 7DS Steering Group	Allows presentation and comparison of results between specialities, sharing of good practice and accountability for improvements across all disciplines
Streaming process to be embedded in ED	Early transfer of appropriate patients to assessment

to allow early identification and transfer of patients requiring speciality review	areas facilitates early discharge and/or Consultant review
Acute Medicine Consultant rota reviewed and changed to provide increased afternoon and evening cover	Medical patients make up largest volume of acute admissions. Increased Consultant presence will improve proportion of patients reviewed on day of admission
Paediatric Consultants working in ED in evenings	Increased evening presence of Paediatric Consultants in ED allows earlier Consultant review.
Frailty Consultant in-reach to ED	Frailty Consultant working in ED each day allows earlier intervention and Consultant review
Changes to 1st Consultant review process to encourage documentation of need for ongoing daily Consultant review	Not all patients require daily Consultant review; clear documentation of frequency of need for daily review will reduce avoidable fails against CS8.
Detailed gap analysis within each speciality to ascertain resource required to meet CS2	Some improvement in performance can be gained via change in practice but consistent performance >90% against CS2 may require increased Consultant presence at weekends or out of hours

The Trust will continue to monitor performance against the Seven Day Services Clinical Standards and implement the new Trust Board Assurance Process, which commenced in February 2019.

2.4.8. Information governance and toolkit attainment levels

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

The Trust looks to benchmark itself against the Data Security and Protection Toolkit (DSP), which replaced the Information Governance (IG) Toolkit. The DSP Toolkit provides a new mechanism for organisations to assess themselves against the National Data Guardian (NDG) 10 data security standards, through confirming assertions and providing supporting evidence.

The requirements for the DSP Toolkit differ from those within the previous IG Toolkit. An overview of the differences are provided below:

- The requirements of the DSP Toolkit are designed to encompass the 10 NDG Data Standards
- The requirements of the DSP Toolkit support key requirements under the General Data Protection Regulation (GDPR), identified in the NHS GDPR Checklist. This will assist the Trust with its obligations in accordance with the GDPR
- The IG Toolkit assessed performance against three levels 1, 2 and 3
- Organisations were required to evidence compliance with (at least) level 2 for all elements of their assessment. The DSP Toolkit does not include levels, and instead requires compliance with assertions and (mandatory) evidence items
- The assertions and evidence items within the DSP Toolkit are designed to be concise and unambiguous. Documentary evidence is only requested where this adds value

St Helens and Knowsley Teaching Hospitals NHS Trust Information Governance Assessment Report overall submission position for 2018-19 was rated as meeting the required standards. This represents a consistent position based on last year's score and means that the Trust is compliant in all sections of the DSP Toolkit. This submission was audited by Mersey Internal Audit Agency and once again, the Trust has maintained its assurance level of "significant" which demonstrates the Trust's commitment to protecting the information it holds and uses.

The Trust continues to enhance its robust Information Governance Framework which is led by Craig Walker, Head of Information Governance, Quality Assurance and Data Protection Officer. Dr Alex Benson, Clinical Director for Burns and Plastic Surgery, is the Caldicott Guardian and is the dedicated designated individual within the Trust who is responsible for ensuring confidentiality of personal information. The Trust also has a Senior Information Risk Owner (SIRO), Christine Walters, Director of Informatics, who is responsible for reviewing and reporting on the management of information risk to the Trust Board. The SIRO is supported by a network of Information Asset Owners (IAOs), who ensure that any identified information risks are appropriately managed in line with the Trust's risk management policy.

The Data Protection Officer, SIRO and Caldicott Guardian are appropriately qualified, trained, registered and accredited.

The Trust has a duty to report any incident regarding breaches of the Data Protection Act to the Information Commissioner's Office (ICO) and for the financial year 2018-19 there were three such incidents. Two of these incidents have been closed by the Information Commissioner's Office with no actions taken against the Trust. The two closed incidents were reviewed by relevant members of staff and members of the Information Governance Team, with actions taken to minimise the likelihood of any reoccurrence. The one remaining incident remains open and we are currently liaising with ICO.

2.4.9. Clinical coding error rate

St Helens and Knowsley Teaching Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2018-19 by the Audit Commission. The Trust was subject to an audit of clinical coding, based on national standards undertaken by Clinical Classifications Service (CCS) approved clinical coding auditors in line with the Data Security & Protection Toolkit 2018-2019. The error rates reported in the latest published audit for that period of diagnoses and treatment coding (clinical coding) have all improved since last year and were:-

2018-19 data reported in January 2019				
Measure	Primary diagnosis incorrect	Secondary diagnosis incorrect	Primary procedure incorrect	Secondary procedure incorrect
Data Security & Protection Toolkit	5%	5.39%	2.88%	6.19%

2.4.10. Data quality

The Trust continues to be committed to ensuring accurate and up-to-date information is available to communicate effectively with GPs and others involved in delivering care to patients. Good quality information underpins effective delivery of patient care and supports better decision-making, which is essential for delivering improvements.

Data quality is fully embedded across the organisation, with robust governance arrangements in place to ensure the effective management of this process. Audit outcomes are monitored to ensure that the Trust continues to maintain performance in line with national standards. The data quality work plan is reviewed on an annual basis ensuring any new requirements are reflected in the plan.

The standard national data quality items that are routinely monitored are as follows:-

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

The Trust has implemented a new Patient Administration System (Medway) which has the functionality to allow for National Spine integration, giving users the ability to update patient details from national records using the NHS number as a unique identifier.

The Medway configuration restricts the options available to users. Validation of this work is on-going and will form part of the data quality work plan for 2019-20

2.4.10.1. NHS number and general medical practice code validity

St Helens and Knowsley Teaching Hospitals NHS Trust submitted records during 2018-19 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data which:

Included the patient's valid NHS number was:

Care Setting	StHK result	National Average
Admitted patient care	99.6%	99.4%
Outpatient care	99.9%	99.6%
Accident and Emergency care	99.1%	97.5%

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

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

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

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

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

- Data Quality Team will continue to monitor data quality throughout the Trust via the regular suite of reports
- Awareness raising sessions in order to focus on addressing any specific issues
- Providing data quality awareness sessions about the importance of good quality patient data and the impact of inaccurate data recording

2.4.11. Benchmarking information

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

2.4.11.1. Benchmarking Information

Please note the information below is based on the latest nationally reported data with specified benchmarks from the central data sources. Any internal figures included are displayed in purple font.

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Summary Hospital-level Mortality Indicator (SHMI)	NHS Digital	Oct-17 to Sep-18	0.991	1.000	0.692	1.268	Next SHMI data (for Jan-18 to Dec-18) due to be published June 2019
SHMI	NHS Digital	Jul-17 to Jun-18	1.004	1.000	0.698	1.257	
SHMI	NHS Digital	Apr-17 to Mar-18	1.025	1.000	0.699	1.232	
SHMI Banding	NHS Digital	Oct-17 to Sep-18	2	2	3	1	
SHMI Banding	NHS Digital	Jul-17 to Jun-18	2	2	3	1	
SHMI Banding	NHS Digital	Apr-17 to Mar-18	2	2	3	1	
% of patient deaths having palliative care coded	NHS Digital	Oct-17 to Sep-18	37.4%	33.6%	14.3%	59.5%	
% of patient deaths having palliative care coded	NHS Digital	Jul-17 to Jun-18	37.5%	33.1%	13.4%	58.7%	
% of patient deaths having palliative care coded	NHS Digital	Apr-17 to Mar-18	37.3%	32.5%	12.6%	59.0%	
The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: Information relating to mortality is monitored monthly and used to drive improvements. The mortality data is provided by an external source (Dr Foster). The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve the indicator and percentage, and so the quality of its services, by: Monthly monitoring of available measures of mortality. Learning from Deaths Policy implemented with continued focus on reviewing deaths to identify required actions for improvement and effective dissemination of lessons learned.							
EQ-5D adjusted health gain: Groin Hernia	NHS Digital	Apr-18 to Sep-18	N/A	N/A	N/A	N/A	Next PROMs data due to be published May-19
EQ-5D adjusted health	NHS Digital	Apr-17 to Mar-18	0.076	0.089	0.029	0.137	The mandatory varicose vein

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
gain: Groin Hernia		(final)					surgery and groin-hernia surgery national PROMs collections have now ended * data suppressed due to small numbers
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-18 to Sep-18 (provisional)	*	0.489	0.407	0.564	
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-17 to Mar-18 (final)	0.411	0.468	0.376	0.566	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-18 to Sep-18 (provisional)	*	0.345	0.227	0.426	
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-17 to Mar-18 (final)	0.280	0.338	0.234	0.417	
EQ-5D adjusted health gain: Varicose Vein	NHS Digital	Apr-18 to Sep-18	N/A	N/A	N/A	N/A	
EQ-5D adjusted health gain: Varicose Vein	NHS Digital	Apr-17 to Mar-18 (final)	*	0.096	0.035	0.134	
The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The questionnaire used for PROMs is a validated tool and administered for the Trust by an independent organisation, Quality Health. The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these outcome scores, and so the quality of its services, by: Delivering a number of actions to improve patient experiences following surgery. Monitoring the PROMs data at the Clinical Effectiveness Council.							
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 16+ readmitted to the Trust within 28 days of	NHS Digital	Apr-11 to Mar-12	12.73	11.45	0.00	17.15	2011-12 still latest data available. Date of next version to be confirmed. Lowest and best national performance based on acute providers

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
discharge							
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 16+ readmitted to the Trust within 28 days of discharge	NHS Digital	Apr-10 to Mar-11	12.60	11.43	0.00	17.10	
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 0-15 readmitted to the Trust within 28 days of discharge	NHS Digital	Apr-11 to Mar-12	11.39	10.01	0.00	14.94	
(Indirectly age, sex, method of admission, diagnosis, procedure standardised) % of patients aged 0-15 readmitted to the Trust within 28 days of discharge	NHS Digital	Apr-10 to Mar-11	10.66	10.01	0.00	14.11	
The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The data is consistent with Dr Foster's standardised ratios for re-admissions. The data is monitored monthly by the Trust Board. The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these scores, and so the quality of its services, by: Working to improve discharge information as a patient experience priority. Reviewing and improving the effectiveness of discharge planning.							
Patient experience measured by scoring the results of a selection of questions from the national inpatient survey focussing	NHS Digital	2017-18	70.5	68.6	60.5	85.0	Next version due Aug-19

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
on the responsiveness to personal needs.							
Patient experience measured by scoring the results of a selection of questions from the national inpatient survey focussing on the responsiveness to personal needs.	NHS Digital	2016-17	68.7	68.1	60.0	85.2	
The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust's vision and drive to provide 5-star patient care ensures that patients are at the centre of all the Trust does. The Trust was rated outstanding overall for caring by the CQC following their inspection in 2018. The survey is conducted by an independent and approved survey provider (Quality Health), with scores taken from the CQC website. The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this data, and so the quality of its services, by: Promoting a culture of patient-centred care. Responding to patient feedback received through national and local surveys, Friends and Family test results, complaints and Patient Advice and Liaison Service (PALS). Working closely with Healthwatch colleagues to address priorities identified by patients, including improving discharge planning.							
Q21d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2018	86.8%	70.0%	41.1%	86.8%	All data is for Acute Providers only
Q21d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2017	83.4%	69.8%	46.8%	85.7%	
% experiencing harassment, bullying or abuse from staff in last 12 months	NHS staff surveys	2018	11.7%	20.0%	28.4%	11.7%	Low scores are better performing trusts
% experiencing harassment, bullying or	NHS staff surveys	2017	13.9%	19.0%	27.4%	13.6%	

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
abuse from staff in last 12 months							
% believing the organisation provides equal opportunities for career progression/ promotion	NHS staff surveys	2018	94.3%	83.9%	69.2%	94.3%	
% believing the organisation provides equal opportunities for career progression/ promotion	NHS staff surveys	2017	93.5%	84.5%	68.6%	94.2%	
The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons; The Trust provides a positive working environment for staff with a proactive Health, Work and Well-being Service. An independent provider, Quality Health, provides the data. The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these percentages, and so the quality of its services, by: Embedding a positive culture with clear visible leadership, clarity of vision and actively promoting behavioural standards for all staff. Engagement of staff at all levels in the development of the vision and values of the Trust. Honest and open culture, with staff supported to raise concerns via Speak Out Safely, Freedom to Speak Up champions and anonymous Speak in Confidence website.							
Friends & Family Test - A&E - Response Rate	NHS England	Mar-19	20.5%	12.3%	0.0%	37.1%	
Friends & Family Test - A&E - Response Rate	NHS England	Feb-19	18.9%	12.2%	0.0%	35.6%	
Friends & Family Test - A&E - Response Rate	NHS England	Jan-19	18.9%	11.9%	0.0%	31.1%	
Friends & Family Test - A&E - Response Rate	NHS England	Dec-18	20.0%	11.4%	0.0%	32.1%	
Friends & Family Test - A&E - % recommended	NHS England	Mar-19	85.5%	85.9%	55.6%	100.0%	
Friends & Family Test - A&E - % recommended	NHS England	Feb-19	86.2%	85.3%	57.0%	100.0%	

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Friends & Family Test - A&E - % recommended	NHS England	Jan-19	85.5%	86.0%	59.7%	100.0%	
Friends & Family Test - A&E - % recommended	NHS England	Dec-18	85.8%	86.5%	42.9%	100.0%	
Friends & Family Test - Inpatients - Response Rate	NHS England	Mar-19	33.1%	24.6%	0.9%	100.0%	National average includes Independent Sector Providers. Response rate Some organisations' data may include response rates of greater than 100%. This occurs when responses relating to discharges in one month are received by organisations too late for that month's submission and are submitted as part of the return in the following month. Patients/Carers/Family members may also choose to submit responses at multiple points during a period of care/treatment resulting in multiple submissions to the same month.
Friends & Family Test - Inpatients - Response Rate	NHS England	Feb-19	33.1%	24.6%	1.9%	100.0%	
Friends & Family Test - Inpatients - Response Rate	NHS England	Jan-19	31.0%	24.0%	1.8%	100.0%	
Friends & Family Test - Inpatients - Response Rate	NHS England	Dec-18	33.0%	22.2%	2.1%	107.7%	
Friends & Family Test - Inpatients - % recommended	NHS England	Mar-19	95.6%	95.7%	76.8%	100.0%	
Friends & Family Test - Inpatients - % recommended	NHS England	Feb-19	95.0%	95.7%	76.3%	100.0%	
Friends & Family Test - Inpatients - % recommended	NHS England	Jan-19	92.9%	95.6%	75.7%	100.0%	
Friends & Family Test - Inpatients - % recommended	NHS England	Dec-18	93.5%	95.6%	80.8%	100.0%	
The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust actively promotes the Friends and Family Test across all areas. The data is submitted monthly to NHS England. The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve these percentages, and so the quality of its services, by: Continuing to promote Friends and Family Test (FFT) using a variety of methods, including face-to-face and technology. Actively working with ward staff and the Trust's Patient Experience and Dignity Champions to improve levels of engagement with the system, to ensure the latest results are shared at local level.							
% of patients admitted to	NHS	Quarter 3	96.40%	95.60%	54.86%	100.00%	National Data for Q4 2018-19

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
hospital who were risk assessed for VTE	England	2018-19					will be published in June 2019.
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 2 2018-19	96.45%	95.44%	68.67%	100.0%	All data is for Acute Providers only
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 1 2018-19	95.17%	95.62%	75.84%	100.0%	
The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: Continued focus on achieving the target of 95% of patients having a VTE risk assessment within 24 hours of admission to ensure that they receive the most appropriate treatment, having achieved 95.92% for 2018-19. Root cause analysis (RCA) undertaken on VTEs recorded on Datix to ensure best practice is followed. During 2018-19, 26 patients developed a hospital acquired thrombosis, of which 19 RCAs have been completed to date and 100% were found to have received appropriate care. Data on VTE risk assessments are submitted to NHS England each month. The St Helens and Knowsley Teaching Hospitals NHS Trust is taking the following actions to improve this percentage, and so the quality of its services, by: Maintaining focus on, and closely monitoring, the rate of risk assessments undertaken by the Quality Committee. Undertaking audits on the administration of appropriate medications to prevent blood clots. Completing RCA investigations on all patients who develop a hospital acquired venous thrombosis to ensure that best practice has been followed. Sharing any learning from these reviews and providing ongoing training for clinical staff.							
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	Internal	April-18 to Mar-19	8.59				
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	GOV.UK	Apr-17 to Mar-18	11.4	13.7	0	91.0	Apr-17 to Mar-18 data was published in July 2018 Data for Apr-18 to Mar-19 due to be published in July 2019
C Difficile rates per 100,000 bed-days for specimens taken from	GOV.UK	Apr-16 to Mar-17	11.4	13.2	0	82.7	

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
patients aged 2 years and over (Trust apportioned cases)							
The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: Infection prevention and control remains a priority for the Trust. All new cases of C. difficile infection are identified by the laboratory and reported to the Infection Prevention Team, who co-ordinate mandatory reporting to Health Protection England. The Trust is maintaining compliance with the national guidance on testing stool specimens in patients with diarrhoea. All cases are thoroughly investigated using RCA, which is reported back to a multidisciplinary panel chaired by an Executive Director to ensure appropriate care was provided and lessons learned are disseminated across the Trust. The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by: Focussing on ensuring staff compliance with mandatory training for infection prevention and control. Actively promoting the use of hand washing and hand gels to those visiting the hospital. Providing a proactive and responsive infection prevention service to increase levels of compliance. Ensuring comprehensive guidance is in place on antibiotic prescribing.							
Incidents per 1,000 bed days	Internal	Oct-18 to Dec-18	39.41	/	/	/	
Incidents per 1,000 bed days	NHS Improvement	Apr-18 to Sep-18	34.95	44.10	22.08	107.37	"Next data to be published in June 2019 Based on acute (non-specialist) trusts with complete data (6 months data)"
Incidents per 1,000 bed days	NHS Improvement	Oct-17 to Mar-18	37.32	42.25	24.96	124.00	
Incidents per 1,000 bed days	NHS Improvement	Apr-17 to Sep-17	40.48	42.10	23.47	111.69	
Number of incidents	Internal	Oct-18 to Dec-18	2438	/	/	/	
Number of incidents	NHS Improvement	Apr-18 to Sep-18	4228	5714	1285	23692	
Number of incidents	NHS Improvement	Oct-17 to Mar-18	4643	5537	1513	19897	
Number of incidents	nrls.npsa.co.uk	Apr-17 to Sep-17	4927	5287	1992	15228	
Incidents resulting in severe harm or death per 1,000 bed days	Internal	Oct-18 to Dec-18	0.16	/	/	/	

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Incidents resulting in severe harm or death per 1,000 bed days	NHS Improvement	Apr-18 to Sep-18	0.09	0.15	0.00	0.54	
Incidents resulting in severe harm or death per 1,000 bed days	NHS Improvement	Oct-17 to Mar-18	0.10	0.15	0.00	0.55	
Incidents resulting in severe harm or death per 1,000 bed days	nrls.npsa.co.uk	Apr-17 to Sep-17	0.12	0.15	0.00	0.64	
Number of incidents resulting in severe harm or death	Internal	Oct-18 to Dec-18	10	/	/	/	
Number of incidents resulting in severe harm or death	NHS Improvement	Apr-18 to Sep-18	11	19	0	87	
Number of incidents resulting in severe harm or death	NHS Improvement	Oct-17 to Mar-18	13	19	0	99	
Number of incidents resulting in severe harm or death	nrls.npsa.co.uk	Apr-17 to Sep-17	15	19	0	121	
Percentage of patient safety incidents that resulted in severe harm or death	Internal	Oct-18 to Dec-18	0.4%	/	/	/	
Percentage of patient safety incidents that resulted in severe harm or death	NHS Improvement	Apr-18 to Sep-18	0.3%	0.3%	0.0%	1.2%	
Percentage of patient safety incidents that resulted in severe harm or death	NHS Improvement	Oct-17 to Mar-18	0.3%	0.3%	0.0%	1.5%	

Indicator	Source	Reporting Period	StHK	National Performance			
				Average	Lowest Trust	Highest Trust	
Percentage of patient safety incidents that resulted in severe harm or death	nrls.npsa.co.uk	Apr-17 to Sep-17	0.3%	0.4%	0.0%	2.0%	
The St Helens and Knowsley Teaching Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust actively promotes a culture of open and honest reporting within a culture of fair blame. The data has been validated against National Reporting and Learning System (NRLS) and HSCIC figures. The latest data to be published is up to September 2018. The Trust's overall percentage of incidents that resulted in severe harm or death was 0.4%. The St Helens and Knowsley Teaching Hospitals NHS Trust has taken the following actions to improve this number and rate, and so the quality of its services, by: Previously committed to the Sign up to Safety campaign to reduce avoidable harm by 50% by 2018. Undertaking comprehensive investigations of incidents resulting in moderate or severe harm. Delivering simulation training to enhance team working in clinical areas. Providing staff training in incident reporting and risk management. Monitoring key performance indicators at the Patient Safety Council. Continuing to promote an open and honest reporting culture to ensure incidents are consistently reported.							
Due to reasons of confidentiality, NHS digital has supressed figures for those areas highlighted with an '*' (an asterisk). This is because the underlying data has small numbers (between 1 and 5)							

2.4.12. Performance against national targets and regulatory requirements

The Trust aims to meet all national targets. Performance against the key indicators for 2018-19 is shown in the table below:

Performance Indicator	2017-18 Performance	2018-19 Target	2018-19 Performance	Latest data
Cancelled operations (% of patients treated within 28 days following cancellation)	Not Achieved	100.0%	99.5%	Apr-18 to Mar-19
Referral to treatment targets (% within 18 weeks and 95th percentile targets) – Incomplete pathways	Achieved	92%	92.4%	Apr-18 to Mar-19
Cancer: 31-day wait from diagnosis to first treatment	Achieved	96%	98.1%	Apr-18 to Mar-19
Cancer: 31-day wait for second or subsequent treatment:				
- surgery	Achieved	94%	96.8%	Apr-18 to Mar-19
- anti-cancer drug treatments	Achieved	98%	100.0%	Apr-18 to Mar-19
Cancer: 62-day wait for first treatment:				
- from urgent GP referral	Achieved	85%	88.3%	Apr-18 to Mar-19
- from consultant upgrade	Achieved	85%	88.3%	Apr-18 to Mar-19
- from urgent screening referral	Achieved	90%	95.4%	Apr-18 to Mar-19
Cancer: 2 week wait from referral to date first seen:				
- urgent GP suspected cancer referrals	Achieved	93%	92.2%	Apr-18 to Mar-19
- symptomatic breast patients	Achieved	93%	91.6%	Apr-18 to Mar-19
Emergency Department waiting times within 4 hours - Type 1 only	Not achieved	95%	74.3%	Apr-18 to Mar-19
Percentage of patients admitted with stroke spending at least 90% of their stay on a stroke unit	Achieved	83%	85.7%	Apr-18 to Mar-19
Clostridium Difficile	Achieved	40	25* 25 positive samples, of which 12 were successfully appealed with no lapses in care	Apr-18 to Mar-19
MRSA bacteraemia	Not achieved	0	1 contaminant	Apr-18 to Mar-19
Maximum 6-week wait for diagnostic procedures: % of Diagnostic Waits who waited <6 weeks	Achieved	99%	99.9%	Dec-18 to Mar-19

3. Section 3

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

3.1. Summary of how we did in achieving our strategies

3.1.1. Clinical and Quality Strategy 2016-20

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

For 2019, there is a new Clinical Strategy, however, there is a summary of progress in delivering the previous strategy below:

1. 4-hour performance is the only major national standard that the Trust has consistently failed to achieve. An improvement trajectory for 2019-20 has been agreed with NHS Improvement and intensive work is underway to achieve this
2. Weekend mortality has fallen significantly over the past couple of years
3. Overall 62-day cancer performance is consistently strong. Several pathways, typically involving other hospitals and teams are less consistent and are subject to intensive improvement work, scrutinised by the Quality Committee
4. VTE assessment has been subject to intensive support and is now consistently above the 95% standard. The implementation of an electronic solution will add further resilience in due course
5. Electronic discharge targets were not possible with the legacy patient administration system, but the new system, Medway, coupled with an interim electronic solution will improve performance pending the introduction of a full electronic patient record in due course. In the interim, a system of early automated notifications provide very basic information about patient admissions within required timeframes
6. Falls performance has continued to improve. The Quality Committee continues to scrutinise this target
7. Timeliness of complaints performance has consistently improved
8. Investment in the Sepsis Team has resulted in very strong overall performance in ED and on the wards. Intensive work is ongoing to improve the timely detection and treatment of all patients, especially young children. As part of learning from a serious incident, new and improved patient-validated discharge information for children who initially presented to ED with possible sepsis is being adopted (from Newcastle)
9. Time to theatre for fractured neck of femur patients had improved on the latest available national benchmark of fragility fracture management
10. Critical care mortality continues to improve and is now better than England average

3.1.2. Nursing and Midwifery Strategy 2014-18

The Strategy's aim was to embed the Chief Nursing Officer's '6Cs' through strong clinical leadership. Progress has been made in all areas and a new strategy is being drawn up to build on our current successes.

