St Helens and Knowsley Teaching Hospitals NHS Trust

STHK Trust Board – March 2020

issued in lieu of meeting

Public Board Papers attached:		
1.	Minutes of the Previous Meeting held on 26th February 2020	Attached
2.	Action Log	Attached
3.	Integrated Performance Report	NHST(20) 19
4.	Committee Report – Executive	NHST(20) 20
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St Helens and Knowsley Teaching Hospitals NHS Trust

Minutes of the St Helens and Knowsley Teaching Hospitals NHS Trust Board meeting held on Wednesday 26th February 2020 in the Boardroom, Whiston Hospital

PUBLIC BOARD

Chair:	Mr R Fraser	(RF)	Chairman
Members:	Ms A Marr	(AM)	Chief Executive
	Mrs V Davies	(VD)	Non-Executive Director
	Mr J Kozer	(JK)	Non-Executive Director
	Mr P Growney	(PG)	Non-Executive Director
	Mr I Clayton	(IC)	Non-Executive Director
	Mrs G Brown	(GB)	Non-Executive Director
	Mrs A-M Stretch	(AMS)	Deputy Chief Executive/Director of HR
	Mrs C Walters	(CW)	Director of Informatics
	Ms N Bunce	(NB)	Director of Corporate Services
	Mr N Khashu	(NK)	Director of Finance & Information
	Mr R Cooper	(RC)	Director of Operations & Performance
	Mr R Pritchard-Jones	(RPJ)	Medical Director
In Attendance:	Mr G Appleton	(GA)	Chair, St Helens CCG *(co-opted member)*
	Mr R Halford	(RH)	Public Health, Knowsley Council *(for item 11 only)*
	Ms J Byrne		Executive Assistant *(Minute Taker)*
Apologies:	Mrs L Knight	(LK)	Non-Executive Director
	Mrs S Redfern	(SR)	Director of Nursing, Midwifery & Governance
	Dr T Hemming	(TH)	Director of Transformation
	Cllr Alan Lowe	(AL)	Halton CCG *(co-opted member)*
	Dr S McNulty		Director of Public Health, Knowsley Council

1. Employee of the Month

The Employee of the Month for December 2019 was awarded to Anna Ebbrell, Ward Manager, Gastroenterology & General Medicine, Ward 3C.

2. Apologies for Absence

Apologies were noted as above. Dr Sarah McNulty, who had been due to present item 11, had sent apologies but had asked her deputy (RH) to attend instead.

3. Declaration of Interests

3.1. There were no declarations of interest.

4. Minutes of the previous meeting held on 29th January 2020

4.1. Correct Record

4.1.1. The minutes were accepted as a correct record once “Shadow Board” was added to minute 12.3.

4.2. **Action List**

4.2.1. Action 9 – AM to discuss the arrangements for the Board Time Out with Jacqui Wallis.

4.2.2. Action 21 – not due until the April meeting.

4.2.3. Action 30 – NK asked for clarity on the expectations for the Board Time Out session. NB clarified it was a broader discussion about the risks associated with commercial contracts, such as the Lead Employer services.

4.2.4. Action 33 – It was noted that the Shadow Board Leadership Development Programme was now underway and would form part of the plans for 2020/21, rather than 2019/20.

4.2.5. Actions 20, 29, 31 and 34 were not due for this meeting.

4.2.6. Actions 28, 32 and 35 had been completed and were closed.

5. Integrated Performance Report (IPR) – NHST(20)012

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

5.2. **Quality Indicators**

5.2.1. RC presented the performance against the key quality indicators on behalf of SR.

5.2.2. There had been no never events in January 2020 and none year to date (YTD).

5.2.3. There had been no cases of MRSA reported in January 2020. RC reported that there had been a positive blood sample for MRSA detected in November; however the Route Cause Analysis (RCA) investigation indicated this was a contaminant and the patient did not come to harm.

5.2.4. There were 11 C.Diff positive cases reported in January 2020 (9 hospital onset and 2 community onset). YTD there had been 45 cases (35 hospital onset and 10 community onset), although 11 cases were still subject to appeal.

5.2.5. The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for January 2020 was 97.1% and YTD performance was 96.4%.

5.2.6. There were no grade 3 avoidable pressure ulcers reported in December 2019 (YTD = 1).

5.2.7. There were no falls resulting in severe harm in December 2019 and 7 in the YTD.

5.2.8. Venous thromboembolism (VTE) assessment performance for December 2019 was 96.16%. YTD performance was 95.57% against a target of 95%.

5.2.9. The latest report HSMR (April – August 2019) was 109.7.

5.3. Operational Indicators

5.3.1. RC presented the update on operational performance.

5.3.2. Performance against the 62-day cancer standard was above the target of 85.0% in December 2019 at 86.2%.

5.3.3. The 31-day cancer target was achieved with 97.1% performance against a target of 96%.

5.3.4. The 2-week rule cancer target was achieved with 93.9% in month against the target of 93%. This was an improving position, although the YTD performance was still 89.9%.

5.3.5. A&E access time performance was 67.4% (type 1) for January 2020. The all types mapped footprint performance was 82.8%. The Trust received 10,077 Type 1 attendances in January 2020 and YTD there had been growth of 5.2% compared to 2018/19.

5.3.6. Ambulance notification to handover time was not achieved in January 2020 with 27:00 mins/seconds on average, against a target of 15 minutes. There were 2,807 ambulance conveyances in January, which was the second highest number of conveyances in Cheshire & Merseyside and Greater Manchester.

5.3.7. The Trust had been set a 40% reduction target in the number of super stranded patients (patients with a length of stay of greater than 21 days) by year end 2019/20. The average number during January was 133 compared with 131 in December, which maintained a 20% reduction from the baseline of 154. In response to a query from GB, RC confirmed the 40% reduction target was set by NHS England/Improvement. The aim of the target was to encourage the local health and care system to work together more effectively.. The difficulties the Trust continued to experience in discharging patients to other settings was acknowledged.

5.3.8. The 18 week referral to treatment target (RTT) was achieved in January with 92.2% compliance against a target of 92%. There were no 52+ week waiters. The 6-week diagnostic target was fully achieved in December with 100% compliance (YTD compliance 99.6%) against a target of 99%.

5.4. Financial Indicators

5.4.1. NK presented the update on the financial performance.

5.4.2. At the end of month 10 (January), the Trust reported a surplus of £0.2m which was in line with agreed plans and assumed full achievement of this year's Provider Sustainability Fund (PSF) funding.

5.4.3. To achieve the year to date position the Trust had utilised c£4.2m of non-recurrent resources.

5.4.4. Agency expenditure at month 10 was £6.6m which was a 2% reduction on last year, although £0.1m above the ceiling issued by regulators.

5.4.5. The Trust's CIP target in year was £16.1m, the Trust had full plans to deliver this target recurrently.

5.4.6. NK reported that good progress had already been made in developing the CIP plans for 2020/21 and work was continuing to identify schemes with CCG colleagues that would result in system savings.

5.5. **Workforce Indicators**

5.5.1. AMS presented the update on the workforce indicators.

5.5.2. Sickness absence in January was 5.5%, against the Q4 target of 4.68%.

5.5.3. Qualified nursing and HCA sickness remained at 6.0% for January, against a Q4 target of 5.3%. AMS reported the Trust was doing all it could to support managers and staff to return to work as soon as possible.

5.5.4. All qualified nursing and midwifery sickness was 4.0%, below the Q4 target of 4.68% and the year to date figure of 4.6%.

5.5.5. Mandatory training compliance for the core skills framework subjects was 84.9% (target = 85%).

5.5.6. Appraisal compliance was 78.4% (target 85%), which was a concern but did follow the usual pattern for the time of year. Managers were being supported and she was confident appraisals rates would increase before the end of March.

6. Committee Report - Executive – NHST(20)013

6.1. AM presented a summary of the issues considered by the Executive Committee at meetings held during January 2020. Key decisions taken were:

6.1.1. Additional capacity and re-structuring of the Cancer Management Services team in response to the growth experienced since 2015 and ahead of the future expansion of cancer services at the Trust.

6.1.2. Approval of project management support to scope the issues impacting on mandatory training access and compliance and to develop an improvement plan.

6.1.3. Agreement to invest in robotic process automation for payroll services to improve efficiency and productivity by reducing routine repetitive tasks for staff. It had been noted that there were also many other potential applications for this technology which could also be explored.

6.1.4. Approval to purchase Microsoft product licences for all HIS partners.

6.1.5. Approval of a business case to establish a bariatric surgery service at the Trust. AM explained that STHK would be the only provider of bariatric surgery in Cheshire & Merseyside. GB asked whether the service would include psychological support before and after surgery. RC explained the Trust would be providing the Tier 4 surgical services; the psychological

support provision was undertaken earlier in the pathway by a Tier 3 provider, so by the time the patient attended the Trust they would already have been psychologically assessed.

6.1.6. AM also highlighted that the Executive Committee had initiated a review of the Anaesthetic and Obstetric on call arrangements, following a recent emergency situation. The incident was still being investigated to identify the route cause and lessons learnt but a number of short term measures had already been put in place and a full options appraisal was being developed. GB commented that the incident had been discussed when she attended a Quality Ward Round on the Maternity unit and had also been reported in detail at the Quality Committee. AM noted that the relatives were likely to want to share their experiences with the Board as a future patient story.

6.1.7. In relation to item 2.3 Lead Employer Opportunities IC commented that it was important to ensure the appropriate infrastructure is in place before services expanded.

6.1.8. IC asked about items 4.4 Upper GI Cancer Project Results and 5.1 Cancer Patient Experience Collaborative and endorsed the importance of the role of Cancer Support Workers to help patients navigate complex treatment pathways involving multiple hospitals. AM explained that the Upper GI cancer pathway in the local area was particularly complicated, involving 4 different hospitals. Macmillan Cancer Support had funded a number of Cancer Support Workers but unfortunately Upper GI was not one of the pathways they had invested in to date. AM had recently written to the Cheshire & Merseyside Cancer Alliance about this specific pathway and the improvements that were needed. RC explained that the Trust was now in a position to deliver the chemotherapy for these cancers locally, which would be of great benefit to the patients, who often presented late and were already in a poor state of health.

6.1.9. The 2019 Patient-Led Assessments of the Care Environment (PLACE) result, as the best performing NHS organisation, with an overall score of 99% and 100% scores in 2 of the 5 categories, was noted by the Board. RF congratulated everyone involved.

6.1.10. The Executive Committee had received a report from SR on the plans to respond to coronavirus and AM confirmed that these were now regular updates. RPJ assured the Board that the Trust remained fully compliant with the latest Public Health England and Department of Health guidance. He confirmed that a number of tests had been conducted on members of the public who had come to the Hospital, but to date none had tested positive.

6.1.11. Board members noted the report.

7. Committee Report - Quality – NHST(20)014

7.1. GB presented the assurance report from the Quality Committee meeting held on 18th February.

7.1.1. Board members noted the slight improvement in ILS/BLS training compliance to 77% in January 2020.

7.1.2. The improvement in safeguarding training compliance had also been noted, with all subjects now achieving the target except PREVENT Level 3, which had however achieved the quarter 3 improvement trajectory at 81%

compliance. The positive outcome of a recent Section 11 Scrutiny Visit had also been reported.

7.1.3. GB drew member's attention to the Quality Committee discussion regarding the Obstetric incident and the actions being taken in response, as reported by the Patient Safety Council.

7.1.4. GB reported that she was assured by the response of the Executive in so quickly investigating the spike in HSMR for July 2019 which had been reported in the national figures in January. This had been a proactive response and the involvement of an external expert to advise the Trust was also welcomed. The initial investigation outcome and action plan had been discussed in depth at the Quality Committee and would continue to be monitored.

7.1.5. There were no formal matters for escalation to the Board from the meeting, but the Committee had expressed concern in relation to the number of reports/presentations deferred and the impact on future agendas. RF observed there was a fine line between having the most current, accurate and thorough information and the timeline in which to prepare it. GB had queried the capacity of the senior nursing team to support the quality governance requirements and this was to be discussed as part of the forthcoming annual effectiveness review and by the Executive Committee.

7.1.6. The report was noted.

8. Committee Report – Finance & Performance – NHST(20)015

8.1. JK presented the Chair's assurance report from the Finance & Performance Committee meeting held on 20th February and highlighted the following points:

8.1.1. An update was received on the St Helens Urgent Treatment Centre including a breakdown of attendances currently and the plans to transform services, for example with the right diagnostic capability to prevent patients having to be referred on to A&E. RPJ had recently visited the UTC and had found the staff to be highly skilled and with lots of ideas for how to improve the care that could be provided.

8.1.2. The National Cost Collection (formally reference costs) results for 2019 had been published and the Trust score was 94 which meant it was 6% more efficient that the national average.

8.1.3. The Committee had received updates on the financial positions of the local financial recovery system partners and discussions to agree the out turn position for 2019/20 that would reduce any further volatility for all parties.

8.1.4. There had been an update on the contract negotiations for 2020/21 and the pressures being faced by the system. GA commented that he felt the St Helens system should be planning for structural changes as the NHS moved towards Integrated Care Organisations (ICO). St Helens CCG had changed their forecast outturn position in the month to a deficit of c£18m. The Trust was aware of this change and had been offering support to the CCG where appropriate. Contract negotiations were ongoing for 2020/21. GA added that it was likely there were likely to be structural changes with the introduction of legislation to shift the formal role of the STP to place- rather than organisational-based. It was agreed that a meeting of executives from both St Helens CCG and the Trust in the near future would be a good forum

to gain a common understanding of the likely future direction and implications locally. **ACTION: AM**

8.1.5. The Committee had noted the CIP plans transacted this year and were assured by the list of potential schemes for 2020/21 totalling £19.0m. RF stated that the achievement of the CIP for 2019/20 was a significant achievement and he was pleased that everyone in the Trust was involved and shared responsibility for delivering the CIP

8.1.6. The Committee had reviewed the Operational Planning guidance 2020/21 budget setting/planning and the draft Trust plan that was to be submitted on 5th March. The draft plan was accepted and given the timescales it was recommended that any further items requiring a decision before the submission date should be delegated to the Executive Committee. The Trust Board agreed this recommendation.

8.1.7. The Board discussed the new immigration rules that had recently been announced and the potential impact on the Trusts ability to recruit overseas. AMS and her team were working through the implications and it was felt that the Trust would easily obtain the 70 points required to sponsor healthcare workers from both within and outside of the EU/EEA, so recruitment should not be adversely impacted. However the cost and time of applying the regulations to EU/EEA Nationals could increase costs. AM commented that the greater concern for the health system maybe in relation to the recruitment of staff to the care sector, which would impact on patient flow. AMS was preparing a briefing paper on the new regulations for the Executive Committee and agreed to also circulate this to the NEDS for information. **ACTION: AMS**

8.1.8. The report was noted.

9. Committee Report – Audit – NHST(20)016

9.1. IC presented the Chair's assurance report following the Audit Committee meeting held on 12th February.

9.2. The committee had received updates from the internal and external auditors, including the audit timetable for 2020 to ensure the annual accounts were available for board approval on 27th May.

9.3. There had been a report from the Anti-Fraud specialist and regular reports covering losses and special payments, aged debt and waivers.

9.4. There were no matters for escalation to the Board.

9.5. The report was noted.

10. Committee Report – Charitable Funds – NHST(20)017

10.1. PG presented the Chair's assurance report form the Charitable Funds Committee meeting on 20th February.

10.1.1. Committee had received an update on fundraising activities, the forward programme and the work of the hospital charity.

10.1.2. The financial position of the charitable fund had been reviewed, including the level of investment and recent income and expenditure.