Elements of the Nursing & Midwifery Strategy (2014-2018) that were delivered this year include:

- Regular reviews of nursing establishments to ensure safe effective care
- Strengthening safe discharges by reviewing ward processes
- Embracing electronic prescribing and medicines administration (EPMA) systems to support the reduction in medication errors
- First Cancer Clinical Nurse Specialist (CNS) annual education day held, "Curious about cancer" (funded by Macmillan) with over 80 delegates from secondary and primary care attending
- Diabetes team 'Cloud' service to improve collaborative working between primary and secondary care, which includes a telephone line for specialist advice for professionals, patients and carers for diabetes advice and support. This runs seven days 8am – 10pm. A new community diabetes specialist nurse has been employed to drive this collaborative working, providing support to practice nurses, care homes, district nurses and other community services and to improve achievement of the NICE recommended treatment targets for cholesterol, blood pressure and blood sugar monitoring

Our senior Nursing, Midwifery and Allied Health Professionals' leadership team is focussed on supporting teams to deliver the best possible care for patients, recognising that leading teams with compassion directly affects the outcomes and experience of our patients.

In preparing the new strategy we have used the National Nursing, Midwifery and Care Staff Framework, Leading Change, Adding Value and the Allied Health Professionals Into Action Framework to guide our plans along with staff feedback to create a plan for the next 3 years.

The strategy includes a focus on communities working together to prevent unnecessary ill-health through an improved focus on health and well-being and a continuous drive to deliver person-centred care.

3.1.3. Human Resources and Workforce Strategy 2014-19

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

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

The Trust has also signed up to the 'Step into Health' programme, which supports military veterans to gain employment in the NHS. The Trust officially pledged to champion the Step into Health campaign and to value the contribution made by military service leavers and their families. The Trust continues to work closely with the Armed Forces Community to provide career and development opportunities and achieved the bronze Armed Forces Covenant – Employer Recognition Scheme award in 2017-18 and silver in 2018-19.

The Trust launched its Workforce Equality, Diversity & Inclusion Strategy and 3 year programme plan In July 2018. The strategy and programme (action) plan outlines the Trust's approach to workforce equality, diversity and inclusion across the next 3 years, 2018–21.

3.1.4. Equality, Diversity and Inclusion Strategy

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

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

In addition to the steering group the Trust also holds monthly Workforce Equality, Diversity and Inclusion meetings to work through the workforce plan that was developed in summer 2018. This robust work plan addresses all elements of equality, diversity and inclusion relating to the staff working in the Trust, and has

initially helped to improve workforce equality monitoring by encouraging staff to update their personal details, in particular information around their sexual orientation and disability status.

During 2018-19, the Trust has developed new and existing policies. These include a new Workforce Transgender Policy and an extended use of interpreting services policy to include the Accessible Information Standard. This will ensure that we are identifying patients' additional communication needs at the earliest opportunity, placing an alert in the patient record to show that a patient has additional needs and a description of what those needs may be.

The Trust's new Patient Access System (PAS), Medway, went live in April 2018. This system is now fully compliant with the requirements of the Accessible Information Standard and staff are able to record a patient's additional communication needs in detail and place an alert on the patient record, which is visible to all staff when they enter the patient record.

All functions provided by the Trust are subject to an equality analysis to ensure that the Trust is neither directly nor indirectly discriminating against members of one or more protected groups. The policy for carrying out an equality analysis provides guidance on the need to carry out a robust analysis on the following:

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

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

A new toolkit has been developed to guide and support staff when carrying out these assessments and includes a section to evidence where consultation (following the Gunning Principles) has taken place and a section to provide assurance that the Public Sector Equality Duty (PSED s149) has been met. This toolkit is especially useful when assessing proposed changes to services or cost improvement programmes.

The Trust held its EDS2 panel/assessment in February 2019. The aim of this panel was
to help develop new equality objectives plus associated action plans based on the barriers and health inequalities that some of our local communities currently face. The equality objectives 2019-23 are:

- To improve access and outcomes for patients and communities who experience disadvantage

- To improve our equality performance by collaboration and partnership working
- To engage and consult with all our local communities, and to raise awareness of health inequalities both within our workforce and in our local communities
- To take steps to ensure that our workforce is broadly representative of the communities we serve, at all levels
- Improve the wellbeing of staff employed in the Trust
- Improve the experiences of Black and Minority Ethnic staff employed in the Trust

The Trust was assessed by Navajo inspectors in February 2019 and were successfully reaccredited with the Navajo Chartermark. The Navajo group meets monthly and during the past 12 months has made significant progress towards retaining this Chartermark, some of the work done by this group includes:

- Setting up a lesbian, gay, bisexual and transgender + (LGBT+) staff network, which is led by staff members
- Development of a workforce transgender policy
- Development of a Caring for Transgender Patients Policy
- Hosting the Trust's first NHS Diversity and Inclusion Conference, where staff received information and training around cultural competency, learning disabilities and the Mental Capacity Act
- Flying the Rainbow Flag to celebrate International Day against Homophobia and Transphobia on all sites where the Trust provides services

Specialist speakers have been invited to this group to train members of the group including:

- Silver Rainbows: part of Cheshire and North Wales Body Positive, who spoke to the group about the issues/barriers faced by older LGBT people when accessing healthcare services
- Transgender speaker (trans man) spoke to the group about his journey through the transition process both from a workforce perspective and also his medical journey and the barriers he encountered along the way
- LGBT Cancer Programme – the co-ordinators of this programme spoke to the group about how often LGBT cancer patients have poorer outcomes than others, partly due to lifestyle choices, but also due to their reluctance to engage with services early on in their illness

The Trust's Patient Inclusion and Experience Lead is part of a steering group working on the Merseyside and Cheshire LGBT Cancer Project. This project is a collaboration between Sahir House in Liverpool and Macmillan to develop resources and training for staff dealing with LGBT cancer patients, with the aim of improving outcomes.

The Trust became a Hate Crime Reporting Centre in February 2019, working in collaboration with Merseyside Police. This is a unique scheme that allows patients, staff and members of our local community to report a hate crime/incident through links on the internet and intranet sites directly to Merseyside Police Hate Crime Co-ordinator. This is a confidential reporting scheme and once a person has raised a concern via this platform the Hate Crime Co-ordinator will contact them directly and arrange to meet them to discuss how best to resolve their concerns. In addition to this scheme, the Hate Crime Co-ordinator has hosted drop in sessions at Whiston

Hospital for over 2 years and in 2018 these sessions were extended to allow additional monthly sessions at St Helens Hospital.

In collaboration with Merseyside CCG's Equality and Inclusion Service and several other local trusts, and in consultation with St Helens Deafness Resource Centre, we have led on the development of a set of quality standards for the providers of interpreting and translation services. These standards have been developed to ensure that people who have limited ability to communicate in English are supported to be able to access and receive high quality healthcare. The quality standards aim to ensure a consistent approach to commissioning interpreting and translation services across the Merseyside healthcare system, to remove unwarranted variation in quality and to ensure that quality drives future procurement and commissioning decisions.

Following the d/Deaf consultation event hosted by Liverpool CCG early in 2019 we have developed an action plan to ensure improvements are made in the service we currently provide to our d/Deaf patients. We are working closely with representatives from St Helens Deafness Resource Centre and Knowsley Healthwatch in order to progress the action plan, which has been incorporated into the overarching Accessible Information action plan.

3.1.5. Freedom to speak up

The Trust is committed to providing and developing a culture where all staff feel empowered to speak up or raise concerns. The Trust values include being open and honest and listening and learning. There a number of supportive facilities for staff to raise concerns, including:

- **Freedom to speak up**

The Trust has appointed four Freedom to Speak up Guardians, who provide support to staff across the organisation. The guardians are representative of various staff groups and backgrounds. They provide an alternative way for staff to discuss and raise concerns and act as an independent and impartial source of advice to staff at any stage of raising a concern.

The work of the guardians has a direct impact on continuously improving safety and quality for our patients, carers and families, as well as enhancing the experience of our staff, by acting on the concerns raised. The Guardians provide feedback to the staff that have raised a concern, in a manner that is supportive, whilst ensuring that there are no repercussions for the person raising a concern.

The Trust works in partnership with the National Guardian's Office and North West Regional Network of Freedom to Speak up Guardians to enhance staff experience with raising concerns.

- **Speak in confidence system**

The Trust has in place an anonymous reporting system, Speak in Confidence, which enables all staff irrespective of position to feel confident that they can raise concerns without disclosing their identify. The system uses a browser-based interface to ensure anonymity so that the concern raiser remains anonymous at all times.

However, the manager receiving the concern is able to provide a response to the concern, to request further information and/or to provide assurances of actions taken to mitigate the risks associated with the concern raised via the on-line system.

- **Raising concerns hotline**

The Trust also has a telephone hotline, which provides access to report any concerns, which are reviewed and actioned by the Assistant Medical Director.

- **Health work and wellbeing hotline**

Staff members have access to a dedicated helpline, to provide advice and support regarding health and well-being aspects relating to work or on the impacting the individual. Individualised support can be offered dependent on the needs and circumstances. Concerns about workplace can be raised through the hotline.

- **Hate crime reporting**

A hate crime is when someone commits a crime against a person because of their disability, gender identity, race, sexual orientation, religion, or any other perceived difference. The Trust, in partnership with the Merseyside Police, launched the first ever Hate Crime Reporting Scheme based at an NHS Trust, as noted in section 3.1.4 above. This is a confidential on-line reporting service that enables anyone from across our organisation and local communities to report, in complete confidence, any incidents or concerns around hate crime to Merseyside Police.

- **Policies and procedures**

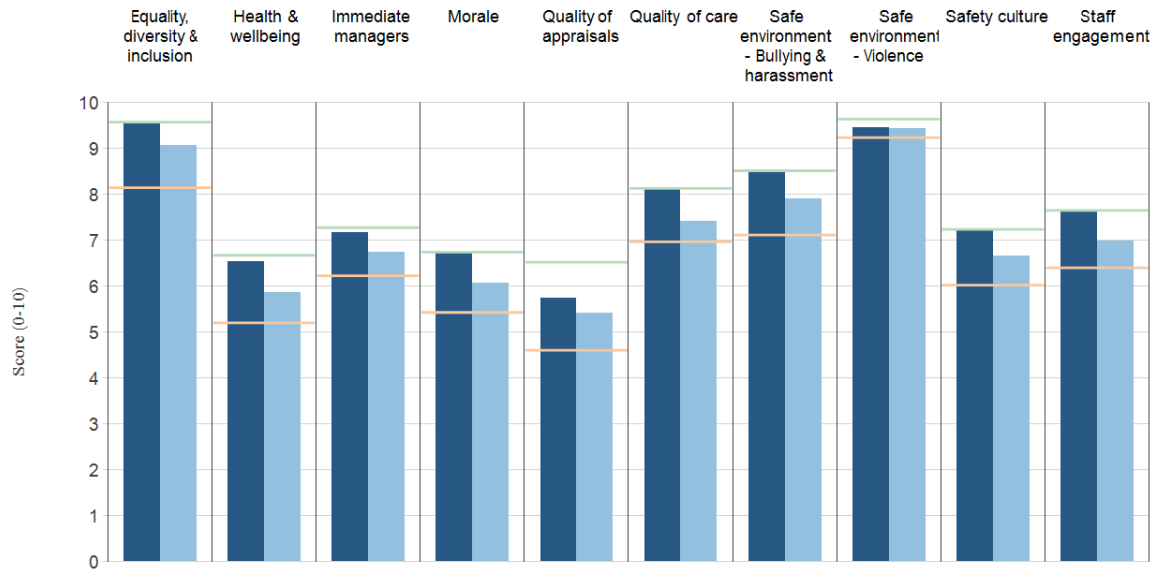
There are a number of Trust policies and procedures that facilitate the raising of staff concerns as follows; Grievance Policy and Procedure, Respect and Dignity at Work Policy, Being Open Policy. Staff are also encouraged to informally raise any concerns to their manager, nominated HR lead or their staff side representative, as well as considering the routes listed above.

3.1.6. Staff survey key questions

The national staff survey provides a key measure of the experiences of the Trust's staff, with the findings used to reinforce good practice and to identify any areas for improvement. The Trust's response rate for the 2018 survey was 51%, which is the highest score for acute trusts in the North West.

A new reporting scheme was introduced, as the 32 key findings previously reported on have been replaced by 10 themes. The themes are positively scored on a 0 to 10 point scale, a higher score indicating a better result.

Overall, the Trust has the highest national score for 6 themes out of 10, and only 0.1 below the best national score for another 2 themes, as indicated below:



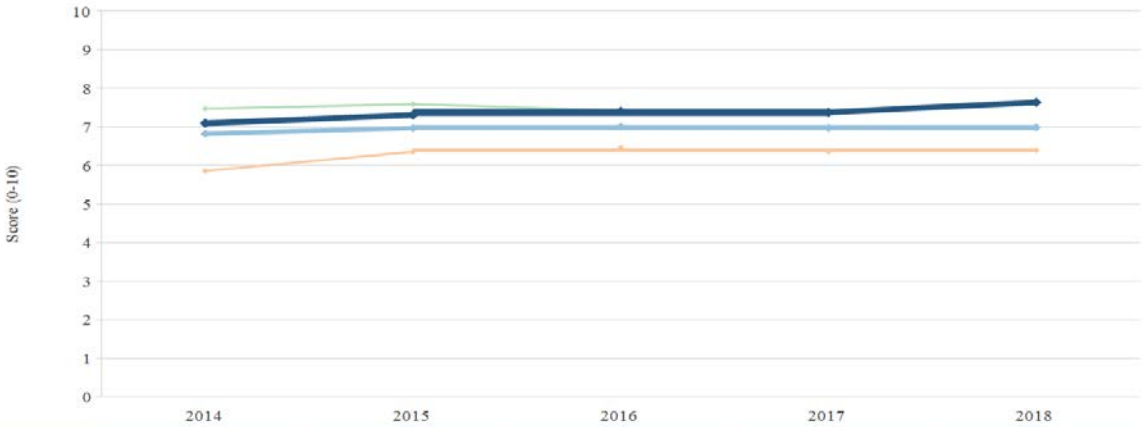
	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
StHK	9.6	6.5	7.2	6.7	5.7	8.1	8.5	9.5	7.2	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

The Trust has been rated as the best place to work in the NHS for the second consecutive year. StHK is also the most recommended acute trust in England to receive care or treatment.

In addition, 88.3% of staff agreed that care of patients/service users is the organisation's top priority, an increase from 83.7% last year and well above the national average of 76%.

The below graphics for staff engagement indicate that our Trust has the best score nationally for the third consecutive year, with a significant improvement since 2014.

Overall Staff Engagement is measured as an average across three themes: advocacy, motivation and involvement. Staff engagement 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

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 or receive treatment" (81% and 87.3% respectively), for which the Trust returned the best scores nationally, as in 2017.

Whilst the overwhelming majority of responses are positive, three areas were identified for improvement: quality of appraisals, work related musculoskeletal problems and violence on staff by patients and their relatives.

These area have the potential to impact on staff morale, therefore, it is imperative that the Trust takes steps to address these. A deep dive has identified the specific areas and staff groups where focussed action will be taken and an action plan has been developed to support this work.

3.1.7. Health, Work and Well-being

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

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

The service has recently been reaccredited to ensure that the service continues to meet the national minimum standard when delivering a Safe Effective Quality Occupational Health Services (SEQOHS). The assessment looks at the following aspects of Occupational Health; business probity, information governance, people, facilities and equipment, relationships with purchasers and workers.

Throughout 2018-2019 there have been a number of activities to encourage staff to improve their well-being. During the month of June 2018 a summer health education and promotion campaign was undertaken by the Health, Work and Well-being Team supported by external speakers (subject matter experts). The campaign was provided at three of the Trust's main locations and included:

- Positive mental health support – which included mindfulness and meditation
- Drug and alcohol awareness
- Skin care
- Sun safety
- Sexual health
- Healthy lifestyle
- Promoting physical activity

The annual Health, Work and Well-being Open Day was held in September 2018, which attracted over 600 staff from all over the Trust. The session provided information on a range of health and well-being topics, for example, mental health

support (mindfulness, employee assistance programme, counselling), increasing physical activity and healthy eating.

The successful flu vaccination programme was launched at the Open Day, 95.4% of frontline healthcare workers were vaccinated, which far exceeds the 75% national CQuIN target. The Trust has been rated as top performing Trust nationally.

In February 2019, we introduced our well-being champions and 40 staff have signed up as champions and will be providing their peers with regular health and well-being updates.

3.1.8. Clinical education and training

The focus on providing excellent clinical education opportunities has continued in 2018-19. This has included extending the simulation programme, including procuring paediatric simulators to enhance the training of staff from neonatal to adolescents, as well as supporting a number of teams across the Trust, such as, sepsis, intensive care and stroke. Provision of simulation in dentistry has increased over the year with the addition of emergency programmes for foundation and core dentists, with positive feedback. The inclusion of simulation in the foundation training programme has continued with aspirations to mirror the successful Core Medical Trainee programme previously introduced.

The education programme designed to support internationally recruited nurses has continued to excel during the year. In addition, the Care Certificate Programme has further developed, since appointing the Clinical Education Support Tutor, with 111 healthcare assistants (HCAs) currently undertaking the programme and 13 successfully completing the qualification. A proposal was agreed for HCAs that have completed the newly devised Assessor Preparation Course, to become assessors of the Care Certificate. This will develop HCA skills in assessing and evaluating their colleagues' practice and provide additional assessors to support the Care Certificate, releasing frontline nurses to focus on being mentors and preceptors. A Care Certificate Policy has been implemented to ensure that the process is standardised.

A new Preceptorship Programme will be launched in April 2019. This will be a 10 day programme and aims to follow a patient's journey from admission to discharge using both simulation and theory. Newly qualified nurses are also invited to attend ongoing development sessions and professional discussion meetings at 3, 6, 9, 12 and 18 months that will held by the Clinical Education Support Tutor and other healthcare professionals within the Trust. The professional discussion meetings explore progress and their thoughts on the Trust's Preceptorship Programme. The development sessions aim to provide newly qualified nurses with more advanced skills such as dealing with difficult conversations and resilience training.

3.2. Patient safety

One of the Trust's key priorities in 2018-19 was to continue to reduce avoidable harm. Avoidable harm is harm that can be prevented.

3.2.1. Falls

The Trust has sustained improvements in falls prevention for patients admitted to the hospital. The falls team continue to develop strategies to minimise the occurrence of inpatient falls and as a result have been able to reduce the number of harm incidents compared to last year.

In 2018-19, the Trust has reported:
- 5% decrease in all inpatient falls.
- 18% decrease in falls incidents resulting in severe harm or above

The Trust has developed and implemented a new falls strategy covering 2018 to 2021. The strategy focuses on seven key areas for improvement:
- Using data to drive improvement
- Lesson learning and information sharing
- Procurement of equipment/services
- Changing culture
- Education and awareness
- Planning and implementation of falls prevention care
- Planning and implementation of post falls care

3.2.2. Venous thromboembolism (VTE)

VTE covers both deep vein thrombosis (DVT) and its possible consequence, pulmonary embolism (PE). A DVT is a blood clot that develops in the deep veins of the leg. However, if the blood clot becomes mobile in the blood stream it can travel to the lungs and cause a blockage (PE) that could lead to death.

Preventing VTE is a national and Trust priority. The risk of hospital-acquired VTE can be greatly reduced by risk assessing patients on admission to hospital and taking appropriate action. This might include prescribing and administration of appropriate medication to prevent blood clots and application of specialised stockings.

VTE risk assessments were completed in 95.92% of patients in 2018-19 compared to 93.7% in 2017-18, exceeding the national target of 95%.

The Trust has increased the number of risk assessments completed and the appropriate prevention interventions by:
- Implementing an electronic VTE risk assessment tool, integrated to the new patient administration system,- Medway, enabling real time performance reviews
- Introducing and sharing of compliance dashboards twice daily
- Undertaking a root cause analysis investigation of all cases of Hospital Acquired Thrombosis in order to prevent it happening again
- Providing immediate feedback/education to ward staff, disseminate learning points and implementing any actions for improvement
- On-going VTE training for all clinical staff.

There has been a 16% reduction in Hospital Acquired Thrombosis, from 31 in 2017-18 to 26 in 2018-19.

3.2.3. Medicine safety

The inpatient electronic prescribing and medicines administration (ePMA) system is now live in all medical inpatient locations in the Trust. The ePMA system enables early identification and rectification of prescribing issues, for example, the use of appropriate antibiotic usage for suspected infections. The system also facilitates electronic ordering of non-stock items significantly speeding up supply and reducing the likelihood of missed doses due to medication unavailability. An electronic transfer of ePMA linked e-discharges is being utilised to further expedite the processing of prescriptions for discharging patients in a timely manner.

The Trust has continued to reduce the number of medication incidents in 2018-19 compared to 2017-18, supported through proactive work streams led by pharmacy:

- 25% decrease in all prescribing errors
- 2% decrease in all administration errors
- 4% decrease in dispensing errors
- 86% decrease in medication incidents resulting in moderate/severe harm or death
- 36% decrease in harmful medication incidents

3.2.4. Pressure ulcers

The Trust is committed to reducing the number of hospital-acquired pressure ulcers developed whilst the patients are receiving inpatient care. The Trust continues to have zero tolerance to hospital acquired grade 4 pressure ulcers and will continue to seek to reduce harm from pressure ulcers, which it has maintained in the last 5 years. In addition, the Trust has reduced avoidable grade 2 pressure ulcers by 18% (5), compared to 2017-18.

It is projected that compared with last year there will be minimal change in the incidence of avoidable grade 1 pressure ulcers. However, this supports high quality care and innovation used in the Trust, as these ulcers have resolved and not deteriorated to a grade 2, due to the commitment of staff, education and availability of resources/equipment.

The Trust has implemented innovative schemes to prevent the development of pressure ulcers which includes:

- Early to bed initiative in the Emergency Department resulting in all patients being risk assessed and placed directly on appropriate pressure relieving mattresses or air mattresses to prevent tissue damage
- Introduction of moisture lesion protocol, supported by a prevalence audit demonstrating a reduction in moisture lesions, supporting the benefits of the introduction of the protocol
- Introduction of ‘Heels RED - think BED’ initiative aimed at reducing the chances of developing heel pressure risks associated with electric profiling beds

- Collaborative working with NHSE Cheshire and Mersey Pressure Ulcer Collaborative Group to improve care standards and innovation in pressure ulcer prevention through shared learning and development of unified protocols
- Continued skill development and training in pressure ulcer prevention for clinical staff, enabling implementation of preventative care and early recognition of tissue damage

3.2.5. Theatre safety

The Trust operating theatre department have a number of initiatives to improve safety of patients, which are highlighted below:

- Development and implementation of National Safety Standards for Invasive Procedures (NatSSIPs) to reduce the number of patient safety incidents related to invasive procedures in which surgical never events could occur
- Development and implementation of Local Safety Standards for Invasive Procedures (LocSSIPs), as per the national guidance. These documents provide a framework for ensuring safety checks are carried out using a nationally approved methodology
- Further work to improve the structure and content of the communication tool used in theatre, enabling all team members to contribute to ensuring safety and minimising errors
- Commitment to 'being open' and enabling staff to speak up in case of any concerns. The Operating Department continues to use the hierarchy challenge tool (HALT), which offers a series of prompts for any team member to tell the team they have a concern. The development and adoption of this tool by the Trust has been recognised as a national pioneer in CQC publication 'Opening the door report' published in December 2018 https://www.cqc.org.uk/sites/default/files/20181224_openingthedoor_report.pdf
- Introduction of crisis trolleys in the operating department, providing a multipurpose equipment base to replace multiple trolleys and equipment used in challenging emergency situations in theatre. This ensures the right equipment is available for clinical teams in the event of a clinical emergency, enabling the right care and treatment to be given to the patient as soon as possible
- Introduction of clinical practice leads, to support the safe development of newly qualified Operating Department Practitioners (ODPs) and registered nurses newly employed to theatre settings. Clinical practice leads provide training and clinical supervision enabling the development of a safe and effective clinical workforce
- Support for the workforce and safe staffing levels through active recruitment process, with higher levels of retention rates. The department has very low turnover rates and has improved retention rates compared with previous years, demonstrating recognition of the support offered to all levels of staff members and higher levels of staff satisfaction
- Operating theatres have also reengineered the patient journey to the theatre, by developing forward wait areas. The new processes help improve the overall patient experience with reduced delays with surgery. The innovative process also offers enhancement in patient safety, by facilitating streamlined checking processes to be carried out before surgery

- The department has also invested in innovative approaches in obstetric care with the introduction of a second midwife or midwife assistant in theatre. Additional resources available allows the midwife to attend to and support new mum and baby, as well as the family member present, allowing the clinical teams to focus on the surgical procedure, enhancing both the safety and the experience for the mother
- Continued to invest heavily in training of clinical and non-clinical skills, in recognition of the value of highly skilled staff to delivering safe care. Simulation exercises are regularly carried out involving multi-disciplinary team members. These exercises are undertaken to familiarise staff members with unfamiliar situations and rare clinical emergencies. The training is underpinned with the principles of human factors and just culture. Incremental challenging scenarios are used to develop skills and confidence amongst staff members

The Operating department has been able to achieve:
- 71% reduction in theatre-related episodes of moderate harms and above
- 17% reduction in all theatre related incidents

3.2.6. National Early Warning Score (NEWS2)

The Trust is a leading performer in transforming clinical care with the adoption of technology. In 2018-19, the Trust aimed to translate these high standards of care into earlier detection of and management of clinically deteriorating patients through the implementation of eNEWS2 electronic observation. NEWS2 has received formal endorsement from NHS England and NHS Improvement to become the early warning system for identifying acutely ill patients, including those with sepsis, in hospitals in England and was implemented across the Trust in March 2019.

3.2.7. Being open – duty of candour

The Trust is committed to ensuring that we tell our patients and their families/carers, if there has been an error or omission resulting in harm. This duty of candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have, or could have, led to significant harm (categorised as moderate harm or greater in severity).

The Trust promotes a culture of openness, honesty and transparency. Our statutory duty of candour is delivered under the Trust's Being Open - A Duty of Candour Policy, which sets out our commitment to being open when communicating with patients, their relatives and carers about any failure in care or treatment. This includes an apology and a full explanation of what happened with all the available facts. The Trust operates a learning culture, within which all staff feel confident to raise concerns when risks are identified and then to contribute fully to the investigation process in the knowledge that learning from harm and the prevention of future harm are the organisation's key priorities.
- The Trust's incident reporting system has a mandatory section to record duty of candour

- Weekly incident review meetings are held, where duty of candour requirements are agreed on a case-by-case basis allowing timely action and monitoring. This allows the Trust to ensure that it meets its legal obligations
- The Trust has continued to raise the profile of duty of candour through the lessons learned processes and incident review meetings
- Duty of candour training is also included as part of mandatory training and root cause analysis training for staff

3.2.8. Never events

Never Events are described by NHS England as serious incidents that are wholly preventable. Guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should be implemented by all healthcare providers.

Each Never Event has a potential to cause serious harm or death. However, serious harm or death is not required for the incident to be categorised as a Never Event. Never Events include incidents such as: wrong site surgery, retained foreign object post-surgical procedure and chest or neck entrapment in bedrails.

For the period 2018-19, the Trust reported one never event, relating to a retained foreign object post-surgical procedure.

The Trust has undertaken significant improvement actions to mitigate the risk of reoccurrence of similar incidents, including:

- Improved surgery safety checklists
- Improvements in theatre environment enabling recording of clinical equipment used
- Development of human factors awareness and rolled out for theatre staff alongside the introduction of Local Safety Standards for Invasive Procedures (LocSSIPs)
- Staff empowered to challenge areas of concern
- Regular communication to staff through the learning events to share lessons, trend analysis and share areas of good practice

The Trust is committed to using Root Cause Analysis (RCA) to investigate adverse events, including Never Events. This approach is underpinned by the Trust's commitment to ensuring an open and honest culture in which staff are encouraged to report any errors or incidents and encourage feedback in the knowledge that the issues will be fairly investigated and any learning and improvement opportunities implemented.

3.2.9. Infection control

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

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

The Trust's infection prevention priorities are to:

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

During the reporting period April 2018 to March 2019 the Trust reported the following:

- MRSA bacteraemia (MRSAb): one positive blood sample, which was a contaminant, against a threshold of zero
- Clostridium Difficile infections (CDI): The Trust has a threshold of 40 cases in 2018-19 and has performed significantly better than this with 25 positive samples of which 12 were successfully appealed as there were no lapses in care
- Methicillin Sensitive Staphylococcus Aureus bacteraemia (MSSAb): The Trust has 31 cases of (MSSAb), To date, only four cases were deemed avoidable following post infection review (PIR)

Lessons learned from PIRs of MRSAb and CDI cases are shared Trust-wide via a monthly infection prevention report. Lessons learned include good practice identified, as well as areas for improvement. This information is also shared monthly with the CCGs.

The latest surgical site infection (SSI) rates related to elective hip and knee procedures from April 2018 to December 2018 are shown below:

- Hips 1.2% against a national average of 1%
- Knees 0.6% against a national average of 1.3%

There was a rise in SSI in total hip replacements following a move of the elective orthopaedic ward from 3alpha to 3E Orthopaedics. Root cause analysis was undertaken on the five cases. One was deemed not an infection. Three were deemed unavoidable superficial infections and one case was an avoidable infection. The Infection Prevention Team has worked collaboratively with the Orthopaedic Directorate to review the patient pathway and ward environment in order to reduce the risk. The infections have reduced since the implementation of the risk reduction measures. Root cause analysis were undertaken for all cases of SSI.

In May 2016, the Government announced its ambition to halve healthcare associated (HCAI) Gram-negative bloodstream infections (GNBSIs) by 2021. As approximately three-quarters of E. coli BSIs occur before people are admitted to hospital, reduction requires a whole health economy approach. The Trust, in collaboration with CCGs and partners, has developed a health economy action plan particularly focusing on a

10% in-year reduction in urinary tract infections and to learn and share lessons. The Trust continues to work closely with the infection prevention, patient safety and quality teams in the wider health economy, attending collaborative meetings across the region in order to improve infection prevention and control practices and monitoring.

The Trust took part in the NHS Improvement National Urinary Tract Infection (UTI) Collaborative to reduce UTIs. A multi-disciplinary team approach was utilised and new initiatives were implemented including the 'Dip or Not to Dip' campaign aimed at reducing the inappropriate use of urinalysis for the diagnosis of UTI and changes in practice were shared Trust-wide and with the CCGs.

The Trust vaccinated over 95% of front-line staff, exceeding the national flu CQuIN target of 75%. In addition, the Trust promoted the flu vaccination with pregnant women and patients in long stay rehabilitation wards. This season the Trust introduced flu vaccinators/champions for every ward and department to make it easier for staff to access vaccination. There were also peripatetic vaccinators throughout the Trust. During the flu season, the Trust had daily flu ward rounds undertaken by the DIPC and respiratory clinician.

The Trust has 21 Consultant infection control champions and over 70 link nurses who attend education and training and complete local audits to monitor compliance.

Key achievements for 2018-19 were:

- PLACE assessments achieved 100% for cleanliness for Whiston and St Helens sites
- Compliance with the prescribed CDI target and under the threshold for 4th consecutive year
- Continued SSI surveillance within elective hip and knee
- Achieved 75.5% aseptic non-touch technique (ANTT) competency for clinical staff
- 100% compliance with carbapenemase-producing enterobacteriaceae (CPE) and MRSA screening
- Ensured that there was infection prevention input into environmental monitoring systems and implementation of national standards for cleanliness and validation of standards
- Ensured there was infection prevention input into new builds and building modification
- Participated in NHSI UTI collaborative to reduce UTI from gram negative organisms
- Implemented electronic assessments for recording patients' bowel habit monitoring using the Bristol Stool Chart and also for CPE risk/screening assessment using the Patientrack system.

3.2.10. Safety Thermometer

The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care during hospital stays.

This measures four key harms: pressure ulcers, falls, catheter acquired urinary tract infection and VTE (blood clots). The Trust has continued to achieve over 98% new harm free care, that is harm that has occurred whilst an inpatient and is one of the best performing trusts in the region.

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

The Trust maintains good practice in relation to the prevention of pressure ulcers, falls with harm and VTE by:

- Ensuring education and training is available for all ward staff to enable them to complete and submit the NHS safety thermometer as required
- Weekly harm review meeting reviews all incidents across the Trust, including falls
- Bi-monthly Falls Improvement Group oversees the implementation of the revised falls strategy and performance manages the associated action plans
- Task and finish group reviewed the bedrail policy and associated falls risk assessment, which has since been implemented across all inpatient areas.
- Ensuring, when possible, a one-to-one staffing ratio is implemented when indicated by the risk assessment for falls, which is being supported by a new Standard Operating Procedure – Supplementary Care
- Providing non-slip anti-embolic stockings
- Continuing to provide education for all clinical staff on VTE, resulting in increased compliance with the prescribing and administration of anticoagulants to prevent these occurring
- Nursing staff attending one hour tissue viability training every three years
- Access to a full day wound management training session
- Providing each ward with a comprehensive tissue viability folder as a staff resource

3.2.11. Safeguarding

The Trust takes its statutory responsibilities to safeguard vulnerable patients of all ages very seriously and welcomes external scrutiny of its robust policies, procedures and processes. The Trust submits quarterly key performance indicator data to the CCGs, including the Trust's policies, for external scrutiny. The Trust also submits responses to the Commissioning Standards template and progress against any required actions. Safeguarding compliance is monitored by St Helens CCG through key performance indicators, who then provide assurance to Halton and Knowsley CCG.

The Trust has a dedicated Safeguarding Team comprising of:

- Assistant Director of Safeguarding
- Named Nurse Safeguarding Children
- Named Doctor, Safeguarding Children
- Named Midwife

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

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

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

3.2.11.1. Safeguarding Children

The Trust continues to work pro-actively with St Helens, Knowsley and Halton Local Safeguarding Children Boards (LSCB) as either a board or committee member. Changes to the LSCB structures and statutory function following the Wood Review are ongoing and due to be finalised in 2019, however, the Trust will ensure that safeguarding continues to be a priority and will maintain partnership working across the footprint.

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

The Trust continues to support and safeguard children at risk of all forms of abuse contributing to the 'early help' agenda and multi-agency safeguarding procedures.

3.2.11.2. Safeguarding Adults

The Trust continues to work pro-actively with St Helens, Halton and the Merseyside Safeguarding Adult Boards as either a board or committee member.

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

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

3.2.11.3. Mental Capacity Act and Deprivation of Liberty Safeguards

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

Quarterly information is supplied to the CCG regarding the applications that are made and the outcome of the application. An MCA audit and the quarterly submissions data indicates that the referrals are appropriate. The Trust will review all MCA/DoLS processes in line with the forthcoming Liberty Protection Safeguards, to ensure robust arrangements are in place when the Trust becomes the Responsible Body for reviewing applications, signing off authorisations and monitoring any restrictions that are deemed necessary, under the new arrangements.

3.2.11.4. Domestic Abuse

The Trust actively contributes to the local domestic abuse agenda with completion of MERIT risk assessment tools, signposting to relevant support agencies or Multi-Agency Risk Assessment Conferences (MARAC), active participation at both St Helens and Knowsley MARAC meetings, together with reports by exception to Halton and Warrington.

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

Contribution to Domestic Homicide Reviews are undertaken as required as requested by Community Safety Partnerships.

3.2.11.5. Learning Disability

Guidance has been implemented for patients with a learning disability attending any department within the Trust on how to meet their individual needs. This is supported by a toolkit to ensure that staff are able to provide the highest standards of care. The Trust works with partner agencies to support the patient journey and to share best practice. Safeguarding Adult staff support this agenda, highlighting and supporting those patients who attend the Trust requiring reasonable adjustments and support with communication whilst using Trust services.

3.3. Clinical effectiveness

The Clinical Effectiveness Council meets monthly and monitors key outcome and effectiveness indicators, such as mortality, nationally bench-marked cardiac arrest data, critical care performance, hip fracture performance, readmissions, clinical audit and application of National Institute for Health and Care Excellence (NICE) guidance.

3.3.1. National Institute for Health and Care Excellence Guidance

St Helens and Knowsley Teaching Hospitals NHS Trust has a responsibility for implementing NICE guidance in order to ensure that:

- Patients receive the best and most appropriate treatment
- NHS resources are not wasted by inappropriate treatment
- There is equity through consistent application of NICE guidance/quality standards

The Trust must demonstrate to stakeholders that NICE guidance/quality standards are being implemented within the Trust and across the health community. This is a regulatory requirement that is subject to scrutiny by the CQC. Responsibility for supporting the implementation and monitoring NICE guidance compliance activity moved to the Quality Improvement and Clinical Audit (QICA) Team in January 2018.

141 pieces of new or updated NICE guidance were released during the year. There is a system in place to ensure all relevant guidance is distributed to the appropriate clinical lead to assess its relevance and the Trust's compliance with the requirements. Action plans are produced for any shortfalls to ensure compliance is achieved. Compliance will be rigorously assessed by mandatory departmental compliance audits reportable through the Trust audit meetings. The Trust is fully compliant with 36 of those guidance papers issued and working towards achieving the remainder.

3.3.2. Mortality

The overall mortality rate for the Trust using the government's preferred measure, Summary Hospital Level Mortality Indicator (SHMI), is 0.99, which is better than expected, better than England, better than in previous years and second best in Cheshire & Merseyside.

The Trust has better than expected, better than England and better than in previous year's rates for both of the other commonly used measures: the Standardised Mortality Ratio (SMR), which is 95.9% and the Hospital Standardised Mortality Ratio (HSMR), which is 98%.

Crude mortality (the simplest measure) has fallen steadily over time and has been consistently better than England and better than the North West average for the past 10 years.

3.3.3. Clinical audit

The Trust has an active clinical audit programme and is an active participant in required national audits where performance is strong. Details of the work undertaken this year are contained in section 2.4.2 above.

3.3.4. Intensive Care National Audit & Research Centre (ICNARC)

The Trust performs well against the national quality indicators, an example being the low number of sepsis admissions compared to other units. This demonstrates that the Trust has a positive response rate to identifying high risk sepsis patients early. There is an ongoing issue with delayed discharges from Critical Care, therefore work continues to ensure the timely step down of patients to wards and substantial progress is being made to ensure patients are discharged from intensive care into a ward bed within four hours of being identified as suitable.

3.3.5. Copeland risk adjustment barometer (CRAB)

The Trust has established a CRAB Benchmarking Group to review trends in mortality and complications at Trust level, department level and surgeon level. CRAB creates an accurate picture of surgical consultants' practice, adjusting for presenting risk, operation complexity and intra-operative complications. It helps to identify best practice and removes the risks of misinterpreting crude mortality statistics. At present, CRAB Surgical only reflects the activity of surgical in-patient episodes and does not assess day-case activity, nor does it reflect the management of medical patients within the Trust.

The CRAB methodology is based on the POSSUM system, the clinical audit system which is widely recommended by national bodies, including the Royal College of Surgeons. It provides high quality clinical process and outcome information, via a a wide range of reports based on extensive data captured before or at the time of operation and documenting the patient's condition. For each case, the risk of mortality or morbidity is calculated using POSSUM algorithms and the raw data may be reviewed by looking at individual cases in the risk report.

Any concerning trends or higher than expected complication or mortality rates are examined for potential causality within the CRAB Benchmarking Group and by each of the core members of the specialty in question. Issues and concerns identified at the CRAB meetings are reviewed by the group as a whole and reviewed in more depth by specialty CRAB representatives. This more detailed review is fed back to the CRAB lead and the reports are adjusted to reflect this. Action plans are generated for each of the monthly meetings and reviewed by all members of the CRAB team to ensure that the issues have been addressed. If improvements in performance are not seen then it is the responsibility of the CRAB representative to escalate to the clinical director of that specialty. Further escalation if required is to the divisional director and any persistent concerns relayed to the Clinical Effectiveness Council (CEC).

The outcomes from this group are fed into the CEC on a quarterly basis, for example, it was identified that post-operative chest infections were higher than national and that an increase in post-operative chest physiotherapy, especially in orthopaedics, general surgery and urology would be beneficial. The Divisional Director of Surgery and CRAB lead attend the CEC.

3.3.6. National Community Hospitals Intermediate Care Audit

The Trust's intermediate care wards participated in the national community hospitals intermediate care audit in 2018, which is published by the NHS Benchmarking Network Community Hospitals.

The findings for Newton Hospital indicated the following positives:

- Higher than national average at accepting step up patients from the community to avoid attending the Emergency Department
- Higher than nationally bed occupancy levels
- Higher than national average Patient Reported Experience Measure (PREM) scores
- Better than national average of referral to commencement of service
- Better than national average of people going back to their usual residence following the service
- Better than national average of improved Modified Barthell scores, which are used to determine the service users' level of dependency on admission to the service and again on discharge

A number of actions are being taken to improve the service provided, including review of two week pathway for suitable patients to reduce length of stay and increasing the number of patients admitted within 48 hours.

3.3.7. Acute kidney injury (AKI)

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

The Trust implemented a multidisciplinary AKI Team comprising three Advanced Nurse Practitioners and a specialist AKI Pharmacist. The team is led clinically by the Consultant and Clinical Director for Acute Medicine. This team was tasked with modernising the quality of care to improve outcomes of patients with AKI. The team provides both care and education; patients are reviewed by AKI specialist nurses and ward pharmacists to ensure that appropriate medical care is provided to limit progression of an AKI and avoid permanent renal damage. The team also provide advice and education to healthcare professionals and are involved in writing and reviewing Trust policies relating to AKI, hydration and fluids.