10.1.3. Committee approved two applications for funding for a 3D body scanner for the Prosthetics Department and a patient pager system for Pharmacy.

10.1.4. An objective for the charity was to increase the involvement of local businesses and also raise the profile and understand ding of the role of the charity with staff.

10.1.5. RPJ informed Board members the prosthetics team had been short-listed for the National Science Officers' Award 2020as a result of their use of the 3D scanner.

10.1.6. RF reminded Board members of the importance of supporting the Charity events, wherever possible.

10.1.7. RF to meet with PG and the Charity Manager to discuss opportunities for corporate engagement with local businesses. **ACTION: RF**

10.1.8. The report was noted.

11. Knowsley Council Public Health Annual Report for 2018/19 – "Keeping Active" – NHST(20)018

11.1. RH presented Knowsley Council's Public Health Annual Report for 2018/19 – "Keeping Active" on behalf of Dr Sarah McNulty, Director of Public Health.

11.2. The ethos behind the report was to encourage and improve physical activity levels in Knowsley residents by delivering a number of targeted programmes and initiatives. Board Members noted physical inactivity contributed to 780 deaths per year in Knowsley and 1 in 6 deaths in the UK.

11.3. To embed health and promote physical activity into future housing developments, Knowsley Council and partners were engaged in an NHS England Healthy New Towns Programme. The population of Knowsley was expected to increase substantially and the design of these new communities would promote more physical activity.

11.4. GB queried whether there was any evidence related to the type of exercise that was most beneficial however, RH explained that it very much depended on the individual. GB wondered whether the message needed to be harder hitting, so the reader was aware of the likely consequence of being inactive, however RH reported that research had shown that shock tactics did not change people's behaviour, however people are motivated by the benefits for those that they care about e.g. grandchildren.

11.5. VD suggested some of this work could be done via the primary care networks, where GPs had a 1:1 relationship with their patients.

11.6. RF thanked RH for attending the meeting.

11.7. The report was noted.

12. Effectiveness of Meeting

12.1. GA thanked RF for a productive and informative meeting.

13. Any Other Business

13.1. RF provided an updated on the Sutton Academy Student who had received CPR from Trust staff.

13.2. RF informed Board members that the Trust had agreed to participate in the Gatenby Sanderson Insight Programme which was designed to support more BAME and Female NED candidates for the NHS. The Trust's commitment would be for 2 "shadow" NEDs over a 12 month period. The placements were planned to start from April 2020.

14. Date of Next Meeting

14.1. The next meeting will be held on Wednesday 25th March 2020 at 09:30 hrs in the Executive Boardroom, Level 5, Whiston Hospital, L35 5DR.

Jayne Byrne pp Richard Fraser

Chairman: ……

25th March 2020

Date: ……

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST PUBLIC BOARD ACTION LOG – 25TH MARCH 2020

No	Date of Meeting (Minute)	Action	Lead	Date Due
9	31.07.2019 (14.6)	AMS to arrange a training and awareness session for Board members on what to consider when implementing a just culture for a future Board development session. **Board Time Out now being arranged for later in the year – AM to discuss with Jacqui Wallis.**	AM	25.03.2020
20	30.10.2019 (14.7)	SRe to work with LK/GB to contextualise complaints information to provide greater clarity for Board members.	SRe/LK/GB	27.05.2020
21	30.10.2019 (15.3)	Layout of the quarterly Learning from Deaths Report to be improved and themes incorporated. **Update: 29.01.2020 – work in progress and new format to be presented for Q3 report in April 2020.**	RPJ	29.04.2020
29	29.01.2020 (12.3)	Add to controls: BAF Risk 5 – "NED attending CCG Governing Body meetings" BAF Risk 6 – "Employee Relations Oversight Steering Group" and "Shadow Board"	NB	29.04.2020
30	29.01.2020 (12.4)	NB/NK to prepare a session on the Trust commercial strategy for the next Board Time Out.	NB/NK	16.04.2020
31	29.01.2020 (14.5)	Key learning from deaths to be included in the Patient Safety Newsletter to provide further coverage to Trust staff.	RPJ	29.04.2020
33	29.01.2020 (15.7)	Include the introduction of a Shadow Board in the Trust's Workforce Leadership Priorities for 2019/20.	AMS	29.07.2020
34	29.01.2020 (15.12)	AMS to include local information from the GMC survey relating to Speciality and Associate Specialist (SAS) and locally employed doctors in next HR Indicators Report.	AMS	29.07.2020
36	26.02.2020 (8.1.3)	Exec to Exec meeting (STHK Trust/St Helens CCG) to be arranged.	AM	25.03.2020
37	26.02.2020 (8.1.6)	Circulate Immigration paper to NEDS following Exec Committee meeting on 27.02.20.	AMS	28.02.2020
38	26.02.2020 (10.1.7)	RF to meet with PG and the Charity Manager regarding raising the Hospital charity profile with local businesses.	RF	25.03.2020

Paper No: NHST(20)019
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 no Never Events in February 2020. (YTD = 0)

There were no cases of MRSA in February 2020. There has been 1 MRSA positive blood sample YTD (target = 0). The RCA indicated this was a contaminant and patient did not come to harm.

There were 2 C.Difficile (CDI) positive cases reported in February 2020 (2 hospital onset and 0 community onset).
YTD there have been 43 cases (33 hospital onset and 10 community onset) which includes 1 further case for appeal and 9 RCA's to be completed . The annual tolerance for CDI for 2019-20 is 48. The new guidance now requires us to include hospital onset and any community cases that have been discharged from hospital in the previous 28 days.

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for February 2020 was 95.3%. YTD rate is 96.3%.

During the month of January 2020 there were 3 falls resulting in severe harm. (YTD Severe harm fall = 10)

Performance for VTE assessment for January 2020 was 95.20% against a target of 95%. (YTD = 95.53%)

There were no grade 3 avoidable pressure ulcers in January 2020. (YTD = 1).

YTD HSMR (April -October) for 2019-20 is 106.5

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: 25th March 2020

Operational Performance

Performance against the 62 day cancer standard was above the target of 85.0% in month (January 2020) at 85.2%. YTD 86.3%. The 31 day target was achieved with 98% performance in month and YTD 97.3% against a target of 96%. The 2 week rule target was achieved with 93.1% in month and 90.2% YTD against a target of 93.0%.

Accident and Emergency Type 1 performance for February 2020 was 71.3% and YTD 69.5%. The all type mapped STHK Trust footprint performance for February was 85.3% and YTD 83.8%**.** The Trust received 9,192 Type 1 attendances in February 2020. Year to date growth in ED attendances is 5.3% up on 2018/19. The work streams, designed to increase performance against the 4 hour standard, continue to focus on driving forward the required improvement. Plans are in place to increase the bed capacity within the Trust which will support the required reduction in bed occupancy leading to decongestion of the A&E department.

Ambulance notification to handover time was not achieved in February 2020 with 15.57 mins on average (target 15 mins). There were 2,550 ambulance conveyances in February . **NB:** ***STHK had the highest number of ambulance conveyances across Cheshire and Merseyside and Greater Manchester in February .***

The Trust has been set a 40% reduction target in the number of super stranded patients (length of stay 21day+) by year end 2019/20. Working from the baseline figure of 154, a 40% reduction would equate to 92 patients. The average number in February was 125 which maintains a 20% reduction from 154 baseline. (133 was the average in January). Medical and Surgical clinical /managerial teams and all CCG and local authority partners are actively engaged in the achievement of the reduction in super stranded. Progress and actions to address are monitored daily.

The 18 week referral to treatment target (RTT) was achieved in February 2020 with 92.1% compliance and YTD 92.1% (Target 92%). There were no 52+ week waiters. The 6 week diagnostic target was achieved in January with 99.7% compliance and YTD compliance 99.6% (Target 99%).

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 month 11 StHK has reported a YTD surplus of £0.9m which is in line with agreed plans and assumes full achievement of PSF funding. The Trust has utilised c£4.2m of non-recurrent options to achieve the reported deficit.

An additional £0.5m relating to 2018/19 PSF has been allocated to the Trust following the redistribution of funds that were unachieved by other organisations. This has been included in our YTD and Forecast position but excluded as a technical adjustment so there is no benefit to the Trust in delivering its agreed control total as per guidance from NHSE/I.

The agency ceiling issued by regulators for 2019/20 is £7.6m. To the end of February the Trust has spent £7.0m on agency which is in line with the agency ceiling issued. The current spend equates to a 5% reduction on last year.

The Trusts CIP target in year is £16.1m, the Trust has full plans that deliver this target recurrently. The Trust continues to identify schemes which will support the delivery of the 20/21 CIP programme. The Trust has been notified by regulators that they will be supporting all health systems on the delivery of CIP in the coming financial year.

Human Resources

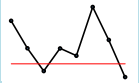
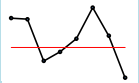
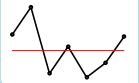
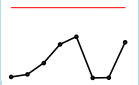
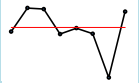
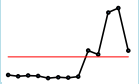
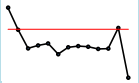
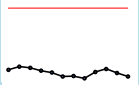
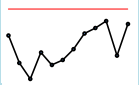
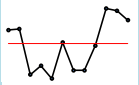
In February sickness was 5.6%, 0.92% higher than Q4 target of 4.68%. Qualified & HCA sickness remained at 6% in February, 0.7% above 2019/20 target, but is 0.1% lower than the 2018-19 position. All qualified Nursing & Midwifery sickness is 4.6% which remains below the Q4 target of 4.68%. The YTD figure is 4.6% which remains 0.2% below the 2018/19 outturn of 4.8%.
Mandatory Training compliance is 85.1% (target = 85%) and appraisal compliance is 80.9% (target = 85%)

The following key applies to the Integrated Performance Report:

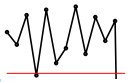
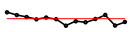
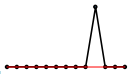
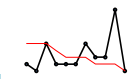
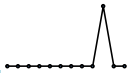
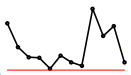
▲ = 2019-20 Contract Indicator
▲£ = 2019-20 Contract Indicator with financial penalty
● = 2019-20 CQUIN indicator
T = Trust internal target
UOR = Use of Resources

Feb-20

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

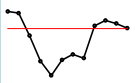
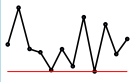
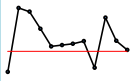
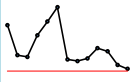
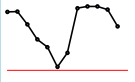
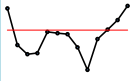
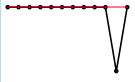
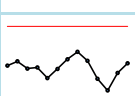
	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
CLINICAL EFFECTIVENESS (appendices pages 32-38)												
Mortality: Non Elective Crude Mortality Rate	Q	T	Feb-20	2.3%	2.4%	No Target	2.2%		A recent sudden and unexpected rise has been reported and key disease areas identified.	Patient Safety and Clinical Effectiveness	A detailed case note review of all deaths has begun, and close work with the CRAB system started to identify the themes and trends that have contributed. In addition to bringing together clinical leaders to go through the data, we have begun a Quality Improvement project in the most important area of Acute Kidney Injury. This is involving new pathways of care being implemented across surgery and then into medical wards. The Learning from Deaths group is closely involved to triangulate any findings and CRAB is being embedded with clinical leadership to allow us to track progress closer to real time and allow proactive rather than reactive management. The findings of the review will result in a detailed action plan to be brought back the governance structure.	RPJ
Mortality: SHMI (Information Centre)	Q	▲	Sep-19	1.08		1.00						
Mortality: HSMR (HED)	Q	▲	Oct-19	108.5	106.5	100.0	101.1					
Mortality: HSMR Weekend Admissions (emergency) (HED)	Q	T	Oct-19	116.7	103.7	100.0	106.9					
Readmissions: 30 day Relative Risk Score (HED)	Q UOR	T	Sep-19	100.7	98.9	100.0	98.3		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.	RPJ
Length of stay: Non Elective - Relative Risk Score (HED)	F&P	T	Oct-19	91.3	92.0	100.0	90.4		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 super stranded patients.	RC
Length of stay: Elective - Relative Risk Score (HED)	F&P	T	Oct-19	105.7	99.9	100.0	111.5					
% Medical Outliers	F&P	T	Feb-20	1.2%	1.0%	1.0%	0.5%		Patients not in right speciality inpatient area to receive timely, high quality care.	Clinical effectiveness, ↑ in Loss, patient experience and impact on elective programme	Robust arrangements to ensure appropriate clinical management of outlying patients are in place.	RC
Percentage Discharged from ICU within 4 hours	F&P	T	Feb-20	17.6%	39.1%	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. Improved performance in January.	RC
E-Discharge: % of E-discharge summaries sent within 24 hours (Inpatients) - TOTAL	Q	▲	Jan-20	71.0%	72.0%	90.0%	71.3%		For IP discharge summaries: An interim Discharge Notification has been developed and was reviewed at the CQPG meeting in January. This summary will be sent within 24 hours. Thereafter a full discharge summary will be sent within 14 days. For OP attendance letters the data which feeds the calculation has been updated with further data cleansing in progress. For ED discharge summaries the NHS Number issue was resolved on 10th October and is now above the target. ED have schedule a meeting at the end of Jan to discuss how we get back to 100% ensuring all discharge clinicians complete a summary.		IP Interim discharge summary is evolving to allow clinically rich and relevant data to be shared with GPs in a timely manner. Both hospital and GP clinical input is feeding into this project.	RPJ
E-Discharge: % of E-attendance letters sent within 14 days (Outpatients) - TOTAL	Q	▲	Jan-20	91.6%	86.6%	95.0%	85.0%					
E-Discharge: % of A&E E-attendance summaries sent within 24 hours (A&E) - TOTAL	Q	▲	Jan-20	96.7%	94.7%	95.0%	96.3%					

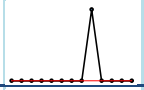
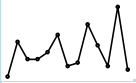
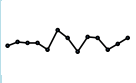
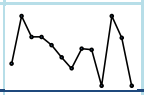
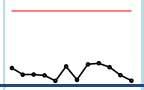
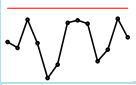
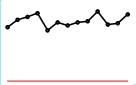
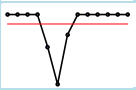
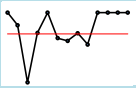
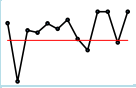
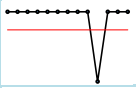
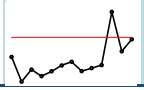
CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 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	▲	Jan-20	91.2%	89.2%	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 40-43)												
Number of never events	Q	▲£	Feb-20	0	0	0	1		No never events reported YTD	Quality and patient safety	Safer surgery actions and checks in place to minimise the likelihood of never events.	SR
% New Harm Free Care (National Safety Thermometer)	Q	T	Feb-20	98.6%	98.8%	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	Feb-20	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. This is supported by EPMA.	RPJ
Number of hospital acquired MRSA	Q F&P	▲£	Feb-20	0	1	0	1		There has been 1 MRSA positive blood sample in November 2019 (target = 0). The RCA indicated this was a contaminant and patient did not come to harm. YTD there have been 62 positive C Diff samples, of which 19 cases have been successfully appealed. 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 hospital onset and community onset C Diff	Q F&P	▲£	Feb-20	2	43	48						
Number of Hospital Acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections	Q F&P		Feb-20	1	25	No Target	31					
Number of avoidable hospital acquired pressure ulcers (Grade 3 and 4)	Q	▲	Jan-20	0	1	No Contract target	0		One category 3 avoidable pressure ulcer reported in November 2019	Quality and patient safety	The incident is currently undergoing an RCA process and will be evaluated for any missed opportunities or lapse in case. If the incident is classified as unavoidable by the panel, the KPI will be amended.	SR
Number of falls resulting in severe harm or death	Q	▲	Jan-20	3	10	No Contract target	18		3 falls resulting in severe harm - reported from ward 5B, 1A and Newton	Quality and patient safety	Falls reduction and improvement work in all areas being undertaken.	SR
VTE: % of adult patients admitted in the month assessed for risk of VTE on admission	Q	▲£	Jan-20	95.20%	95.53%	95.0%	95.94%		VTE performance monitored since implementation of Medway and ePMA. Performance remains above target.	Quality and patient safety	Every effort is being made to supplement routine reviews with additional activity to support performance pending electronic solution. The long term strategy will be to move assessment into e- prescribing allowing simultaneous assessment and therapeutic prescription.	RPJ
Number of cases of Hospital Associated Thrombosis (HAT)		T	Jan-20	3	21	No Target	26					
To achieve and maintain CQC registration	Q		Feb-20	Achieved	Achieved	Achieved	Achieved		Through the Quality Committee and governance councils the Trust continues to ensure it meets CQC standards. Trust rated as outstanding following the 2018 inspection.	Quality and patient safety		SR
Safe Staffing: Registered Nurse/Midwife Overall (combined day and night) Fill Rate	Q	T	Feb-20	95.3%	96.3%	No Target	96.5%		Shelford Patient Acuity undertaken bi-annually	Quality and patient safety	Safe Care Allocate has been implemented across all inpatient wards. All wards are receiving support to ensure consistency in scoring patients. Recruitment into posts remains a priority area. Unify report has identified some specific training relating to rostering and the use of the e-Roster System. This is going to be addressed through the implementation of a check and challenge process at ward level.	SR
Safe Staffing: Number of wards with <80% Registered Nurse/Midwife (combined day and night) Fill Rate	Q	T	Jan-20	1	4	No Target	0					