In 2018-19 the team:

- Collaborated with 'Think Kidneys' (NHS England and Renal Registry Support Programme) to lead an inaugural AKI Nurse Education day for the North
- Conducted health promotion on World Kidney Day and patient focus groups
- Presented on improving timeliness of medication review in patients with AKI posters at the following conferences:
    - Clinical Pharmacy Congress
    - UK Kidney Week
    - UK Renal Pharmacy Group
- Led a workshop in September 2018 for UK Renal Pharmacy Group
- Were invited to present at an AQuA collaborative
- Were finalists at the HSJ Patient Safety Congress awards in 2 categories
    - Deteriorating patients and rapid response systems
    - Improving safety in medicines management

The AKI pharmacist developed the AKI e-learning package for the Centre for Postgraduate Pharmacy Education – due to launch later in 2019.

3.3.8. Promoting health

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

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

The Trust has an effective volunteering service and has 360 volunteers currently working across the organisation, with recruitment events held every other month. The Trust's Volunteer Department has continued to work with the Department for Work & Pensions to support people back into employment, through building confidence, learning new skills and improving both mental and physical well-being through becoming a volunteer at the Trust. Current volunteers are offered a variety of training opportunities that will be advantageous should they wish to apply for Trust jobs or employment outside of the organisation.

The volunteers undertake a wide range of roles throughout the Trust, including:

- Meeting and greeting patients on arrival at Whiston and St Helens hospitals, outpatients and the Emergency Department, including helping to direct people to the appropriate location and providing information to patients and visitors
- Supporting pharmacy to achieve timely delivery of discharge medications
- Providing befriending service on inpatient wards and undertaking enhanced roles such as dining companions, prevention of delirium and spiritual care
- Administration roles, undertaking wide range of duties across the Trust, including maintaining notice boards and leaflet racks in different departments

The Volunteer Service is also working on a ward telephone answering pilot and supporting the Trust's Pets as Therapy policy, as therapy dogs can help patients in many ways, including reducing anxiety.

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

3.4. Patient experience

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

Patient stories remain a pivotal part of the patient experience agenda throughout the Trust. Patient stories are shared in a number of forums including the Trust Board, Patient Experience Council and the Patient Experience and Dignity Champions group. Patients and their families are welcomed and encouraged to present their experiences in their own words and make suggestions to improve the patient journey.

Patient stories have contributed to a number of positive service improvements, including the introduction of open visiting in Critical Care, improving the responsiveness of phlebotomy services for patients receiving palliative care to enable blood tests to be performed before or within their clinic appointment and the recruitment of additional staff to the palliative care team including a bereavement lead. One story has also been shared with colleagues in the local Clinical Commissioning Group to disseminate learning and support the development of integrated pathways.

A range of mediums have been used to deliver stories including patients and their relatives attending in person and submitting stories for staff to deliver on their behalf.

The Patient Experience Manager engages with at least five patients or carers each day in a range of settings, including wards and outpatient clinics. This provides valuable information regarding the patient and carer experience 'as it happens'. This allows prompt identification of any individual issues which can be easily resolved or may require escalation to clinical staff and also any themes or trends that may be emerging across the trust.

A number of actions have taken place this year to enhance the patient and carer experience. These include the approval of an Animal and Pet Therapy Policy to provide guidance for those patients who may benefit from animal assisted therapy while in hospital and a review of arrangements for transgender patients attending gynaecology clinic following their transition. Amendments have also been made to the automated message left when attempting to obtain feedback from patients following attendance at outpatient clinics. This was completed in direct response to information received from a patient and their relative.

A Carers' Passport is also under development that will be recognised across a number of trusts in the area. This will recognise carers as partners in care to improve the experience of both patients and their carers.

The Trust has continued to engage with patients via a number of patient participation groups. Forums take place within the specialities of paediatrics, maternity, diabetes, gastroenterology, the continence service and rheumatology. The Trust-wide patient participation group was re-launched at an event held in January 2019 and was attended by a wide range of participants. This provided the opportunity for staff to share the Trust's developments with patients, carers and members of the community, who were also able to provide their comments on the new draft Patient Experience Strategy.

What our patients said about us in 2018-19

Radiology

I was sent today to Whiston radiology department for an abdominal scan. My wife and I were treated very well by the very caring staff at the unit. Everything was explained very thoroughly and the staff were on hand to answer any questions that we had. This is the third time that I have had a CT scan at Whiston and I am always treated very well. I cannot fault the staff in any way and even though they were very busy you never feel neglected during busy times.

Thank you to all of the nurses in this department, you are all a credit to the profession and to the hospital. We would all be in a sorry state without you and your professionalism and warm hearts. Brilliant !!

Ward 3A

I was admitted to ward 3A at Whiston Hospital on Christmas Day with an infected hand. The care I received was excellent. All of the staff were helpful and caring. The ward was very clean and a pleasant restful environment. I'm very grateful to everyone who was there for me when I needed medical care I'm sure they would have rather been at home. Thank you everyone for managing to be so professional and pleasant despite being at work on Christmas Day.

Stroke ward

Nurses on the Stroke ward were brilliant and gave care of the highest standard. Many quite young nurses were brilliant in their devotion to patient care, watching very elderly constantly and doing all they could to alleviate any difficulties.

My baby was born prematurely at 34 weeks. The staff and doctors on the special care baby unit (SCBU) are absolutely outstanding, the level of care and respect they give is second to none. After coming home for a little short while my little boy was admitted to ward 3F and spent time in high dependency unit. I really can't thank all the staff enough especially the paediatric doctor, she looked after my son on SCBU and on 3F she made me feel so at ease at such a difficult time. She and along with all the medical staff made my son better and for that I can't thank them enough!!

Cardiology

Staff in the Cardiology Department were absolutely brilliant. They were efficient, cheerful, and extremely helpful, especially the Cardiac Nurses. Excellent treatment and customer service skills.

3.4.1. Friends and Family Test

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

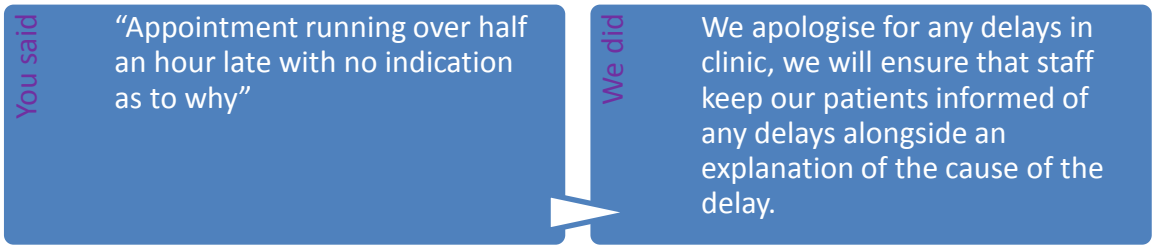
The feedback gathered is used to identify themes or trends, stimulate local improvement and empower staff to carry out changes that make a difference to patients and their care.

The Trust uses a variety of survey options, with inpatient ward areas and maternity services providing patients with a postcard on discharge and Emergency Department and outpatient areas use texting and interactive voice mail service.

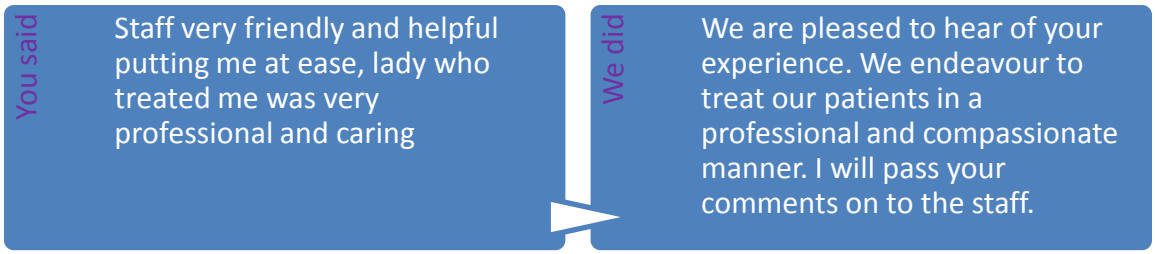
The Trust's inpatient response rate at the end of March 2019 was 33.1% compared to the national average of 24.6% (based on March 2019 inpatient national data and including independent sector providers). Each ward or department within the Trust monitors the patient feedback and creates 'you said, we did' posters for display. These posters reflect our response as a result of patient comments and are invaluable in maintaining staff motivation and influencing change. Some examples include:

Allen Day Unit

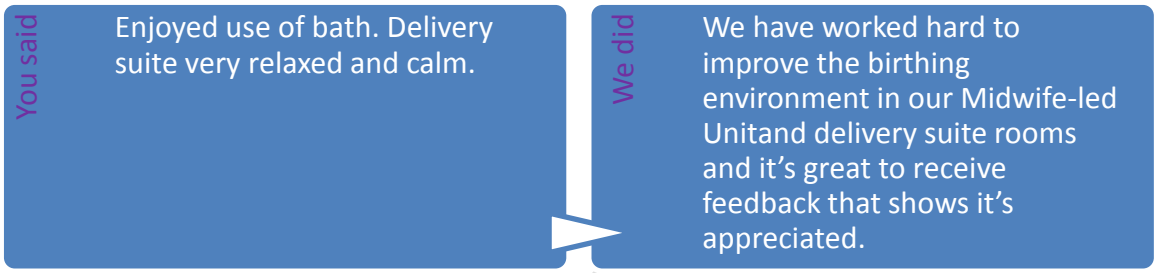
Outpatients



Ophthalmology Clinic



Delivery Suite



3.4.2. Complaints

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

In 2018-19, the Trust received 267 new complaints that were opened for investigation. This represents an increase of 18.7% in comparison to 2017-18, when the trust received 225 new complaints. However, there was a decrease in the number of complainants that were dissatisfied with the initial response and raised a stage two complaint; 37 in 2018-19 compared to 44 in 2017-18. The total number of PALS contacts increased by 36% to 3174 in 2018-19.

Work remains ongoing to improve the timeliness of responses to those who made the effort to highlight concerns about their care. The average time to respond to new complaints within the agreed timescale has improved significantly from 67% in 2017-18 to 92.1% in 2018-19.

The Trust has continued to conduct the Complaints Satisfaction Surveys throughout 2018-19, with a copy of the survey sent out with all response letters. There were 25 responses in total received in 2018-19, a 9.3% response rate. A summary of the findings is below, noting that the % figures provided are based on the number of respondents answering the specific question:

- 92% found it very or fairly easy to complain

- 88% felt that their complaint had been responded to in a reasonable timescale
- 80% confirmed that they felt that they had been treated with respect throughout the process with 16% confirming that they had been treated with respect some of the time
- 88% confirmed that the reasons for the Trust's decision was made clear to them
- 76% were very or fairly satisfied with the way the complaint was handled

The Complaints Team are continuing to work hard on reducing the time taken to provide complaints responses, whilst maintaining the quality of the investigation and response.

A number of actions were taken as a result of complaints made in 2018-19. The issues highlighted through a complaint relating to a missed diagnosis at birth involving a newborn was shared at the Obstetrics and Gynaecology Risk Management Group, Paediatric Clinical Governance and Surgical Care Group Quality Governance and Risk Management meetings. A task and finish group has been established to review processes for paediatric referrals following birth and work is in progress to develop a robust failsafe system of monitoring referrals following the newborn and infant physical examination (NIPE).

Other actions taken include:

- Staff reminded to wear their identity badge at all times and to introduce themselves at the start of every shift
- Introduction of a new template for plastic surgery secretariat to use to inform GP and breast surgeons of any abnormal reports that they are made aware of. The aim of this is to ensure that investigation reports are sent from plastic surgery without delay
- Additional staff have been appointed following expansions in the Lilac Centre
- New patient experience board has been placed in the Lilac Centre
- Radiology has implemented a daily 'stat run' which identifies what needs to be reported on in priority order with a new internal escalation process for radiology staff to follow
- The Omnicell (medicines dispensing computer) now flags up a warning when patients are prescribed Clarithromycin to make sure they are not on a statin, which is contraindicated

3.5. Service developments

3.5.1. Surgical Care Group

3.5.1.1. Nurse Led Fascia Iliac Compartment Blocks (FICB)

The Trust's Hip Fracture Nurse Specialist is currently working with the anaesthetists to complete the necessary training and competencies to perform a fascia iliac compartment block to reduce pain. Pain can have significant physical and psychological effects on the patient, as well as requiring opiate pain relief, which can lead to respiratory depression, hypotension and confusion. Using fewer opiates for elderly patients should lead to less episodes of delirium. The patients that have had this procedure so far have been extremely comfortable and not as confused post operatively. This helps with therapy and supports early discharge.

3.5.1.2. Introduction of virtual fracture clinics

An orthopaedic consultant and a physiotherapist undertake two sessions per week and contact patients by telephone to ask a set of pre-agreed questions relating to fracture, pain and pain management. The service is aimed at patients who will not require interventions such as cast change/application, repeat X-rays, removal of sutures or wound checks. The provision of virtual fracture clinics will free up appointment slots for patients who need to be seen face-to-face and provide better flexibility and communication for patients. This initiative is currently being evaluated.

3.5.1.3. Burns and Plastics

An Outreach Burns Nurse Specialist has been appointed to provide support in the community in all aspects of burn care, supporting admission/readmission avoidance especially in patients with infections such as multiple-drug-resistant pseudomonas aeruginosa. The Outreach Burns Nurse Specialist also acts as clinical educator, providing education to district nurses and walk in centres regarding burn care.

3.5.1.4. Maternity

The Maternity Service has been involved within the National Maternal and Neonatal Health Safety Collaborative and is focussing on the recognition and management of deterioration in babies, including improved processes relating to the neonatal sepsis pathway**.** The aim of phase one of the locally designed Improving Neonatal Sepsis Pathway Outcomes **(**INSPO) Project was to increase the number of eligible babies who receive intravenous (IV) antibiotics within an hour, without separation of mum and baby, by 75% by March 2019. The project has achieved 100% of all babies from the Delivery Suite receiving IV antibiotics, within an hour, from decision to delivery, without separation from mum, since December 2018. Phase two of the project will spread the improvement to the whole of the Maternity Service concentrating on the postnatal ward.

The Maternity Services has developed pathways of care to achieve the national ambition of 'Continuity of Carer' for 20% of women. The service has successfully booked 45% of women onto a continuity of carer pathway, exceeding the national target. The development of these pathways has seen extensive improvements and re-design of community midwifery teams and midwifery-led clinical care. This work has further seen the development and utilisation of midwifery-led services in the alongside midwifery led unit, the 'Sapphire Suite', with an increase of women opting to mobilise and use the birthing pool. Development of pathways to achieve continuity of carer for high-risk women has been concentrated on women who are having their next birth after caesarean section.

3.5.2. Medical Care Group

3.5.2.1. Nutrition

The Trust's new Nutrition Specialist Nurse has made a significant contribution to improving patients' nutritional care, supporting admission avoidance, reducing length of inpatient stay and improving the quality of nutritional care. This has been achieved

via daily parenteral nutrition (PN) ward rounds, nutrition multi-disciplinary team clinics and the delivery of timely assessments and interventions for patients who require total parenteral nutrition (TPN), percutaneous endoscopic gastrostomies (PEG), naso-gastric (NG) tubes/nasal bridles or naso-jejunal (NJ) tube insertions. Timely reviews of patients in the Emergency Department has aided those who have removed feeding tubes to have them replaced quickly and facilitated early discharge home, saving approximately 82 bed days. The initiation of a telephone helpline and nurse-led day case clinic for patients requiring assessment, care or removal of feeding tubes has led to significant improvements in the care for outpatients, with regular follow up for those requiring it.

3.5.2.2. Gastrointestinal (GI) Physiology

GI Physiology is a new service providing diagnostic testing to primarily assess gut function, through the investigation of patients with symptoms of dysphagia, gastroesophageal reflux disease (GORD), faecal incontinence and chronic constipation. Investigations are performed as day case procedures using state of the art equipment to measure acidic/non-acidic reflux and/or assessing muscle pressure in the oesophagus, stomach or anorectum.

Small Bowel Capsule Endoscopy is also a new procedure to the Trust. It involves the swallowing of a small, wireless camera capsule to assess small bowel pathology. This investigation allows for the assessment of the full length of the small bowel, which cannot be achieved by conventional endoscopy. This can improve the diagnoses of conditions such as inflammatory bowel disease, obscure GI bleeding and some GI cancers.

The introduction of efficient in-house physiological testing has significantly reduced patient waiting time for these procedures from up 9 months, to within 4 weeks.

3.5.2.3. Acute Medical Unit (AMU)

The Acute Medical Unit is a dedicated care unit that provides assessment and treatment for adult patients with medical conditions when they are first admitted to hospital. This year the assessment area within the Acute Medical Unit has further enhanced the facilities to provide a better patient experience. The assessment area has developed a very successful new ‘pull’ model that now assesses adult medical patients referred via both the Emergency Department as well as primary care. The AMU has shown significant improvements in the national Society for Acute Medicine benchmarking Audit in 2018. The new model has reduced the number of medical patients waiting for a bed in the Emergency Department, decreased the length of stay on the Unit, increased the proportion of discharges, as well as shown a reduction in crude mortality. The Acute Medical Unit has purchased a ward-based drug dispensing machine, Omnicell, that has enabled on ward dispensing and significant improvement to turnaround times for discharge medication provision.

3.5.2.4. Diabetes

Last year, the Diabetes Team were successful in winning a bid for transformation funding from NHS England, which continues to be invested in the following:

- Inpatient diabetes specialist care provided seven days a week, focussing on key areas such as reducing emergency admissions in people with diabetes, driving up the quality of diabetes care across the Trust and reducing length of stay
- Improved foot service with increased capacity in the diabetes foot clinics to support a reduction in outpatient waits for assessment, with an anticipated reduction in risk around the deterioration of foot conditions
- The Specialist Diabetes Team has improved the structured education programme for people with type 2 diabetes, delivering evening and weekend education sessions
- The 'Cloud' service is improving collaborative working between primary and secondary care, which includes a telephone line for specialist advice for professionals, patients and carers for diabetes advice and support
- The Diabetes team have been involved in a National Adult Diabetes Inpatient Audit (NADIA) collaborative project with pharmacy looking to reduce a number of indicators relating to medication errors and inpatient hypoglycaemia and diabetic ketoacidosis. This work was highly commended and is due to be presented at the annual Diabetes UK (DUK) conference. It has led to a number of initiatives including a change in the way that we deliver diabetes inpatient education for staff including simulation-based model teaching sessions

3.5.2.5. Stroke

The following developments have been delivered or continued in 2018-19:

- Phase 1 of the stroke reconfiguration delivered with all strokes across Mid-Mersey with onset within 4 hours attending Whiston as the first port of call; Phase 2 commenced in April 2019, with all strokes from Mid-Mersey attending Whiston
- Increased access to thrombectomy
- Established innovative and award-winning telemedicine service for six month stroke reviews, which has been piloted for therapy environmental visits to determine if more efficient care can be provided
- Established a stroke prevention and education role to optimise the care of patients with asymptomatic, known atrial fibrillation to ensure they receive anticoagulation if appropriate. Atrial fibrillation is a leading cause of large strokes and subsequently death on the stroke unit. The goal for 2019-20 will be to influence the long-term management of at least 50 patients, leading to the prevention of one death and one patient from requiring institutional care
- Development of a hyper acute stroke unit (HASU)-based orthoptics service. This provides vital assessment of eye function following stroke, which helps guide the therapy teams and clinicians regarding the impact of stroke upon visual impairment; and/or the impact of existing visual impairments upon stroke. This has been a major piece of quality improvement, which was presented by the Lead Consultant as an exemplar of national good practice at the UK Stroke Forum and was extremely well-received. This model of care is now being adopted by a number of other centres

3.5.2.6. Liver Nurses

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

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

3.5.3. Primary and Community Care Group

The Trust has established a Primary and Community Care Group following the recent acquisition of various community and primary care services to ensure their effective delivery and to maintain high quality patient care out of hospital. This will in turn reduce the demand on the hospital-based services and ensure patients receive the right care, in the right place at the right time.

The Care Group has senior clinical leadership included in the management structure to ensure consistent, high quality clinical practice is delivered across community and primary care services.

3.5.4. Clinical Support Services Care Group

3.5.4.1. Therapy Services

Therapy Services constantly strive to improve services offered to patients to promote independence and support safe discharge from hospital. The Trust delivers an in-service training programme for all grades of therapists to support knowledge and skill development and promote evidence-based practice. There have been many initiatives and developments throughout the year, including:

Speech and Language Therapists:

- Implemented an International Dysphagia Descriptor Standardisation Initiative (IDDSI) to improve the safety of patients with eating, drinking and swallowing disorders
- Introduced e-referral pathway for inpatients, which has improved the governance of patient data and reduced delays in assessment
- Introduced e-triage for outpatient referrals to allow quicker triaging and reducing delays in appointments being offered

Trauma & Orthopaedics Therapy Team:

- Trialled early supported discharge for patients with fractured neck of femur, who can be supported at home, reducing their length of stay and promoting independence at home. Early results are good and the service is looking at ways to fully introduce this initiative

Medicine for Older People (MOP) Therapy Team:

- Parkinsons Disease Group has moved from an 8 week to a 12 week programme, incorporating a more graded programme of exercises and more structured external speakers, following feedback in a patient survey

Dietetics Service:

- Produced nutrition newsletters to be displayed on Trust intranet, highlighting health promotion events and ‘hot topics’

Critical Care & Surgery Therapy Team:

- Developed a therapy communication board that will go behind the patients' beds on Critical Care to document therapy input with the patient, for example, how they transfer/mobilise, what diet they are having and speech and language recommendations

3.5.4.2. Prostate Cancer Pathway

The Prostate Timed Pathway Working Group has implemented changes to the prostate cancer pathway that have reduced the time from referral to diagnosis by an average of 12 days. This has been achieved by increasing prostate biopsy capacity, introducing rapid access magnetic resonance imaging (MRI) slots and collaborative working with radiology and pathology departments to reduce reporting times.

3.5.4.3. Cancer Services

There have been a number of developments within our cancer services during 2018-2019 and these are summarised below:

- First Advanced Nurse Practitioner (ANP) in Oncology to be based within a chemotherapy unit. This has had a positive impact on both patient experience and clinical management of patients with complications of chemotherapy. The role has reduced the number patients referred to the emergency department and enabled patients to be managed in an ambulatory setting and, importantly, to stay in their own homes and continue with their treatment. Given the success of the post, a second ANP was appointed in the Autumn
- The Trust was successful in a bid to Macmillan to review current pathways of care for upper gastrointestinal cancers. This group of patients have to travel to various trusts for consultations and treatment and often struggle with complications of their cancer. The innovative project aims to design a pathway that enables patients to have reduced numbers of hospital attendances and receive the care they need locally. The project is led by a member of our Upper Gastrointestinal Macmillan Cancer nursing team and includes input from dietetics
- The Trust has successfully implemented virtual working for patients referred with a suspicion of cancer by their GP or who attend for a chest X-ray and require further investigation. The service started in September 2018 and has already positively impacted on multidisciplinary team (MDT) working and patient pathways. The project is led by a Respiratory Consultant and the lung cancer MDT
- The Trust was successful in a bid with Cheshire and Merseyside Cancer Alliance to participate in a workforce project involving cancer navigators. The navigators co-ordinate the pathway of patients referred on a two-week wait (2WW) pathway to the colorectal and lung cancer teams. The impact of the roles has already demonstrated a reduction in appointment attendances and streamlined the patient experience. A third navigator has since been appointed to the acute oncology vague symptom team.

3.6. Summary of national patient surveys

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

3.6.1. National inpatient survey

The Trust participated in the annual National Inpatient Survey 2017 coordinated by the Care Quality Commission. The results were published in June 2018 and the Trust's response rate was 36% compared to the national response rate of 41%.

The Trust was included in the best performing trusts nationally for the following indicators and was rated about the same as other trusts for the remaining indicators:

- Noise from other patients – not being bothered by noise at night from other patients (7.3/10)
- Cleanliness of rooms or wards – (9.6/10)
- Choice of food – having been offered a choice of food (9.6/10)
- Privacy for discussions – for being given enough privacy when discussing their condition or treatment (9.1/10)

The Trust is taking a number of actions to improve patient care including:

- Enhancing the discharge process
- Improving the quality of written information provided to patients
- Reiterating the importance of staff introducing themselves
- Working with volunteers to support patient mealtimes

3.6.2. National Emergency Department survey

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

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

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

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

- Ongoing provision of information about waiting times for patients to be examined, which will be further developed by the installation of TV screens in the new extension opened in February 2019
- An extension to the previous building has been completed, which has increased the availability of cubicles within the main department. There is also a new reception area and triage room
- Provision of a water fountain in the waiting room, accessible for both patients and relatives

- Introduced new ways of working to allow an earlier first point of contact to reduce the time waiting to be examined and assessed. A doctor is identified every shift to be available to assess patients in various clinical areas (triage/stretcher triage/paediatric unit)
- A doctor is identified per shift to be the “Emergency Response” doctor who will be called for and will attend to any patient within the department who triggers an alert via the national early warning score (NEWS), thus reducing any delays for reviews and treatments
- Increased training and development for nursing staff and implementation of patient group directives to allow nursing staff to provide simple pain relief prior to patients being seen by medical staff remains ongoing

3.6.3. National children and young people survey

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

For the experiences of children aged 8-15 years, the Trust scored ‘much better than expected’ and was one of only five trusts in the country to achieve this maximum score. The Trust scored about the same as others for children aged 0-7 years.

There were 15 areas in which the Trust was rated better than other trusts including:
- Children and young people feeling they had enough privacy during their care and treatment
- Children and young people saying staff spoke with them about how they were going to care for them
- Children and young people saying they were able to ask staff questions
- Children and young people saying that hospital staff spoke with them when they were worried
- Parents and carers saying they had confidence and trust in staff treating their child
- Parents and carers saying they received enough information about their child's new medication
- Children and young people saying they were told who to contact if they were worried about anything when they got home
- Children and young people saying they were told what would happen next after they left hospital

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

An action plan is in place to continue to improve the services provided to children and young people, with a number of changes implemented, including:
- Increased awareness of play facilities available to babies, children and young people
- Ensuring consistency of communication regarding care plans with parents, carers and patients to avoid any conflicting information being given

- Improving food satisfaction rates for children in the 0-7 years age group
- Improved communication for surgical patients before and after an operation or procedure

3.6.4. National maternity survey

The Care Quality Commission published the results of the 2018 maternity survey in January 2019. The national response rate was 37% and St Helens and Knowsley Teaching Hospitals NHS Trust's response rate was 27%, compared to 21% the previous year.

The survey provides information on women's experiences during all aspects of their maternity care, including antenatal care, postnatal care, the care received during labour and birth. The Trust was rated about the same as other trusts for all of the indicators.

An action plan has been developed with particular focus on the other areas where improvements can be made, including:

- ensuring women know they can choose which maternity provider and professional will be in charge of their care
- Reviewing the reasons why women experienced a delay in their discharge after the birth

The Continuity of Carer pathway for Midwife-Led Care has commenced across the Community Teams. A woman will receive joined up care between a small community midwifery team and the midwives on the Midwife-Led Unit (MLU) throughout her pregnancy, birth and post-natal period. Community midwives will be able to attend the MLU and provide some aspect of care for their own women when they are in labour. Approximately 18% of all births occur on the well-established MLU currently.

3.6.5. National cancer patient experience survey (NCPES)

Patient comment

> From seeing my GP to my OPD with the consultant and ongoing surgery and treatment, all staff (from consultant to ancillary staff) were excellent. All were knowledgeable and caring in their roles and had a caring manner. I was treated with care and speed. ... My disabled husband needs a wheelchair and was allowed to visit outside of visiting hours, which made parking easier.

The NHS England National Cancer Patient Experience Survey (NCPES) is designed to monitor national progress on cancer care, to drive forward quality improvement and to inform the work of groups supporting patients. The survey was developed and has been run by Quality Health for the Department of Health since 2010. It is the largest and most comprehensive survey of cancer patients in the world.

Patients treated for cancer within the Trust have rated the level of care they received, scoring their overall care as 8.9 out of 10, placing the Trust above the national average rating of 8.8.

In the 2017 NCPES patients placed the Trust as best across the Cheshire and Merseyside Cancer Alliance for:

- Providing patients with details of support groups (89%)
- Access to information about chemotherapy treatment (87%)
- Access to information about chemotherapy working (81%)
- Access to information on financial help (75%)
- Access to information on free prescription (85%)

The Trust was amongst the highest scoring trusts in Cheshire and Merseyside Cancer Alliance for:

- Patients having the name of a Clinical Nurse Specialist (93%)
- Seen as soon as necessary by GP (89%)
- Staff doing everything to control the pain (85%)
- Staff asking for the patient's preferred name (59%)
- Patients felt able to discuss fears with staff as inpatient (59%)

The Trust was above the expected range for:

- Patients being seen as soon as necessary (89%)
- Hospital staff giving information on getting financial help (75%)
- Patients given understandable information about if chemotherapy is working (81%)

A number of developments have been made to address areas highlighted by the survey, including:

- Standardised written information on discharge from inpatient stay in breast services
- Awareness raised with clinical staff on managing patient flows through breast clinic appointments, including start times and delays undertaken
- Patient information packs introduced at diagnosis for colorectal cancer patients
- Trust invitation letter amended advising patients that they may receive results of tests and can bring a relative to support them in urology and endoscopy
- Colorectal clinical nurse specialist (CNS) attends ward board round and is involved in care of suspected cancer patients admitted as emergency
- Ward teams updated on behavioural standards and introduction of senior nurse ward round
- Bowel school includes health and social needs assessment, which is shared with ward team
- End of treatment summary template agreed by gynaecology, urology and breast and rolled out November 2018
- Increased number of patients have a holistic needs assessment (HNA) and care plan across all cancer sites (monitored as part of NHS England targets)
- Named trials champion in each MDT who works with trials team
- Support worker in skin and haematology services checks that patients know the name of their CNS during the information ward round

- Skin cancer patients offered opportunity to discuss concerns with Consultant, documented in ward round book or in communication sheet within nursing records
- Matrons and CNS actively promote “My name is…”
- End of treatment support and information on side effects facilitated at the Cancer Health and well-being events (monitored as part of NHS England targets)
- Advance care planning and advanced communication skills training added on compliance matrix for CNS
- Patient experience working group established
- World café event for upper gastrointestinal cancer patients and carers
- Introduced FFT to nurse-led cancer clinics to provide more immediate feedback
- Cancer teams engaged in practice nurse education events facilitated by the Cancer Alliance
- Appointment of a benefits advisor has been instrumental in the Trust being number one in the Cancer Alliance for benefits advice

The Trust continues to strive towards improving patient experience and a comprehensive action plan has been put into place by the clinical teams to address any issues raised where the scores were below average for individual tumour sites.

The full report can be found at http://www.ncpes.co.uk

4. Annex

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

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

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

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered 2018-19
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with Department of Health guidance.

The Trust Board of Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Trust Board

Richard Fraser
Chairman

Ann Marr
Chief Executive

4.2. Written statements by other bodies

4.2.1. Halton Borough Council

HALTON BOROUGH COUNCIL

Ann Marr
Chief Executive
St Helens and Knowsley Teaching Hospitals NHS Trust
Whiston Hospital
Warrington Road, Prescott
Merseyside, L35 5DR

Our Ref EST/STHKTH

If you telephone 0151 511 7398
please ask for: Emma Sutton-Thompson

Date 17th May 2019

E-mail address Emma.Sutton-Thompson@halton.gov.uk

Dear Ann,

Quality Accounts 2018 - 2019

Further the Joint Quality Accounts event held on 10th May 2019 that your colleague Sue Redfern attended to present a summary of your Quality Accounts, I am writing with the Health Policy and Performance Board comments. The Health Policy and Performance Board particularly noted the following key areas:

During the year 2018/19 the Board were pleased to note that St Helen's and Knowsley Teaching Hospitals NHS Trust (SHKTH) made progress against the following areas:

- Best acute trust in the NHS for the third consecutive year with outstanding results, published in March 2019, with the Trust rated as the best place to work and receive treatment in the NHS;
- Best acute trust nationally for the second year running in 2018 for the Patient Led Assessments of the Care Environment (PLACE); and
- Maintained and improved quality indicators, including: 99.1% harm free care; no grade 3 or 4 pressure ulcers; and reduced number of harms from falls.

The Board were particularly pleased to hear about the CQC rating of Outstanding which is a great achievement and one you and your staff should be proud of.

During her presentation, Sue talked about the nurses that have been brought over from India and the Board were really pleased to hear the support that these nurses have received in settling in to their new environment and communities, and the fact

that all 57 have remained at Whiston hospital and are encouraging other nurses to join them. It is refreshing to hear of innovative solutions to workforce challenges.

The Board are pleased to note the following Improvement Priorities for 2019 – 2020 and look forward to hearing about progress on these next year:

- **Safety** - Ensure timely and effective assessment and delivery of care within the Emergency Department;

- **Effectiveness** - Maximise the effectiveness and utilisation of new electronic systems to improve the timeliness and effectiveness of patient care; and

- **Patient Experience** - Increase the proportion of patients who report that they have received an appropriate amount of information to meet their needs in a way they can understand.

The Board would like to thank SHKTH for the opportunity to comment on these Quality Accounts.

Yours sincerely,

Councillor Joan Lowe
Chair, Health Policy and Performance Board

4.2.2. Independent Auditor

4.3. Amendments made to the Quality Account following feedback and written statements from other bodies

Section	Amendment
1.1	Total number of incidents included alongside percentage figures
2.1.1	Reference to never event expanded to include additional detail
2.1.1	Additional narrative added relating to the community services the Trust provides
3.3.8	Additional information relating to the roles of the volunteers

5. Abbreviations

AHPs	Allied Health Professionals
AKI	Acute kidney injury
AMD	Age-related Macular Degeneration
AMU	Acute Medical Unit
ANTT	Aseptic Non-Touch Technique
BAPEN	British Association of Parenteral and Enteral Nutrition
BPH	Benign prostatic hyperplasia
BSI	Blood stream infection
BTS	British Thoracic Society
CCGs	Clinical Commissioning Groups
CHPPD	Care Hours per Patient per Day
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Airways Disease
CPE	Carbapenemase-producing Enterobacteriaceae
CQC	Care Quality Commission
CQuIN	Commissioning for Quality and Innovation
CRAB	Copeland Risk Adjusted Barometer
CRN, NWC	Clinical Research Network, North West Coast Research
DATIX	Integrated Risk Management, Incident Reporting, Complaints Management System
ED	Emergency Department
EDS or EDS2	Equality Delivery System
ePMA	Electronic Prescribing and Medicine Administration
ePR	Electronic Prescribing Record
eTCP	Electronic Transfer of Care to Pharmacy
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends & Family Test
GI	Gastrointestinal
GNBSIs	Gram-negative bloodstream infections
GORD	Gastroesophageal reflux disease
GP	General Practitioner
HCAI	Healthcare associated infections
HF	Heart Failure
HNA	Holistic Needs Assessment
HSCIC	Health and Social Care Information Centre
HSMR	Hospital Standardised Mortality Ratio
HWWB	Health, Work and Well-being
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care National Audit & Research Centre
ICO	Information Commissioner's Office
IDDSI	International Dysphagia Descriptor Standardisation Initiative
IQILS	Improving quality in liver services
JAG	Joint Advisory Group
LARC	Long-acting reversible contraception
LGBT	Lesbian, gay, bisexual, transgender
LGBTIQ	Lesbian, gay, bisexual, transgender, intersex and questioning

LSCB	Local Safeguarding Children Board
LUTS	Lower urinary tract symptoms
MARAC	Multi-Agency Risk Assessment Conferences
MBRRACE-UK	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK
MDT	Multi-disciplinary Team
MEWS	Modified Early Warning Score
MINAP	Myocardial Ischaemia National Audit Project
MLU	Midwife-led Unit
MOP	Medicine for Older People
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant staphylococcus aureus
MTI	Medical Training Initiative
NAOGC	National Audit Oesophago-Gastric Cancer
NBOCAP	National Bowel Cancer Audit Programme
NCAA	National Cardiac Arrest Audit
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCPES	National Cancer Patient Experience Survey
NELA	National Emergency Laparotomy Audit
NEWS	National Early Warning Score
NG	Naso-gastric
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NIPE	Newborn and Infant Physical Examination
NIHR	National Institute for Health Research
NJ	Naso-jejunal
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NMC	Nursing and Midwifery Council
NNAP	National Neonatal Audit Programme
NPCA	National Prostate Cancer Audit
NPSA	National Patient Safety Agency
NRLS	National Reporting Learning System
ODPs	Operating Department Practitioners
PALS	Patient Advice and Liaison Service
PCNL	Percutaneous Nephrolithotomy
PE	Pulmonary Embolus
PEG	Percutaneous Endoscopic Gastrostomy
PFI	Private Finance Initiative
PLACE	Patient-Led Assessments of the Care Environment
PN	Parenteral Nutrition
PROMs	Patient Reported Outcome Measures
QCAT	Quality Care Accreditation Tool
QIP	Quality Improvement Project
RACPC	Rapid Access Chest Pain Clinic
RCA	Root Cause Analysis
RCEM	Royal College of Emergency Medicine
RN	Registered Nurse

SAMBA	Society for Acute Medicine (SAM) Benchmarking Audit
SEQOHS	Safe Effective Quality Occupational Health Services
SCR	Summary Care Record
SHMI	Summary Hospital-level Mortality Indicator
SIRO	Senior Information Risk Owner
SMR	Standardised Mortality Ratio
SSNAP	Sentinel Stroke National Audit Programme
STI	Sexually Transmitted Disease
STP	Sustainability and Transformation Plan
SUS	Secondary Uses Service
TARN	Trauma Audit & Research Network
TPN	Total Parenteral Nutrition
VTE	Venous Thromboembolism

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)47
Title of paper: Single Oversight Framework – Annual Board Declarations
Purpose: To provide the Board with assurance that the Trust continues to take account of external strategic developments that could impact the future direction of the organisation and all regulatory requirements to comply with governance good practice.
Summary: The NHSI single oversight framework requires NHS Trust Boards to make annual declarations in relation to compliance with the NHS Provider Licence (www.gov.uk/government/Annex_NHS_provider_licence_conditions.pdf) The Single Oversight Framework (SOF) bases its oversight on the NHS provider licence. NHS Trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Conditions G6 and FT4) and must self-certify under these licence provisions. NHS Trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements.
Trust objectives met or risks addressed: Provide high quality sustainable services
Financial implications: This paper does not include a request for additional funding
Stakeholders: Patients, Staff, Commissioners, Regulators
Recommendation(s): The Board is asked to approve the self-declarations; • The Board approves the annual declaration of compliance with the Provider Licence condition G6 • The Board approves the annual declaration of compliance with the Provider Licence condition FT4
Presenting officer: Nicola Bunce, Director of Corporate Services
Date of meeting: 29th May 2019

Single Oversight Framework – Annual Board Declarations

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

4.1 Board declaration – Licence Condition G6

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

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

The suggested form of declaration is;

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

Sources of assurance for the Board that it can make this declaration are;

- Continued CQC registration
- CQC Inspection ratings
- MIAA audits of the Trust Risk Management Process and Board Assurance Framework

Recommendation

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

4.2 Board declaration – Licence condition FT4

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

The suggested form of declaration is;

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

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

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

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

The Board is satisfied that the systems and/or processes referred to above should include but not be restricted to systems and/or processes to ensure:
(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

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

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

- CQC Inspection Report (Rated Outstanding overall and for the Well led domain)
- Corporate Governance Statement made as part of the annual report and accounts and reviewed by the Trusts auditors
- Annual Board effectiveness review of 2018/19
- Trust accountability framework and annual business cycle
- NHS Improvement segmentation rating – March 2019

Recommendation

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

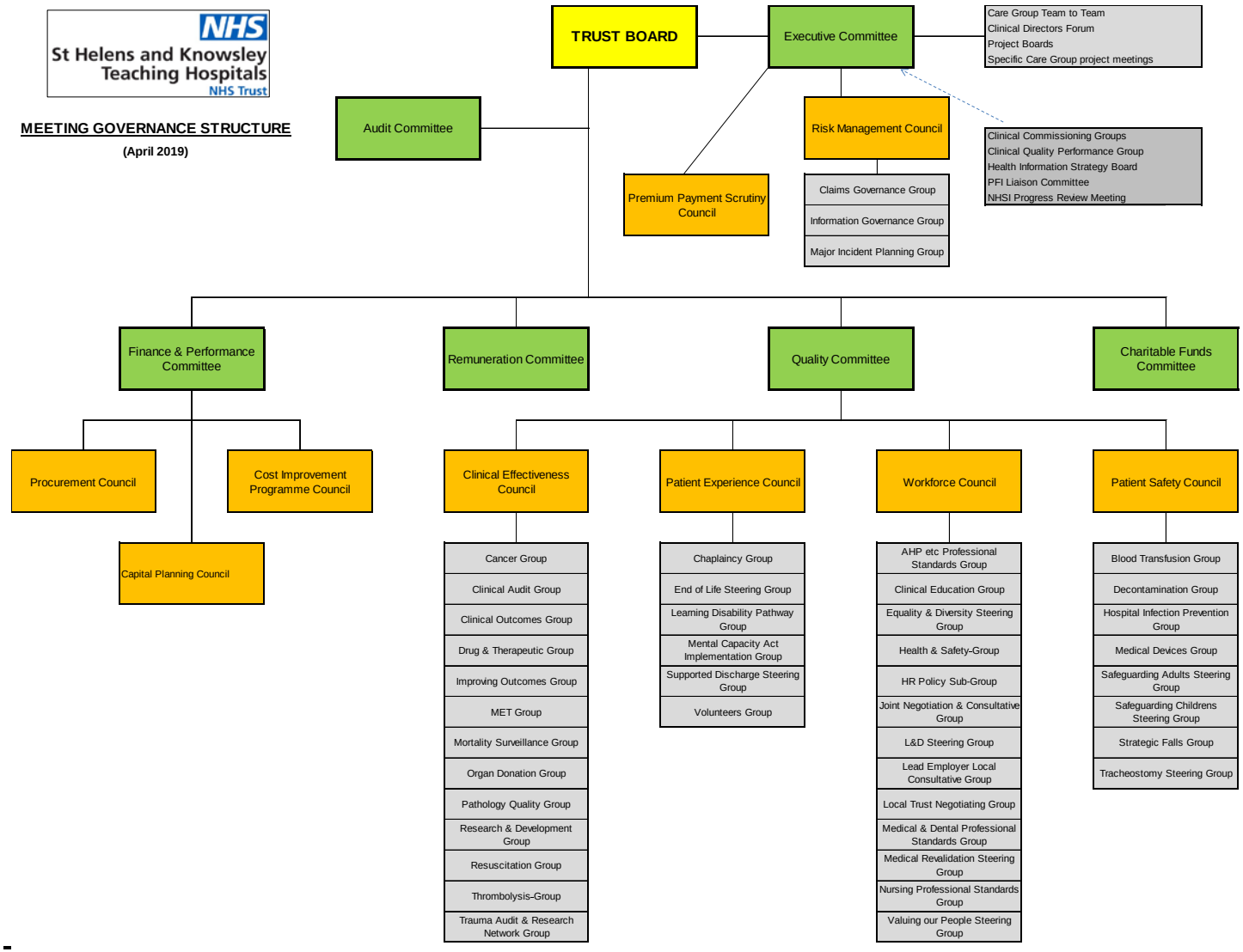
ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)48
Title of paper: Trust Board and committee effectiveness review – Revised Terms of Reference (ToR).
Purpose: To provide the Board with a pack of revised Board and Committee ToR that reflect the outcomes of the 2018/19 meeting effectiveness review process.
Summary: 1. The annual effectiveness review of the Board and its Committees has been undertaken in the last 3 months, reflecting the meetings that took place in 2018/19. 2. The detailed review of each committee has or will be reported at its next scheduled meeting, and a summary of the findings of each review reported to the Audit Committee. 3. The conclusion of the reviews is that the purpose, remit and organisation of the Trust Board and its Committees remain fit for purpose and provides the assurance that the Trust is effectively and appropriately managed. This evidence supports the development of the Annual Governance Statement. 4. The final part of this review is the issuing of revised ToR for each forum incorporating any agreed changes. 5. The changes ensure that as a whole the Board governance structure remains comprehensive and there are clear lines of accountability.
Trust objective met or risk addressed: Supports the Trust to maintain effective systems of governance to meet best practice and regulatory requirements
Financial implications: None directly from this report.
Stakeholders: Directors, Staff, Patients, Regulators and other stakeholders.
Recommendation(s): To approve the updated ToR which reflect the outcomes of the Board effectiveness review.
Presenting officer: Nicola Bunce, Director of Corporate Services.
Date of meeting: 29th May 2019.