Feb-20

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

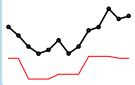
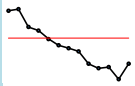
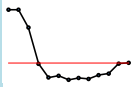
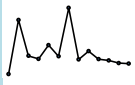
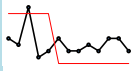
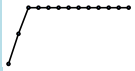
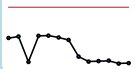
	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (appendices pages 44-52)												
Cancer: 2 week wait from referral to date first seen - all urgent cancer referrals (cancer suspected)	F&P	▲ £	Jan-20	93.1%	90.2%	93.0%	92.2%		2 week performance continues to achieve the standard although YTD is still slightly behind. 2 week access remains a pressure for services. 31 day Target achieved in month. 62 Day target met. Ongoing cancer service redesign happening in collaboration with commissioners including SFIT and RDC pilots commencing early 2020.	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 Radiologist recruited, to start early 2020. 4. Trust pilot site for SFIT lower GI which will improve cancer access and pathways. full roll out of pilot commenced early 2020 5. Trust commenced Rapid Diagnostic Service early 2020	RC
Cancer: 31 day wait for diagnosis to first treatment - all cancers	F&P	▲ £	Jan-20	98.0%	97.3%	96.0%	98.1%					
Cancer: 62 day wait for first treatment from urgent GP referral to treatment	F&P	▲ ●	Jan-20	85.2%	86.3%	85.0%	88.3%					
18 weeks: % incomplete pathways waiting < 18 weeks at the end of the period	F&P	▲	Feb-20	92.1%	92.1%	92.0%	92.4%		Impact of pension / tax rules on Consultant WLI activity resulting in increase in WL and wait times	Surgical Beds have now been converted to Medical bed capacity. Bed availability to manage the Surgical demand could result in backlog increasing. Additional risk also caused by impact of RMS and MCAS	18 weeks performance continues to be monitored daily and reported through the weekly PTL process. A backlog management plan is in place and alternatives to Whiston theatre and bed capacity are being sought to counter the significant non-elective demand. Actions to maintain and improve RTT performance reliant on theatre and bed capacity along with staff availability in collaboration with CCG's in ensuring RMS delivers in a sustainable and manageable way. ongoing pension / tax negotiations locally and nationally	RC
18 weeks: % of Diagnostic Waits who waited <6 weeks	F&P	▲	Jan-20	99.7%	99.6%	99.0%	99.9%					
18 weeks: Number of RTT waits over 52 weeks (incomplete pathways)	F&P	▲	Feb-20	0	0	0	0					
Cancelled operations: % of patients whose operation was cancelled	F&P	T	Feb-20	1.0%	0.7%	0.8%	0.8%		Reportable cancellations were higher in February due to consultant sickness and bed capacity issues. The trust continues to achieve the national performance target.	Patient experience and operational effectiveness Poor patient experience	Proactive system in place to monitor, manage and prevent cancelled operations within the care group. Lessons learned from the 28 day re-list patient in January have been feedback to the relevant departments for learning and reflection.	RC
Cancelled operations: % of patients treated within 28 days after cancellation	F&P	▲ £	Jan-20	100.0%	98.7%	100.0%	99.5%					
Cancelled operations: number of urgent operations cancelled for a second time	F&P	▲ £	Feb-20	0	0	0	0					
A&E: Total time in A&E: % < 4 hours (Whiston: Type 1)	F&P	▲	Feb-20	71.3%	69.5%	95.0%	74.3%		Accident and Emergency Type 1 performance for February 2020 was 71.3% and YTD 69.5%. The all type mapped STHK Trust footprint performance for February was 85.3% and YTD 83.8%. The Trust received 9,192 Type 1 attendances in February 2020. Year to date growth in ED attendances is 5.3% up on 2018/19. The work streams, designed to increase performance against the 4 hour standard, continue to focus on driving forward the required improvement. Plans are in place to increase the bed capacity within the Trust which will support the required reduction in bed occupancy leading to decongestion of the A&E department. Ambulance notification to handover time was not achieved in February 2020 with 15.57 mins on average (target 15 mins). There were 2,550 ambulance conveyances in February . NB: STHK had the highest number of ambulance conveyances across Cheshire and Merseyside and Greater Manchester in February .	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. Continue with daily AMU/ED huddles which is proving beneficial. COPD pilot in place from December continues with benefits realised of avoiding admission.	RC
A&E: Total time in A&E: % < 4 hours (Mapped STHK Footprint – All Types)	F&P	▲	Feb-20	85.3%	83.8%	95.0%	87.1%					
A&E: 12 hour trolley waits	F&P	▲	Feb-20	0	0	0	0					

	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
PATIENT EXPERIENCE (continued)												
MSA: Number of unjustified breaches	F&P	▲ £	Feb-20	0	2	0	0		MSA breach occurred on ICU due to delay in stepping level 1 patients down for 24 hours (involved 2 patients only) as Trust was at full capacity and patients in ED waiting beds. All actions taken to try prevent this.	Patient Experience	All patients waiting step down are highlighted at bed meeting x 3 daily and an escalation plan is in place to prevent this reoccurring where possible.	RC
Complaints: Number of New (Stage 1) complaints received	Q	T	Feb-20	21	294	No Target	266		% new (Stage 1) complaints resolved within agreed timescales continues to remain above the 90% target, year to date, although there was a dip in February. Number of new complaints received decreased in February.	Patient experience	The Complaints Team continue to focus on increasing response times with active monitoring of any delays and provision of support as necessary. Training in complaints investigations and statement writing was delivered in January at Whiston Hospital and February at St Helens Hospital to support staff across the Trust and to continue to raise the importance of responding in a timely manner. Additional meetings have been put in place with departments where support is required, including ED.	SR
Complaints: New (Stage 1) Complaints Resolved in month	Q	T	Feb-20	30	285	No Target	241					
Complaints: % New (Stage 1) Complaints Resolved in month within agreed timescales	Q	T	Feb-20	86.7%	92.6%	No Target	92.1%					
DTOC: Average number of DTOCs per day (acute and non-acute)	Q	T	Jan-20	18	20	No Target	19		In January 2020, the average number of DTOCS (patients delayed over 72 hours) was 18.		Tracking meetings happen with LA/CCG and wards twice weekly to ensure the numbers of DTOCs are maintained below 20.	RC
Average number of Stranded patients per day (7+ days LoS)	Q	T	Feb-20	336	337							
Average number of Super Stranded patients per day (21+ days LoS)	Q	T	Feb-20	125	129							
Friends and Family Test: % recommended - A&E	Q	▲	Feb-20	86.7%	86.5%	90.0%	86.0%		The YTD recommendation rates remain above target for inpatients, antenatal, postnatal and community postnatal, but slightly below target for ED, Outpatients and delivery in line with previous month.	Patient experience & reputation	The profile of FFT continues to be raised by members of the Patient Experience Team, by attendance at ward meetings, the Patient Experience and Dignity Champions and monthly Team Brief. The display of FFT feedback via the 'You said, we did' posters continues to be actively monitored and regular reminder emails are issued to wards that do not submit the posters by the deadline. 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 are available for 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. Additional awareness raising of the need to increase the number of posters display is on the agenda for March's Ward Manager and Matron meeting.	SR
Friends and Family Test: % recommended - Acute Inpatients	Q	▲	Feb-20	96.1%	95.6%	90.0%	94.7%					
Friends and Family Test: % recommended - Maternity (Antenatal)	Q		Feb-20	100.0%	98.8%	98.1%	98.7%					
Friends and Family Test: % recommended - Maternity (Birth)	Q	▲	Feb-20	100.0%	97.7%	98.1%	98.1%					
Friends and Family Test: % recommended - Maternity (Postnatal Ward)	Q		Feb-20	100.0%	96.9%	95.1%	94.8%					
Friends and Family Test: % recommended - Maternity (Postnatal Community)	Q		Feb-20	100.0%	99.6%	98.6%	98.0%					
Friends and Family Test: % recommended - Outpatients	Q	▲	Feb-20	95.0%	94.6%	95.0%	94.2%					

Feb-20

St Helens and Knowsley Teaching Hospitals NHS Trust

CORPORATE OBJECTIVES & OPERATIONAL STANDARDS - EXECUTIVE DASHBOARD

	Committee		Latest Month	Latest month	2019-20 YTD	2019-20 Target	2018-19	Trend	Issue/Comment	Risk	Management Action	Exec Lead
WORKFORCE (appendices pages 54-61)												
Sickness: All Staff Sickness Rate	Q F&P UOR	▲	Feb-20	5.6%	5.2%	Q1 - 4.25% Q2 - 4.35% Q3 - 4.72% Q4 - 4.68%	5.0%		In February sickness was 5.6%, 0.92% higher than Q4 target of 4.68%. Qualified & HCA sickness remained at 6% in February, 0.7% above 2019/20 target, but is 0.1% lower than the 2018-19 position.	Quality and Patient experience due to reduced levels staff, with impact on cost improvement programme.	The HWWB Strategy and Action Plan is being presented at Workforce Council in March 2020 that includes a programme of wellbeing events that are being rolled out across the Trust, including Mental Health First Aid Training and Mindfulness Sessions. A more compassionate approach to leadership is being promoted as part of the Trust's Improving People Practices Action Plan. The Attendance Management Policy & Procedure is being reviewed alongside key policies such as Disciplinary and Grievance with wrap around communication and training plans.	AMS
Sickness: All Nursing and Midwifery (Qualified and HCAs) Sickness Ward Areas	Q F&P UOR	T	Feb-20	6.0%	5.9%	5.3%	6.1%					
Staffing: % Staff received appraisals	Q F&P	T	Feb-20	80.9%	80.9%	85.0%	89.6%		Appraisal compliance in February is below target by 4.1%. An improvement on last month. Mandatory training compliance has improved by 0.2% since last month an is above the target by 0.1%.	Quality and patient experience, Operational efficiency, Staff morale and engagement.	Appraisal compliance has seen an improvement in performance in month but is below the target. This may be impacted by the transfer to and implementation of the new Workpal system. To mitigate this, use of the legacy appraisal system is being extended to ensure recovery of compliance. L&OD continue to support managers using MyWorkPAL for the first time. Managers report they are struggling to identify sufficient capacity to complete appraisal due to activity levels. HRPS and L&OD are monitoring performance across all mandatory subjects and supporting managers and Subject Matter Experts to make improvements where necessary.	AMS
Staffing: % Staff received mandatory training	Q F&P	T	Feb-20	85.1%	85.1%	85.0%	95.3%					
Staff Friends & Family Test: % recommended Care	Q	▲	Q2	94.1%		No Contract Target			For both questions the Trust returned the best scores nationally.	Staff engagement, recruitment and retention.	The Q3 survey covering all areas of the Trust closed on the 30th November. Results were published 18th February 2020.	AMS
Staff Friends & Family Test: % recommended Work	Q	▲	Q2	82.8%		No Contract Target						
Staffing: Turnover rate	Q F&P UOR	T	Feb-20	0.6%		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 62-67)												
UORR - Overall Rating	F&P UOR	T	Feb-20	3.0	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	Feb-20	14,112	14,112	16,100	14,978					
Reported surplus/(deficit) to plan (000's)	F&P UOR	T	Feb-20	924	924	3,900	(597)					
Cash balances - Number of days to cover operating expenses	F&P	T	Feb-20	4	4	2	5					
Capital spend £ YTD (000's)	F&P	T	Feb-20	6,420	6,420	7,872	9,642					
Financial forecast outturn & performance against plan	F&P	T	Feb-20	3,900	3,900	3,900	(597)					
Better payment compliance non NHS YTD % (invoice numbers)	F&P	T	Feb-20	87.8%	87.8%	95.0%	91.2%					