GOVERNANCE STRUCTURE 2019/20



TERMS OF REFERENCE 2019/20

TRUST BOARD – Terms of Reference 2019/20	
Authority	St Helens and Knowsley Teaching Hospitals NHS Trust (the Trust) is a body corporate which was established under the St Helens and Knowsley Hospital Services National Health Service Trust (Establishment) Order 1990 (SI 2446) amended by 1999 (No 632) (the Establishment Order). The principal place of business of the Trust is the address as per the establishment order. The terms under which the Trust Board operates are described in the Standing Orders section of the Corporate Governance Manual (section 7.3).
Delegated Authority	The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, and their specific executive powers shall be approved by the Board, and appended within the Corporate Governance Manual. The Board has delegated authority to the following Committees of the Board i) Audit Committee ii) Remuneration Committee iii) Quality Committee iv) Finance & Performance Committee v) Charitable Funds Committee vi) Executive Committee
Agendas	The Board will have a forward work programme for the ensuing year that provides an outline plan for reporting throughout the year. This will include items on quality, performance and statutory compliance as well as reports from the Trust's Committees where more in-depth scrutiny of items has occurred in the presence of both Non-Executive and Executive Directors. This does not prevent agenda items being added as required and may result in items being deferred to another month if the agenda becomes too congested. A Board member desiring a matter to be included on an agenda shall make their request to the Chairman 10 days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman. Where a petition has been received by the Trust the Chairman of the Board shall include the petition as an item for the agenda of the next Board meeting.
Accountability and reporting	All ordinary meetings of the Board are open meetings which members of the public can attend to observe the decision-making process of the Trust. They are

	not open meetings where the public have a right to contribute to the debate, however, contributions from the public at such meetings can be considered at the discretion of the Chairman. Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers. Exceptionally, there may be items of a confidential nature on the agenda of these ordinary meetings from which the public may be excluded. Such items will be business that: i) relate to a member of staff, ii) relate to a patient, iii) would commercially disadvantage the Trust if discussed in public, iv) would be detrimental to the operation of the Trust.
Review	Each year the Board will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the ToR.
Membership	**Core Members (voting)** Non-Executive Chairman (chair) 5 Non-executive Directors (one of which will be appointed Vice Chair, and one appointed Senior Independent Director) Chief Executive 4 Executive Directors (to include Director of Finance, Medical Director, Nursing Director plus one other. One to be the nominated Deputy Chief Executive) Collective Responsibility - Legally there is no distinction between the Board duties of Executive and Non-Executive Directors; both share responsibility for the direction and control of the organisation. All Directors are required to act in the best interest of the NHS. There are also statutory obligations such as quality assurance, health and safety and financial oversight that Board members need to meet. Each Board member has a role in ensuring the probity of the organisation's activities and contributing to the achievement of its objectives in the best interest of patients and the wider public. <u>In attendance</u> The Board shall be able to require the attendance of any other Director or member of staff.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year.

Quorum	50% of the core membership must be present including at least one Executive Director and one Non-Executive Director.
Meeting Frequency	The Trust Board will meet monthly (with the exception of August and December). All meetings will have public and private elements.
Agenda Setting and papers	Minute production and distribution is via the office of the Director of Corporate Services. Documents submitted to the Trust Board should be in line with the corporate standard.

AUDIT COMMITTEE – Terms of Reference (2019/20)	
Delegated Authority	The Trust shall establish a Committee to be known as the Audit Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Board may request the Committee to review specific issues where the Board requires additional scrutiny and assurance.
Role	The Committee shall review the establishment and maintenance of an effective system of integrated governance internal control and risk management across the whole of the organisations clinical and non-clinical activities that support the achievement of the Trust's objectives.
Duties	The Committee will undertake the following duties: <u>Internal Control and Risk Management</u> 1. In particular the Committee will review the adequacy of: - All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board. - The structures, processes and responsibilities for identifying and managing key risks facing the organisation. - The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any other reporting and self-certification requirements. - The operational effectiveness of policies and procedures - The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Directorate of Counter Fraud Services. 2. The Committee will: - Provide an overview of the effectiveness of the assurance framework; - Provide an oversight role in respect of the governance structure and the linkages with other committees; - Consider the findings of other significant assurance functions (e.g. regulators, professional bodies, external reviews);

	- Review the arrangements and their effectiveness for which staff may raise, in confidence, any concerns; - Ensure there is a clear policy for the engagement of internal and external auditors to supply non-audit services, to ensure auditor independence and objectivity; - Review the work of other Trust Committees whose work will provide relevant assurance to the Audit Committee's own areas of responsibility; - Request and review reports, evidence and assurances from Directors and managers on the overall arrangements for governance, risk management and external control. <u>Internal Audit</u> 3. To consider the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal. 4. To review the internal audit programme, consider the major findings of internal audit investigations (and management's response), and ensure coordination between the Internal and External Auditors. 5. To ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation. <u>External Audit</u> 6. Establish an auditor panel with formal terms of reference to consider the appointment of the External Auditor and to ensure the on-going independence of the Auditor, making recommendations to the Trust Board. (See Appendix A.) (The Audit Committee should assess a prospective auditor panel member's independence by considering whether his or her circumstances could affect his or her judgement and by a number of factors – for example, recent employment with the Trust, close family ties to its directors, members, advisors or senior employees or a material business relationship with the Trust.) 7. Consider the audit fee, as far as the rules governing the appointment permit, and make recommendation to the Board when appropriate. 8. Discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with other External Auditors in the local health community. 9. Review External Audit reports, including value for money reports and annual audit letters, together with the management response. 10. Review the adequacy and effectiveness of statements within the quality account together with the external audit assurance. 11. Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-statutory audit work including the pre-approval by the

	Audit Committee's Auditor Panel for this work. <u>Financial Reporting and Governance</u> 12. Review the annual report and financial statements before submission to the Board, focusing particularly on: - The Annual Governance Statement; - Changes in, and compliance with, accounting policies and practices; - Unadjusted mis-statements in the Financial Statements; - Letters of representation; - Major judgemental areas, and; - Significant adjustments resulting from the audit. 13. Consider any proposed changes to Standing Orders and Standing Financial Instructions and to the Scheme of Reservation and Delegation of Powers including delegated limits and make recommendations to the Trust Board. (NB. All of these are incorporated within the Trust's Corporate Governance Manual.) 14. Consider any proposed changes to the Trust's Standards of Business Conduct Policy and Anti-Fraud, Bribery and Corruption Policy and make recommendations to the Trust Board. 15. Review responsibilities in respect of the appropriate processes and compliance with Standing Orders for the use of the seal (delegated from the Board), tender waivers, losses and special payments, and aged debt, gifts and declarations of interests.
Review	Terms of reference and effectiveness of the Committee will be reviewed annually each February and included in the report to the Board.
Membership	<u>Core Members</u> The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than 3 members. <u>In attendance</u> The Director of Finance, the Head of Internal Audit and a representative of the External Auditors shall normally attend meetings. However at least once a year the Committee may wish to meet with the External and Internal Auditors without any Executive Board Director present. The Committee shall be able to require the attendance of any other Director or member of staff. Specifically, the Committee should consider inviting the Chief Executive to attend the Audit Committee to discuss the Annual Governance Statement and

	Internal Audit Plan.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible, - Contribute fully to discussion and decision-making, - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	A quorum shall be 2 members.
Accountability & Reporting	The council reports to the Trust Board and a written summary of the latest meeting is presented to the next Board meeting by the Audit Committee Chair.
Meeting Frequency	Meetings shall be held not less than three times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Director of Finance and Information. Documents submitted to the Committee should be in line with the corporate standard.

QUALITY COMMITTEE – Terms of Reference 2019/20	
Delegated Authority	The Trust shall establish a Committee to be known as the Quality Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to quality of services and subsequent risk to patients. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported to the Board for approval before action. The Board may request the committee to review specific aspects of quality performance where the Board requires additional scrutiny and assurance.
Role	To enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to: 1. Provide assurance to the Board on patient safety, clinical effectiveness, patient experience and workforce issues 2. Identify, prioritise and manage risk arising from clinical care 3. Ensure the effective and efficient use of resources through evidence-based clinical practice 4. Protect the health and safety and wellbeing of Trust employees 5. Ensure compliance with legal, regulatory and other obligations.
Duties	The Committee will undertake the following duties:- 1. To provide assurance to the Board on the delivery of the Trust's Clinical and Quality Strategy, based on the Trust's vision for 5-star patient care, through scrutiny of relevant quality indicators in the IPR 2. To recommend measures of success /targets in relation to new quality improvement initiatives so that the Board can monitor outcomes 3. To monitor the Trust's performance against other internal and external quality targets via the IPR and to advise the Board of relevant actions if performance varies from agreed tolerances 4. To take appropriate action to address any under-performance, initiating and monitoring quality improvement programmes, and where necessary escalating issues to the Board 5. To oversee the production of the Annual Quality Account and review the final draft prior to submission to the Board for approval 6. To provide assurance on the delivery of the agreed Annual Quality

	Account priorities through Council reports 7. To approve policies and procedures in respect of quality and if necessary make recommendation to the Board 8. To agree the ToR and the annual work programme for the reporting Councils, ensuring that the governance of all relevant aspects of quality is delegated appropriately 9. To receive assurance reports from the Council chairs following each meeting of the Councils and to request in-depth reviews or commission independent audits where necessary. In addition, to receive annual reports prior to submission to the Board, e.g. complaints, infection control, safeguarding, medicines management, mixed-sex declaration, CQC compliance, the clinical audit programme, and medical revalidation 10. To assess the equality impact of proposed service developments or service changes 11. To undertake any reasonable quality related reviews as directed by the Board or initiated from work of the Committee or its Councils 12. To provide assurance that appropriate quality governance structures, processes and controls are in place through reviewing relevant internal and external reports (including CQC recommendations and compliance, national patient surveys) and assessing the Trust's performance against each.
Review	The Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	**Core Members** Non-Executive Director (chair) Non-Executive Directors x 2 Chief Executive Director of Human Resources /Deputy CEO Director of Finance Medical Director Director of Nursing & Midwifery Director of Operations & Performance Director of Corporate Services Care Group Medical Directors The attendance of fully briefed deputies, with delegated authority to act on

	behalf of core members is permitted. <u>In attendance-</u> In addition to formal members the Care Group Quality and Nursing Leads, Deputy Medical Directors, the Deputy Director of Nursing & Quality, the Assistant Director of Governance, the Deputy Director of Human Resources and any Assistant Director of Operations, may be in attendance. The Committee shall be able to require the attendance of any other Director or member of staff. Members are selected for their specific role or because they are representative of a professional group or Department. As a result members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making, and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and one Non-Executive Director.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet monthly each year with the exception of August and December.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Director of Nursing, Midwifery and Governance. Documents submitted to the Committee should be in line with the corporate standard.

FINANCE & PERFORMANCE COMMITTEE – Terms of Reference (2019 - 20)	
Delegated Authority	The Trust shall establish a Committee to be known as the Finance and Performance Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to financial and operational performance and subsequent risk of the Trust. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported for approval before action. The Board may request the Committee to review specific aspects of financial or operational performance where the Board requires additional scrutiny and assurance.
Role	To enable the Board to obtain assurance that the Trust has robust activity and financial plans in place to meet both short and long-term sustainability objectives, and maintain the Trust as a going concern. To contribute to the overall governance framework, and support the development and maintenance of effective financial and performance governance arrangements throughout the Trust to promote the efficient and effective use of resources and identify, prioritise and manage risk from Trust activities.
Duties	The Committee will undertake the following duties:- 1. To review and make recommendations to the Board on the annual financial and business plan and the assumptions which underpin it, and the Trust's longer-term financial and operational strategies 2. To review the performance of the Trust against all elements of the Trust finance and activity objectives via the monthly Finance and Performance Report. To make recommendations to the Board on key risks, and actions to ensure the Trust performs to the optimum level and operates within the resources available 3. To oversee the Trust's commercial strategy and oversee the further development of Service Line Management to contribute towards effective decision making underpinning service developments and market strategy 4. To review proposed cost improvement programme and to monitor implementation and report, to the Board, proposals for corrective actions considered if required 5. To monitor the financial and non-financial benefits realisation from approved business cases to provide assurance of a return on investment 6. To approve policies and procedures in respect of finance and performance and if necessary make recommendation to the Board

	7. Based on forecast resources available, to plan the five year rolling capital programme and in year delivery of the agreed capital programme 8. To review and monitor progress with annual contract negotiations and the impact on Trust sustainability; escalating any concerns to the Board 9. To consider relevant central guidance, benchmarking reports, reference costs or consultations and where appropriate make recommendations to the Board 10. To set the ToR including the annual work programme for the reporting Councils, ensuring that the governance of all relevant aspects of finance and performance is delegated appropriately 11. To receive assurance reports from the Council chairs following each meeting of the Procurement, CIP and Capital Planning councils and to request in-depth reviews or commission independent audits where necessary. 12. To undertake any reasonable finance and performance related reviews as directed by the Board or initiated from work of the Committee or its Councils 13. To provide assurance that appropriate governance structures, processes and controls are in place through reviewing relevant internal and external reports (including Lord Carter and GIRFT report recommendations) and assessing the Trust's performance against each
Review	Each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	**Core Members** Non-Executive Director (chair) Non-executive Director x 2 Director of Finance Deputy CEO/Director of HR Medical Director Director of Operations & Performance The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. <u>In attendance-</u> In addition to core members the Director of Corporate Services, Deputy Director of Finance, Assistant Director(s) of Finance and nominated deputy to the Director of Ops may be in attendance. The Committee shall be able to require the attendance of any other Director or member of staff.

	Members are selected for their specific role or because they are representative of a professional group or Department. As a result members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making, and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and one Non-Executive Director.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet monthly each year with the exception of August and December.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Director of Finance and Information. Documents submitted to the Committee should be in line with the corporate standard.

EXECUTIVE COMMITTEE – Terms of Reference (2019/20)	
Delegated Authority	The Trust shall establish a Committee to be known as the Executive Committee which will formally be constituted as a Committee of the Board.
Role	The Executive Committee meeting is established as the most senior executive forum within the Trust. This forum will be the final arbiter on all operational issues. The prime role of meetings is to consider the operational issues within the Trust along with the coordination of work programmes required to deliver the annual and strategic objectives of the organisation.
Duties	Duties of the Committee will include: 1. To review and approve business cases for the appointment of consultants and key Trust staff, or the creation of such posts 2. To review and approve business cases for new service developments, material expansion or reduction of existing services including capital developments (within the approved budgets or delegated authority of the Chief Executive), arising within the year. 3. To monitor the delivery and benefits realisation of approved business cases and service developments 4. To review and approve significant tender/bid documents submitted by the Trust for new services 5. The management of issues with reputational and relationship management significance 6. The monitoring of Trust performance against all objectives, standards and targets including the development of any remedial actions 7. Receiving and considering the Chair's report from the Risk Management Council and other appropriate supporting groups 8. Governance matters including preparation and arrangements for regulatory review 9. Brief the Trust's senior managers on the business and decisions made at the Executive Committee
Review	Each year the Committee will undertake an Annual Meeting Effectiveness Review. Part of this process will include a review of the Committee Terms of Reference.
Membership	Core membership of the meeting will comprise: - Chief Executive (chair) - Deputy CEO/Director of Human Resources (vice chair) - Medical Director

	- Director of Nursing, Midwifery and Governance - Director of Finance and Information - Director of Operations & Performance - Director of Corporate Services - Director of Informatics. - Director of Transformation - Director of Integration The attendance of deputies will not routinely be permitted, however attendance by Trust staff and stakeholders is envisaged for specific agenda items.
Attendance	Members are expected to attend a minimum of 70% of meetings. Members are expected to: - Ensure that they read papers prior to meetings - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress - Contribute fully to discussion and decision-making.
Quorum	A quorum will be 50% attendance. Where a decision is to be taken with financial consequences, the delegated authority for expenditure as contained in the Trust's Standing Financial Instructions must be adhered to.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	Meetings will be scheduled weekly on a Thursday.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the Trust office secretariat under the direction of the EA to the Chief Executive. Documents submitted to the Committee should be in line with the corporate standard.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)49
Title of paper: Information Governance Annual Report (including the Freedom of Information Annual Report)
Purpose: To provide the Trust Board with assurance that St Helens and Knowsley Teaching Hospitals Trust operates within the parameters defined in the Data Security and Protection Toolkit (DSPT) and have completed the annual submission to demonstrate such compliance.
Summary: In April 2018, the Information Governance Toolkit was replaced by the Data Security and Protection Toolkit. This replacement was designed to ensure that organisations are implementing the ten data security standards recommended by Dame Fiona Caldicott, the National Data Guardian for Health and Care and confirmed by the Government in July 2017. The ten data security standards apply to all health and care organisations. When considering data security as part of the well-led element of their inspections, the Care Quality Commission (CQC) will look at how organisations are assuring themselves against these new standards. For 2018-19 the Trust must demonstrate compliance with Information Governance requirements by completing the new NHS Digital 'Data Security and Protection Toolkit`. This Report summarises the Trust's Data Security and Protection Toolkit submission for 2018-19 and confirms that the Trust was able to make a satisfactory return, which was subsequently audited by MIAA.
Corporate objectives met or risks addressed: Communications, Systems and Safety, Risk Management, Efficiency and Performance.
Financial implications: None directly from this report.
Stakeholders: Staff, Patients, Executive Committee, Trust Board and Commissioners.
Recommendation(s): • The Board to note and approve the content of this paper; • Be assured that robust arrangements are in place to effectively manage the Information Governance Agenda within the Trust.
Presenting officer: Christine Walters, Director of Informatics
Date of meeting: 29th May 2019

Information Governance Annual Report

Introduction

The NHS Information Governance Framework is the means by which the NHS handles information about patients and employees, in particular personal identifiable information. The Data Security and Protection Toolkit (DSPT) is the successor framework to the Information Governance Toolkit (IG Toolkit) and remains an online tool that enables organisations to measure their performance against data security and information governance requirements set out in legislation and Department of Health policy.

The Toolkit has been developed in response to The National Data Guardian Review (Review of Data Security, Consent and Opt-Outs) published in July 2016 and the government response published in July 2017. The rationale behind the redesign is to reflect the changes in legislation, this being the introduction of the General Data Protection Regulation 2016/679 and the Data Protection Act 2018.

All organisations that have access to NHS patient information must provide assurances that they are practising good information governance and use the Data Security and Protection Toolkit to evidence this by the publication of annual assessments. It is also a contractual requirement in the NHS England standard conditions contract that relevant providers publish DSPT assessments on an annual basis:

> *"The Provider must complete and publish an annual information governance assessment and must demonstrate satisfactory compliance as defined in the Data Security and Protection Toolkit, as applicable to the Services and the Provider's organisation type."*

It remains Department of Health policy that all bodies that process NHS patient information for whatever purpose should provide assurance via the DSPT.

Larger organisations, such as Acute Trusts, are also required to have their IG Toolkit submission externally audited to ensure the accuracy of their submission.

Failure to complete the Data Security and Protection Toolkit can have serious implications for organisations. As this is a contractual obligation with Commissioners, non-compliance could incur financial penalties or impact the Trust's ability to bid for new services in the future. The Information Commissioner has also indicated that satisfactory completion of the Data Security and Protection Toolkit can act as a strong mitigation against regulatory fines imposed should an incident be reported to them.

Executive Summary

The requirements of the Data Security and Protection Toolkit (DSPT) are designed to encompass the National Data Guardians 10 data security standards. The requirements of the DSPT support key requirements under the General Data Protection Regulation (GDPR), identified in the NHS GDPR checklist, which the Trust has successfully implemented.

The DSPT has been developed to reduce the burden and duplication that existed in its predecessor the IG Toolkit. The previous functionality of the IG toolkit whereby for each requirement the Trust would attain either level 0,1, 2 or 3 with an associated percentage score being achieved is no longer in place. The Trust was previously required to provide evidence of compliance with (at least) level two for all elements of their assessment.

The DSPT does not include requirements but instead requires compliance with assertions and (mandatory) evidence items. Unlike the IG Toolkit, organisations will now pass by completing all of their mandatory requirements or fail because they have not done so.

The Trust initially assessed itself against the 10 standards and the associated assertions that sit under each standard. Evidence items sit under assertions and represent an indicator of maturity in that area. For example, in order to comply with standard number one, the Trust must comply with six assertions that sit under this standard as shown below.

1 Personal Confidential Data

All staff ensure that personal confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is only shared for lawful and appropriate purposes.

1.1.1	Name of Senior Information Risk Owner.	Mandatory	**COMPLETED**
1.1.2	SIRO Responsibility for data security has been assigned.	Mandatory	**COMPLETED**
1.1.3	Name of Caldicott Guardian.	Mandatory	**COMPLETED**
1.1.4	Who are your staff with responsibility for data protection and/or security?	Mandatory	**COMPLETED**
1.1.5	Staff awareness - Leadership (Q1) I feel data security and protection are important for my organisation.		**COMPLETED**
1.1.6	Name of Appointed Data Protection Officer.	Mandatory	**COMPLETED**

For the Trust to achieve “standards met”, which is the equivalent of making a “satisfactory submission” under the IG Toolkit, the Trust must have completed all of the mandatory items in its DSPT.

Our initial assessment was submitted to NHS Digital in October 2018 with an action plan developed through to March 2018 to address the new requirements contained within the DSPT which are summarised below:

- Leaders and Board members receive suitable data security and protection training;
- Organisations undertake process reviews to identify and improve processes that have caused breaches or near misses;
- NHS Organisations must act on CareCERT alerts and notifications;
- Organisations must complete a specific business continuity test for data security;
- Organisations must survey their software for unsupported systems;
- Organisations must ensure all networking components have had their default passwords changed;
- Large organisations must ensure their web applications are secure against the top 10 Open Web Application Security Project (OWASP) vulnerabilities;

- Large organisations must undertake a penetration test annually;
- Large organisations must flag any suppliers with significant issues complying with the National Data Guardian standards to the board;

Mersey Internal Audit Agency (MIAA) carried out an audit of the Trust's Toolkit submission (as required of larger NHS organisations) during two visits in October 2018 and January 2019 to assess the Trust's compliance against these standards. MIAA audited 17 out of 40 assertions, which span across 4 of the 10 standards.

The audited requirements covered elements of; Personal Confidential Data, Management of Data Access, Responding to Incidents and Accountable Suppliers.