APPENDIX A

St Helens and Knowsley Teaching Hospitals NHS Trust

			Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	2019-20 YTD	2019-20 Target	FOT	2018-19	Trend	Exec Lead
Cancer 62 day wait from urgent GP referral to first treatment by tumour site																					
Breast	% Within 62 days	▲£	96.0%	83.3%	100.0%	100.0%	84.6%	73.7%	100.0%	89.7%	100.0%	89.5%	100.0%	100.0%	100.0%	92.1%	85.0%		96.5%		
	Total > 62 days		0.5	2.5	0.0	0.0	1.0	5.0	0.0	2.0	0.0	2.0	0.0	0.0	0.0	10.0			5.0		
	Total > 104 days		0.5	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					
Lower GI	% Within 62 days	▲£	87.5%	72.7%	80.0%	94.4%	100.0%	88.9%	60.0%	60.0%	85.7%	100.0%	78.9%	100.0%	50.0%	82.0%	85.0%		86.6%		
	Total > 62 days		1.0	1.5	1.0	0.5	0.0	0.5	3.0	2.0	1.0	0.0	2.0	0.0	2.0	11.0			10.5		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0					
Upper GI	% Within 62 days	▲£	84.6%	88.9%	75.0%	88.9%	85.7%	83.3%	90.9%	100.0%	85.7%	100.0%	87.5%	88.9%	100.0%	90.8%	85.0%		74.7%		
	Total > 62 days		1.0	0.5	1.5	0.5	1.0	1.0	0.5	0.0	1.0	0.0	1.0	0.5	0.0	5.5			12.0		
	Total > 104 days		0.0	0.0	0.5	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.5	0.0	1.0					
Urological	% Within 62 days	▲£	85.2%	87.8%	90.9%	87.1%	91.3%	96.9%	87.5%	83.3%	92.3%	84.6%	92.0%	86.4%	86.4%	88.5%	85.0%		86.0%		
	Total > 62 days		2.0	2.5	1.5	2.0	1.0	0.5	2.5	3.0	1.0	2.0	1.0	1.5	1.5	16.0			29.0		
	Total > 104 days		0.0	0.0	0.5	0.5	1.0	0.0	0.5	0.5	0.0	0.0	0.5	0.5	1.0	4.5					
Head & Neck	% Within 62 days	▲£	25.0%	0.0%	100.0%	0.0%	25.0%	0.0%	16.7%	50.0%	28.6%	28.6%	20.0%	66.7%		30.6%	85.0%		57.1%		
	Total > 62 days		1.5	0.5	0.0	1.5	3.0	0.5	2.5	1.5	2.5	2.5	2.0	1.0		17.0			12.0		
	Total > 104 days		0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	1.5	1.0		0.0		3.0					
Sarcoma	% Within 62 days	▲£			50.0%			100.0%		100.0%	50.0%	100.0%	0.0%	100.0%		66.7%	85.0%		85.2%		
	Total > 62 days				0.5			0.0		0.0	1.0	0.0	1.0	0.0		2.0			2.0		
	Total > 104 days				0.0			0.0		0.0	0.0	0.0	0.0	0.0		0.0					
Gynaecological	% Within 62 days	▲£	57.1%	88.9%	77.8%	66.7%	100.0%	40.0%	83.3%	40.0%	50.0%	0.0%	75.0%	54.5%	80.0%	66.3%	85.0%		77.8%		
	Total > 62 days		1.5	0.5	1.0	2.0	0.0	3.0	1.0	3.0	1.0	0.5	1.0	2.5	1.0	15.0			10.0		
	Total > 104 days		0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.5	0.0	0.0	0.0	1.5					
Lung	% Within 62 days	▲£	92.9%	81.8%	92.9%	71.4%	100.0%	88.2%	100.0%	100.0%	57.1%	90.0%	100.0%	58.3%	100.0%	86.4%	85.0%		90.4%		
	Total > 62 days		0.5	1.0	0.5	1.0	0.0	1.0	0.0	0.0	3.0	1.0	0.0	2.5	0.0	8.5			8.0		
	Total > 104 days		0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	2.0					RC
Haematological	% Within 62 days	▲£	50.0%	0.0%	83.3%	100.0%	80.0%	100.0%	50.0%	85.7%	100.0%	78.9%	100.0%	86.7%	80.0%	84.9%	85.0%		76.7%		
	Total > 62 days		2.0	2.0	1.0	0.0	1.0	0.0	1.0	1.0	0.0	2.0	0.0	1.0	1.0	7.0			9.5		
	Total > 104 days		1.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0					
Skin	% Within 62 days	▲£	93.7%	88.1%	94.9%	95.0%	97.1%	94.4%	92.8%	95.0%	98.2%	80.2%	94.4%	95.8%	78.4%	91.4%	85.0%		93.4%		
	Total > 62 days		2.0	2.5	1.0	1.0	0.5	1.5	2.5	1.5	0.5	8.0	1.5	1.0	5.5	23.5			20.5		
	Total > 104 days		0.0	0.0	0.0	0.0	0.0	1.5	1.0	0.5	0.0	1.5	0.5	0.5	1.5	7.0					
Unknown	% Within 62 days	▲£	100.0%	66.7%	100.0%	100.0%	50.0%	100.0%		100.0%				100.0%	0.0%	69.2%	85.0%		93.9%		
	Total > 62 days		0.0	0.5	0.0	0.0	1.5	0.0		0.0			0.0	0.0	0.5	2.0			1.0		
	Total > 104 days		0.0	0.5	0.0	0.0	0.5	0.0		0.0						0.5					
All Tumour Sites	% Within 62 days	▲£	86.7%	82.6%	90.0%	89.6%	87.6%	85.6%	85.7%	85.9%	86.2%	83.1%	88.9%	86.2%	85.2%	86.3%	85.0%		88.3%		
	Total > 62 days		12.0	14.0	8.0	8.5	9.0	13.0	13.0	14.0	11.0	18.0	9.5	10.0	11.5	117.5			119.5		
	Total > 104 days		2.0	2.0	1.0	1.5	2.0	1.5	3.0	1.0	2.5	5.0	1.0	1.5	2.5	21.5					
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%	66.7%							80.0%	85.0%		90.0%		
	Total > 31 days		0.0	0.0				0.0	0.5							0.5			1.0		
	Total > 104 days		0.0	0.0				0.0	0.0							0.0					
Acute Leukaemia	% Within 31 days	▲£								100.0%		100.0%				100.0%	85.0%		66.7%		
	Total > 31 days									0.0		0.0				0.0			1.0		
	Total > 104 days									0.0		0.0				0.0					
Children's	% Within 31 days	▲£															85.0%				
	Total > 31 days																				
	Total > 104 days																				

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(20)020
Title of paper: Executive Committee Chair's Report
Purpose: To provide assurance to the Trust Board on those matters delegated to the Executive Committee.
Summary: The paper provides a summary of the issues considered by the Executive Committee at the meetings held during February 2020. There were a total of 4 Executive Committee meetings held during this period. The Executive Committee approved: • The selection of cold decontamination equipment suppliers for the St Helens Hospital unit; • Proposals to put in place Authorised Person (Decontamination) arrangements as recommended by JAG; • Approval to train 3 cohorts of Nurse Associates; • The establishment of a Better Rostering Steering Group. The Committee also considered regular assurance reports covering; the Risk Management Council and Corporate Risk Register, mandatory training and appraisals, Coronavirus and safer staffing. There were also progress reports for a number of other key organisational objectives.
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: 25th March 2020

CHAIR'S REPORT FROM THE EXECUTIVE COMMITTEE

1. Introduction

There were 4 Executive Committee meetings in February 2020.

At every meeting the committee reviews any bank or agency staff requests that would breach the NHSI cost thresholds.

2. 6th February 2020

2.1 Quality Account – Quality Improvement Priorities 2020/21

Committee reviewed progress with the 2019/20 Quality Account improvement objectives and feedback from the Patient Experience Council to agree the proposed improvement objectives for 2020/21, to be consulted upon.

2.2 St Helens Hospital - Cold Decontamination Equipment Approval

The Director of Corporate Services introduced the paper which detailed the procurement process to select a number of preferred providers in different categories, which best met the Trust technical specification and requirements. Committee gave approval for the contracts to be awarded for the equipment at St Helens Hospital.

2.3 Authorised Person (Decontamination)

The Director of Operations and Performance introduced a paper which detailed the proposed arrangements for the Trust to put in place an Authorised Person (Decontamination) to meet the requirements of the recent Joint Advisory Group on Gastro Intestinal Endoscopy (JAG) audit. Vinci Facilities had been identified as the preferred option to provide the service. The proposal was approved.

2.4 Trainee Nurse Associates (TNA) Business Case

The Deputy CEO/Director of Human Resources presented the business case which proposed training 4 cohorts of Nurse Associates between 2020 and 2023. Committee noted that some central funding was available to support the training and backfill costs of TNA's, but there was still a considerable cost to the organisation. For future workforce resilience and to develop new roles it was agreed that the Trust should introduce the Nurse Associate role, with the exact size of each cohort to be agreed with finance (subsequently confirmed as 12 per annum).

2.5 IT Five Year Forward View

The Director of Informatics presented the revised capital and revenue plans to support the Trust IT strategy, for information. Each request for capital funding would be subject to separate business case approval.

2.6 HIS Cost Model

The Director of Informatics presented the cost modelling for the 2020/21 budget for each of the HIS partner organisations. Direct costs of the HIS services were apportioned

based on the organisations usage and all organisations also made a contribution to the Trusts overhead and indirect costs for hosting the HIS.

2.7 Staffing Proposals for the Modular Ward

The Director of Operations and Performance presented the updated staffing model, including reablement and pharmacy staff. Further modelling was required to confirm the nursing needs of the "good to go" patients who would be transferred to this ward.

3. 13th February 2020

3.1 Risk Management Council (RMC) Assurance Report and Corporate Risk Register (CRR)

The Director of Corporate Services presented the Chair's report from the RMC held in February. The report also included feedback from the Information Governance and Claims Governance Steering Groups.

3.2 Establishing a Better Rostering Steering Group

The Director of Nursing, Midwifery and Governance proposed the establishment of a new group to oversee the consistent and effective application of e-Rostering. The Group would report via the Workforce Council. The Executive approved the proposal.

3.3 Safer Staffing Report – January 2020

The Director of Nursing, Midwifery and Governance presented the safer staffing figures for January and the detailed analysis of staffing from December. The overall RN fill rate for January was 97%.

3.4 Impact of EPMA on antibiotic prescribing

Committee discussed the reduction in antibiotic reviews since the introduction of EPMA. Investigation had revealed this was principally an issue for surgical patients due to the management of surgical ward rounds. New developments planned for EPMA would ensure a review was prompted when due. Immediate actions were agreed to increase reviews, whilst the upgrade was being planned. The review rate would be monitored.

3.5 "Swiss" Nurse effectiveness

The Director of Operations and Performance had investigated a query in relation to re-attenders to ED for patients with respiratory conditions who had been seen by the "Swiss" Nurse. The re-attendance rate was 8.3% for those patients who had been admitted and 5.3% for patients who were not admitted. This compared favourably to the overall re-attendance rate for ED patients, which was circa 15%. This investigation demonstrated the benefits of the "Swiss" Nurse.

3.6 Integrated Performance Report (IPR) – January 2020

The Director of Finance and Information presented the IPR for review. Committee discussed the on-going investigation into the HSMR spike in July 2019.

3.7 Coronavirus Update

The Director of Nursing, Midwifery and Governance provided an update on the latest guidance to be issued by Public Health England (PHE) and NHSE/I on testing suspected cases.

4. 20th February 2020

4.1 Mandatory Training and Appraisal

The Deputy CEO/Director of HR presented the latest compliance figures for the staff reporting to each Director. The appraisal compliance figures were a concern and alongside Myworkpal electronic recording of appraisal information the previous paper forms were being re-introduced to support more managers to complete overdue appraisals.

4.2 Quarter 3 CQUIN Performance

The performance in achieving the £4m CQUIN targets and income was reviewed, with actions agreed where there was an identified risk that the full CQUIN would not be delivered by the end of the financial year.

4.3 Digital Aspirant Programme (DAP)

The Director of Informatics provided an update on the DAP application and approval process and the preparations the Trust was putting in place ahead of the expected announcement by NHSX.

4.4 Research Income

The Medical Director provided feedback on the latest recruitment to patient studies and opportunities to increase research participation and income.

5. 27th February 2020

5.1 Cheshire and Merseyside Pathology Network – Draft Network Agreement

The Director of Operations and Performance introduced the Cheshire and Merseyside Pathology Network Programme Director, who explained to the Executive the purpose of the Network Agreement. The agreement remained in draft but was to be agreed before the business case to introduce pathology hubs was presented. The agreement was designed to set out the principles for how NHS Trusts would work together. The Trust agreed to submit a formal response with comments on the draft agreement.

5.2 On Call Arrangements – Anaesthetics and Obstetrics

The Medical Director provided an update on the current position and national guidance. Committee agreed a number of immediate actions to provide additional assurance and further proposals to be developed for the Committee to review.

5.3 New Immigration Rules

The Deputy CEO/Director of HR presented a briefing on the governments proposed changes to the immigration rules from January 2021and an analysis of the potential

impact on the Trust. Arrangements to apply for settled status for EU staff before the end of December 2020 were also discussed.

5.4 System Assurance Meeting

The Director of Integration presented the Key Lines of Enquiry (KLOE) that had been submitted to NHSE/I in advance of the system assurance meeting on 3rd March. This was a single document setting out the system position.

5.5 Halton Urgent Treatment Centres (UTC)

The Chief Executive provided an update on the latest developments concerning the arrangements for the Halton UTC contracts.

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

Trust Board

Paper No: NHST(20)024

Title of paper: Trust Objectives 2020/21

Purpose: To approve the Trust Objectives for 2020 – 21

Summary:

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

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

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

Stakeholders: Staff, Regulators and Health System Partners.

Recommendation(s): Review the draft Trust Objectives for 2020 -21, in advance of presentation to the Trust Board for approval.

Presenting officer: Ann Marr, Chief Executive.

Date of meeting: 25th March 2020.

Trust Objectives 2020/21

Objective	Lead Director	Measurement	Governance Route	Target Completion Date
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 Continue to increase the range of services provided 7 days a week	MD	• Achieve the national targets for 90% of patients across all the 7 day services metrics by 2021, in particularly improve performance in 2019/20 against the targets for: ➢ 90% of patients to receive a senior clinical review each day ➢ 90% of patients to be assessed by a Consultant within 14 hours of admission	Quality Committee	
1.2 Ensure patients in hospital remain hydrated, to improve recovery times and reduce the risk of deterioration, kidney injury, delirium or falls (QA)	DoN	• Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place • Quarterly audits to ensure fluid balance charts are up-to-date and completed accurately • Reduced rates of AKI and electrolyte disorders with associated reduction in mortality from these disorders, measured by Copeland Risk Adjusted Barometer (CRAB) data	Quality Committee	
1.3 Continue to ensure the timely and effective assessment and care of patients in the emergency department (QA)	DoOp	• 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 confirmed via regular audits • Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring	Quality Committee	

Objective	Lead Director	Measurement	Governance Route	Target Completion Date
		• Compliance with safety checklists to ensure timely assessment and treatment of patients confirmed via regular audits		
1.4. Increase capacity at Whiston Hospital and improve clinical adjacencies at the Trust to optimise patient flow	DoOp/ DoCS	• Complete the scheme to create 60 additional beds on the Whiston Hospital site • Progress the capital schemes planned for 2020/21 that will expand the emergency department and Paediatric assessment area and progress the ambulatory and Same Day Emergency Care (SDEC) redesign. • Continue to review care pathways to reduce variation and duplication	Trust Board	
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 Continue to learn lessons and change practice by improved measuring of the outcomes for our patients	MD	• Use available date to identify where care for patients can be improved, allowing targeted projects to make long lasting changes to practice. • Reduce AKI by 20% • Reduce hospital acquired pneumonia by 10% • Use lessons learnt from incidents, complaints and claims to improve practice and reduce similar incidents in the future	Quality Committee	
2.2 Reduce avoidable harm by preventing pressure ulcers (QA)	DoN	• Quarterly audit to confirm compliance with Trust policy in the identification of patients at risk of developing pressure ulcers and in the provision of appropriate equipment to support prevention • 10% reduction in avoidable category 2 pressure ulcers from 2019-20 baseline	Quality Committee	
2.3 Reduction in hospital acquired blood	DoN	• Achieve or improve upon the Trust incidence levels set by		

Objective	Lead Director	Measurement	Governance Route	Target Completion Date
stream infections (C-Diff and E-Coli)		NHSE/I • Fully implement the C-Diff action plan • Share lessons from RCA's • Audit compliance with Trust guidance for the timeliness of testing	Quality Committee	
3. 5 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 Improve the effectiveness of the discharge process for patients and carers (QA)	DoOp	• Ensure sufficient and appropriate information is provided to all patients on discharge • Improve Inpatient Survey satisfaction rates for receiving discharge information • Improve audit results (minimum 75%) for the number of patients who have received the discharge from hospital booklet • Achievement of 30% target for patients discharged before noon during the week and 85% of the weekday average discharges to be achieved before noon at the weekends consistently across all wards.at weekends • Implementation of standardised patient equipment ordering process for aides required at home	Quality Committee	
3.2 Integrate and transform the community health services that will be directly provided by the Trust from April 2020 and continue to improve end to end pathways of care	DoOp	• Assimilate the new the Community Nursing and Paediatric services that are transferring to the Trust and make staff feel welcome • Optimise the delivery of integrated care pathways across primary, community and secondary care working with primary care networks to provide care closer to home and avoid unnecessary hospital admissions	Quality Committee	