The Trust has subsequently received the audit report from MIAA – the Trust has maintained its rating of 'Significant/Substantial Assurance'.

Substantial Assurance

This assurance rating once again demonstrates the Trust's commitment to the ever-evolving Information Governance Agenda.

Senior Information Risk Owner Update (SIRO)

This section of the paper is designed to inform and give assurance to the Board of progress made against the Information Governance work programme for 2018-19.

This section will provide assurance, from the SIRO, that the Trust:

- Have a sufficient framework in place to ensure compliance with all elements of the Information Governance Agenda;
- Have an active and effective Information Governance Steering Group forum, meeting regularly;
- Manage and investigate any Information Governance / Confidentiality incidents and issues.

Role of the SIRO

Christine Walters, Director of Informatics, is the Trust's registered SIRO. The role of SIRO at all NHS Trusts has been mandated since 2007, following significant data losses in the public sector.

The SIRO is required to be an Executive Director, Chief Information Officer or a Senior Manager with access to the Trust Board. The SIRO is expected to understand how the strategic business goals of the organisation may be impacted by information risk.

The key responsibilities of the SIRO are to:

- Take ownership of the risk assessment process for information and cyber security risk, including review of an annual information risk;
- Review and agree action in respect of identified information risks;

- Ensure that the organisation's approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff;
- Provide a focal point for the resolution and / or discussion of information risk issues;
- Ensure the Board is adequately briefed on information risk issues;
- Ensure that all care systems information assets have an assigned Information Asset Owner.

The SIRO also takes overall ownership of the Trust's Information Risk Policy (incorporated within the Network & Information Security Risk Policy); act as a champion for information risk on the Board and provide written advice to the Accounting Officer on the content of the Trust's Statement of Internal Control in regard to information risk.

The SIRO will implement and lead the NHS Information Governance (IG) risk assessment and management processes within the Trust and advise the Board on the effectiveness of information risk management across the Trust.

Information Governance Aims

The SIRO has a responsibility for ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The focus of DSPT is on setting standards and providing tools to achieve them. The standards provide assurance across ten areas.

1 Personal Confidential Data
2 Staff Responsibilities
3 Training
4 Managing Data Access
5 Process Reviews
6 Responding to Incidents
7 Continuity Planning
8 Unsupported Systems
9 IT Protection
10 Accountable Suppliers

Reassurance will be regularly provided to the Board of the on-going commitment to meet with NHS Standards in Information Governance and Information Security.

Information Governance Steering Group

The Information Governance Steering Group (IGSG) is a standing committee accountable to the Trust Risk Management Council and ultimately the Trust Board. The Group, which has been operational since January 2008, oversees the implementation of the Information Governance Agenda throughout the organisation.

Its main purpose is to support and drive the broader Information Governance Agenda and provide the Trust Board with the assurance that effective Information Governance best practice mechanisms are in place within the Trust.

The IGSG is chaired by the Trust Caldicott Guardian, with the Trust SIRO as Deputy Chair. Core membership includes Trust Directors and Assistant Directors, Heads of Quality, Heads of Service and Senior Managers.

This year has seen the IGSG address two major changes that have completely transformed the Information Governance Landscape. One of these has been the introduction of the new DSPT, which has been described above. However, it was the introduction of the General Data Protection Regulation (GDPR) that came into force in May 2018, which has required significant resources to address the implications the new legislation has introduced.

The main issues addressed as part of the plan were as follows:

1. The appointment of a suitably experienced and appropriately resourced Data Protection Officer (DPO);
2. The recording of all data processing activities with their legal bases and data retention periods;
3. Ensuring demonstrable compliance with enhanced requirements for transparency and fair processing, including notification of rights;
4. Provision of copies of personal data with accompanying supporting information free of charge;
5. Amendment of processes to ensure the notification of personal data breaches within 72 hours to the Information Commissioner;
6. Provide more detailed information to key staff - Information Asset Owners, staff responsible for Subject Access Requests (requests from patients/staff for their information), staff who deal with contracts, those likely to design and implement new ways of using data and Communications staff;
7. Ensure that the Trust is able to demonstrate that it is working towards compliance and accountability.

The remit of the IGSG has also seen the Group address the following topics in addition to GDPR and DSP Toolkit compliance:

- Introduction to the Data Security and Protection Toolkit – including DSP Toolkit submission & Action Plans
- Introduction to GDPR including key changes and GDPR Action Plan
- IG Issues including British Medical Association GP GDPR guidance
- Data Loss and data breach reporting procedure
- Data Protection Impact Assessments
- Role of the Data Protection Officer (DPO)
- DPA 2018/GDPR compliant Privacy Notice
- Cyber Security
- Subject Access Requests and their increase in numbers
- Access to Health Record and Disclosure of Personal Confidential Data
- Staff Awareness
- Risk Register updates (standing Agenda item)
- Caldicott Issues Log Report (standing Agenda item)

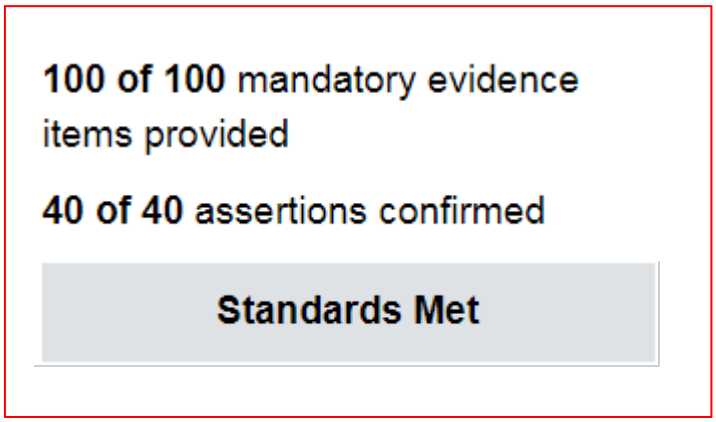
Reportable Incidents

The Trust has a duty to report any incident regarding breaches of the Data Protection Act to the Information Commissioner's Office (ICO) and for the financial year 2018-19 there were three such incidents. All three of these incidents have been closed by the Information Commissioners Office with no actions taken against the Trust. The three closed incidents were reviewed by relevant members of staff and members of the Information Governance Team, with actions taken to minimise the likelihood of any reoccurrence.

Annual Submission

The Information Governance Steering Group was asked to approve and sign off the 31st March 2019 DSP Toolkit position prior to formal submission.

The Trust position was reported as below -



Progress Reporting

Progress against the DSP Toolkit is monitored by the Head of Information Governance & Quality Assurance – Data Protection Officer (DPO) and the IG Steering Group.

A report on progress prior to each submission is presented by the Head of Information Governance & Quality Assurance – (DPO) to the IG Steering Group and subsequently to the Risk Management Council, then ultimately to the Trust Board by the Senior Information Risk Owner.

Where standards were not being met, action plans were prepared and were monitored to ensure improvement and compliance.

Caldicott Guardian

Mr Alex Benson is the Trust's registered Caldicott Guardian. Mr Benson is tasked with ensuring that the personal information about those who use its services is used legally, ethically and appropriately, and that confidentiality is maintained. Mr Benson provides leadership and informed guidance on complex matters involving confidentiality and information sharing. Caldicott Guardianship is a key component of the broader information governance agenda.

NHS organisations have been required to appoint a Caldicott Guardian since 1999, when it was mandated by NHS England. The Caldicott Guardian has a key role in ensuring that the Trust achieves the highest practical standards for handling patient information. This includes representing and championing confidentiality requirements and appropriate information sharing at the highest level of the Trust.

The purpose of this section is to provide assurance, to the Trust Board, that the Caldicott Guardian function within the Trust is operating at a satisfactory level and that it is appropriately supported within the existing Information Governance structure.

The Trust Caldicott Guardian is supported by the Director of Informatics in her role as Senior Information Risk Owner (SIRO) and the Head of Information Governance & Quality Assurance – (DPO) Officer and his team, comprising of a Senior Information Governance Officer, two Information Governance Officers and an Information Security Officer.

As Chair of the Trust's Information Governance Steering Group, the Caldicott Guardian is also assisted by a number of senior members of staff who are members of this Group. These include, Trust Directors, Heads of Quality, Heads of Service and senior Managers.

The Caldicott Guardian believes that he has enough support to carry out his duties appropriately.

Conclusion

It is vital that the Trust looks to strengthen its existing Information Governance compliance whilst building on existing good practices. The Information Governance Agenda will continue to expand with the introduction of new technologies and more collaborative working, so it is therefore vital that the IG Steering Group continue to monitor the progress and implementation of the Information Governance Agenda within the Trust.

Freedom of Information Annual Report

Introduction

This report is designed to provide the Trust Board assurance that the Trust is compliant with Freedom of Information legislation. Statistical analysis of the requests and responses for 2018-19 will be shown here, comparing the year of the report to previous years where relevant.

Further analysis is available on request if members of the Board would like to see anything not shown here.

Table 1 – Annual Comparison of Requests by Applicant Type as a comparison.

	Total	Press	Public	Staff	Commercial	Student/ Research	MPs	Not Given	Other
Annual Total 17-18	673	172	93	2	344	24	16	3	19
Annual Total 18-19	717	95	197	0	316	74	5	0	30

In total, we have seen an increase in requests of 44. This is an increase of just over 6.5% on the previous year.

While it appears a somewhat negligible increase on the previous year, it is not entirely reflective of the increase we have seen in recent months compared to last year. As you can see in the table below, the start of the calendar year has seen an increase of 32 compared to the same time last year, an increase of nearly 20%.

Table 2 – Comparison for Jan- Mar 2018 and Jan-Mar 2019.

January – March 2018	January – March 2019
166	198

A thematic analysis suggests that this increase is due to a rise in requests requesting information regarding the Trust's Brexit planning and treatment for knife injuries, both of which have been heavily reported in the local and national media.

While this may mean we are getting a number of requests for the same types of information, nuances between the requests have affected our ability to streamline or "fast track" these requests, meaning that just as much resource is needed to process these types of requests in order to ensure a full and comprehensive response is given.

Chart 1 - Categories of Request for 2018/19.

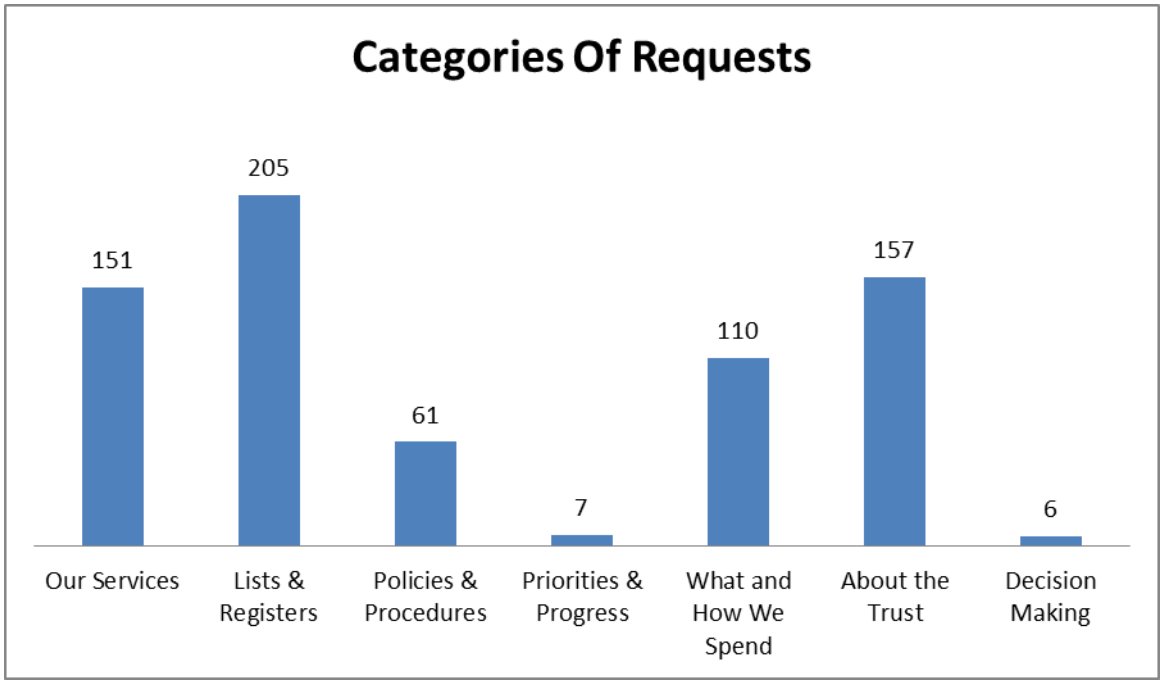


Table 3 - Examples of Category Request

Category	**Example of Request**
About the Trust	1. Overseas Visitors 2. New Systems Implemented
Decision Making	1. Maternity Closures 2. A&E Diversions
Lists & Registers	1. Software Systems 2. Asbestos
Our Services	1. Accident and Emergency 2. Human Resources
Policies & Procedures	1. Energy Efficiency 2. Compromise Agreement
What & How we spend	1. Monies owed for treatments 2. Locum Staff Spend

Categories are defined by the FOI Team once a request is received at the Trust. Examples of each type of request are shown in Table 2 above and more information is available from the FOI Team.

Chart 2 – Requests by Applicant Type

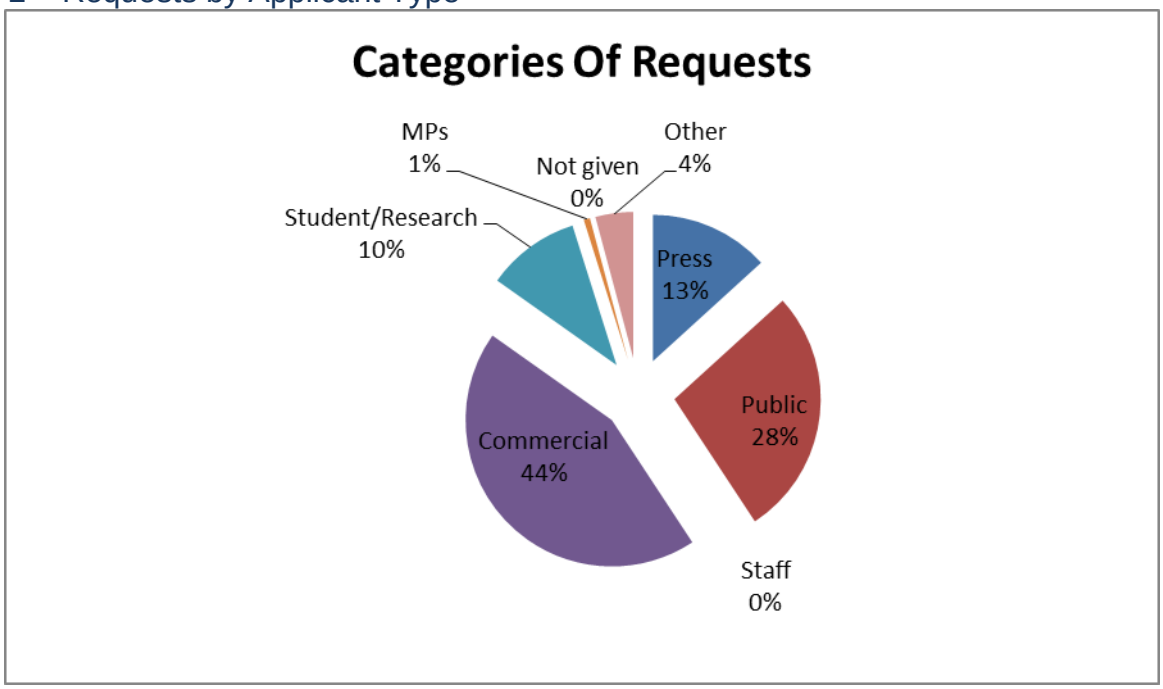
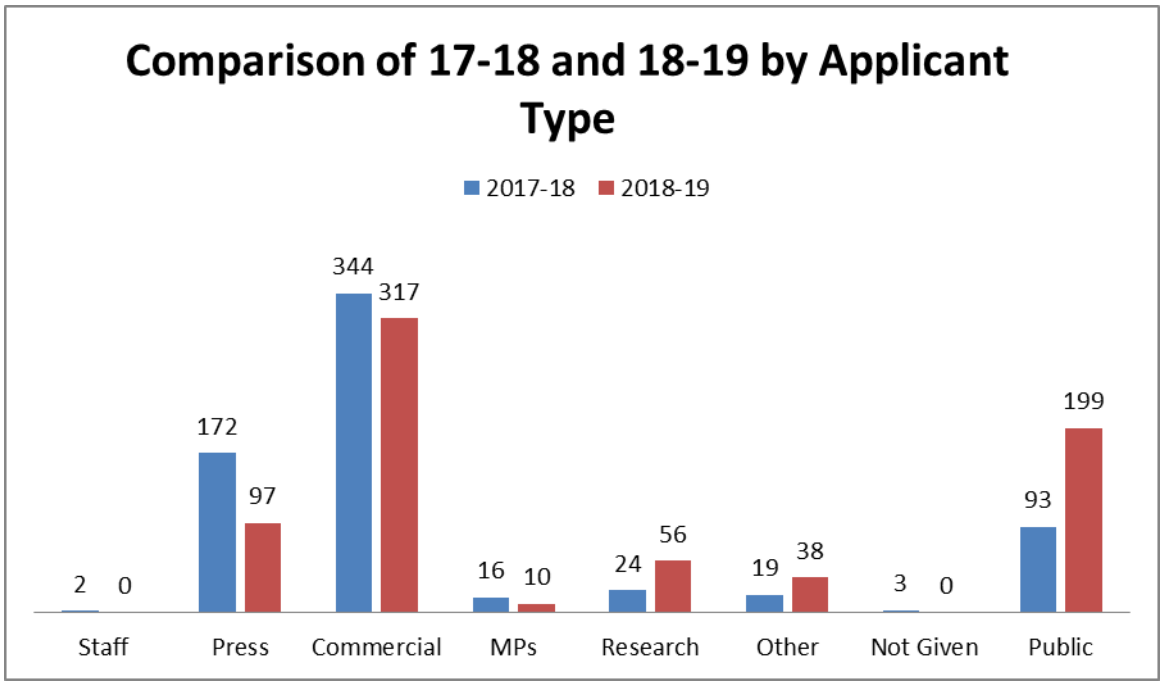


Chart 3 – Comparison of 2017-18 and 2018-2019 Applicant Type



Continuing from the trend of the previous year the applicant type is predominantly commercial organisations requesting information about the Trust. These requests make up 44% of the total received.

While we have seen a significant drop in requests from the press, the FOI Act remains an avenue that both local and national journalists use to extract information from the Trust, and the team always works closely with the Media PR and Communications Team around these types of requests.

This year we have seen a marked increase in requests from members of the public. As noted above, there are a number of topics being widely reported in the media that may have contributed to this increase. The increase of 106 equates to an increase of 113% in this area.

Performance

The Trust received 717 FOIA requests for 2018-2019; compared to 673 requests for 2017-2018. The Trust strives to respond to all requests in accordance with the 20 working days timeframe that the legislation dictates. Out of the 717 requests received, the Trust responded to 32% within 20 working days and 48% of responses were released after the deadline.
At the time of writing, the remaining 20% of requests were still open. This compliance figure can be attributed to the significant increase in and the complexity of requests the Trust has had to manage during 2018-2019.

We will look to increase compliance levels going forward by re-educating staff on their responsibilities and we will continue to monitor the volume of requests closely.

The IG Team are exploring options to introduce new technology to streamline the process from start to finish.

Appeals

The Trust has received no requests for appeals this year.

Conclusion

The number of Freedom of Information requests received by the Trust has increased this year. The numbers received continues to have a real impact on resources. This has undoubtedly affected the Trust's compliance with the statutory timescales contained within the FOIA.

This increase also has highlighted some of the challenges we have had in dealing with extremely complex requests that we are now receiving from requestors that have an increased awareness of Freedom of Information legislation.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(19)50

Title of paper: Review of Trust Objectives 2018 -19

Purpose: To present the full year progress report against the 2018/19 Trust objectives.

Summary:

1. The Trust Board agreed twenty-seven objectives for 2018/19 at the Board meeting in March 2018.
2. The objectives are split into 9 categories; 5 representing the Trusts Five Star Patient Care criteria of care, safety, pathways, communication, and systems. There are then 4 categories covering; organisational culture and support for the workforce, operational performance, financial performance, efficiency and productivity and strategic plans
3. This paper summarises the progress achieved against each of the objectives at the end of the financial year;

	Completed
	In progress but not be completed/achieved by 31st March 2019
	Little progress made or not achieved

4. The ratings show that:
   a. 23 objectives are rated green (83%)
   b. 4 objectives are rated graded amber (17%)
   c. None of the objectives are rated as red (0%)

Trust objective met or risk addressed: provides assurance to the Board that the Trust is making sufficient progress in delivering its annual plan.

Financial implications: None directly from this report.

Stakeholders: The Trust, its staff and all stakeholders.

Recommendation(s): The Board is asked to note the progress that was made in achieving the 2018/19 Trust objectives.

Presenting officer: Ann Marr, Chief Executive.

Date of meeting: 29th May 2019.

Trust Objectives 2018/19 – End of year progress review

	Completed		In progress but not completed/achieved by 31st March 2019		Little progress made or not achieved

Objective	Lead Director	Measurement	Governance Route	Progress Report	RAG
1. 5 STAR PATIENT CARE Care ***We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families***					
1.1 Improve the effectiveness of discharge planning (QA Priority) 1.1.1 Increase the proportion of discharges achieved before midday to at least 33% 1.1.2 Increase discharges at the weekend to be at least 85% of the weekday average 1.1.3 Improve effective communication with patients with regard to discharge planning	DoOps	33% of patients to leave hospital by noon on the day of discharge, including weekends. Reduce the number of complaints associated with discharge processes.	Quality Committee	There has been an increase in the number of patients discharged by midday from 14.1% in April 2018 to 28.5% in March 2019. There is targeted work to increase weekend discharges as part of the Executive led Urgent and Emergency Care Council improvement programme. Re-established and reviewed the discharge policy and information for patients and relatives, which is given to patients on admission to the ward. In conjunction with this a Trust wide patient information and communication plan has been developed in response to the inpatient survey.	Amber
1.2 Maintain effective assessment and monitoring of all patients in the Emergency Department (QA Priority) 1.2.1 The Emergency Department safety checklist is used and recorded for all patients 1.2.2 Undertake eMEWS or National Early Warning Score (NEWS) - which must be implemented during 2018/19 – assessments for all patients 1.2.3 Effective allocation of appropriate staffing, to be able to undertake the assessments	DoOps	Regular audit, monitoring of patient safety incidents and eRoster compliance	Quality Committee	The emergency department safety checklist is incorporated into patient documentation, and its consistent use is being audited. eMEWS is in place in the department. NEWS2 has been implemented across all inpatient wards and is planned to roll out to ED. Effective scheduling of staff to meet demand is a key workstream for the Medical Care Group, and is monitored daily to ensure appropriate allocation.	Green
1.3 Achieve the national seven day services clinical standards across the Trust (QA Priority)	DoOps & MD	Pharmacy, Therapy, Diagnostics, Frailty	Quality Committee	7-day service provision has been improved (quantity and quality). The last NHSE 7-day services audit and Board assurance	Amber

Objective	Lead Director	Measurement	Governance Route	Progress Report	RAG
1.3.1 Expand the range of services available 7 days a week 1.3.2 Increase the reported % of patients receiving a senior clinical review each day 1.3.3 Increase the reported % of patients being assessed by a Consultant within 14 hours of admission		National Target - 90% of patients		report shows that the Trust is achieving all of the standards for 7 day consultant led services, except patients assessed by a consultant within 14 hrs of admission, which has improved to 64%. The Trust is therefore making progress towards the 2020 national targets. Plans are being developed within each Care Group and systems established to ensure on going self-audit. The SDEC capacity capital plans will also help in due course. The Trust has expanded other services to 7 days including the frailty service, extended opening hours for pharmacy at the weekend and increased therapy presence at the weekend.	
2. 5 STAR PATIENT CARE Safety ***We will embed a culture of safety improvement that reduces harm, improves outcomes and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care***					
2.1 Reduce further the rate of avoidable harm from falls, pressure ulcers and medication incidents (QA Priority) 2.1.1 Falls – 10% reduction from 2017/18 baseline for moderate and severe harm 2.1.2 Pressure Ulcers – maintain zero tolerance of grade 3 or 4. Deliver a 15% reduction in grade 2 pressure ulcers compared to 2017/18 2.1.3 Medication Incidents – Following the implementation of EPMA (in Q3) to identify trends and develop a targeted action plan e.g. Insulin prescribing and administration	DoN	Monthly monitoring and reporting /RCA process and lessons learnt	Quality Committee	Trust reported 25% less falls in the moderate and severe category compared to 2017/18, with an 18% reduction in falls leading to severe harm. No avoidable hospital acquired grade 3 or 4 pressure ulcers reported during 2018/19 18% reduction in avoidable grade 2 pressure ulcers and an 8% reduction in total number of avoidable pressure ulcers overall. New pressure ulcer prevention initiatives/ interventions include posters on beds relating to heel pressure ulcer prevention and an evaluation of moisture lesion prevalence. EPMA is being rolled out across the Trust. In 2018-19 there was an 87% decrease in medication incidents compared with 2017/18, including a 36% decrease in harmful medication incidents in 2018/19 compared with 2017/18 (36 in 2018/19 compared to 56 in 2017/18) and no (0) incidents resulting in moderate to severe harm compared to 4 in 2017/18.	Green
2.2. Implement changes as a result of lessons learned from incidents and complaints (QA Priority)	DoN	Incidents, complaints and claims quarterly reports.	Trust Board	QWR summary reports made twice a year to Quality Committee. The QWR process has been revised and is supported by a new SOP, summary and feedback template for “you said, we did”	Green

Objective	Lead Director	Measurement	Governance Route	Progress Report	RAG
2.2.1 Annual complaints report to identify themes from 2017 -18 2.2.2 Monthly publication of lessons learnt and discussion at Ward/Department governance meetings 2.2.3 Audit compliance and impact		Audit and spot checks via QWRs		Audits of the dissemination process of sharing learning though safety huddles has been undertaken, evidencing high levels of compliance and usage. Lessons learned and safety messages are shared through Team Brief's bi-monthly safety bulletin. As part of the mortality review process, key learning is disseminated across the organisations and also forms the agenda for key governance groups and committees. Each complaint response includes any learning that has been identified and the necessary actions for each area. A summary of lessons learned and actions taken from complaints across the Trust is included in reports to the Board, Quality Committee and Patient Experience Council. Complaints are a standing agenda item on the Care Group and ward governance meetings to ensure that lessons are shared and to embed any actions taken to improve the quality of patient care. CQC report highlighted a number of examples of changes made throughout the organisation as a result of lessons learned, indicating a culture of improvement based on learning	
2.3. Fully establish the systems for reviewing hospital deaths, identifying and sharing learning and reporting the outcomes, in line with best-practice national guidance. 2.3.1 Quarterly publication of the Trust's screening and review of all deaths 2.3.2 Identification of two learning points 2.3.3 Evidence that the learning points have been disseminated throughout the Trust 2.3.4 Evidence that the learning has changed practice	MD	Publication of mortality reviews each quarter Audit of lessons learned and changes in practice	Trust Board	Learning from deaths continues to improve. Board reporting is now clearly established and a system for tracking 'sharing' and lessons learned is in place. The policy was updated to reflect the new guidance on supporting bereaved relatives and to incorporate learning from the CQC inspection. Thematic analysis will start to be reported in 2019/20. 2.3.1 Completed 2.3.2 Completed 2.3.3 Completed 2.3.4 Completed	Green
3. STAR PATIENT CARE Pathways ***As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient***					
3.1. Increase the percentage of e-discharge summaries sent within 24 hours to 85% (QA	DoI	Achieve 85% by Q4 2018/19	IPR	All inpatient and A&E discharges (100%) are transferred electronically.	Amber

Objective	Lead Director	Measurement	Governance Route	Progress Report	RAG
Priority)				The Trust is achieving 71.1% of inpatient discharges sent within 24 hours, 96.4% of A&E discharges sent with 24 hours and 85.2% of Outpatient discharges sent within 14 days (Trust Month 11 Integrated Performance Report). This is an improvement on last year; however, the target has not been met in one key area, inpatients. Work will continue in 2019/20 to achieve the compliance level in all 3 areas.	
3.2. Maximise the benefits of the adult community Nursing services in St Helens **3.2.1** Deliver end to end pathways to reduce duplication and number of handoffs e.g. Adult Continence, Heart Failure and Respiratory.	DoOps	Improved patient experience Fewer hospital admissions	Quality Committee	Further services were successfully transferred to the Trust in April 2018 and work is on-going to realise the benefits of single integrated pathways. Growth in A&E attendances and NEL admissions for St Helens CCG are significantly less than other boroughs. Amalgamation of the specialist community services in to the acute Trust has also reduced patient handoffs.	Green
3.3. Implement solutions to increase Car Parking capacity to improve the experience and access for staff, patients and visitors.	DoCS	Increase car parking spaces by 419 by September 2018	Executive Committee	Work to create additional car parking was completed and the new Delph Lane car park opened in February 2019, which has had a significant positive impact on patient and visitor parking in the multi storey care park.	Green
4. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**					
4.1. We will improve the systems used to investigate and respond to complaints and to respond to 90% of complaints within the agreed timescale. 4.1.1 Improve the accuracy and quality of complaints responses – 85% right at first draft 4.1.2 Improve the learning from complaints to change practice (same process as 2.3) 4.1.3 Respond to 90% of complaints within the agreed timescales 4.1.4 Reduce the number of 2nd level complaints where the complainant is unsatisfied with the initial response 4.1.5 Produce a quarterly report on complaint satisfaction survey results	DoN	Achieve 90% by September 2018 Reduction on 2nd level complaints Audit of lessons learnt	Quality Committee	Complaint response times have been consistently improved throughout the year. The Trust achieved 92.1% complaints responded to within the agreed timescales during 2018-19 In quarter 4 2018-19: • 7.5% of draft complaints requiring additional information • 39% required modification by the Executive • 53.8% first drafts approved The number of second stage complaints has decreased from 44 in 2017/18 to 37 in 2018/19 a16% reduction. A summary of the findings from the complainant satisfaction survey is included in each quarterly report with good levels of satisfaction reported throughout the year, with: • 92% finding it easy to complain • 88% stated their complaint had been responded to in a	Green

Objective	Lead Director	Measurement	Governance Route	Progress Report	RAG
				reasonable timescale • 88% confirmed that the reasons for the Trust's decision was made clear to them • 76% were satisfied with the way the complaint was handled	
4.2. We will fully implement the action plans developed in response to the results of the; 4.2.1 National inpatient survey 4.2.2 National maternity inpatient survey	DoN	Monitoring of action plans	Quality Committee	Action plans are in place for all national patient surveys, including cancer experience, maternity and inpatient surveys. These are monitored at the Patient Experience Council and reported to the Quality Committee. In addition, the Executive Committee undertook a deep dive of the inpatient survey action plan to ensure effective actions were being taken, with the most recent update in April.	Green
4.3. Use patient feedback to shape future service developments – identifying themes from all sources of feedback e.g. F&FT, Healthwatch, patient surveys, ask Ann, complaints, PLACE 4.3.1 Produce a thematic annual report from all patient feedback 4.3.2 Agree 2 -3 priority initiatives in response to the key issues identified 4.3.3 Publicise the changes made and the difference it has made to patients	DoN	Feedback from Healthwatch F&F test responses and approval ratings. Annual PLACE assessment You said we did reports	Quality Committee	Healthwatch quarterly reports have consistently remained positive, with actions implemented that address any concerns highlighted. The F&FT response rates are consistent and the approval ratings have remained high for all areas. These are reported monthly via Team Brief, IPR and reports to the Patient Experience Council. The annual PLACE score results were excellent with the Trust achieving the highest scores in all categories. Examples of changes made in response to patient feedback are reported to the Patient Experience Council with quarterly reports provided. A summary of changes made as a result of patient feedback is included in the Quality Account.	Green
5. 5 STAR PATIENT CARE – Systems ***We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes***					
5.1 Implement the new Patient Administration System with minimal disruption to contractual or operational performance.	DoI	Achieve BAU state by August 2018	Executive Committee	The new Patient Administration System was delivered in the majority of Trust operational and clinical areas without disruption. Although, there have been some specific areas of additional support required as a result of the significant change of systems. The Trust is now operating at pre-Medway business as usual levels.	Green

Objective	Lead Director	Measurement	Governance Route	Progress Report	RAG
5.2 Make the most effective use of the skills of the nursing workforce by implementing an electronic system (SafeCare) to ensure optimal deployment of nursing resources. (QA Priority) 5.2.1 Appoint the lead nurse 5.2.2 Implement the system to be able to use to inform staffing decisions from September 2018	DoN/DoHR	Safer staffing reports – maintain over 90% Care Hours Per Patient – maintain 3 hours	Quality Committee	SafeCare has been rolled out successfully to 100% of all adult inpatient wards. This supports daily staffing reviews to ensure safe staffing skill mix across all wards to ensure deployment of nursing resources. Weekly compliance achieves 90-100% in all areas SafeCare is being used to review ward staffing compared to patient dependency using the Shelford methodology The lead nurse started in post January 2019. Safer staffing fill rates are 96% during 2018-19. CHPPD is achieved on the majority of wards and is reported monthly in the safer staffing report. Further analysis the benchmarking data is in progress.	Green
5.3 Implement phase 1 of the Shared Care Record with partners in St Helens.	DoI	Shared care record operational by March 2019	Executive Committee	The Shared care record is fully live and being actively used by all partner organisations.	Green
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 the number of staff who retire and return and promote flexible working 6.1.4 Provide development opportunities including rotational programmes 6.1.5 Expand the Trust preceptorship and whole career development to more staff groups	DoHR	HR Indicators Reports	Trust Board	The Trust has seen a significant improvement in retention and recruitment during the year. 57 international recruits are working within the Trust as at the end of March 2019. Further nurses are in the pipeline for arrival in 2019. In total 130 permanent new nurses have been recruited to the Trust in 2018-19. 89 HCAs have been recruited to the Care Certificate programme and 6 have successfully completed the qualification. Numbers of nurse vacancies has reduced by circa 40%. Turnover amongst clinical staff reduced by 3%. Time to hire has reduced by 36% (to an average of 41 days)	Green

Objective	Lead Director	Measurement	Governance Route	Progress Report	RAG
				Virtually eliminated use of high cost agency for RN nursing shifts and Zero use for HCAs. With overall reduction in agency spend. Clinical Education Support Tutor appointed and commenced in post in May 2018 to support preceptorship and whole career learning, with the new preceptorship programme launched in April.	
6.2 Make further improvements to the Trust so it is increasingly recognised as an employer of choice. 6.2.1 Act on feedback from staff survey to include an increase in rate of appraisals, staff satisfaction in care they provide and reduction in staff experiencing physical violence from patients 6.2.2 Conduct local impact assessment surveys, prior to the 2018 staff survey	DoHR	Quarterly Reports NHS Staff Survey Action Plan	Workforce Council	A staff survey report and action plan was presented to the Trust Board in April. This included specific actions to address reported incidents of violence to staff. There are quarterly progress reports to the Quality Committee via Workforce Council. Use of local mini cultural surveys has enabled a more detailed understanding of the areas in need of additional support which had led to individualised OD plans. Appraisal- a revised Appraisal 'e' form launched. Training amended and also relaunched. Management and Appraisal tool (WorkPal) launched 1st April 2019 with full roll out completion during May 2019.	Green
6.3 Optimise the apprenticeship levy to support staff in realising their potential. 6.3.1 Offer a broad range of apprenticeship schemes to staff to develop skills and aid retention 6.3.2 Utilise the levy to support new roles such as c12 nursing associates, c20 apprenticeship nurse degrees and physician associates when frameworks are in place. 6.3.3 Support the development of new roles e.g. advanced care practitioners to address staff shortages	DoHR	E-rostering Programme Board reports	Executive Committee	The Trust is offering a range of apprenticeships utilising the funding paid through the Apprenticeship Levy. To date 127 staff are accessing apprenticeships in addition to; 2 initial cohorts (13 staff) of Nurse Apprenticeships, with a further cohort (of 10) due to commence in September 2019. In January 2019 the first cohort of 16 Nursing Associates, commenced. 4 Operating Department Practitioners apprenticeships commenced in March 2019. Expansion of widening access opportunities with development of a Healthcare Cadet Scheme in association with St Helens, Knowsley and Cowley Colleges. The Trust currently supports 62 cadets and will see this increase to 120 cadets from September 2019. Funding for a range of Advanced Clinical/ Nurse Practitioner	Green

Objective	Lead Director	Measurement	Governance Route	Progress Report	RAG
				roles has been secured through HEE and utilised to support development of advanced practice in ED, Care of the Elderly/ Frailty and Oncology.	
6.4 Expand the implementation of e-rostering to allied health professionals to support effective use of resources across all staff groups 6.4.1 Implement e rostering for AHPs by end of Q3 2018/19 6.4.2 Optimise the benefits of e rostering for doctors in training to ensure effective deployment of staff.	DoHR	E-rostering Programme Board reports	Executive Committee	Implementation of e-Rostering to AHPs has been completed. E-Rostering was implemented for Junior Doctors from August 2018. The implementation allows the Medical HR team to monitor and support services in achieving the deadlines outlined in the 2016 terms and conditions and NHS Employers best practice guidance. This ensures that generic work schedules are issued a minimum of 8 weeks before the rotation and rotas are issued a minimum of 6 weeks before the rotation for all trainees employed and rotating into STHK.	Green
7. OPERATIONAL PERFORMANCE ***We will meet and sustain national and local performance standards***					
7.1 Plan to achieve national performance access standards including: 7.1.1. The agreed trajectory for emergency access standards 7.1.2. Cancer treatment standards 7.1.3. 18 week access to treatment for planned care 7.1.4. Diagnostic tests completed within 6 weeks 7.1.5. Ambulance handover	DoOps	IPR	Finance and Performance Committee	The Trust achieved all national performance access standards, except for Accident and Emergency 4 hour access. 62 day cancer treatment access targets achieved 18 week RTT access standard achieved Diagnostic waiting time standard achieved The ambulance handover standard was achieved for 10 of the 12 months, compared to 5 of the 12 months in the previous year.	Green
7.2 **Plan to achieve local performance indicators including**: 7.2.1 CQUINS 7.2.2 Contract performance indicators and compliance 7.2.3 Activity levels to meet Trust operational plans.	DoOps	Contract Monitoring	Finance and Performance Committee	The majority of CQUIN targets have been achieved. Ongoing discussions with CCGs about the remainder. The Trust is achieving contract performance indicators and quality standards Due to service disruption caused during the implementation of the new PAS and the IT outage in addition to the increasing NEL activity not all activity plans were achieved.	Amber
7.3 We will use benchmarking and comparative data e.g. GIRFT and Model Hospital to increase the productivity of our Theatres and outpatient clinics	DoOps	GIRFT Model Hospital		The Trust has completed a Use of Resources assessment with NHSI based on Model Hospital data and achieved a good rating. The Trust has nominated 2 Model Hospital champions to work with the national NHSI team	Green

Objective	Lead Director	Measurement	Governance Route	Progress Report	RAG
				The Trust continues to participate in GIRFT reviews and relevant data from both GIRFT and Model Hospital is actively used at speciality level to support delivery of productivity improvements e.g. Ophthalmology	
8. FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY ***We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money***					
8.1 We will use benchmarking and reference costs to achieve best practice; 8.1.1 Maintain reference cost index of less than 100 8.1.2 Improve performance against all three of the procurement efficiency standards	DoF	Annual Reference Costs NHSI Annual Benchmarking review Annual procurement performance score Model Hospital	Finance and Performance Committee	Reference Cost results for 2017/18 are lowest ever at 91, an improvement of 7 points compared to the previous year. This is one of the best results for acute hospitals in the north region. The StHK Procurement service is now ranked 7th nationally in the procurement league table (an improvement of 96 places in two years) and the highest ranked service in Cheshire and Merseyside.	Green
8.2 We will continue to work with partners across Cheshire and Merseyside and in local Integrated care systems to provide non-clinical back-office services, where economies of scale can be demonstrated; 8.2.1 Pathology Network 8.2.2 HR Services 8.2.3 Business Information 8.2.4 Informatics and IT 8.2.5 Financial Services	DoF	Annual Reference Costs NHSI Annual Benchmarking review Annual procurement performance score Model Hospital	Finance and Performance Committee	NHSI back office benchmarking performance has improved compared nationally and against the STP organisations. In the STP all functions are within the best or 2nd best quartile. Best quartile opportunity is calculated at only £1.4m with £0.9m being IT related. This does not factor in quality of service in achieving best quartile. Continued engagement with Pathology Network developments at both Southport & Ormskirk level and C&M STP level. HR continues to provide commercial services and during 2018/19 won the HEE tender for lead employer across the North West. A joint Business Information Unit has been established for St Helens Cares Continued involvement with the C&M Collaboration at Scale Work streams for Finance, IT and Governance.	Green
9. STRATEGIC PLANS ***We will work closely with NHS Improvement, and commissioning, local authority and provider partners to develop proposals to improve the clinical and financial sustainability of services***					
9.1 We will work closely with community, primary and social care to support; 9.1.1 Integrated out of hospital pathways 9.1.2 Admission avoidance	DoT	IPR & Corporate Activity Reports	Executive Committee	This is a strategic ambition that will take longer than 12 months to achieve, with good progress being made during 2018/19. Community COPD team, community cardiac nurses and	Green

Objective	Lead Director	Measurement	Governance Route	Progress Report	RAG
				rehabilitation team and frailty nurses are now working in St Helens to avoid admissions and provide integrated out of hospital pathways. Collection of accurate and timely falls data for over 65 year olds in ED is supporting increased referrals to community falls team. Executive MADE held on a monthly basis to ensure timely discharge and a reduction in DTOCs across our footprint. Marshalls Cross Medical Centre is working closely with the End of Life Care teams in the community to avoid admissions and manage patients well in the community. Marshalls Cross Medical Centre is working with St Helens Central locality primary care network to support primary care at scale.	
9.2 We will collaborate with partners in the development and implementation of integrated care partnerships in order to benefit patient experience through the provision of integrated high quality, safe, efficient and effective services.	DoT		Executive Committee	This is a strategic ambition that will take longer than 12 months to achieve. **St Helens:** Joint Director of Integration appointed. Governance and accountability system established with a MOU to support closer partnership working formally agreed by all partners in January 2019. Trust representatives attend the St Helens Cares Executive Board; People's Board and Local Care System Programme Board. A Provider Board to be chaired by the Trust CEO has been agreed. A review of therapy services across primary, secondary and community care across St Helens has been undertaken and a report is expected shortly. **Knowsley:** Integrated care system (ICS) proposals continue to develop. The Trust is supporting the development of a community frailty service. Trust representatives attend the Knowsley Health and Wellbeing Board, the Knowsley Better Together Health and	Green

Objective	Lead Director	Measurement	Governance Route	Progress Report	RAG
				Care Executive Group, and the Early Intervention and Prevention Steering Group. **Halton:** Integrated care system (ICS) proposals continue to develop. The Trust is supporting the development of a community frailty service. DoT is the SRO for the Enablers workstream of One Halton, and coordinates the enabler subgroups. The DoOps is the co-SRO for the Urgent and Crisis care workstream of One Halton. Trust representatives attend the Halton Health and Wellbeing Board, the One Halton Providers Alliance and the One Halton Forum. All places within the Cheshire and Merseyside Health and Care Partnership are beginning to implement single handed care, are participating in shared training as part of the moving with dignity initiative and most organisations are partners in the moving with dignity initiative, seeking to reduce length of stay in acute/intermediate care, and enable patients/ residents to remain in their own homes as long as possible.	
9.3 We will meet all the compliance requirements set by NHSI in the Single Oversight Framework to maintain the long-term sustainability of clinical services for local people, collaboratively with partners where appropriate. 9.3.1 Commission an independent Well Led Review 9.3.2 Participate fully in the Cheshire and Merseyside Health and Care Partnership	DoCS	Meet all reporting and compliance requirements and deadlines Maintain segmentation rating	Executive Committee	CQC completed the Well Led inspection in August 2018 and was rated as outstanding for the Well Led domain. The Trust continues to be classified as segment 2 by NHSI. The Trust has a leading role in several of the C&M H&SCP Collaboration at Scale corporate services and clinical work streams and senior representation on all relevant work streams	Green

ENDS