Objective	Lead Director	Measurement	Governance Route	Target Completion Date
		• Improve patient experience scores and feedback related to discharge		
3.3 Transformation of Urgent Treatment Centre (UTC) to maximise capacity, throughput and patient experience	DoOp	• Attendance rate at UTC and associated 4 hour performance • Reduced rate of A&E attendances and hospital admissions • Reduced deflection rate from UTC to A&E • Implementation of condition specific pathways • Improve patient satisfaction and experience ratings	Finance and Performance Committee	
3.4 Review Trust Acute medical care pathways to ensure optimal configuration	DoOp	Agree the optimal configuration of services to; • Reduced number of patient ward moves • Reduced number of FCEs • Implement direct to specialty pathways • Improve patient satisfaction and experience ratings	Executive Committee	
3.5 Increase the opportunities for patients to enter research studies and increase the number of clinical trials that the Trust participates in.	MD	• Increase recruitment to research studies by 20% • Open more trials across both commercial and portfolio studies	Quality Committee	
3.6 Continue to redesign outpatients pathways through transformation and modernisation	DoI/DoOp	• Continued roll-out of Telehealth across identified specialties • Optimisation of current systems to continue the reduction in DNAs • Reduction in complaints from patients due to late or over-running clinics • Reduced travelling time and costs for clinicians using the technology to provide outreach services	Executive Committee	

Objective	Lead Director	Measurement	Governance Route	Target Completion Date
		• Extra clinical capacity that can now be invested back into patient care in the acute setting or scheduling more clinics • Reduced car parking congestion		
4. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**				
4.1 Increase the proportion of patients who report that they have received an appropriate amount of information about their care (QA)	DoN	• Improved scores for responses to patient questionnaires for questions relating to receiving the right level of information	Quality Committee	
4.2 Implementation of an automated switchboard system that improves the experience for the public/patient by introducing automatic call routing to the desired ward/department whilst reducing call wait times.	DoI	• Achieve a target of 95% phone calls answered and routed through to the appropriate department • Reduce average call answering time to 20 seconds	Executive Committee	
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 Digitise more of the paper based medical record e.g. observation charts, nursing assessments and care plans, AHP assessments and care plans and inpatient clinical narrative	DoI	• Reduce the amount of paper produced as part of the paper based medical record by 25% . • Reduce time spent by clinicians using paper-based processes by providing them access to a full and salient electronic documentation trail of a patient's care from wherever they need access • Reduce length of stay through identification of deterioration early leading to earlier intervention • Enabling speciality reviews of patient pathways resulting in the reduction in variation in patient care		

Objective	Lead Director	Measurement	Governance Route	Target Completion Date
5.2 Reduce PC login times making it faster for staff to log on to systems to access the right patient information quickly and easily	DoI	• Reduce the time to log on to a PC by at least 50% • Benchmark login times over a period of time in Q2 of 2020/2021 (Windows 10) compared to a period of time in Q4 of 2019/2020 (Windows 7).	Executive Committee	
5.3 Implementation an integrated bed management and discharge planning system to allow Clinicians to see patient status "at a glance" and improve the accuracy of information on patient flow, to support admission and discharge decisions by the Site Management teams	DoI/DoOp	• Reduced the time taken to admit patients to wards from A&E • Increase the % of patients discharged before midday. • Support the reduction in bed occupancy to 92% • Reduce the number of medical patients who have to outlie in surgical beds • Help support reduction in length of stay • Improve access to patient information for Clinicians, to enable more effective prioritisation		
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 where our people feel valued and supported to care for our patients.**				

Objective	Lead Director	Measurement	Governance Route	Target Completion Date
6.1 By making the Trust the best place to work we will continue to implement innovative approaches to recruitment, retention and staff development to provide high quality care	DoHR	• Ensure that 80 additional permanent new nurses, 50 further nurses 20 medical and dental posts are recruited via international recruitment programmes • Create more opportunities for staff to retire and return, transfer between wards for job enrichment, or adopt flexible approaches to working • Reduce staff turnover rates and improve labour stability rates • Comply with NICE guidance and the NHS People Plan in the extended range of support services available to improve the health, well-being and resilience of our staff • Increase the % of the apprenticeship levy that is allocated • Recruitment of 24 trainee nursing associates and develop new posts and appropriate specialist training routes for 4 Advanced Care Practitioners and 10 Physician Associates • Enhance the provision of development opportunities to support talent management and retention	Trust Board	
6.2 Continue to respond to feedback from staff to improve appraisals to support staff to deliver high quality patient care.	DoHR	• Engage with staff about what a quality appraisal looks like • Improve the staff survey results for the quality of appraisals for all staff • Provide targeted training for managers on appraisal skills	Quality Committee	
6.3. Improve the compliance delivery and ease of access of mandatory training for all staff	DoHR	• Undertake a review of how mandatory training is currently delivered • Engage staff and managers in new ways of delivery • Explore innovative and engaging delivery methods by learning	Trust Board	

Objective	Lead Director	Measurement	Governance Route	Target Completion Date
		from the best in class		
6.4 Continue to listening to our staff to ensure we remain an employer of choice	DoHR	• NHS Staff Survey Action Plan monitoring • WRES & WDES Action Plan monitoring	Executive Committee	
6.5 Release time to care by continuing with the implementation of the e-rostering, activity manager and e-job planning systems to ensure the optimum design of the workforce and the right number and skill mix of staff	DoHR	• Implement e-rostering to 100% of all staff remaining staff to include non-clinical and corporates services staff • 100% of specialist nurses have e-job plans with refreshed job descriptions that reflect to needs of the service • Completion of the implementation and embedding of the Activity Manager for theatres all surgical specialities by 2021 • Deliver the benefits realisation plan for "Better eRostering" all for Medical Staff, Nursing & AHP's by 31st March 2021 • Produce reports from the Roster perform, Activity Manager and Safe Care systems to demonstrate safe levels of staffing based on the acuity of patients	Executive Committee	
7 OPERATIONAL PERFORMANCE **We will meet and sustain national and local performance standards**				
7.1 Achieve national performance and access standards	DoOp	• Improvement trajectory for emergency access standards including any new measures • 62 day cancer treatment standard • 18 week access to treatment for planned care • Diagnostic tests completed within 6 weeks • Ambulance handover times	Finance and Performance Committee	
7.2 Maximise the productivity and effectiveness of clinical services through the use of benchmarking and	DoOp	• Continued participation in national programme of GiRFT reviews and delivery of the resulting action plans	Finance and Performance Committee	

Objective	Lead Director	Measurement	Governance Route	Target Completion Date
comparative data e.g. GiRFT and Model Hospital to ensure that all services meet best practice standards		• Previous reviews undertaken to be monitored at committee level to provide assurance regarding delivery		
8 FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY **We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money**				
8.1 Use the Model Hospital benchmarking and reference costs information to optimise the efficiency of services and deliver the cost improvement targets	DoF	• Annual Reference costs maintained at less than 100 • NHSE/I Annual Benchmarking review and action plans if the Trust is an outlier on any metrics • Procurement league ranking to be consistently best quartile in country.	Finance and Performance Committee	
8.2 Work with health care organisations across Cheshire and Merseyside to explore opportunities for collaborative corporate services	DoF	• Membership of the Collaboration at Scale Board and leadership of the Finance, HR Services, Legal, Risk and Governance work streams.	Finance and Performance Committee	
8.3 Delivery of the agreed Trust financial plans: outturn, CIPs, cash balances and capital resources recognising the assumptions within the plan and system influence to its delivery.	DoF	• Achieve the planned I&E deficit of 0.3m • Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income • Deliver the approved capital programme.	Finance and Performance Committee Audit Committee	
9 STRATEGIC PLANS **We will work closely with NHS Improvement, and commissioning, local authority and provider partners to develop proposals to improve the clinical and financial sustainability of services**				
9.1 Continue to meet all regulatory and accountability requirements whilst working collaboratively to achieve system success	DoCS	• Meet statutory responsibilities • Within these work in partnership across the Cheshire and Merseyside HCP to achieve the goals of the NHS LTP for collaboration and integration	Trust Board	
9.2 Working with health and care system partners to develop plans to implement	DoT/DoInt	• Launch the St Helens Place Based Plan 2020-24	Trust Board	

Objective	Lead Director	Measurement	Governance Route	Target Completion Date
the ambitions of the NHS Long Term Plan for the local population		• Development a 'Place' Dashboard to measure the delivery of the plan and demonstrate the impact of integrated care • Support the Primary Care Networks to deliver the Primary Care Network (PCN) Service Specifications		
9.3 Provide leadership and direction as part of the C&M HCP to achieve clinically and financially sustainable acute services.	DoInt	• Develop areas for collaboration that bring benefits for patients and partner organisations • Leadership of the Acute Sustainability Programme	Trust Board	

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(20)025

Title of paper: To advise the Board of the planned financial budgets for 2020/21

Purpose: To allow the Trust Board to review what the financial plans for 2020/21 would have been. (These plans were developed before the national instructions of financial plans were given relating to management of COVID-19).

Summary:

The attached paper provides details of the financial plans for 2020/21 (before impact of COVID).

These budgets will be subject to change as a result of numerous issues including:

- Response to COVID-19, including mandatory suspension of PbR and exceptional costs
- The final release of new tariffs.
- External approval of the Trusts capital programme.

The Trust was issued with a Financial Improvement Trajectory (FIT) of a £0.3m deficit. For the trust to achieve this position assumptions in planning included:

- The income & expenditure plan included within this paper
- Delivery of activity and growth modelled
- A Cost Improvement Programme (CIP) of c£15m
- Achieve all CQUIN standards

To date there is no guidance on how the FIT will be managed for 2020/21.

The Trust has set an indicative capital plan of £27m. This includes the planned increased adjustments for IFRS 16. We expect that this will be deferred another year due to COVID-19 pressures. In order to deliver this capital programme, the Trust will need to secure external financing of c£8m.

Once more clearer guidance is provided on financial expectations a revised and more up to date financial plan will be presented to the Board.

At this stage we have been informed to assume a break even position on income and expenditure up to July 2020 at the earliest. This is based on a block contract arrangement with all our commissioners to assist with cash flow and certainty of position.

Corporate objectives met or risks addressed: Financial Delivery

Financial implications: None

Stakeholders: Trust Board

Recommendation(s): To note the planned financial budgets and accept block contracts for up to July 2020 as per national instructions. We have been informed to plan for a break-even position for the duration of the block contract arrangements.

Presenting officer: Nik Khashu (Director of Finance)

Date of meeting: 25th March 2020

1. Income and Expenditure plans

1.1 For 2019/20 the Trust was forecasting a £3.9m deficit (including PSF funding) when the draft plans were submitted. For 2020/21 the final plans propose a delivery of a £0.3m deficit that will allow the Trust to access £0.3m financial recovery fund (FRF) upon delivery of the plan and subsequent FRF conditions. The table below summarises the proposed Income & Expenditure for the 2020/21 year.

			2020/21				
Turnover		**2019/20**	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Total operating income	+	428,493	108,560	112,364	116,471	117,097	454,492
Less capital donations/grants income impact	-	(31)	0	0	0	0	0
Remove impact of prior year PSF post accounts reallocation	-	(515)					
Total turnover	+	**427,947**	**108,560**	**112,364**	**116,471**	**117,097**	**454,492**
Performance including PSF, FRF and MRET funding							
Surplus/(deficit) before impairments and transfers	+/-	4,354	(5,773)	(1,581)	2,904	4,374	(76)
Adjusted financial performance surplus/(deficit) including PSF, FRF and MRET funding	+/-	**3,900**	**(5,754)**	**(1,562)**	**2,923**	**4,393**	**0**
Performance excluding PSF, FRF and MRET funding							
Adjusted financial performance surplus/(deficit) including PSF, FRF and MRET funding	+/-	3,900	(5,754)	(1,562)	2,923	4,393	0
Less PSF, FRF and MRET funding	-	(6,488)	(74)	(74)	(74)	(72)	(294)
Adjusted financial performance surplus/(deficit) excluding PSF, FRF and MRET funding	**+/-**	**(2,588)**	**(5,828)**	**(1,636)**	**2,849**	**4,321**	**(294)**

1.2 Trust planned turnover would have increased from £428m to £455m making StHK the second largest provider in Cheshire & Merseyside behind the newly merged Royal Liverpool University Teaching Hospital.

1.3 During 2019/20 the Trust utilised non-recurrent benefits to deliver the forecast outturn. As these benefits are not available in 2020/21 the Trust will need to set a higher CIP to deliver a more sustainable and recurrent underlying position.

1.4 The income and activity plan has been produced using the 2019/20 forecast outturn as a starting point adjusting for any non-recurrent income streams, as well as the full year effect of any in year service developments and growth assumptions. The Trust has also adjusted the conversion rate on A&E attendances for non-elective admissions to reflect the increase capacity from the modular build.

1.5 The Trust has worked closely with commissioning organisations on agreeing contracts for the forthcoming year, these contracts have yet to be signed. (Discussions have been paused as a result of the current COVID-19 outbreak).

1.6 National pay and prices have been set at 2.5% with a 1.1% efficiency deflator. The national uplifts do include pay awards for the forthcoming year but does not include any allocation for the increase in employer pension contributions. This will remain being paid centrally as in 2019/20.

1.7 The Trust has planned for full achievement of all CQUIN schemes in 2020/21. The Trust has not planned for any KPI failures included in the NHS contract that would incur penalties.

1.8 The table overleaf shows the change in activity level between forecast outturn and the plan for 2020/21.

Point of Delivery	2019/20 FOT at Month 7	2020/21 Plan Including Growth	% Growth 20/21 v 19/20*
Accident & Emergency	116,629	126,253	8%
Non Elective Spells	76,400	81,901	7%
Elective Spells	6,364	6,324	-1%
Day Cases	48,155	50,823	6%
Maternity Pathway	5,966	5,950	0%
Outpatient First Attendances	135,366	146,082	8%
Outpatient Follow Ups	309,940	319,757	3%
Outpatient Procedures	104,784	122,314	17%
Rehabilitation	18,179	20,265	11%
Audiology	3,913	3,789	-3%
Direct Access	1,021,767	1,037,871	2%
Unbundled Diagnostic Imaging	63,563	67,042	5%
Excess Bed Days	11,841	12,133	2%
Other Non PbR	109,081	109,886	1%
Total	**2,031,946**	**2,110,390**	

1.9 The change in Non-Elective spells includes the full implementation of the additional capacity (Bevan Lodge).

1.10 The increase in A&E attendances includes the transfer of the St Helens Urgent Treatment Centre (UTC).

2. Cost Improvement Plans (CIP)

8.1 The 2020/21 plans require the delivery of a £15m CIP, this represents c3% of the Trusts planned turnover for the year.

2.1 The Trust has made good progress in identifying schemes to deliver this target with 32% RAG rated as green.

Green	£	4,802
Amber	£	7,334
Red	£	6,897
Total	£	19,034

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

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

2.4 There is no CIP mitigation reserve included within the plan. As a result the Trust will be looking to identify schemes of c£21m in year to allow for a 70% conversion rate. As in previous years any schemes that are not delivered will remain as potential opportunities for future years.

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

2.6 The Trust is currently engaged in Health Economic summits within the St Helens cares and Mid Mersey partners. While this may not deliver savings during 2020/21 it is putting initiatives in place to deliver system wide opportunities in future years. This will enable the Trust to work collaboratively with its local partners to ensure sustainable Health services over the next 5 years.

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

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

3.1 The current capital plans assume PDC for the Ambulatory Care redevelopment and the Digital Aspirant Programme (DAP).

3.2 As a result of the significant PFI capital costs in year and other vital expenditure, the Trust will need to apply for c£8m of capital loans. The Trust has been in discussions with regulators regarding the situation but this is a risk.

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

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

4.1 Depreciation has been based on the current profile of the Truss assets.

4.2 The current plans assume that no revenue loans will be required to support operational costs.

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

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

4.5 The Trust has panned for the conversion of historical loans into PDC in line with planning guidance.

5. Financial Implications of COVID-19

5.1 The Trust received a letter on the 17th March from Simon Stevens outlining the NHS response following the rapidly increasing pandemic. The proposals include:

5.2 Assume postponement of all non-urgent elective operations from the 15th April for a period of at least 3 months. **This is not reflected in these Trust plans presented.**

5.3 Discharge all patients who are fit to leave with Community providers taking immediate and full responsibility for all discharges. **No increases in community provision have been included in these Trust plans presented.**

5.4 **All organisations to move to block contract payments** "on account" for an initial period of 01/04/2020 to 31/07/2020, with suspension of the usual PbR national tariff architecture and associated administrative/transactional processes. The block contract offer is being calculated centrally and will be released w/c 23rd March.

5.5 **Additional funding to cover extra costs of responding to the coronavirus emergency. Guidance will be released w/c 23rd March with how Trusts can be reimbursed for these costs.**

5.6 **Suspension of the operational planning process for 2020/21. This will mean the Trust will be operating without a signed contract for the first third of the financial year.**

6. Recommendation

6.1 The Trust Board are asked to note the draft plan as the initial financial statements for 2020/21 noting that there will be significant changes as a result of the NHS response to the current COVID-19 pandemic.

6.2 When further clearer instruction is provided, revised financial statements will be shared with the Board for consideration.

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(20)026

Title of paper: Care Quality Commission (CQC) compliance and registration

Purpose: This paper provides a summary of policies, process and practices across the Trust to demonstrate how on-going compliance is maintained with the fundamental standards required by the CQC (Appendix 1), to provide assurance to the Board.

Summary: The Trust is required to register with the CQC and has a legal duty to be compliant with the fundamental standards set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

The latest Trust inspection took place in July/August 2018 and covered the following areas:

- Use of resources;
- Surgery;
- Urgent and emergency care;
- Maternity;
- Community services;
- Marshalls Cross Primary Care Service;
- Well-led domain.

The final report was published on 20th March 2019 and the overall Trust rating was outstanding.

The report identified three breaches of the CQC regulations in relation to Marshalls Cross Medical Centre. Actions have been taken to address the three issues internally, which have been assessed by Mersey Internal Audit Agency and found to be compliant. Appendix 1 provides an updated summary of compliance against each of the relevant standards.

Corporate objectives met or risks addressed:

Care, safety and communication

Financial implications:

The CQC charges all providers an annual registration fee to cover its regulatory activities, 2019/20 fee = £238,394.

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

Recommendation(s):

For the Trust Board to:

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

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

Date of meeting: 25th March 2020

Appendix 1

St Helens and Knowsley Teaching Hospitals NHS Trust

Compliance with CQC Regulations and Fundamental Standards

Key	This paper was updated on 6th March 2020
	Full assurance in place in STHK
	Process in place, further work required until full assurance can be given
	No assurance in place
	Position not yet assessed and, therefore, not known
	Not applicable

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
No FS maps to this regulation	5 - Fit and proper persons: directors	People with director-level responsibility for meeting the standards are fit to carry out this role.	**Well-led**	Remuneration	DoHR		Process in place for confirming all current Directors including Non-Executive Directors meet the required standard, which is applied to all new appointments and renewed annually. All records available for review by CQC if required.
No FS maps to this regulation	6 - Requirement where the service provider is a body other than a partnership	Provider is represented by an appropriate person nominated by the organisation who is responsible for the management of regulated activity.	**Well-led**	Executive	DoNMG		Director of Nursing, Midwifery and Governance is the Accountable Person registered with the CQC. Director of Nursing registered with the CQC as responsible officer and confirmed in updated certificate dated 02/12/2019.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
No FSs map to this regulation	8 - General	Registered person must comply with regulations 9 to 19 in carrying on a regulated activity	**Well-led**	Quality	DoNMG		See information below for compliance
1	9 - Person-centred care	Providers must do everything reasonably practicable to put patients at the centre and to reflect personal preferences, taking account of people's capacity and ability to consent.	Safe, **Caring,** Responsive	Quality	DoNMG		All patients are assessed on admission and have comprehensive treatment/care plans in place. Trust has examples of adjustments made to meet individual needs, including electronic alerts, health passports, side-rooms, additional staffing where needed, promotion of John's Campaign to support carers who wish to stay with patients/carer beds, hearing loops & communication aids. In outpatients, double, early and late appointments are used along with desensitising visits to clinics. Specialities have developed their own pathway supporting people with additional needs and include imaging, endoscopy and pre-operative assessment. For complex patients, best interest decision-making and journey planning involving multi-disciplinary teams are routine. Mental Capacity Act included in mandatory training with compliance achieved year-to-date. Up-to-date Consent Policy in date and available on the Trust's intranet and consent training provided quarterly. Compliance with nursing care indicators is regularly audited and reported to each ward and the Patient Experience Council. The Trust received an overall rating of outstanding for the caring domain, with examples of compliance sited in the CQC inspection report, including the fact there were sufficient numbers of trained nursing and support staff with an appropriate skill mix to ensure that patients' needs were met appropriately and promptly. The CQC observed positive interactions when staff were seeking consent.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
2	10 - Dignity and respect	Have due regard to the Equality Act 2010 protected characteristic – staff demonstrating compassion and respect. Maintain privacy **at all times**, including when sleeping, toileting and conversing.	Safe, **Caring,** Responsive	Quality	DoNMG		The Trust's values include respectful and considerate and these are reiterated at interview, on induction and during appraisals. Values based recruitment is in place for all staff. Privacy and dignity is assessed as part of CQC inspection and external PLACE assessments. Trust rated best nationally in latest PLACE assessment for third year running. 2019 inpatient survey results state 90% patients' privacy maintained definitely and 9% to some extent. Privacy and dignity consistently scores highly in the Nursing Care Indicators. Any areas of concern highlighted through the complaints process are responded to and actions taken to address shortfalls. Provision of Single Sex Accommodation Policy in place, which requires any breaches to be reported via the Datix system. Annual mixed sex declaration submitted to the Board each March with two breaches reported in 2019-20 for step down patients in Critical Care and none for over two years prior to this.
3	11 - Need for consent	All people using the service or those acting lawfully on their behalf give consent. (Meeting this regulation may mean not meeting other regulations eg this might apply in regard to nutrition and person centred care. However, providers must not provide unsafe or inappropriate care just because someone has consented.)	**Safe,** Responsive	Quality	MD		Up-to-date Consent Policy in place and patients are consented using standard Trust forms for all procedures. Annual consent audit undertaken as part of the clinical audit programme which is reported to the Clinical Effectiveness Council. CQC observed positive interactions when staff were seeking consent. Consent training provided quarterly. Any incidents where consent issues are identified, including through claims and complaints, are investigated and actions taken to deliver improvements.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
4	12 - Safe care and treatment	Assessing risks against health and safety standards, mitigating risks, staff providing care have relevant qualifications, competence, skills and experience, ensure premises and equipment used are safe for intended purpose. Ensure sufficient quantities of medicines/equipment to remain safe. Proper oversight of safe management of medicines. Infection prevention and control (IPC).	**Safe**	Quality; Workforce Council; Executive	DoHR, DoNMG, DoCS,		H&S risk assessments in place and outlined in H&S Policy & supporting documents. Work place inspections reported to Health and Safety Committee which reports to Workforce Council and programme of environmental checks in place, with actions taken to address any issues identified. Relevant checks against job description/person specification undertaken as part of recruitment process for all staff. Annual appraisals confirm staff have maintained knowledge and expertise to undertake roles and responsibilities. Missed doses of medication are recorded in patient notes, on Datix and are audited. Pharmacy undertake audits of missed doses and medicines security, providing feedback to individual wards for improvement. Improvements noted in the latest medicines security audits reported to the Quality Committee. Programme of medical device maintenance in place. Compliance with infection prevention is audited monthly and root cause analysis undertaken on any serious incidents, including C.Diff/MRSA cases. No MRSA bacteraemia (one contaminant) reported year to date in 2019-20 and actions taken following rise in C.Diff cases across the Trust. In relation to Marshalls Cross Medical Centre actions were taken to strengthen the processes for the following, which have been reviewed by MIAA and confirmed as completed: • Follow up of uncollected prescriptions • Monitoring of NICE guidelines • Managing patients on high risk medicines • Undertaking risk assessments

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
5	13 - Safeguarding service users from abuse and improper treatment	Zero tolerance approach to abuse and unlawful discrimination and restraint, including neglect, degrading treatment, unnecessary restraint, deprivation of liberty. All staff to be aware of local safeguarding policy and procedure and actions needed if suspicion of abuse.	**Safe**	Quality, Workforce Council	DoNMG, DoHR		The Trust has a zero tolerance approach to abuse, discrimination and unlawful restraint. The Trust has a Raising Concerns Policy and also Disciplinary Policy and Procedure in place for any staff who fail to meet the Trust's values and ACE behavioural standards. Each clinical area has a Safeguarding file with key information to ensure all suspicions are reported appropriately. Safeguarding level 1 is the minimum mandatory requirement for all staff, with level 2&3 targeted at those who require it, ie those working with children and young people and those in decision-making roles respectively. Compliance with training reported to the Quality Committee noted the targets were met for all three levels for children and adults and that the Trust was meeting the CCG agreed trajectory for PREVENT training. Awareness of Deprivation of Liberty Safeguards (DoLS) is included in induction and mandatory training. The Trust provides training in conflict resolution. CQC inspection report highlighted that the relevant policies and procedures were in place, with robust training and support from the Safeguarding Team to ensure patients receive appropriate care.
6	14 - Meeting nutritional and hydration needs	People who use services have adequate nutrition and hydration to maintain life and good health.	**Effective**	Quality	DoNMG		Nutrition and hydration screening tools in place (MUST) and relevant patients have food charts. There is a red tray and red jug system in place for patients who require additional support with eating and drinking. All general wards operate protected mealtimes. Patients are regularly assessed to note any changes in nutrition and hydration status. Trust rolled out the Malnutrition Universal Screening Tool (MUST) for adults to ensure compliance with NICE guidance in 2015 which is now included in the electronic risk assessments. Improved compliance in the recording of MUST scores and implementation of relevant care plans has been noted. In addition, electronic fluid balance charts to support appropriate recording of hydration are now in place and an action plan to continue to improve hydration is in place. The volunteer service has increased the number of trained dining companions to further support patients during meal times.

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
7	15 - Premises and equipment	Premises and equipment are clean, secure, suitable, properly used/maintained, appropriately located and able to maintain standards of hygiene. Management of hazardous/clinical waste within current legislation. Security arrangements in place to ensure staff are safe.	**Safe**	Quality	DoCS		The Trust was rated best acute Trust for Patient Led Assessments of the Care Environment (PLACE) programme in 2017, 2018 and 2019. The Trust achieved 100% for; • cleanliness • condition, appearance and maintenance of the hospital buildings A comprehensive internal environmental audit is undertaken to maintain these exceptionally high standards. Workplace inspections and COSHH risk assessments in place. Waste Management Policy in place with regular awareness raising and training provided for staff. Security service provided 24 hours per day and Lone Worker Policy in place.
8	16 - Receiving and acting on complaints	All staff to know how to respond when receiving a complaint. Effective and accessible system for identifying, receiving, handling and responding to complaints, with full investigation and actions taken. Providers must monitor complaints over time looking for trends and areas of risk.	**Responsive**	Quality	DoNMG		Staff aware of how to manage complaints at a local level, including local resolution where possible, with involvement of PALS. Improvements to the management of complaints remain ongoing, with effective system in place via Datix for recording and monitoring each complaint. Themes and actions taken identified and reported to Patient Experience Council, the Quality Committee and the Board, to support Trust-wide lessons learned.

Appendix 1

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

Appendix 1

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
10	18 - Staffing	**Sufficient numbers** of suitably qualified, competent, skilled and experienced persons deployed to meet CQC requirements.	**Safe, Effective**	Workforce Council	DoHR		Comprehensive workforce strategy in place supported by Recruitment and Retention Strategy, including targeting workforce hotspots and proactive international recruitment for both medical and nursing staff. The Trust has an ongoing collaboration with Masaryk University, Brno, Czech Republic to recruit newly qualified doctors who trained using the English syllabus. There is an active recruitment programme for the nursing and midwifery workforce, on-going throughout the year. The Trust continues to explore all possible opportunities to attract and retain nurses, midwives, operating department practitioners (ODPs) and allied health professionals: • 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, 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 15 trainees due to complete their training in December 2020, and a further 24 to commence training in 2020 (March and September) • Implementing the Trust's Preceptorship Plus and Foundations in Clinical Leadership, alongside a nursing leadership development programme • Implemented e-rostering, e-job planning and activity manager for allied health professionals to ensure the most effective rostering and planning of work There is a comprehensive workforce performance dashboard, which enables detailed monitoring/oversight. A safer staffing report is presented every month to the Quality Committee, with detailed staffing review reported to the Board twice yearly including nurse establishment and patient acuity. In relation to Marshalls Cross Medical Centre action was taken to ensure sufficient numbers of suitably qualified, competent, skilled and experienced people to provide formal clinical leadership, including increased GP lead sessions.

Appendix 1

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

Appendix 1

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

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(20)027
Title of paper: Elimination of Mixed Sex Accommodation - Declaration
Purpose: To provide assurance to the Trust Board that the Trust has complied with the national guidance to eliminate mixed sex accommodation.
Summary: All trusts are required to make an annual declaration confirming compliance with the guidance in relation to elimination of mixed sex accommodation. Failure to comply with the guidance could result in significant financial penalties for breach of contractual standards, unless it would be in the overall best interests of the patient or is their personal choice. The annual declaration must be published on the Trust website. Two breaches were declared in 2019-20, in relation to one incidence within Critical Care. The Trust continues to implement the Provision of Same Sex Accommodation Policy in order to reduce the risk of any further breaches.
Corporate objectives met or risks addressed: Safe and effective care
Financial implications: Financial penalties apply if breaches occur
Stakeholders: All staff and external partners
Recommendation(s): The Board approves the declaration in relation to the elimination of mixed sex accommodation
Presenting officer: Sue Redfern, Director of Nursing, Midwifery & Governance
Date of meeting: 25th March 2020

Eliminating Mixed Sex Accommodation Declaration

1. Background

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

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

1.3 Further guidance, ‘Delivering same-sex accommodation’ was issued by NHS England and NHS Improvement in September 2019 which provided clarification about what constitutes a breach.

1.4 Trust Boards are required to declare compliance annually and if they are not able to do so, they may declare non-compliance however significant financial penalties may apply under such a circumstance.

2. Declaration of Compliance

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

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

2.3 Sleeping accommodation does not include areas where patients have not been admitted, such as cubicles in the Emergency Department or assessment areas.

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

3. Data collection and performance

3.1 2019-20 year to date there have been two mixed sex breaches reported via Unify (the national reporting system). There was one incidence which affected two patients within Critical Care.

3.2 Financial penalties apply to all non-clinical breaches, with £250 per person that the breach applies to.

4. Current Situation

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

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

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

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

4.5 The Trust's Provision of Same Sex Accommodation was updated in 2020 and is available for staff on the Trust's intranet.

5. Patient experience

5.1 Year-to-date there have been seventeen concerns raised regarding privacy and dignity, however, there were no complaints specifically about breaches of single sex accommodation.

6. Recommendation

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

ENDS

St Helens and Knowsley Teaching Hospitals NHS Trust

TRUST BOARD

Paper No: NHST(20)028
Title of paper: Annual Staff Survey Report & Action Plan
Purpose: To provide the Trust Board with an overview of the outcomes of the Staff Survey for 2019 and recommended actions.
Summary: This paper highlights the outcome from the 2019 staff survey which is very positive. Under the revised reporting scheme introduced in 2019, the Trust has recorded the best score nationally for 5 of the 11 themes and second best nationally for a further 5 themes. The five year look back revealed notable results such as: best national score for 'quality of care' since 2015 and for 'staff engagement' since 2016. There are some areas of concern which will form the basis of the 2020-2021 action plan, most notably: The quality of appraisals, health & wellbeing and staff motivation.
Corporate objectives met or risks addressed: Developing Organisational Culture and supporting our workforce, Safety, Communication
Financial implications: No new financial requirements from this paper
Stakeholders: Staff, Staff Side colleagues, Service users, Line Managers, CCG, CQC.
Recommendation(s): Members are asked to approve: The Board is requested to note the outcomes and accept for progression into a detailed milestone plan with interventions to address the areas of concern.
Presenting officer: Anne-Marie Stretch, Director of HR & Deputy CEO
Date of meeting: 25th March 2020

St Helens and Knowsley Teaching Hospitals NHS Trust
2019 NHS Staff Survey Report

1. INTRODUCTION

During October and November, 300 NHS organisations in England took part in the 2019 NHS Staff Survey. Over 1.1 million full-time and part-time staff directly employed by an NHS organisation on 1st September 2019 were invited to participate. Over 569,440 responses were received, a return rate of 48%.

A sample of 1250 St Helens and Knowsley Teaching Hospitals NHS Trust (STHK/ Trust) staff took part in the survey, administered on our behalf by Quality Health. The sample was generated at random, determined by the total number of staff employed on a national sliding scale and included those on maternity leave.

The results were published nationally on 18th February 2020.

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

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

This report provides the conclusions arising from evaluation of the survey data.

Detailed results are available on the Trust Intranet Staff Survey pages, with a breakdown of the responses to each question available from the following site:http://www.nhsstaffsurveyresults.com

2. QUESTIONNAIRE CONTENT

The core questionnaire used for the 2019 survey remains unchanged to that used in 2018. Results are reported both as individual question responses and as Themes. An additional theme, 'Team Working' was introduced for this survey.

The 11 current themes are:

- 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
- Team working

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

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

3. RESPONSE RATE

3.1 Local

570 completed questionnaires were returned from an initial sample of 1250. The response rate to the Staff Survey was therefore **46%** (570 usable responses from a final sample of 1,239).

3.2 National

The average national response rate for Acute Trusts in England was 47%, whilst the highest response rate was 55%.

3.3 Respondent Demographics

The 570 respondents comprised the following groups:

Gender	%
Male	18
Female	79
Prefer to self-describe	2
Prefer not to say	1

Age	%
66+	1
51-65	37
41-50	26
31-40	20
21-30	17

Ethnicity	%
White	93
Asian/Asian British	3
Other Asian	2
Black African	1
Other ethnic groups	1

Sexual orientation	%
Heterosexual	94
Gay man	1
Gay woman	1
Prefer not to say	4

Religion	%
No religion	27
Christian	65
Hindu	1
Muslim	1
Prefer not to say	4

Physical or mental health conditions	%
Yes	19
No	81

Length of Service	%
More than 15 years	35
11-15 years	12
6-10 years	15
3-5 years	17
1-2 years	12
Less than 1 year	8

Occupational Group	%
AHP, Scientist, Technical	20
Medical & Dental	6
Nurses & Midwives	24
Healthcare Assistants	11
Wider Healthcare Team	35
General Management	1
Public Health	1
Other occupational group	1

4.0 RESULTS

To support benchmarking of performance, the results for all organisations are presented within one of 7 national benchmarking groups as detailed below. Each group comprises the data for like organisations, weighted to account for variations in individual organisational structure:

- Acute
- Combined Acute & Community
- Acute Specialist
- Mental Health/Learning Disability
- Combined mental Health/Learning Disability & Community
- Community
- Ambulance

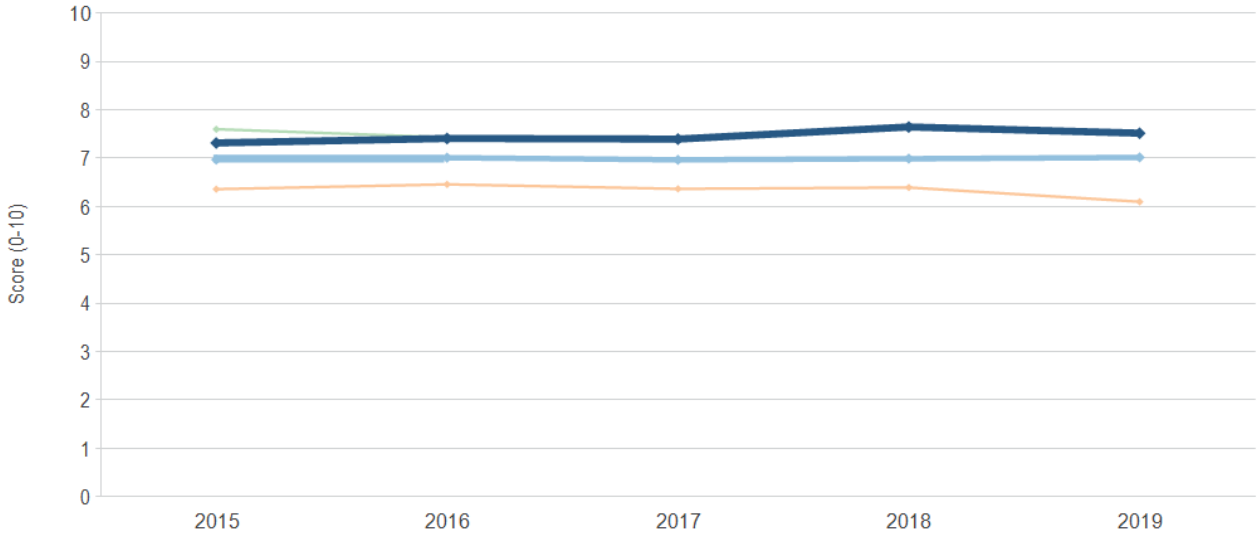
As in previous years, the Trust sits in the 'Acute' organisations benchmarking group.

4.1 Overall Staff Engagement

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

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

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

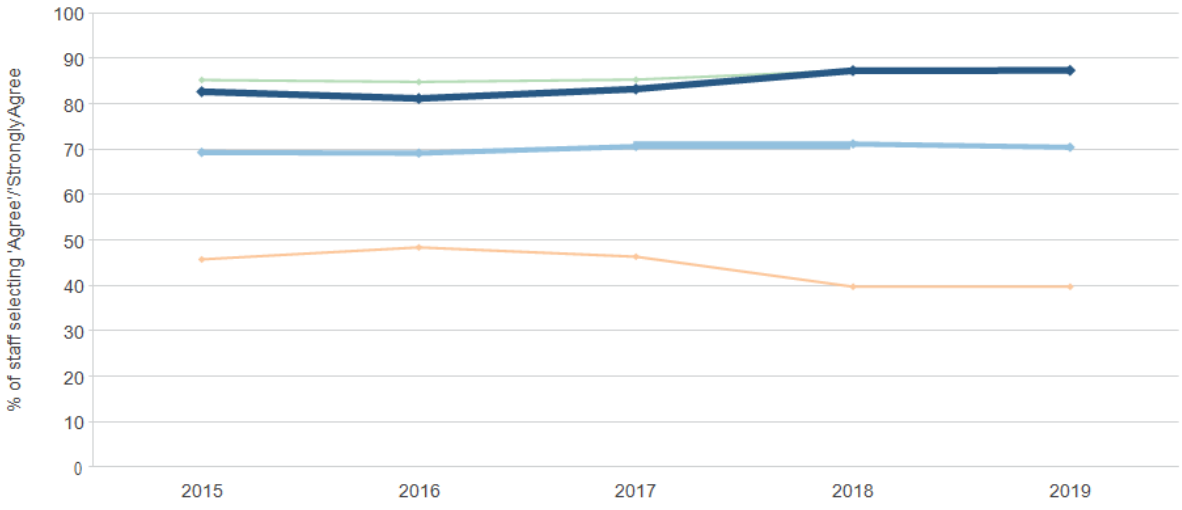


	2015	2016	2017	2018	2019
Best	7.6	7.4	7.4	7.6	7.5
STHK	7.3	7.4	7.4	7.6	7.5
Average	7.0	7.0	7.0	7.0	7.0
Worst	6.4	6.5	6.4	6.4	6.1

Fig.1

The above graphics indicate that our trust has the **best score nationally** for the **fourth consecutive** year.

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 receive care treatment (87.4%), for which the Trust returned the **best scores nationally** since 2018, a 4.7% score increase since 2015, as reflected in the below five year look back (Fig.2).



	2015	2016	2017	2018	2019
Best	85.3%	84.8%	85.3%	87.3%	87.4%
STHK	82.7%	81.2%	83.3%	87.3%	87.4%
Average	69.3%	69.1%	70.6%	71.2%	70.5%
Worst	45.8%	48.4%	46.4%	39.7%	39.7%

Fig. 2

4.3 Themes

4.3.1 Results

Out of the 11 themes, the Trust holds the **best score nationally** for 5 and second best nationally for another 5.

Fig.3 also indicates a positive trend since 2015 on 4 themes (Immediate Managers; Safe Environment – Violence; Safety Culture and Staff engagement). In addition, the Trust has retained the best national score from 2018 for 5 themes: Morale, Quality of Care, Bullying & Harassment, Safety Culture and Staff Engagement.

Morale
In the 2018 survey, a measurement for staff morale was introduced. The Trust has obtained the **best score nationally,** which is 6.7, for both 2018 and 2019.

Theme	Score (where measured)					Current national position
	2015	2016	2017	2018	2019	
Morale	-	-	-	6.7	6.7	Best nationally
Quality of Care	8.1	8.2	7.9	8.1	8.1	Best nationally
Safe Environment – Bullying & Harassment	8.4	8.5	8.3	8.5	8.5	Best nationally
Safety Culture	7.0	7.0	7.0	7.2	7.2	Best nationally
Staff Engagement	7.3	7.4	7.4	7.6	7.5	Best nationally
Equality, Diversity & Inclusion	9.4	9.4	9.4	9.6	9.3	Second best nationally
Health & Wellbeing	6.6	6.8	6.6	6.5	6.5	Second best nationally
Immediate Managers	7.0	7.1	7.0	7.2	7.2	Second best nationally
Safe Environment – Violence	9.3	9.3	9.3	9.4	9.5	Second best nationally
Team Working	6.7	7.0	6.9	7.0	7.1	Second best nationally
Quality of Appraisals	5.5	5.8	5.6	5.7	5.4	-

Fig.3

4.3.2 Notable data contributing to the themes

The most notable scores from the questions used to create the 11 themes are detailed below:

Q.14 Does the organisation act fairly with regards to career progression?: the Trust has retained the **best national score** for the 3rd consecutive year, the 2019 score being 91.9%.

	2015	2016	2017	2018	2019
Best	93.3%	91.7%	93.6%	94.3%	91.9%
STHK	92.4%	91.6%	93.6%	94.3%	91.9%
Average	86.9%	86.5%	84.8%	84.0%	84.4%
Worst	69.6%	67.1%	68.7%	69.3%	70.7%

Q.11b In the last 12 months have you experienced musculoskeletal problems as a result of work activities?: Measures put in place following last year's results have resulted in the Trust obtaining **best score nationally** in 2019.

Best	21.5%
StHK	21.5%
Average	29.7%
Worst	36.2%

The following 3 questions were introduced in 2018 and the Trust has recorded the **best score nationally** in both 2018 and 2019:

Q.4j I receive the respect I deserve from my colleagues at work

	2018	2019
Best	79.0%	81.9%
STHK	79.0%	81.9%
Average	70.8%	71.4%
Worst	62.6%	62.4%

Q.6a I have unrealistic time pressures

	2018	2019
Best	28.3%	31.2%
STHK	28.3%	31.2%
Average	20.9%	21.9%
Worst	14.6%	17.6%

Q.6c Relationships at work are strained

	2018	2019
Best	55.4%	57.4%
STHK	55.4%	57.4%
Average	42.8%	44.1%
Worst	32.2%	36.8%

Q.7a I am satisfied with the quality of care I give to patients/service users: although slightly lower than in 2018, the Trust's 2019 score is the **best nationally** for 2nd year running.

	2015	2016	2017	2018	2019
Best	90.7%	88.6%	88.1%	89.5%	87.3%
STHK	89.0%	88.6%	85.4%	89.5%	87.3%
Average	82.3%	83.0%	80.6%	79.9%	80.7%
Worst	72.9%	74.0%	72.9%	72.2%	68.0%

Q.7c I am able to deliver the care I aspire to: the fiver year lookback shows that STHK has retained the **best score nationally** for the 5th consecutive year.

	2015	2016	2017	2018	2019
Best	79.6%	80.5%	76.8%	81.0%	80.3%
STHK	79.6%	80.5%	76.8%	81.0%	80.3%
Average	67.6%	69.6%	66.7%	66.8%	68.3%
Worst	54.3%	56.1%	57.9%	58.0%	55.5%

Q.13c Staff experiencing harassment, bullying or abuse at work from other colleagues: the Trust's score has improved by 3% since 2015, being the **best nationally** in 2019.

Best	12.9%
StHK	12.9%
Average	20.3%
Worst	26.5%

Q.4i The team I work in often meets to discuss the team's effectiveness: the Trust's score of 68.6% is the highest since 2015 and also the **best nationally** in 2019.

Best	68.6%
StHK	68.6%
Average	60.3%
Worst	47.6%

4.5 Whilst the majority of responses are very positive, there are 4 areas for which the results are not as we would wish. Areas of note are:

4.5.1. Quality of appraisals.

Although 89.7% of staff reported having an appraisal in the last 12 months, (above the national average and just 5.7% below the best national score), the theme score for quality of appraisals (5.4) is lower than the national average by 0.2.

This theme comprises responses to the following questions:

Question	Positive responses ('yes' definitely' and 'yes, to some extent')	'Yes, definitely' response only
Q19b: Did the appraisal help you to improve how you do your job?	71%	22%
Q19c: Did the appraisal help you agree clear objectives for your work?	84%	32%
Q19d: Did the appraisal leave you feeling that your work is valued by your organisation?	78%	32%
Q19e: Were the values of your organisation discussed as part of the appraisal process?	85%	42%

For each of the above questions, staff could respond 'yes, definitely', 'yes, to some extent' or 'no', with only the 'yes, definitely' answers taken into account. Including all positive responses, the Trust performance is above the national average, as only the 'yes, definitely' answers are used, the performance is less positive.

There is notable variance in responses by staff group, with positive scores from Community Services and St Helens Hospital, especially within the nursing and midwifery workforce, and less favourable responses from Medicines Management, Medirest, Clinical Support Services at Whiston Hospital and staff based at Alex Park.

Action to improve this theme will focus on understanding the positive deviance of those staff that responded 'yes, definitely' and those that responded 'yes, to some extent' or 'no', in order to identify relevant actions required. Please see Appendix 3 – Action Plan.

4.5.2 Managers

The results for the following 3 questions don't contribute to the 'Immediate Managers' theme for which the Trust has the second best national score, questions regarding managers have been identified as not being where we would wish and, after carrying out a deep dive, areas for improvement have been established within Medicines Management and Medirest:

Question	STHK (%)		Medicines Management (%)		Medirest (%)	
	Strongly agree	Agree	Strongly agree	Agree	Strongly agree	Agree
q8b: My immediate manager can be counted on to help me with a difficult task at work	36	40	24	29	24	33
q9c: Senior manager here try to involve staff in important decisions	9	26	12	18	5	29
q9d: Senior manager act on staff feedback	13	27	12	12	5	14

4.5.3. Health, well-being and safety at work

The Trust's score of 78.4% for the organisation taking action on reported errors, near misses or incidents (q17c) is only 2.3 below the best national one, however, data analysis has identified 2 areas where the score is significantly lower than the Trust's score, with actions presented in the action plan. These areas are: Corporate Services based at Alex Park (69%) and Medicines Management (71%).

The question is mainly directed at patient-facing staff, therefore one of the actions will be to determine how staff at Alex Park, who are non-clinical and with no access to clinical areas, have understood the question.

4.5.4. The organisation

The Trust score for 'Staff receiving regular updates on patient/service user experience' (Q22b) has decreased by 3.1% since 2018 and is now 3.4% lower than the best national score. The areas returning the lowest score (50% for each) are Medicines Management and Medirest and have been included in the action plan. It is unclear if respondents from these areas selected a negative response due to their interpretation that @patient/service user' relates to clinical activity which they are unlikely to receive regular updates on as they are non-clinical. The following answer options are available: strongly disagree/disagree/neither agree nor disagree/agree/strongly agree/don't know. There is no 'not applicable' option.

The score for 'Staff often thinking about leaving the organisation' (Q23a) is only 1.2% higher than the best national score at 20.8%, however this has increased since 2018 when the Trust had the best national score (19.1%). Retention of staff is a priority for the organisation and so actions exist in the plan (Appendix 3) to understand the reasons behind the scores and take restorative action.

5.0 CONCLUSIONS AND RECOMMENDATIONS

The Trust has worked hard over the last 12 months in the delivery of the 2019-20 staff survey action plan and to engage with, support and develop its workforce and would like to recognise the progress made in what continues to be an extremely challenging operational environment.

Following the successful implementation of the 2018-2019 survey action plan, the Trust now has best national score recorded for the question 'staff experiencing musculoskeletal problems (MSK) as a result of work activities', with the Trust's score being 3.3% improvement on 2018.

It is disappointing that despite featuring as part of the 2019-20 action plan, the quality of appraisals has seen deterioration and this now forms the main focus of our actions and recovery plan for 2020-2021.

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

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

5.1 Publicising the results

Results will be presented to staff and managers by Quality Health on 9th April 2020, it is important that staff see the benefits of participating in this survey and are aware both of the outcomes from the Staff Survey and the resultant actions. In support of this, with the support of the Media and Communications team, the results of the staff survey will be publicised through all available channels including:

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

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

6.0 Action required by the Board

The Trust Board are asked to note the content of this report and to approve and support the recommendations. Actions to address the limited areas of concern will be incorporated into the Staff Survey Action Plan for 2020-2021, monitored by the Workforce Council and Quality Committee as part of the Board Governance Assurance Framework.

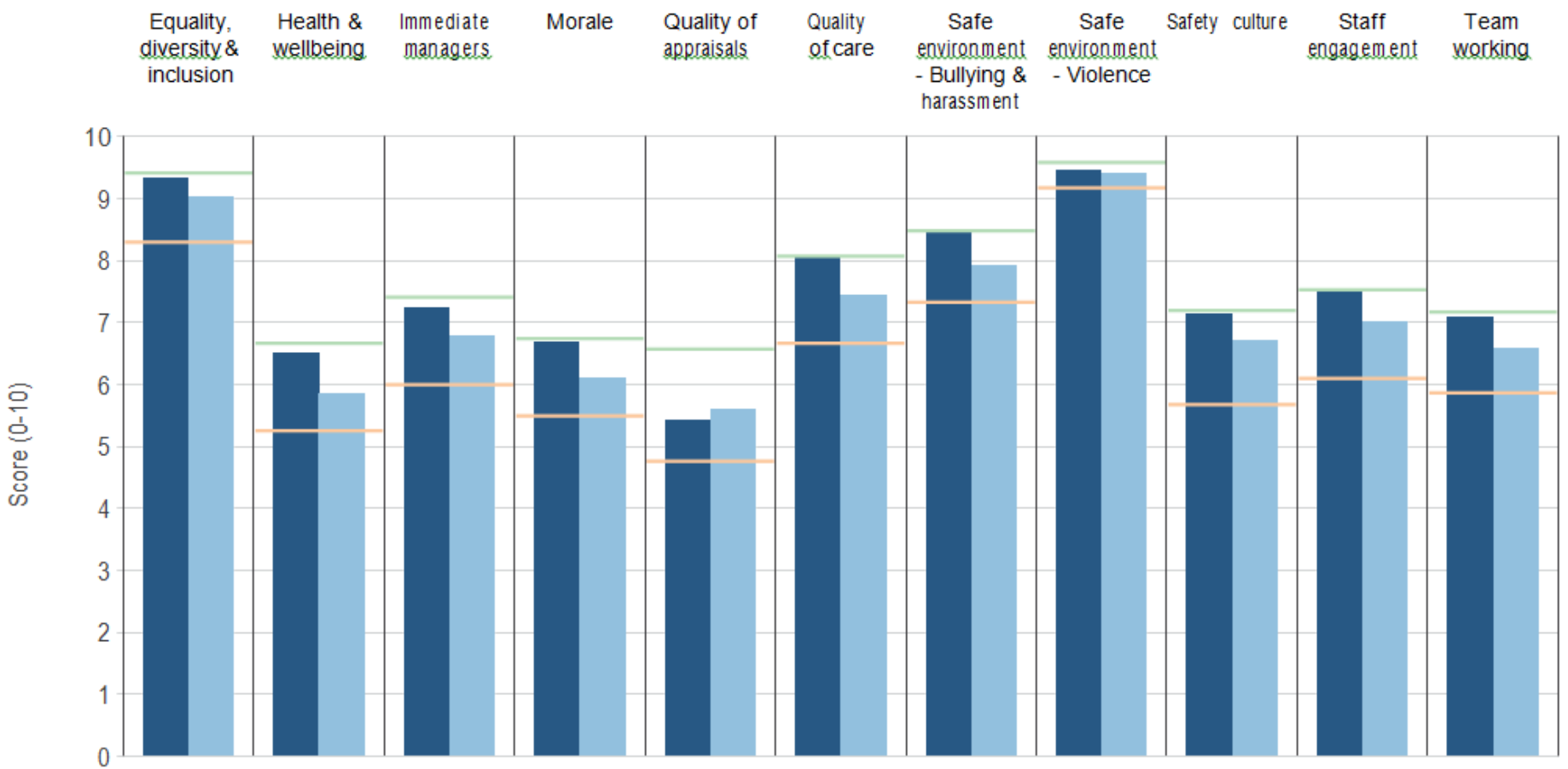
APPENDIX 1 – Questions feeding into the 10 themes

Theme	Questions	%		
		StHK	Best	Av.
1. Equality, diversity & inclusion	“Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?”	91.9	91.9	84.4
	“In the last 12 months have you personally experienced discrimination at work from any of the following? Patients / service users, their relatives or other members of the public”	4.5*	3.3	6.8
	“In the last 12 months have you personally experienced discrimination at work from any of the following? Manager / team leader or other colleagues”	4.5*	4.5	7.5
	“Has your employer made adequate adjustment(s) to enable you to carry out your work?"	79.8	85.8	73.4
2. Health & wellbeing	"How satisfied are you with the opportunities for flexible working patterns?"	53.1	62.0	52.6
	“Does your organisation take positive action on health and well-being?”	41.6**	45.4	28.2
	“In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?”	21.5*	21.5	29.7
	“During the last 12 months have you felt unwell as a result of work related stress?”	31.5*	31.3	39.8
	“In the last three months have you ever come to work despite not feeling well enough to perform your duties?”	50.7*	48.0	56.8
3. Immediate managers	“How satisfied are you with each of the following aspects of your job? The support I get from my immediate manager.”	76.7	79.5	69.4
	“My immediate manager gives me clear feedback on my work.”	67.4	69.9	61.4
	“My immediate manager asks for my opinion before making decisions that affect my work."	60.9	62.4	55.4
	“My immediate manager takes a positive interest in my health and well-being.”	75.4	77.8	68.1
	“My immediate manager values my work.”	78.6	80.2	72.3
	“My manager supported me to receive this training, learning or development.”	55	63.3	55.0
4. Morale	“I am involved in deciding on changes introduced that affect my work area / team / department.”	54.4	62.1	52.2
	“I receive the respect I deserve from my colleagues at work.”	81.9	81.9	71.4
	“I have unrealistic time pressures.”	31.2	31.2	21.9
	“I have a choice in deciding how to do my work.”	58.1	60.9	53.9
	“Relationships at work are strained.”	57.4	57.4	44.1
	“My immediate manager encourages me at work.”	75.1	79.4	69.9
	“I often think about leaving this organisation.”	20.8*	19.6	28.3
	“I will probably look for a job at a new organisation in the next 12 months.”	15.5*	14.5	19.9
	“As soon as I can find another job, I will leave this organisation.”	9.8*	8.7	14.3
5. Quality of appraisals	“It helped me to improve how I do my job.”	21.9**	35.1	23.3
	“It helped me agree clear objectives for my work.”	30.7**	46.6	35.9
	"It left me feeling that my work is valued by my organisation."	30.6**	43.3	33.6
	“The values of my organisation were discussed as part of the appraisal process."	39.5**	53.3	37.8
6. Quality of care	“I am satisfied with the quality of care I give to patients / service users.”	87.3	87.3	80.7
	“I feel that my role makes a difference to patients / service users”	92.6	93.4	89.7
	“I am able to deliver the care I aspire to”	80.3	80.3	68.3
7. Safe environment -	“In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public”	25.4*	23.4	28.7

Theme	Questions	%		
		StHK	Best	Av.
Bullying & harassment	"In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Managers"	6.7*	6.4	13.1
	"In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Other colleagues"	12.9*	12.9	20.3
8. Safe environment - Violence	"In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives or other members of the public"	15.1*	11.3	15.1
	"In the last 12 months how many times have you personally experienced physical violence at work from...? Managers	0.2*	0.1	0.6
	"In the last 12 months how many times have you personally experienced physical violence at work from...? Other colleagues"	0.6*	0.6	1.6
9. Safety culture	"My organisation treats staff who are involved in an error, near miss or incident fairly."	63.7	71.1	59.6
	"When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again."	78.4	80.7	70.2
	"We are given feedback about changes made in response to reported errors, near misses and incidents."	68.7	72.2	60.1
	"I would feel secure raising concerns about unsafe clinical practice."	75.2	77.0	70.4
	"I am confident that my organisation would address my concern."	68.8	69.6	57.7
	"My organisation acts on concerns raised by patients / service users."	83.7	84.5	72.9
10. Staff engagement	"I look forward to going to work."	61.5	68.8	60.2
	"I am enthusiastic about my job."	78.3	81.7	75.3
	"Time passes quickly when I am working."	75.7	81.9	76.9
	"There are frequent opportunities for me to show initiative in my role."	78.1	79.4	72.8
	"I am able to make suggestions to improve the work of my team / department."	77.6	81.9	73.6
	"I am able to make improvements happen in my area of work."	58.4	67.6	56.0
	"Care of patients / service users is my organisation's top priority."	87.2	88.0	77.4
	"I would recommend my organisation as a place to work."	78.0	78.9	62.5
	"If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation."	87.4	87.4	70.5
11. Team working	"The team I work in has a set of shared objectives."	78.9	83.4	72.0
	"The team I work in often meet to discuss the team's effectiveness."	68.6	68.6	60.3

* the lower the score the better
** 'yes, definitely' answers only

APPENDIX 2 – National benchmarking of theme results



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
STHK	9.3	6.5	7.2	6.7	5.4	8.1	8.5	9.5	7.2	7.5	7.1
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	567	564	564	559	487	482	562	561	565	564	560

APPENDIX 3 – Staff Survey recommended actions 2020-2021

Quality of appraisals			
Recommendation	**Intervention**	**Lead**	**Anticipated deadline**
Q19b: Did the appraisal help you to improve how you do your job? Q19c: Did the appraisal help you agree clear objectives for your work? Q19d: Did the appraisal leave you feeling that your work is valued by your organisation? Q19e: Were the values of your organisation discussed as part of the appraisal process?	Focus sessions with areas of both the lowest and highest scores for each questions 19b to 19e in order to understand the reasons for their relative responses.	Adam Rudduck, Assistant Director of Organisational Development	30th April 2020
	Review outcomes of the focus sessions to establish specific actions/interventions to improve the quality of appraisals.		15th May 2020
	Review appraisal content to ensure it delivers relevant actions identified from the focus sessions and enables the opportunity for staff to participate in an appraisal which delivers questions 19b to 19e.		15th May 2020
	Review appraisal system to ensure it: • enables in the simplest way a quality appraisal; • provides robust data on completion and quality of appraisals.		31st May 2020
	Review the training in quality appraisals		31st May 2020
	Implement quality appraisal system		30th June 2020
	Implement updated training		30th June 2020
	Assess by survey staff experience in using the updated system		31st August 2020

Managers			
Recommendation	**Intervention**	**Lead**	**Anticipated deadline**
Q8b: Managers being counted on to help staff with difficult tasks at work Q9c: Senior managers involving staff in important decisions Q9d: Senior managers acting on staff feedback	Focus sessions with areas with the lowest scores for questions 8b, 9c and 9d in order to understand how are staff interpreting the question and what their understanding of 'difficult tasks', 'senior managers' and 'important decisions' is.	Adam Rudduck, Assistant Director of Organisational Development	30th April 2020
	Review outcomes of the focus sessions to establish specific actions/interventions and allocation for action to specific teams.		15th May 2020
	Devise a glossary of terms in order to reduce ambiguity of certain questions and ensuring that all staff have clarity of what they are being asked to give feedback on.		31st July 2020
	Promote outcomes of staff engagement events (Team Talks, cultural surveys) through Team Brief, News N Views (where applicable) and other communication channels as deemed appropriate by Media & Comms department.		31st August 2020

Health, well-being and safety at work			
Recommendation	**Intervention**	**Lead**	**Anticipated deadline**
Q17c. The organisation taking action on reported errors, near-misses and incidents	The Assistant Director of Patient Safety to work with managers in areas with a low score for this indicator, in order to understand the causative factors and agree and implement methods of reducing the instances when no action is being taken to prevent the re-occurrence of the incidents.	Rajesh Karimbath, Assistant Director of Patient Safety	

The organisation			
Recommendation	**Intervention**	**Lead**	**Anticipated deadline**
Q22b. Staff receiving regular updates on patient/service user experience feedback	Establish through focus groups whether staff in the highlighted areas have chosen to give a negative response due to the fact that a 'not applicable' answer option was not available.	Adam Rudduck, Assistant Director of Organisational Development	30th April 2020
	Review outcomes of the focus sessions to establish specific actions/interventions and allocation for action to specific teams.		15th May 2020
	Devise a glossary of terms in order to reduce ambiguity of certain questions and ensuring that all staff have clarity of what they are being asked to give feedback on.		31st July 2020
Q23a. Staff often thinking about leaving the organisation	Analyse data from exit interviews submitted by staff from the highlighted areas to understand reasons for leaving the organisation and also carry out stay interviews in order to identify and address potential reasons leading to a high turnover rate.	Laura Codling, Head of Strategic Resourcing	